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Cornwall Council Active Travel Social Prescribing Pilot - Process evaluation report

Authors
Helen Frankland
Mark Wilson

UNIVERSITY OF BATH

Centre for Climate Change and Social Transformations

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/

This report was authored by:

Helen Frankland - Public Health Practitioner (Intermediate), Cornwall Council
Mark Wilson - University of Bath, Centre for Climate Change and Social Transformations

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

[1] See: Local Transport Plan - Cornwall Council

Summary

Cornwall Council is working 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 are to promote increased levels of physical activity through walking, wheeling and cycling, support modal shift to active travel, address any barriers to using active modes, and demonstrate links between infrastructure provision and social prescribing schemes. The pilot is being conducted in Bodmin, Penzance, and St Austell and the China Clay Area.

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

This report is the first of two which will present the findings of an evaluation study to measure the outcomes for the participants (n=97). Data sources used to evidence these outcomes include pilot monitoring data, case studies, and a survey which explores the participants' current travel behaviours and their perceptions of active travel.

Survey data reveals most participants have a positive attitude towards using active travel, but lack the confidence and capabilities to use active modes, particularly cycling. Three quarters of the participants have a long-term health condition and require more health care than the control group. Our findings indicate several positive outcomes from the pilot so far: a shift to active modes, reduced inequalities in access and mobility, reduced psychological barriers, and improved wellbeing. In terms of the number of people supported by the programme, the pilot is on track to meet all of its targets by the end of the delivery period (June 2025).

Key learnings from the pilot implementation include: 1) engaging with the Health Improvement Practitioners increases the participants' motivation, capabilities and opportunities to use active travel; 2) collaboration and knowledge sharing between the service providers ensures a focus on the participants' needs and can support them along a progressional pathway; and 3) expanding the referral routes to include wider community health programmes increases the potential for reaching more people who would benefit from targeted support.

Recommendations for supporting participants include highlighting the social and wellbeing benefits of active travel, providing appropriate clothing and footwear, and using the Active Travel Workbook to set personal goals and self-monitor progress.

Contents

1 Overview of the Cornwall ATSP Pilot

The Cornwall Active Travel Social Prescribing Pilot is one of eleven pilots taking place across England. The pilots are funded by Active Travel England[2] and they explore how walking, wheeling[3] and cycling activities can be socially prescribed[4]. Individual pilots investigate the outcomes of active travel social prescribing (ATSP) in their specific region and context, and collectively they form part of a national evaluation of ATSP being 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 pilot (2022-2025). The pilot is managed by Cornwall Council's Public Health team and delivered by Healthy Cornwall[5]. The pilot delivery team includes the ATSP Pilot Manager (Natalie Russell), a Public Health Practitioner (Intermediate) who is responsible for leading the evaluation of the pilot (Helen Frankland), and three Health Improvement Practitioners (HIPs; Louise Argent, Carol Gill and Kate Jilbert). The pilot is 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 are 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 the social prescribing schemes. An evaluation study will measure the outcomes for the pilot participants, including uptake of active travel, changes in their attitudes towards using active modes, and health and wellbeing benefits. The study will also consider potential societal impacts of the intervention, such as decreased demand on the health care system or reduced CO_2 emissions. This report is the first of two which will present the findings of the evaluation study.

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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

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 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]. The disparity in these figures highlights 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 (Table 1). These three locations therefore provide a range of cases to compare how effective the social prescribing model is at encouraging uptake of active travel in different contexts, and whether the intended health and wellbeing outcomes of ATSP differ in those contexts.

Table 1, ATSP pilot locations – levels of existing active travel infrastructure and social prescribing provision

	High social prescribing provision	Medium social prescribing provision	Low social prescribing provision
High active travel infrastructure			Bodmin
Medium active travel infrastructure		Penzance	
Low active travel infrastructure	St Austell and the China Clays Area		

1.2 Description of the ATSP intervention

There are two components of the Cornwall ATSP intervention:

1. A range of active travel activities provided by community-based service providers. These activities vary in terms of their target social group and intended outcomes.
2. One-to-one support by Council Health Improvement Practitioners (HIPs), who provide tailored sessions with pilot participants (referred to as 'clients' in this report) to increase their knowledge of, and motivation for, active travel.

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

Community-based active travel provision

The Cornwall pilot uses a co-production approach, collaborating with organisations that provide activities which meet local needs and engage 'hardly reached' members of their communities. There are 17 service providers taking part in the pilot. Nine providers deliver walking/wheeling-related 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 deliver cycling-related activities, including one-to-one and group coaching sessions to build confidence, bike maintenance workshops, and bike/e-bike loans. The remaining three are: an organisation that supports a homeless community to engage in active travel; an organisation that supports a learning disabilities community to use active modes; and a project to create an active travel map of the local area. A list of the providers and the activities they offer can be found in Appendix 7.2.

In April 2024, grants were awarded to the service 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 service providers.

Health Improvement Practitioner support

Clients receive one-to-one support from a HIP to enable them to embed active travel in their everyday lives. In their sessions with clients, the HIPs highlight the benefits of active travel and draw upon behavioural science techniques, such as intention formation and self-monitoring of behaviour. The HIPs identify the specific needs of each client and link them to the most appropriate active travel service providers in their locality. The HIPs can also issue incentives which enable active or sustainable travel, such as Beryl Bike[8] minutes or bus passes.

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

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

1.3 ATSP pilot eligibility criteria and referral process

The pilot is targeted at individuals who may benefit from tailored support to use active modes of travel. Patients registered with GPs in Bodmin, Penzance, and St Austell and the China Clay Area can be referred by their GP or a social prescriber. Eligible participants must be one or more of the following:

- Adults with poor mental health and wellbeing
- Adults with poor physical health (including long-term health conditions)
- Disabled people (adults)
- Unemployed adults
- Adults 50+

Monitoring data indicates that, in most cases, clients are eligible for the pilot on more than one criterion.

Changes to the referral process

Referrals to the pilot from GPs or social prescribers have been low. To address this, the ATSP 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. Active travel service providers can also recruit clients and refer them to the local HIP for one-to-one support. This is called 'reverse social prescribing'.

These changes to the referral process are a key learning from the Cornwall pilot; this is discussed further in section 5.2.

Number of referrals to the Health Improvement Practitioners

The HIP intervention is being trialled by Cornwall Council and so there is no stipulated target from Active Travel England for the number of referrals[9]. The total number of clients referred to the HIPs is 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 and five clients have dropped out since starting the programme. Further information on the different referral routes can be found in Appendix 7.4.

[9] The number of referrals to the HIPs differs from the number of people supported by the service providers to engage in active travel activities. Service providers can directly recruit people within their local communities and so the overall number of people supported to engage in active travel is larger than the number of HIP referrals. This is discussed further in section 4.2.

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. Participation in the pilot evaluation study is not a requirement for receiving HIP support. Of the 97 clients that are working with a HIP, 67 agreed to take part in the evaluation study.

1.4 Literature review – active travel and theoretical frameworks

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[10]. Further research identified the important role of motivation and social support for cycling[11], which in some cases can moderate the impact of barriers such as inclement weather or a lack of infrastructure[12].

Two well-established behaviour change frameworks are the COM-B model[13] and the Theoretical Domains Framework[14]. 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

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[10] 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

[11] 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

[12] 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

[13] 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

[14] 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.

integration of the schemes, controversy) as well as the enablers (new routes, perceived health or sustainability benefits)[15]. Another study examined the propensity of UK school children and their parents to cycle and similarly found *motivation* and *opportunity* to be key determinants of behaviour[16].

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. A categorisation of the pilot activity functions, according to the COM-B model and the Theoretical Domains Framework, can be found in Appendix 7.3.

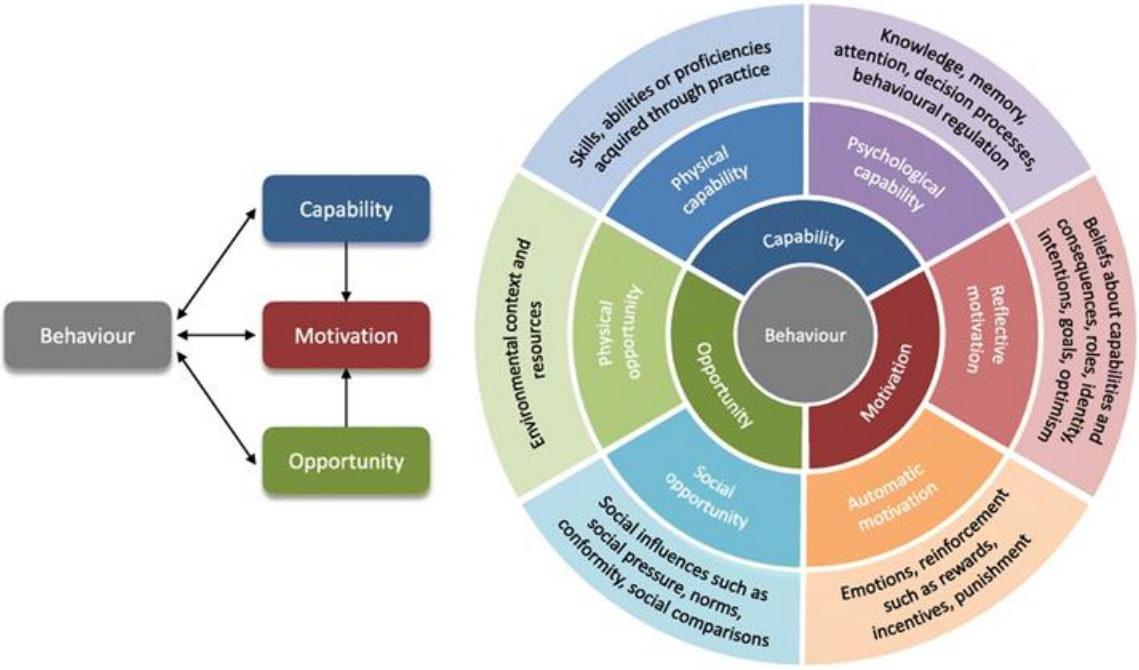


Figure 1, The COM-B model (Michie et al., 2011)

[15] 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

[16] 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

2 Evaluation study methodology

This section describes the data collection activities used to measure and evaluate the pilot outcomes. For this process evaluation, data was collated from multiple sources, analysed, and then used to evidence the progress of the pilot against the 'Cornwall ATSP pilot logic framework' (Appendix 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?

At the process evaluation stage (this report), there is insufficient data to comprehensively answer these research questions, although preliminary findings do indicate some positive outcomes (see sections 4 & 5). These research questions will be revisited in final evaluation report (due June 2025).

2.2 Research ethics 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 remains valid until 31st July 2025. The REC reference number is 0996-968. Monitoring data and case study data, collected by the Council's ATSP 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

Clients referred to the HIPs were invited to take part in the evaluation study. The clients who agreed (n=67) were asked to complete a questionnaire survey before and after they are prescribed the ATSP activities to measure any changes in their travel behaviours, their attitudes towards active travel, or their health and wellbeing. The clients complete these surveys in conversations with their HIP. A control group of Cornwall residents (n=300), who do not receive the active travel intervention, also completed this 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 will be collected over the next six months. The survey structure is presented in Table 2 (see page 13) and the survey

protocols can be found in Appendices 7.5 and 7.6. Most of the survey questions are duplicated from the template provided by Active Travel England[17]. 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.

Section 3 of this report presents descriptive statistics of the clients' and control group's responses to the pre-intervention survey questions, as well as the results of between-group analysis which explored differences in the two groups' travel behaviors, attitudes, health, and wellbeing. The statistical tests used for this analysis were Independent-samples t-test, Welch t-test, Mann-Whitney U test, and Fisher's exact test.

2.4 Semi-structured interviews

The survey findings will be supported by semi-structured interviews (n=20) with clients to provide in-depth qualitative data on their experiences of taking part in the pilot and whether it has influenced their attitudes and behaviours towards active travel. The client interview protocol can be found in Appendix 7.7. Interviews will also be conducted with some of the service providers (n=6) and members of the Council's ATSP delivery team (n=4), to explore their experiences of supporting clients and providing active travel activities. These interviews will take place towards the end of the pilot and so are not presented in this report.

2.5 Monitoring data, case studies, learning logs and monitoring forms

There are four additional sources of data which have been used to evidence the outcomes and key learnings from the pilot so far (see sections 4 & 5). The first is monitoring data of client referrals and the provision of active travel activities, compiled by the ATSP Project Manager. The second is anonymised case studies developed by the ATSP Project Manager and some of the service providers. The third is learning logs from members of the ATSP delivery team, which they used to record their reflections on the pilot design and implementation. The fourth is interim monitoring forms that were submitted by the service providers; these forms detail their activities, as well as their feedback on what is working well or otherwise in their respective projects.

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

Table 2, 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-

3 Pre-intervention survey findings

This section presents results from the pre-intervention survey. Between-group analysis was used to compare the clients that chose to take part in the evaluation study (n=67) with the control group (n=300) in terms of their current travel behaviours, their attitudes towards active travel, their health and wellbeing, and their sociodemographic characteristics.

3.1 Sociodemographic characteristics

Table 3 shows the postcode area where the clients live. Participation in the evaluation study is 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[18]. 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[19]. 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 3, Postcode area

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

Table 4 is a summary of the participants' sociodemographic characteristics. Relative to the control group, a higher proportion of clients are female, have a long-term health condition,

[18] 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.

[19] 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

Table 4, Summary of survey participants' sociodemographic characteristics

	ATSP clients (n=67)		Control group (n=300)	
Sociodemographic characteristic	Frequency	%	Frequency	%
Gender:				
Female	44	65.7	139	46.3
Male	22	32.8	159	53.0
Non-binary	1	1.5	1	0.3
Ethnicity:				
White (English/Welsh/Scottish/Northern Irish/Cornish/British; Irish; Gypsy or Irish traveller)	64	95.5	264	88.0
Any other White background	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
Have an undergraduate or postgraduate degree	9	13.5	150	50.0
Employed (full- or part-time, including self-employed)	18	26.9	236	78.7
Combined household income:				
Less than £26,000	32	48.5	63	21.0
£26,000 - £63,999	9	13.6	166	55.3
£64,000 - More than £96,000	1	1.5	65	21.7
Prefer not to say	24	36.4	6	2.0
Have a longstanding health condition	50	74.6	87	29.0
Have children living at home	23	34.3	113	37.7
Live in a rural area (countryside, village or small town)	60	89.5	218	72.7
Bike owner (a conventional bike or e-bike, in good working order)	20	29.9	145	48.3
Car owner (in household)	50	74.6	285	95.0

are less likely to be in employment and have a lower household income. In terms of their potential travel options, clients are less likely to own a bicycle or a car. A more complete profile of the survey participants' sociodemographic characteristics can be found in Appendix 7.8.

Figure 2 shows a high proportion of clients are in the older age categories, likely reflecting the eligibility criteria of the pilot. However, the pilot is reaching people from younger age groups because one in three (31.3%) clients is aged 44 or younger. The clients are statistically significantly older than the control group[20].

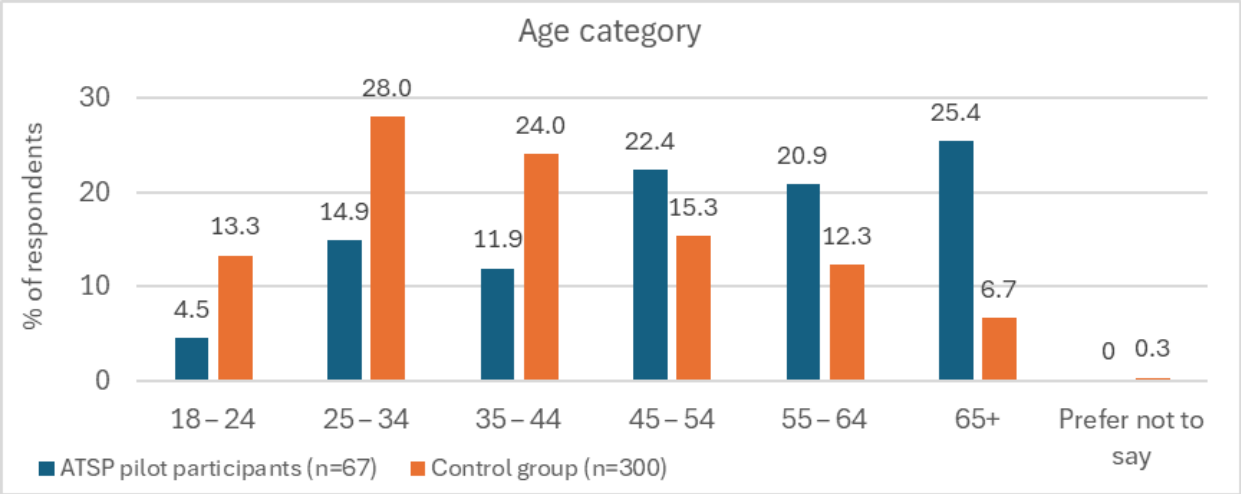


Figure 2, Participants' age category

3.2 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[21]. Those who had walked or wheeled in the past four weeks were asked how often they

[20] A Mann-Whitney U test revealed the ATSP clients are statistically significantly older (mean rank = 243.03) than the control group participants (mean rank = 170.16), U = 6028.0, z = -5.194, p = .001. The median for ATSP clients = 45 – 54, whereas the median for the control group = 35 – 44.

[21] 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).

walk/wheel (Figure 3). Over half (54.2%) of clients walk/wheel five or more days per week, which is more frequently than the control group[22].

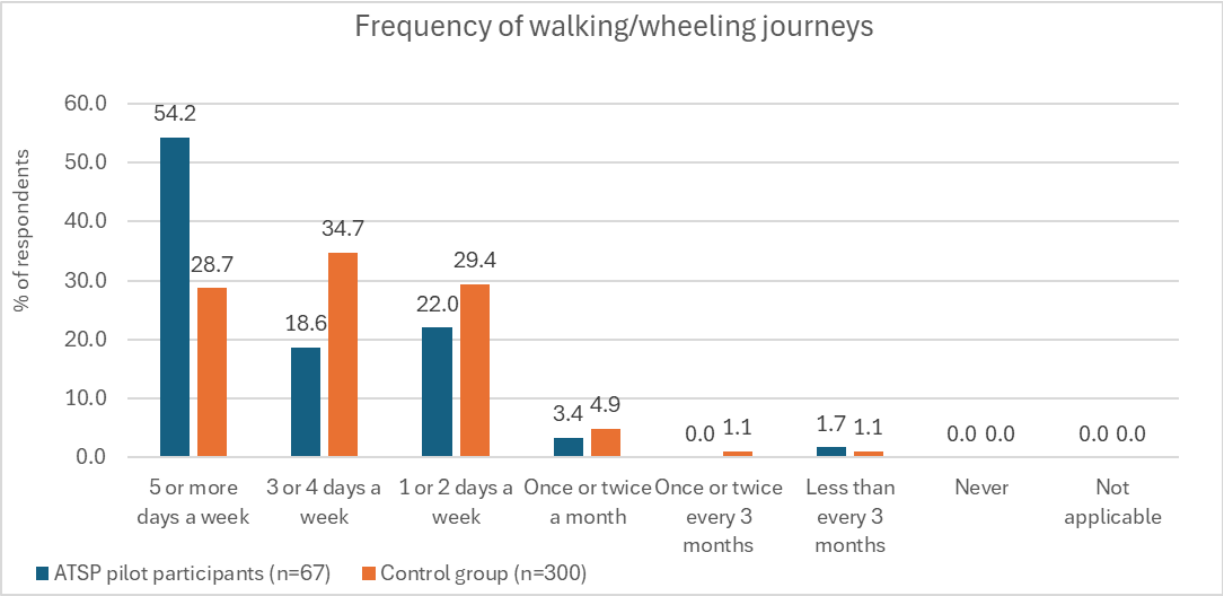


Figure 3, Frequency of walking/wheeling journeys

Cycling

Participants were asked how often they use a bicycle; Figure 4 shows 13.5% of clients cycle on a weekly basis. However, over three quarters (77.6%) of clients never use a bicycle, which corresponds with the high proportion (56.7%) that do not own a bike (Table 5). The clients travel less frequently by bicycle, compared to the control group[23].

[22] 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.

[23] 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.

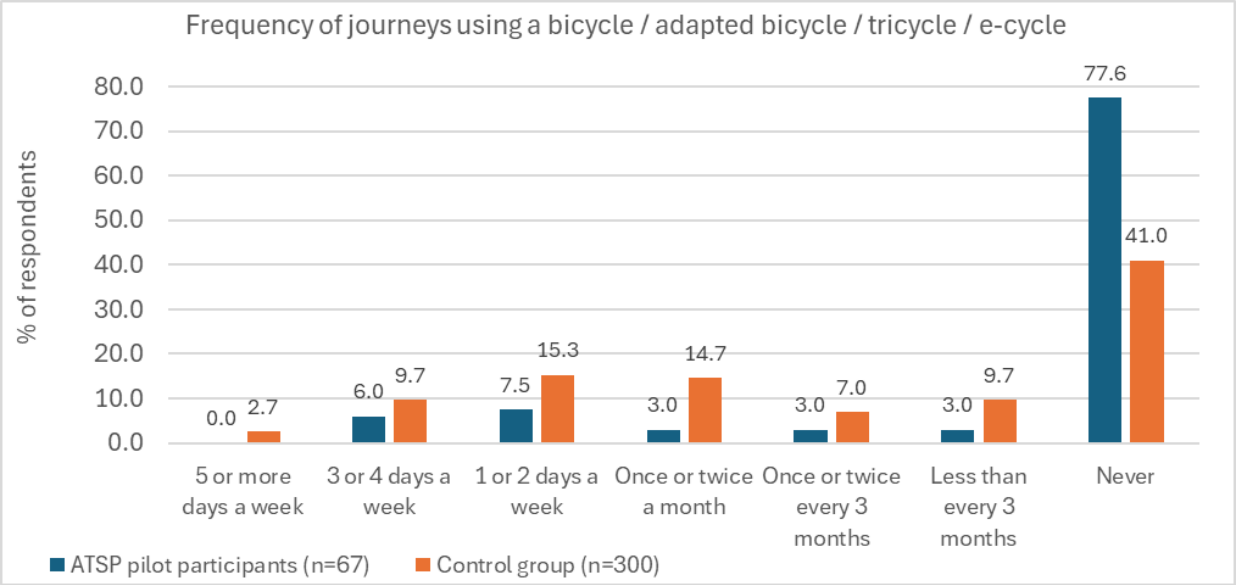


Figure 4, Frequency of journeys using a bicycle / adapted bicycle / tricycle / e-cycle

Table 5 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.%)[24]. Bike ownership among the control group is comparable with a previous study of Cornwall residents[25].

Table 5, Bicycle ownership

	ATSP clients (n=67)		Control group (n=300)	
Bike ownership category*	Frequency	%	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

[24] 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, $p = .001$

[25] 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

* 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%)[26]. Figure 5 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).

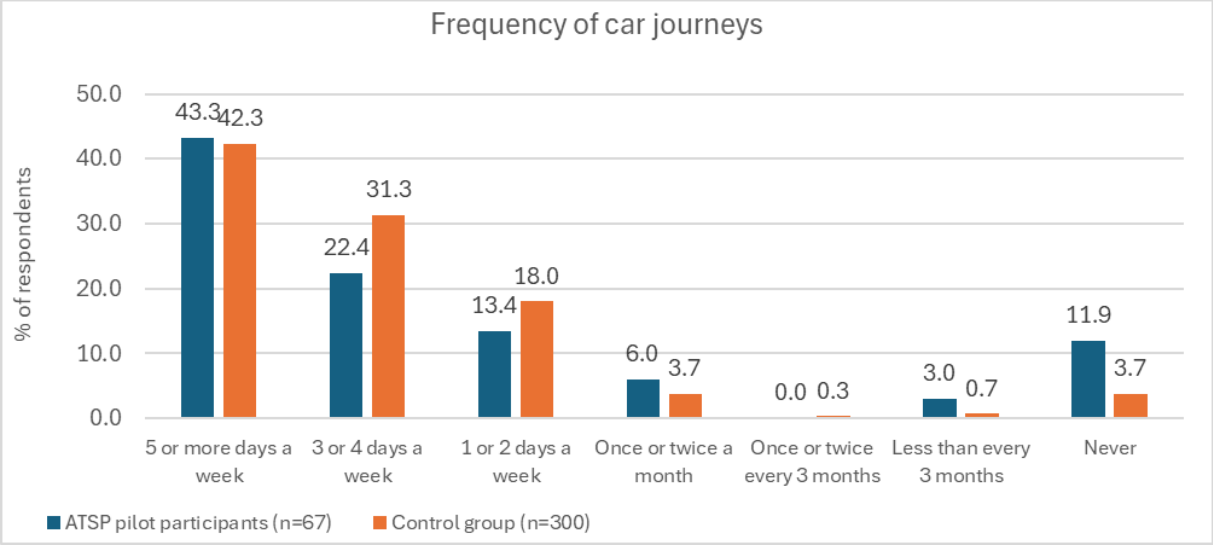


Figure 5, Frequency of car journeys

Private car is the dominant mode of transport in Cornwall[27] 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 3, 4 and 5; 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 6 shows the clients made fewer trips by car and active modes, compared to the control group[28]. Thus, the clients and the control group

[26] 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, $p = .001$

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

[28] 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), $t(291) = 9.092$, $p = .001$

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.

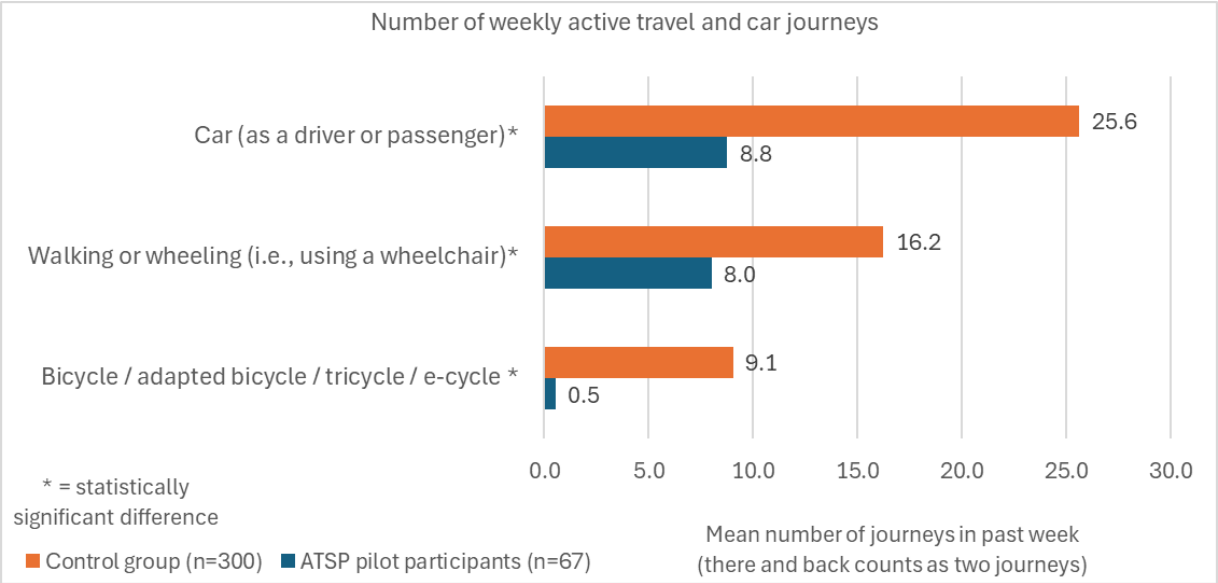


Figure 6, Number of weekly active travel and car journeys

The distances travelled by active modes and car were also explored. Figure 7 shows the clients travel shorter distances by bike than the control group[29], 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).

— 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), $t(323) = 8.954$, $p = .001$

[29] 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), $t(207) = 7.513$, $p = .001$

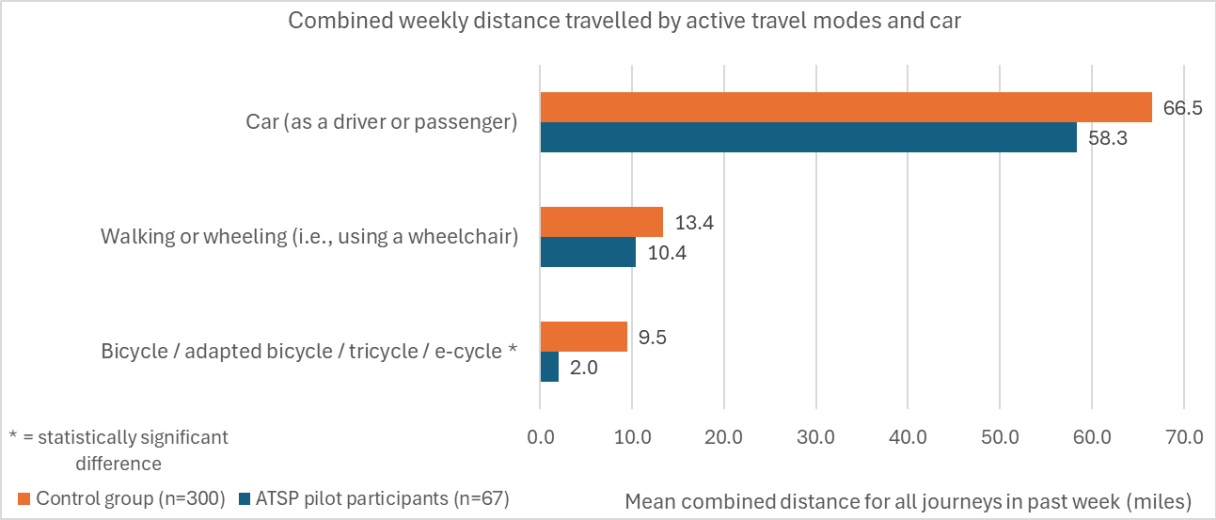


Figure 7, Combined distance travelled by active modes and car, per week

Travel by public transport

Table 6 shows clients travel less frequently by bus or coach, compared to the control group[30]. One in six (16.5%) clients use a bus on weekly basis, compared to one in three (36.1%) control group participants.

Table 6, Frequency of bus or coach journeys

	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

[30] 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 7 shows the clients travel less frequently by train or tram, compared to the control group[31]. Only 3.0% of clients use trains on a weekly basis.

Table 7, Frequency of train or tram journeys

	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 8 shows the clients travel less frequently by taxi, compared to the control group[32]. Two thirds (67.2%) of clients never use a taxi.

Table 8, Frequency of taxi or private hire rental journeys

	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

[31] 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.
[32] 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.

3.3 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 9 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 9, Participants' awareness of walking/wheeling routes in their local area

	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 10 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 10, Participants' confidence when walking/wheeling

	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[33]. Figure 8 shows 22.4% of clients feel 'very safe' when walking or wheeling, compared to 32.7% of the control group.

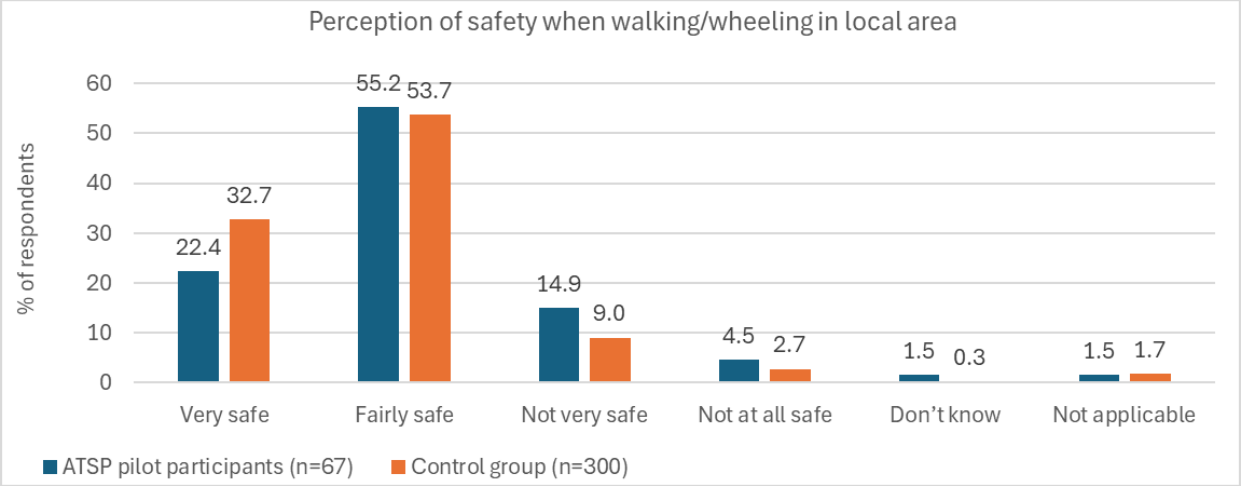


Figure 8, Participants' perception of safety when walking/wheeling in their local area

Table 11 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).

[33] 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 11, Participants' attitude towards walking/wheeling as a form of transport

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 9 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[34].

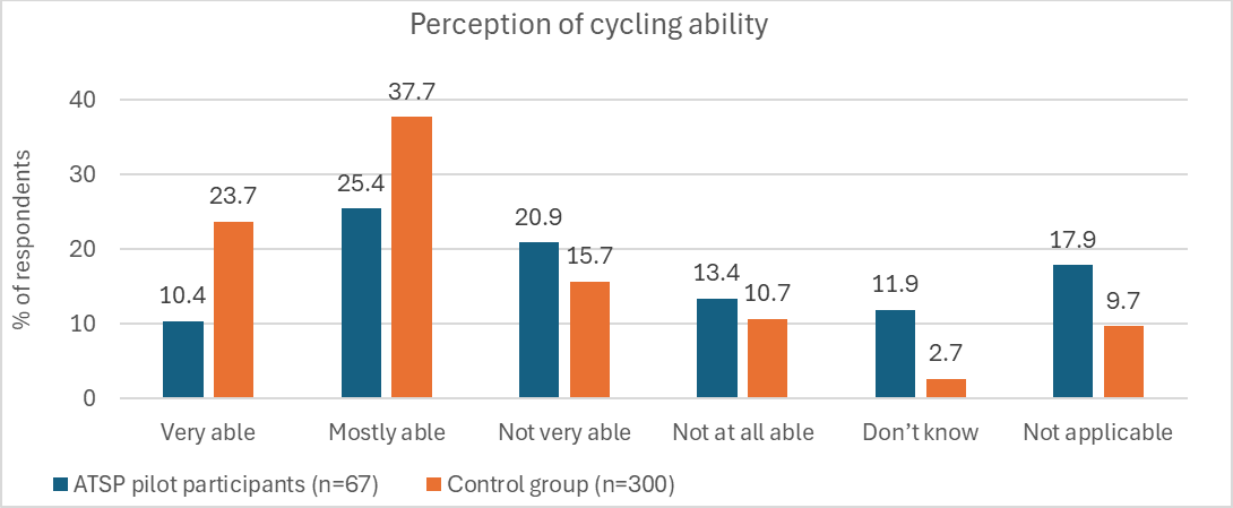


Figure 9, Participants' perceptions of their cycling ability

[34] 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 12 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 9). There was no statistically significant difference between clients and the control group for awareness of cycling infrastructure (Mann-Whitney U test).

Table 12, Awareness of cycling infrastructure in their local area

	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 10 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[35].

[35] 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)

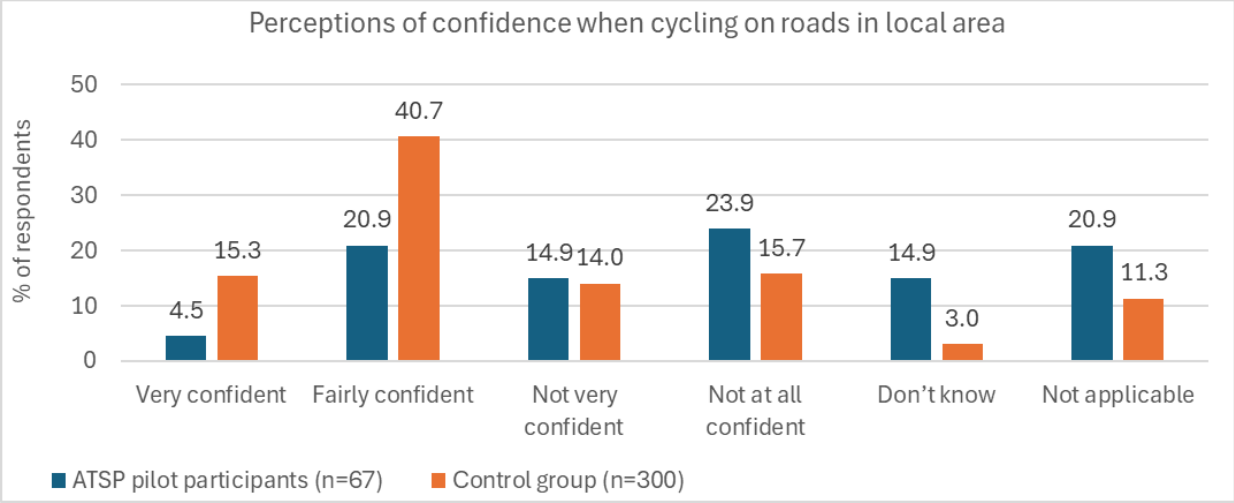


Figure 10, Participants' perceptions of confidence when cycling on roads in local area

Figure 11 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[36].

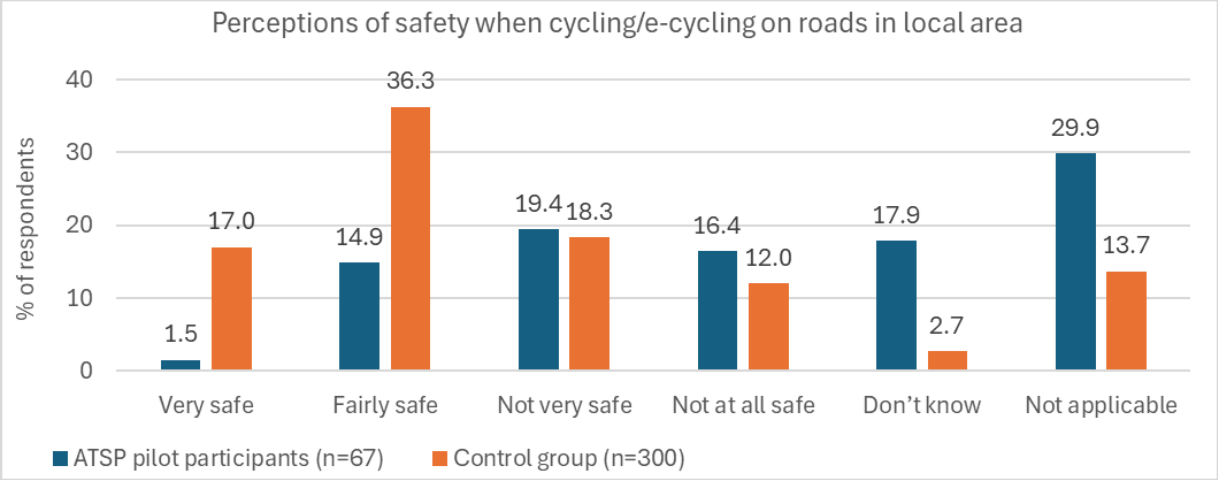


Figure 11, Participants' perceptions of safety when cycling/e-cycling on roads in their local area

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 13). There was no statistically significant difference between the clients and the control group (Mann-Whitney U test).

[36] 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).

Table 13, Participants' attitude towards cycling as a form of transport

	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

3.4 Physical activity

Participants were asked which physical activities or sports they have done in the last four weeks. Table 14 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 14, Physical activities or sports the participants have done in the last four weeks

	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 15 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 15, Median frequency of physical activities or sports the participants have done in the last four weeks

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

3.5 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 16 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%)[37].

[37] 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 16, Proportion of participants with a long-term health condition

	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 17). 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 17, Impact of long-term health condition on participants' ability to carry out day-to-day activities

	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 12 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[38].

[38] 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.

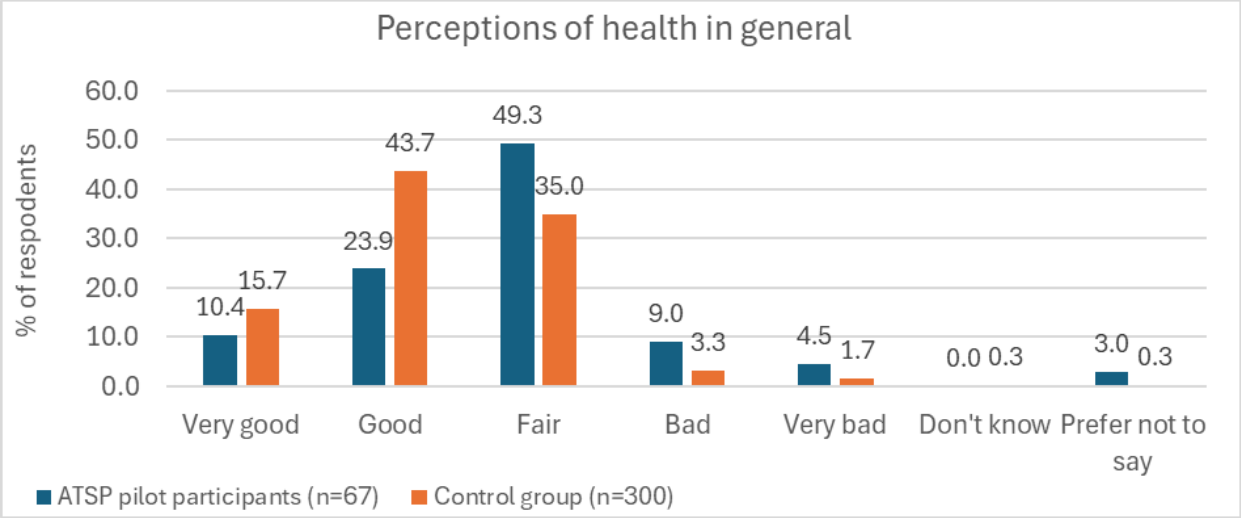


Figure 12, Participants' perceptions of their health in general

Figure 13 shows the clients reported higher current levels of pain, compared to the control group participants[39]. Approximately one third (31.3%) of clients do not currently feel any pain at all, compared to 45.3% of the control group.

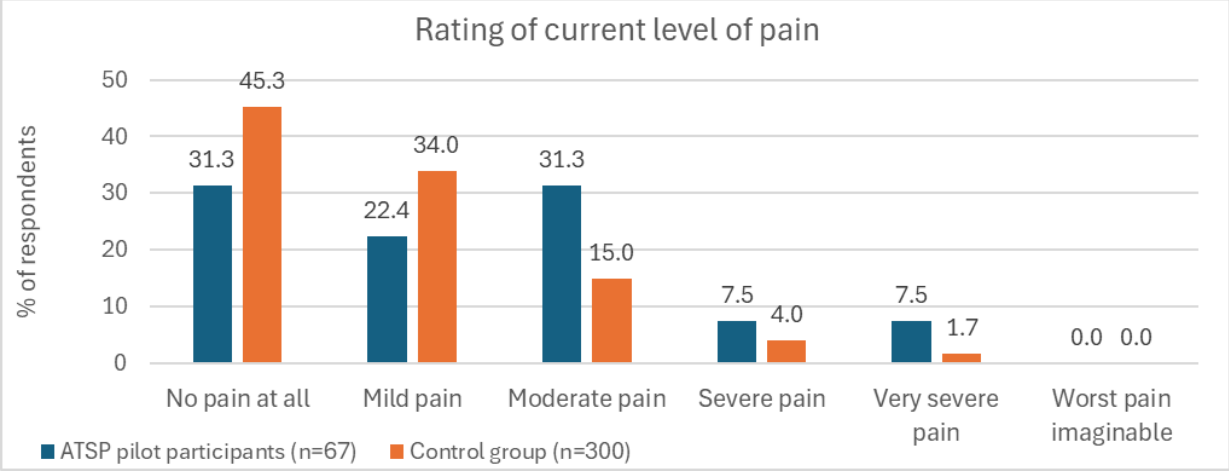


Figure 13, Participants' rating of their current level of pain

Participants who reported experiencing pain were asked about the cause(s). Table 18 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

[39] 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[40]. 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 18, Cause(s) of pain that the participants are currently experiencing

	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 14 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[41].

[40] 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, $p = .008$

[41] 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.

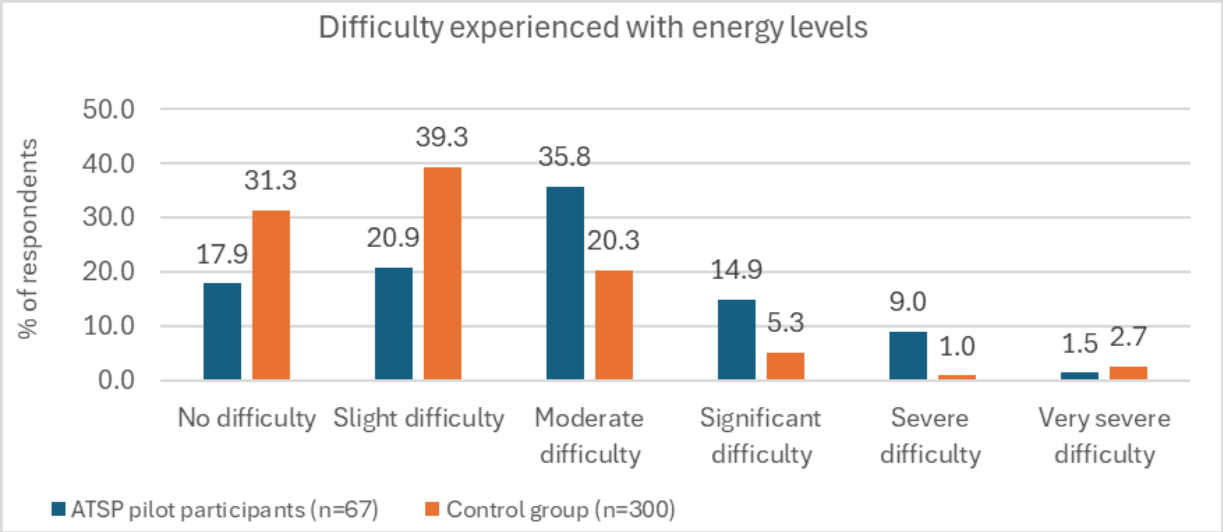


Figure 14, Participants' level of difficulty they experience with their energy levels

Figure 15 shows clients visit their GP more frequently than control group participants[42]. One in four (26.9%) clients visited their GP more than ten times in the past 12 months.

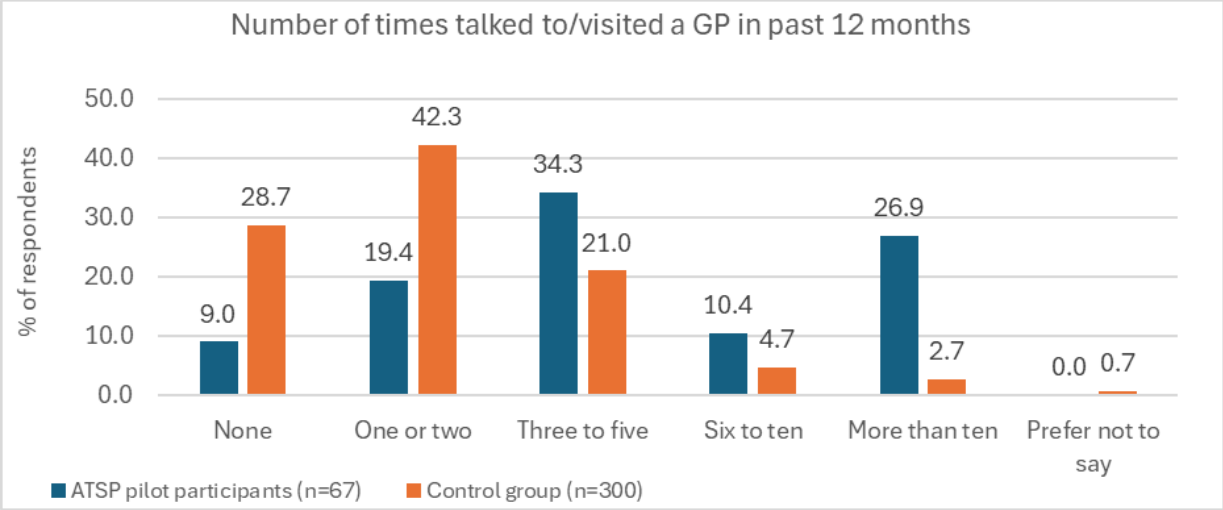


Figure 15, Number of times participants have talked to or visited their GP/family doctor in the past 12 months, about their own health

[42] 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 16 shows clients visit hospital for their own health more frequently than control group participants[43]. One in ten (10.5%) clients visited hospital six times or more in the past 12 months.

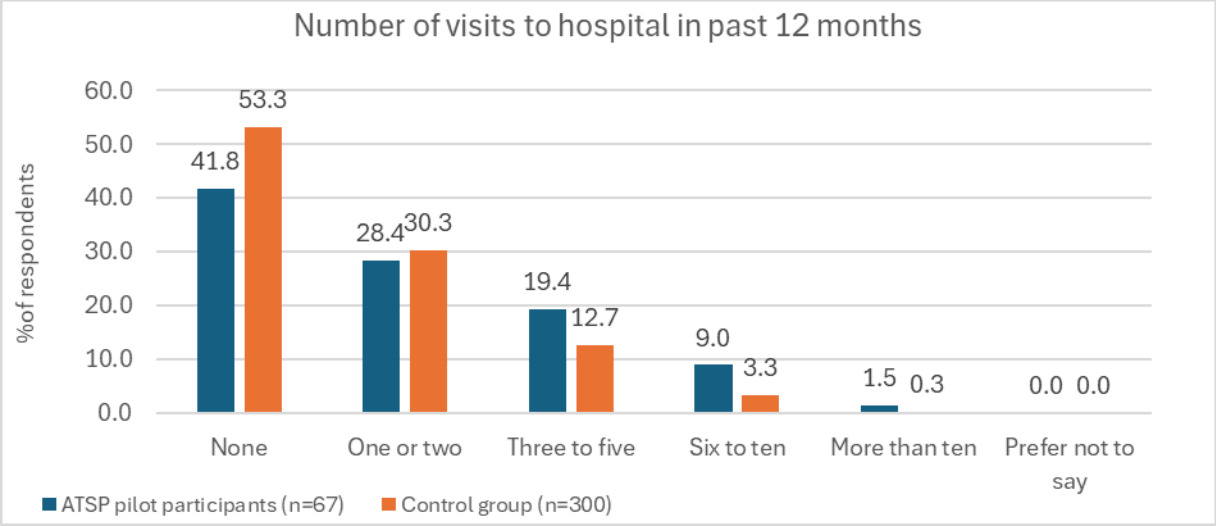


Figure 16, Number of visits to hospital in the past 12 months, about their own health

3.6 Wellbeing

The survey included six metrics which relate to mental wellbeing, 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 17), 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)[44]. There were no statistically significant differences in the

[43] 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.

[44] 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

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

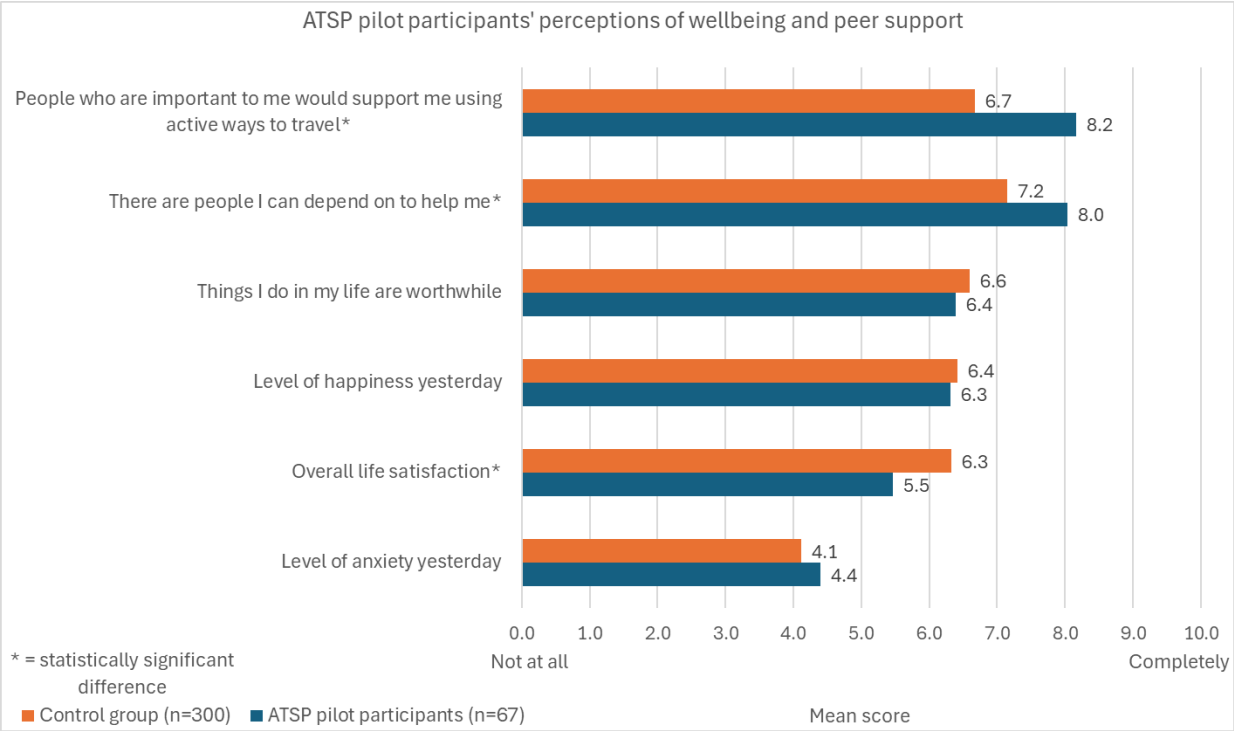


Figure 17, Perceptions of wellbeing and peer support

4 Review of progress using the ATSP pilot logic framework

This section reviews the progress of the pilot in meeting its objectives, as detailed in the Cornwall ATSP pilot logic framework (Appendix 7.1). The pilot's activities, outputs and outcomes are evaluated, using all of the evidence that is available at the interim stage.

4.1 Activities

The first component of the ATSP intervention is community-based provision of walking/wheeling and cycling activities. As of September 2024, the majority of the service providers' projects are up and running. A complete list of the 17 providers and the activities they offer can be found in Appendix 7.2, and the primary mechanisms of these activities for influencing behaviour change can be found in Appendix 7.3 (i.e., the COM-B model). To provide a few examples, *Ride On Ebikes* operate in all three pilot areas and have 12 e-bikes that can be loaned to clients for up to three months at a time. This activity influences behaviour by providing the opportunity to use an e-bike for an extended period, which enables clients to see whether they enjoy riding an e-bike and how active travel could be incorporated into their daily lives. *Bosvena Health* operate in Bodmin and deliver guided walks from a local GP practice. This activity influences behaviour at the capability level, as the clients can experience walking in a safe and supportive environment, and observe the walk leaders 'modelling' active travel behaviour. *Cornwall Life Recycle* operate in all three areas and deliver training to ride and maintain a bike. They provide cycling/adaptive cycling confidence sessions and help people plan routes. Their training influences behaviour at the capability and motivation levels.

The second component of the ATSP intervention is the HIP one-to-one support. The HIPs have worked with 97 clients since the pilot started. The number of sessions with each client has varied, depending on the individual's needs and goals, but ranges from one to four sessions. The HIPs work with clients to understand their personal situation, identify any barriers, set active travel goals (motivation) and connect them with local service providers (opportunity, capability). Viewed through the COM-B lens, the HIP intervention targets all dimensions to maximise the potential for behaviour change. Moreover, they respond to the client's specific needs and ensure the active travel provision is relevant to the individual, recognising that a 'one-size-fits-all' approach will likely be less effective.

4.2 Outputs

Monitoring data indicates that all of the output targets will be met by the end of the pilot (Table 19). Two of the targets, 124 x walking/wheeling activities and 24 x co-design events, have already been achieved. The ATSP delivery team are confident that the project is on track to meet, and exceed, all of the remaining output targets by the end of the pilot.

Looking ahead, the number of walking/wheeling activities delivered during the pilot is anticipated to be almost four-fold the original target. Forecasted numbers for the cycling activities (i.e., cycling activities, cycle loan provision, e-bike loan provision) also look very strong, suggesting these targets will be met by a significant margin. Sixteen case studies have been completed and a further fifteen are expected by the end of the pilot (see Appendix 7.10).

The number of direct participants in social prescribing activities is currently less than half of the pilot output target (the top row of Table 19). This is primarily due to the service providers' readiness to deliver their projects; some were ready to begin their activities immediately when they received ATSP funding in April 2024, whereas others required time to recruit and train staff before they could launch. Moreover, some providers have taken a phased approach, focusing initially on preparation activities to ensure they were ready to engage with clients. For instance, *Sustainable PNZ* created the 'Greenways Map' which involved testing routes to ensure the directions are accurate, the paths are clear, and to identify any accessibility issues. *Sustainable PNZ* are now ready to run provider-led walks in the Penzance area. Some service providers that launched slightly later are expected to reach large cohorts of clients, and so the ATSP delivery team do not envisage any difficulty in reaching this output target in the remaining 10 months of the pilot.

Table 19, Cornwall ATSP output targets and the current numbers of participants or activities

Output targets	Target for the pilot (2022-2025)	To date (end of August 2024)
990 direct participants in social prescribing activities (number of people)	990	439[45]
108 cycling activities (number of people)	108	93
130 cycle loan provision (number of loans)	130	113
140 e-bike loan provision (number of loans)	140	114
124 walking/wheeling activities (number of people)	124	182
24 co-design events (number of events)	24	85
18 case studies (number of case studies)	18	16

Additional outputs

It is important to highlight some further outputs that have benefitted clients, service providers and residents in Cornwall. These outputs have emerged during the pilot and are in addition to those listed in the grant agreement with Active Travel England (Appendix 7.1), and at no extra cost. These activities are presented in Table 20 and include outreach events, training sessions for volunteers who run activities, and new maps showing active travel routes. These additional outputs will likely reinforce the legacy of the pilot by increasing awareness of local active travel services and infrastructure, equipping clients to engage in active travel, and upskilling community-based organisations to support people to use active modes in the future.

[45] This figure is not calculated by totalling the numbers of participants from the walking/wheeling or cycling activities in Table 19. It is calculated by tallying the number of unique individuals supported by the HIPs or one of the 17 active travel service providers. Some clients have taken part in multiple activities, with different service providers. The service providers have not provided lists of participants' names, and so the ATSP delivery team is unable to identify which participants have taken part in multiple activities. Thus, there is a risk of double-counting in this figure.

Table 20, Additional outputs of the Cornwall ATSP pilot

Description of additional output	To date (end of August 2024)
Special promotion (number of people) — Outreach activities to promote engagement in active travel (e.g., *Lanhydrock* are working with the diabetic service in Bodmin; *British Cycling* attended the 'Sports in the Park' event in Bodmin)	161
Volunteers trained (number of people) — Volunteers working with active travel groups and service providers in the three pilot areas	45
Equipment bought for clients (number of people) — e.g., waterproof clothing, high visibility clothing, appropriate footwear	27
Creation of new active travel maps (number of maps): — Sustrans x 3. Sustrans were commissioned to produce three interactive maps, one for each of the three pilot areas. These maps show local routes and enable members of the public to report any barriers to active travel that they encounter — Sustainable PNZ x 2 (one physical map and one digital map) — Eden Project x 1 — Volunteer Cornwall x 1	7
Active Travel Workbook (number of workbooks) — This tool was designed by Carol Gill, one of the HIPs, to support clients to reach their active travel goals (see Appendix 7.11)	1

4.3 Outcomes

There is no post-intervention survey or client interview data available for the Process Evaluation. Thus, the main data sources for evidencing client outcomes are the ATSP delivery team's learning logs, the service providers' interim monitoring forms, and the case studies. Collectively, these sources indicate several positive outcomes from the pilot so far: mode shift, increased physical activity, reduced inequalities in access and mobility, reduced psychological barriers, and improved wellbeing.

Mode shift

A core objective of the pilot is to encourage a shift to active modes of travel, particularly for short journeys. *Into Bodmin* organises guided walks, or 'walking buses', from different neighbourhoods into Bodmin town centre. Following a few initial walks, *Into Bodmin* found *"at least half the group have reported a modal shift in their thinking about local trips and are often making the choice to walk."*[46] A further example was provided by *Whole Again Communities*, which supports people in Penzance to walk instead of driving or taking a taxi:

> "*One recently retired participant wanted to progress using the car at least 50% less and bus and walk for all leisure and shopping trips. He now carries a rucksack everywhere; walks almost every day and said he loves purchasing food shopping on a day-to-day basis.*" [47]

These examples reveal more positive attitudes towards active travel, but also how mode shift may result in the formation of new habits around day-to-day activities, such as food shopping. If clients recognise benefits for their own lives, active travel can become the preferred option for short journeys (motivation).

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[48]. This can constrain access to local services, education and employment opportunities, which risks entrenching inequalities related to poverty. One case study illustrates how HIP one-to-one support enabled a client to use Beryl Bikes for accessing a training course:

> "*I received a referral for an unemployed mum who suffers with anxiety. She doesn't have a car so she had to walk her children to school and would often be late for the course. She was keen to start cycling to reduce the amount of time it takes her to get to the project she's engaged with. We set a goal for her to use the Beryl Bike to and from the project three times a week. She was given an initial 400 free Beryl Bike minutes to assist her to build confidence using Beryl Bikes. She has found that this has*

[46] Into Bodmin – Interim monitoring form
[47] Whole Again Communities - Interim monitoring form
[48] See: Wilson, M., and Whitmarsh, L. (2023). Cornwall Council behaviour change and engagement programme – survey of residents

massively helped as she can now arrive at the course on time and is much less anxious regarding her commute every day."[49]

This combination of goal setting (motivation) and Beryl Bike minutes (opportunity) enabled the client to more easily access education as well as improve her mental wellbeing. Other clients have similarly benefitted from an allocation of minutes to try Beryl Bikes; those allocated a 400 minute bundle averaged 32 trips from May to September 2024 (Appendix 7.9).

There are also examples of the pilot reducing inequalities in mobility. *Cornwall Life Recycle* reported increased levels of physical activity among their clients, including among *"adults that never even thought that they would be able to access cycling due to long term health condition or disability."*[50] A HIP supported one client who had recently undergone heart surgery and was lacking fitness and confidence to walk or cycle for short journeys:

"She was keen and motivated but wanted to take part in group activities to 'do something enjoyable with others' so the HIP gave her information on local walking and cycling areas and connected her to several local projects (two of which are funded through the Cornwall ATSP Fund). She is now taking part in confidence building sessions with Cornwall Life Recycle to use her e-bike and to participate in led rides in her local area. She is accessing the group Wellbeing Walk at the local leisure centre."[51]

Reduced psychological barriers

One of the strengths of the Cornwall ATSP pilot is its capacity to cater for the specific needs of individual clients, both in terms of providing a wide range of active travel activities for varying ability levels (see Appendices 7.2 & 7.3), and also the tailored sessions with the HIPs through which they can support clients along a progressional pathway. For example, one client lacked the confidence to cycle on roads or trails, despite being physically able to ride a bike:

"*She uses car for journeys when shopping or collecting heavy items. She rides an exercise bike at home and owns a road bike but has not ridden the road bike for approximately seven years. The HIP supported the client in progressing from riding her exercise bike to riding a bike on the road. She connected her to Bikeability to get confidence to ride e-bike and gave her a bundle of Beryl Bike minutes.*"[52]

[49] Appendix 7.10 – Case study 1
[50] Cornwall Life Recycling – Interim monitoring form
[51] Appendix 7.10 – Case study 4
[52] Appendix 7.10 – Case study 6

This case study reveals how the HIP worked with the client to overcome psychological barriers, as well as develop her physical capabilities through professional training on how to cycle on roads and ride an e-bike.

Increased social interaction and improved wellbeing

The final outcome relates to more opportunities for social interaction and feeling part of the local community, and the wellbeing benefits for clients this engenders. *British Cycling* supports people to learn to ride a bike or e-bike and recently used the Treyla Community Space in Penzance to run a session with ten unemployed adults. They reported *"increased self-esteem, friendship, and rapport building between themselves [the clients] and the staff members who took part. A rekindled love of cycling and interest in where they could take part again soon."*[53] The HIPs' learning logs record many similar examples of increased motivation associated with social engagement. For some clients, active travel behaviours can take time to become embedded in their everyday routines, yet increased social interaction and improved wellbeing are often more immediate benefits which arise from their participation in the pilot.

4.4 Impacts

It is too early at this stage to determine the broader impacts of the Cornwall ATSP pilot. This will be a focus of the final evaluation report (due in June 2025), when we can evidence potential impacts using pre- and post-intervention survey data, as well as interview data from the clients, the service providers and the ATSP delivery team.

[53] British Cycling – Interim monitoring form

5 Key learnings from the ATSP pilot

This section builds on section 4 by highlighting some key learnings from the implementation of the pilot. These include the benefits of collaboration, adopting a 'test and learn' approach to allow flexibility in the pilot delivery, and identifying the barriers and enablers of active travel.

5.1 Collaboration and 'test and learn'

The HIPs' engagement with community groups and service providers at the start of the pilot provided a strong knowledge base of existing active travel provision, as well as the needs of different target groups. This ensured the grass-roots organisations were supported in their understanding of what the pilot's overarching objectives are. Due to this, the standard of applications to the ATSP Fund was high. Successful applications had a clear understanding of the needs of the clients and this guided their intervention design and their implementation plan. Moreover, this engagement process was essential for building trust and identifying opportunities for collaboration between different partners.

These discussions have continued through regular service provider meetings, held every two months, and this enables the providers to reflect, learn, and work together to deliver activities. For example, the providers involved in the BEAT engagement event (*GLL Leisure*, *Cornwall Life Recycle*) shared the venue costs to reduce their expenditure[54]. *British Cycling* donated high visibility clothing to *Cornwall Life Recycle*[55]. This collaborative approach has supported clients along a progressional pathway; one individual started cycling confidence sessions with *Cornwall Life Recycle*, then received a 3-month hire of an e-bike from *Ride On E-Bikes,* and now participates in led rides with *British Cycling*[56].

The pilot has employed a flexible 'test and learn' approach. Following the launch of their projects, some service providers identified what is working well and what aspects are not working well, and have made changes to increase participant numbers and/or the clients' experience of the activity. For example, after initial low uptake and reflecting on their clients' needs, *IntoBodmin* altered the route of their guided walks to encourage greater participation. Similarly, *Bosvena Health* adjusted the route of their led walks from the local GP surgery, again considering the needs of their clients.

[54] ATSP Project Manager learning log
[55] ATSP Project Manager learning log
[56] HIP learning logs

5.2 Changes to the social prescribing referral model

Another example of 'test and learn' has been the referral model. It became evident early in the pilot that referrals from social prescribers and link workers would not meet the logic framework targets in terms of the number of clients taking part in active travel activities. The ATSP Project Manager, in discussion with the Council's Public Health Team, therefore decided to widen the scope of referral routes to include Allied Health Professionals, Healthy Cornwall, and employment workers. In line with recent guidance from the Social Prescribing Network[57], these partners can be considered part of a wider social prescribing 'ecosystem'. Expanding the number of referral routes increases the potential for reaching more clients and may be particularly important for supporting clients in areas where social prescribing networks are less developed.

A further change enabled 'reverse social prescribing', a term used by the research team at Sheffield Hallam University[58] to describe how the HIPs can receive referrals from active travel service providers, in addition to the HIPs referring clients to the providers. These providers are embedded in their local communities and so can identify individuals who they feel they would benefit from one-to-one support from a HIP. The HIP ultimately decides if the client is eligible for the support programme, but this change increased the reach of the pilot and ensured more clients benefitted from the HIP intervention.

A final observation is that Cornwall has a well-established social prescribing network, but this can change. The Sustrans feasibility study, conducted in 2022, identified St Austell's network as 'mature'. It is likely this is no longer the case due to staff turnover and sickness. Moreover, new social prescribers would benefit from a comprehensive handover process to ensure they are aware of the existing social prescribing activities and opportunities in their area, so they do not have to build their networks from scratch.

5.3 Interaction between social prescribing activities

One important finding from the pilot is that social prescribing activities can interact, thus supporting clients to achieve health and wellbeing outcomes in multiple ways. Some active travel projects that were awarded an ATSP grant connected with existing social prescribing provision. *The Eden Project* is using their grant to support clients who were already attending

[57] 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/

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

their prescribed activities, such as therapeutic horticulture[59]. The grant enables their clients to attend these activities using active travel. Similar links to existing social prescribing provision have been forged by *Cornwall Life Recycle* and *Bosvena Health*. The former is connected to Mental Health Teams and is supporting clients to cycle. For the latter, the grant has been used to back-fill a social prescriber position and offer walks from the local GP surgery. *Bosvena Health* is also working with *Lanhydrock* (National Trust) to deliver a walking and cycling programme for people with diabetes.

5.4 Barriers and enablers of active travel

There are two main mechanisms for identifying the barriers the clients experience, as well as the enablers; these are 1) the one-to-one sessions with the HIPs, and 2) knowledge sharing at the service provider meetings. Without these mechanisms, capturing this information in a timely manner would be challenging and some of these barriers, if unaddressed, can swiftly demotivate clients. Table 21 presents an overview of the barriers and enablers identified so far. The barriers relate to personal circumstances (e.g., caring responsibilities, lack of appropriate footwear), safety concerns, a lack of active travel infrastructure, and overgrown or poorly maintained cycle routes and footpaths. Inadequate public transport services were also mentioned, highlighting that the use of active travel can interact with other modes of transport. The enablers are opportunities for social connection, the expertise and enthusiasm of the activity facilitators, the provision of clothing or footwear, and installing rest stops along active travel routes.

Table 21, Barriers and enablers of active travel for ATSP clients

Barriers
Poor health of spouse/partner
Lack of adequate clothing or footwear
Safety concerns (i.e., walking alone)
Safety concerns related to a lack of infrastructure (e.g., a lack of footpaths/cycle lanes on busy roads near St Mewan School, St Austell)
Lack of active travel infrastructure or public transport services: — A lack of cycle storage in/near flats — No bus stop outside Bridge Road Flats, St Austell — Discontinued bus routes through Trethurgy, near St Austell — Infrequency of bus services
Beryl Bike bays not in a suitable location (e.g., Cywoone Hill, Penzance)

[59] See: Nature Connections – activities for better health and wellbeing | Eden Project

Overgrown vegetation on walking/wheeling paths or cycle routes
Lack of maps detailing safe cycle paths

Enablers
Social interaction and a sense of community
Provision of equipment or clothing (e.g., step counters, walking shoes or trainers)
Trained and knowledgeable walk leaders
Rest stops/benches along footpaths and cycle routes
Footpaths that are separated from traffic
Existing active travel infrastructure

The pilot is already addressing some of these barriers, for example providing active travel maps and appropriate clothing. Overcoming infrastructure deficits is more challenging and would require investment as well as involvement from other teams within the Council.

The need for pre-intervention support

A specific need has been identified by the HIPs; some individuals require pre-intervention support to engage in active travel[60]. For example, some clients wish to try leisure-based walking/wheeling or cycling activities initially to gain confidence, prior to moving onto active travel-based goals. A further example is that clients who require a medical alert card need this to be in place first, in order for them to feel safe when walking/wheeling or cycling on their own, or using public transport. This finding suggests our target groups' needs may require more attention to ensure they are physically and psychologically ready to engage in active travel (i.e., the capability level). A client's specific needs can be identified and discussed during initial sessions with a HIP or social prescriber.

5.5 Active travel infrastructure

As described above, a lack of infrastructure can constrain the use of active travel. The provision of infrastructure, as with social prescribing networks, can change. One salient example is Beryl Bikes, which have now been withdrawn from St Austell due to low levels of usage. Beryl Bikes are currently not available in Bodmin, which leaves Penzance as the only case site where Beryl Bikes can be hired. The original Sustrans feasibility study indicated that St Austell had the lowest level of pre-existing infrastructure and so removing Beryl Bikes augments this infrastructure deficit.

[60] HIP learning logs

More positively, the pilot has resulted in some instances of improving infrastructure in the St Austell area. Scoping work conducted by one of the HIPs identified a footpath linking the village of St Dennis to Natural England's Goss Moor Nature Reserve as not clearly marked, and that better signage would encourage more people to use the path. The HIP carried out surveys to understand the most useful measure for footpath users (i.e., time, distance, or number of footsteps). The Council's Public Health team liaised with the landowner, Natural England, to discuss how people can travel to the reserve in an environmentally sustainable way. Members of Cornwall Council Regulatory Services and the Cormac Countryside Service team supported the installation of the signposts.

Another example of the pilot resulting in infrastructure improvements can be found in Bodmin. Coast Path Connectors is a National Lottery Heritage Fund project that aims to open coastal walking to more people. The project's goal is to help improve equity of access along the South West Coast Path by supporting local people to use the trails for their health and wellbeing, through a network of volunteers. The HIP identified there was no direct link connecting Bodmin to the Coast Path and, liaising with the Coastal Path Connector lead for the area, a new route has now been added.

The Sustrans interactive maps have been a useful tool for identifying infrastructure barriers to active travel. The response rate for the St Austell map has been reasonable, but there is currently limited usage of the Bodmin and Penzance maps. The HIPs are well-positioned in their communities to promote the maps and encourage more people to use them, alongside colleagues in the Public Health, Healthy Cornwall and Council communications teams.

There is currently insufficient data to determine the relationship between active travel infrastructure and the maturity of social prescribing networks in the three case areas, one of the key objectives of the pilot. This will be discussed in the final evaluation report.

6 Key findings and recommendations

The final section presents key findings and some recommendations for the remainder of the pilot.

6.1 Key findings

Travel behaviours, before taking part in the pilot:

— Over half (54%) of clients walk/wheel five or more days per week. However, over three quarters (78%) never use a bicycle.
— Three quarters (75%) of clients own a car and they use it relatively frequently; 43% use their car five or more days per week and a further 22% use it three to four days per week.
— Clients rarely use public transport.

Perceptions of active travel, before taking part in the pilot:

— Most clients are either 'very favourable' (46%) or 'fairly favourable' (33%) towards walking/wheeling as a form of transport. However, some feel 'not very confident' (19%) or 'not at all confident' (6%) when walking/wheeling in their local area.
— The majority of clients (61%) have a favourable attitude towards cycling as a form of transport. A high proportion of clients feel 'not very confident' (15%) or 'not at all confident' (24%) when cycling on roads in their local area.
— Clients feel less safe than control group participants when walking/wheeling or cycling.

Health and wellbeing, before taking part in the pilot:

— Three quarters (75%) of clients have a long-term health condition. One in four (27%) visited their GP more than ten times in the past 12 months.
— Compared to the control group, clients experience worse health; they require more GP appointments, more hospital visits, experience higher levels of pain, and have more difficulty with their energy levels.
— Clients reported lower levels of life satisfaction, but higher levels of peer support for using active ways to travel, compared to the control group.

Outputs from the Cornwall ATSP pilot so far:

— The pilot is on track to meet all of the output targets from the ATSP pilot logic framework by the end of the delivery period. Two of the targets, 124 x walking/wheeling activities and 24 x co-design events, have already been achieved.

— There are several additional outputs which could reinforce the legacy of the pilot, such as equipping clients to engage in active travel, upskilling community-based active travel organisations, and raising awareness of local active travel routes.

Client outcomes from the Cornwall ATSP pilot so far:

— Available data indicates the pilot has resulted in increased physical activity, reduced inequalities in access and mobility, reduced psychological barriers, and improved wellbeing.
— The combination of HIP one-to-one support and community-based active travel provision is effective at increasing clients' capabilities, motivation and opportunities to use active modes.

Barriers to, and enablers of, active travel identified in the pilot:

— The main barriers relate to safety concerns, a lack of active travel infrastructure, overgrown or poorly maintained footpaths/cycle routes, and personal circumstances (e.g., caring responsibilities, lack of appropriate footwear)
— The enablers are opportunities for social connection, the expertise of the activity facilitators, provision of clothing or footwear, and installing rest stops along active travel routes.

Referral routes and community-based provision:

— Referrals from social prescribing networks have been relatively low. Expanding the referral routes to include delivery partners and wider community health programmes increases the potential for reaching more clients.
— Collaboration and knowledge sharing between active travel service providers, facilitated by the ATSP delivery team, ensures a focus on the clients' needs and can support them along a progressional pathway.

6.2 Recommendations

The remaining ATSP funding has now been allocated and so these recommendations focus on practical actions the ATSP delivery team or the service providers can take to support clients or ensure the legacy of the pilot.

Supporting clients:

— Continue to use the Active Travel Workbook in the Cornwall pilot and recommend it to ATSP pilots in other parts of England. The workbook is a user-friendly tool for supporting clients to understand what active travel is, set personal goals, and self-monitor their progress (see Appendix 7.11).

— Highlight the social benefits of ATSP activities to potential and existing clients. The Cornwall pilot has shown this is a key enabler of active travel and an important co-benefit of taking part.
— Most clients have a favourable view of active travel as a form of transport, but may lack confidence. Build on this pre-existing motivation for using active modes by focusing on capabilities and providing opportunities through the service provider network fostered during this pilot.
— Where possible, provide active travel clothing and footwear to clients who do not own these items. This was identified as an important enabler of active travel and is relatively cost-effective.
— Ensure clients who require pre-intervention support are assisted in this process, particularly if this requires engaging with organisations or community groups they are unfamiliar with (e.g., obtaining a medical alert card, connecting with leisure-based walking/wheeling or cycling groups).

Collaboration between service providers:

— Continue the regular service provider meetings to create further opportunities for collaboration and knowledge sharing. These meetings benefit the providers, the clients, and support the legacy of the pilot by building trusted relationships within communities.
— Develop informal referral mechanisms between service providers to ensure clients can continue along a progressional pathway. Some clients may start with one activity initially, but may be interested in activities offered by other providers as they gain confidence, capabilities and motivation.

Social prescribing referral and HIP support:

— Promote a referral model which encompasses other community health programmes and 'reverse social prescribing'. The Cornwall pilot, in alignment with evidence from the wider social prescribing community[61], has demonstrated that flexibility in the referral process can identify and reach more clients.
— Promote the combination of HIP one-to-one support and community-based active travel provision to other ATSP pilots. This proven model enables support to be tailored to the specific needs of individual clients.

[61] See: https://www.socialprescribingnetwork.com/

Active travel provision and infrastructure:

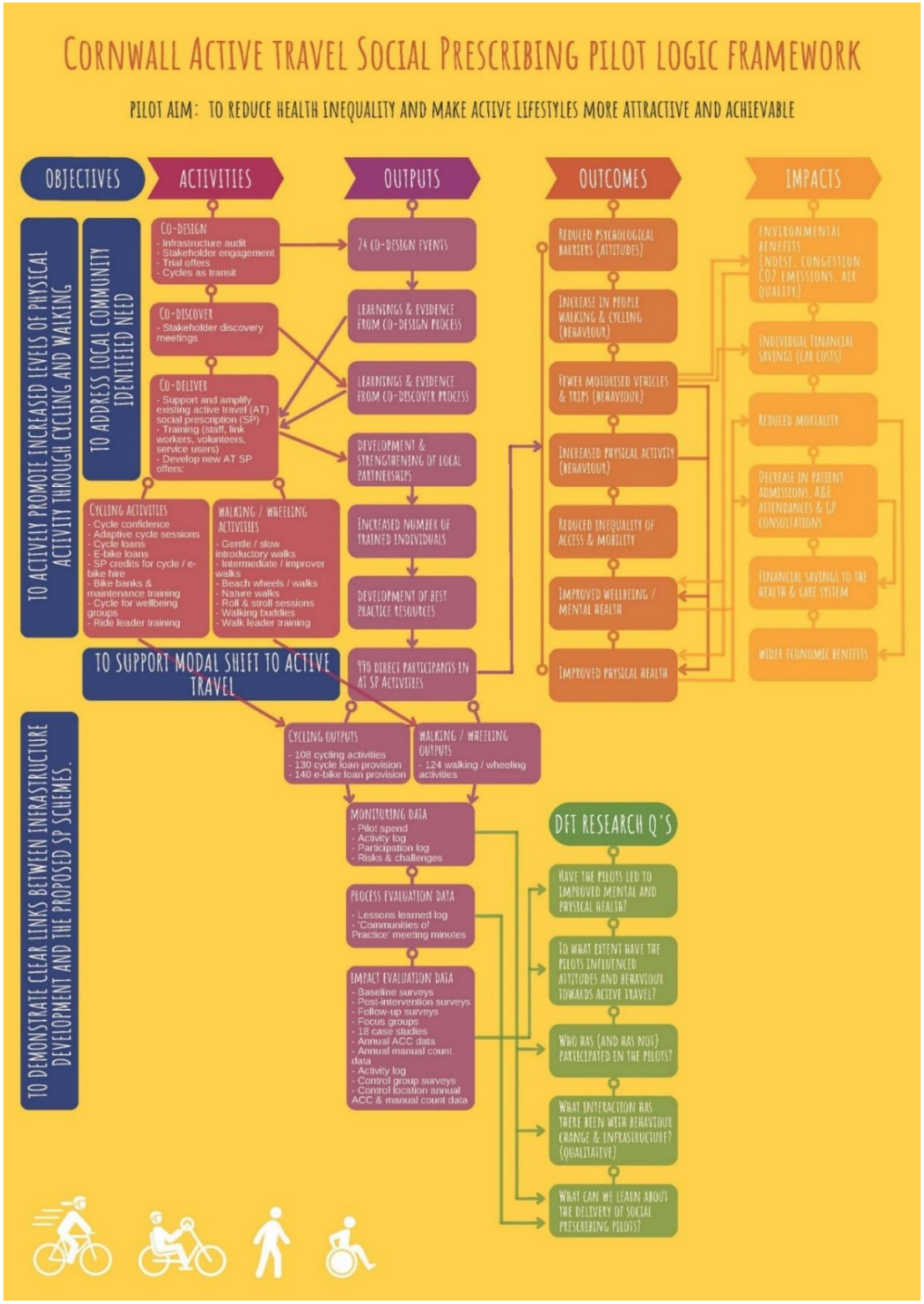
- A lack of infrastructure is a major barrier to active travel in Cornwall and the Council is already developing Local Cycling and Walking Infrastructure Plans to address this[62]. However, this pilot and previous research[63] identified better maintenance of existing paths, providing rest stops, and improving signage can facilitate access. These actions may be cost-effective and quick to implement in the short term, with the support of other Council teams and community partners.
- Use all available communication channels to promote active travel activities and infrastructure in the three pilot locations. This includes highlighting local community organisations and groups which offer active travel activities, new and existing active travel maps, and the case studies which provide relatable success stories.

[62] For example: Penzance & Newlyn Cycling and Walking Infrastructure Plan | Let's Talk Cornwall

[63] 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

7 Appendices

7.1 Figure 18, Cornwall ATSP pilot logic framework



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

Table 22, 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. Penzance, St Austell & The China Clay Area, Bodmin.	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.
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 23, 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.
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 24, 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 Transport for People Experiencing Homelessness. Penzance, St Austell & The China Clay Area, Bodmin.	St Petrocs is supporting people living in supported housing to use public transport. They build up the confidence of clients to use trains, buses and Beryl Bikes/cycle hires.

7.3 Table 25, COM-B dimensions and Intervention functions of service provider activities

Project name	COM-B dimension[64]	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
Waymaking Bodmin	Opportunity	Persuasion	

[64] 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

Eden Nature Connects	Opportunity	Education	Environmental restructuring

Theoretical Domains Framework[65] – 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)

[65] 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.

7.4 ATSP pilot referral routes – evaluation study participants

Figure 19 shows the referral routes for the clients taking part in the evaluation study.

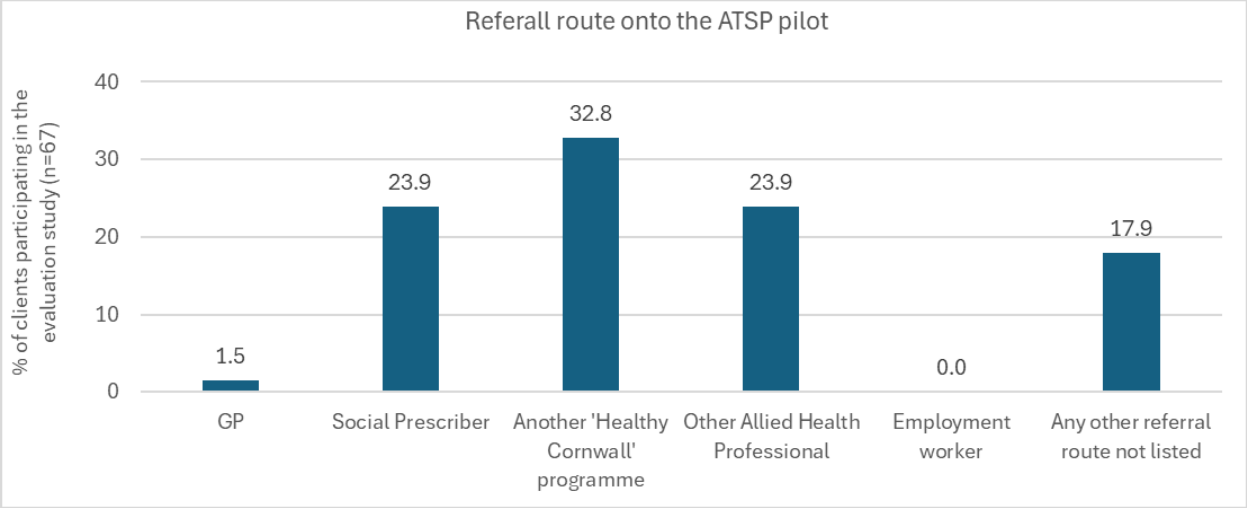


Figure 19, Referral routes onto the ATSP pilot - evaluation study participants

Table 26 provides further detail on three of the referral routes presented in Figure 19; these are the additional routes following the initial low referral numbers from a GP or social prescriber.

Table 26, Referral routes onto the ATSP pilot – evaluation study participants

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
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

Referral routes	Frequency	Valid %
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

7.5 Pre-intervention survey protocol

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.

7.6 Post-intervention survey protocol

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:

3. Complete the first survey before you start the support programme with your Health Improvement Practitioner. **You have already completed Survey 1 - thank you!**
4. 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:

7.7 Semi-structured interview protocol – ATSP 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.

7.8 Sociodemographic characteristics – pre-intervention survey participants

This information is summarised in section 3.1, but is presented here in full.

Table 27 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 27, Location of home

	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 28 shows a high proportion of clients are in the older age categories, likely reflecting the eligibility criteria of the pilot. However, the pilot is reaching people from younger age groups because one in three (31.3%) participants is aged 44 or younger. The clients are statistically significantly older than the control group[66]. The distribution of the control group is slightly skewed towards the younger age categories.

Table 28, Age category

	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

[66] 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[67] (Table 29).

Table 29, Gender

	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 30).

Table 30, Sexual orientation

	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 31 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.

[67] 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 31, Ethnicity

	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 32 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 32, Household composition

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 33). A smaller proportion of ATSP clients (13.5%) have an undergraduate or postgraduate degree than control group participants (50.0%)[68]

Table 33, Education

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

[68] 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 cell counts in Table 33 are less than five and this invalidates conducting a Chi-square test of homogeneity).

Table 34 shows the survey participants' employment status; a smaller proportion of ATSP clients are in part- or full-time employment than control group participants[69].

Table 34, Employment status

	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 35 shows the clients tend to earn less than the control group[70]. 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.

[69] 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 cell counts in Table 34 are less than five and this invalidates conducting a Chi-square test of homogeneity).

[70] 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 35, Household combined income (per year, before tax deductions)

	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 36), although car ownership is notably lower among the clients (74.6%) than the control group (95.0%)[71].

Table 36, Household car ownership

	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

[71] 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, $p = .001$

7.9 Table 37, Clients' uptake of Beryl Bikes

Some clients were allocated free bundles, of either 400 minutes or 100 minutes, to try using Beryl Bikes. Table 37 shows their aggregated use of Beryl Bikes from May to September 2024.

Use of Beryl Bikes	400 minute bundle	100 minute bundle
Number of bundle redemptions	12	6
New Beryl users	3	3
Total number of journeys	225	13
Total number of users	7	5
Total distance travelled (km)	499	42
Total journey time (hours)	40	6
Average distance travelled (km)	2.2	3.2
Average journey time (minutes)	11	28
Average rides per user	32	2.6

7.10 Case studies of client participation in the ATSP pilot

Cornwall Active Travel Social Prescribing Pilot – Case Studies - May 2024

The following case-studies outline the support being provided to eight clients in the Cornwall ATSP pilot up to May 2025. They are anonymous.

Background information:

- Cornwall Council has funding from Active Travel England to pilot Active Travel Social Prescribing. More information about the pilot is available at https://www.cornwall.gov.uk/health-and-social-care/public-health/public-health-campaigns/active-travel-social-prescribing-atsp-pilot/
- The Cornwall pilot is operating in three distinct locations in Cornwall: Penzance, St Austell & the China Clay Areas, and Bodmin.
- The pilot has three Health Improvement Practitioners (HIPs) that provide a behaviour change intervention to clients and connect them to existing and new provision. The HIPs operate in the community and work closely with social prescribing link workers, health services (such as the diabetic service), third sector organisations, existing walking and cycling provision, and the 17 projects supported by Cornwall's ATSP community fund (such as Cornwall Life Recycle).
- In Cornwall there are publicly available electric bikes called 'Beryl Bikes' (https://beryl.cc/) and the ATSP pilot has been provided with bundles of minutes by the Transport team to give to clients at no cost to the client or the pilot.

Case Study 1: Supporting a client to start actively travel using existing Beryl Bikes

The following case-study highlights the importance, from a health perspective, of addressing transport related social exclusion. This is really important to enable people to access services, employment and education to support their wellbeing and reduced entrenched inequalities related to poverty.

The Cornwall ATSP Health Improvement Practitioner *(HIP 2 - anonymised)* accepted a referral from a support worker at from a community organisation in West Cornwall, which provides a variety of projects to support local people into employment. HIP 2 says: 'After a lot of initial groundwork creating a really good working relationship with the staff, I received a referral for an unemployed mum who suffers with anxiety. She doesn't have a car so she was having to walk her children to school and would often be late for the course. She was keen to start cycling to reduce the amount of time it takes her to get to the project she's engaged with. We set a goal for her to use the Beryl Bike to and from the project three times a week. She was given an initial

400 free Beryl Bike minutes to assist her to build confidence using Beryl Bikes. She has found that this has massively helped as she can now arrive at the course on time and is much less anxious regarding her commute every day. One of the barriers is that there is a really steep hill where she lives and that's why an e-bike is better than a pedal bike.'

Case Study 2: Supporting a client with learning difficulties to use his electric bike to make local journeys

The following case-study highlights that the barrier for the client wasn't the lack of resource (they had their own bike), but rather a lack of confidence to use it. They benefited from the support of the HIP and the provider.

The Cornwall ATSP Health Improvement Practitioner *(HIP 2 - anonymised)* accepted a referral for a client needing cycle confidence sessions. The client was connected to Cornwall Life Recycle, a provider supported with a grant by Cornwall's ATSP Fund. Cornwall Life Recycle provide bikeability (including adaptive cycling). HIP 2 says: 'I received a referral for a gentleman with learning difficulties. He has his own electric bike but lacks confidence to use it for commuting to his voluntary job. He currently walks a lot to travel actively but would love to use his bike more and get to places in less time than walking. Around twice a week he gets a taxi to destinations that are more than 2 miles from his house, what he feels are too far to walk, but he would travel to them on his bike if he could gain more confidence. We set this as a goal for him to swap out his taxi journeys to his electric bike instead. His main barriers were going downhill on the bike and lack of confidence on busy roads. Cornwall Life Recycle is providing the client with weekly sessions to build up his confidence on his own electric bike. This has massively increased his independence.'

Case Study 3: 'Making it social' to support a client to walk short journeys

The following case-study highlights the importance of 'making it social' to facilitate people to start walking. This aligns with what we know from behaviour change science that 'making it social' is a facilitator. It also demonstrates how the HIP offers a multi modal approach that combines weight loss/health advice and physical activity to remove barriers to active travel.
The Cornwall ATSP Health Improvement Practitioner *(HIP 3 - anonymised)* accepted a referral from a social prescriber link worker in East Cornwall. The client was a male unemployed mobility scooter user with long term health conditions who struggled with a poor level of physical health. He used his scooter for short journeys, but wanted to improve his fitness so that he could walk instead. He often used taxis and found this costly. The HIP met with the client and he liked the idea of engaging in activities with other people. He felt participating with others would help maintain his motivation for engagement. The HIP worked with him to set some travel goals and

connected him to a low intensity walking group at the local leisure centre (a new provision supported by the Cornwall ATSP Fund) and to Healthy Cornwall services to access weight management and healthy lifestyle advice. The client is attending the walking provision on a weekly basis and is enjoying the social and physical element of the session. The leisure centre has empowered him to get involved in additional support through them, creating a domino effect where the client is offered further intervention.

Case-study 4: Providing a package of walking and cycling support to a client who recently had heart surgery

The following case-study highlights how the HIPs take an assets-based approach to supporting clients, building on their existing resources and connecting them to existing and new provision in the community. It highlights how the ATSP pilot is having an impact on the development of other service provision.

The Cornwall ATSP Health Improvement Practitioner *(HIP 3 - anonymised)* accepted a referral from a social prescriber link worker to support a female client who had recently had heart surgery. She wanted to regain her fitness and gain confidence to engage in walking and cycling as a means of making local/short journeys. She had her own e-bike but didn't feel confident using it. Her dominant mode of transport was the car. The HIP worked with the client to provide gentle encouragement and set some goals. She was keen and motivated but wanted to take part in group activities to 'do something enjoyable with others' so the HIP gave her information on local walking and cycling areas and connected her to several local projects (two of which are funded through the Cornwall ATSP Fund). She is now taking part in confidence building sessions with Cornwall Life Recycle to use her e-bike and to participate in led rides in her local area. She is accessing the group Wellbeing Walk at the local leisure centre. And she is engaged with the South West Coastal Path (SWCP) connector walk. As part of the pilot, the HIP encouraged SWCP to create a new walking group for Bodmin people to connect them to the north coast at no cost to the ATSP pilot.

Case study 5: Supporting a deaf client to make multi-modal journeys

The following case-study highlights the role that the bus has on enabling people to build walking into their everyday journeys. It illustrates how many clients who are socially prescribed have complex needs and role HIPs have in making clients feel comfortable.

The Cornwall ATSP Health Improvement Practitioner *(HIP 1 - anonymised)* identified a deaf unemployed client who used the car as her primary mode of transportation. HIP 1 discussed with client about building walking into her everyday life and provided a bus pass (free to the

client) to enable her to start making multi-modal journeys, embedding walking into everyday life. The client has increased her walking and is interested in being connected to a cycling project when she feels ready.

Case study 6: Supporting a client down a progressional pathway

The following case-study highlights how the HIPs support clients down a progressional pathway from using a static bike at home to accessing publicly available e-bikes and riding on the road. It shows how HIPs nudge clients to build confidence to swap everyday car journeys for walking and cycling.

The Cornwall ATSP Health Improvement Practitioner *(HIP 1 - anonymised)* identified a self-employed female who lacked confidence to ride a bike on roads/cycle trails. She uses car for journeys when shopping or collecting heavy items. She rides an exercise bike at home and owns a road bike but has not ridden the road bike for approx. 7 years. HIP 1 supported the client to progress from riding her exercise bike to riding a bike on the road. She connected her to bikeability to get confidence to ride e-bike and gave her a bundle of Beryl Bike minutes.

Case study 7: Overcoming health anxieties to start walking for travel

The following case-study highlights the importance of having staff who understand health concerns and can identify that something as simple as having a medical alert card can facilitate a client to start making multi-modal journeys by bus.

The Cornwall ATSP Health Improvement Practitioner *(HIP 1 - anonymised)* accepted a referral from a social prescriber link worker for a female with a physical health condition. Her barriers to active travel were health related and she was very anxious because her health condition meant that she could have a medical emergency at any time. HIP 1 provided gentle encouragement and encouraged the client to get a medical alert card so that she felt more confident being outside her home and using the bus alone. The HIP also connected the client to local wellbeing walks and the client's confidence has grown to the point where she is interested in talking part in training to become a walk leader herself.

Case study 8: Providing a package of support for an elderly client to enable her to overcome her fear of falling and start walking into town again

The following case-study highlights the role of the HIP in connecting socially prescribed clients to a range of walking and health interventions.

The Cornwall ATSP Health Improvement Practitioner *(HIP 3 - anonymised)* accepted a referral from a social prescriber link worker for an elderly female client who had a fear of falling, preventing her engagement in walking. She had lost confidence in her own ability but wanted to be able to walk into town independently again. The HIP provided gentle supportive encouragement, supported the client to set herself some goals and connected her to walking provision and health interventions. The client is accessing the group walking session at the leisure centre and is interested in joining a walking bus when it starts (both of these projects are supported by the Cornwall ATSP Fund). The walking bus takes groups of people by foot into the town centre. The HIP also made an internal referral for the client to Healthy Cornwall's Healthy Lifestyle group, and signposted her to the local Diabetic Support Group, which she is accessing. The HIP made the client aware of Cornwall's fall prevention programme called Icare Imove. Without the HIP's intervention the client wouldn't have accessed this package of support.

For more information about the Cornwall ATSP pilot please contact the Project Manager Natalie Russell *(email address removed)*

7.11 Active Travel Workbook

This workbook was designed by one of the HIPs, Carol Gill, to support clients in achieving their active travel goals.

Please see next page.

Active Travel England

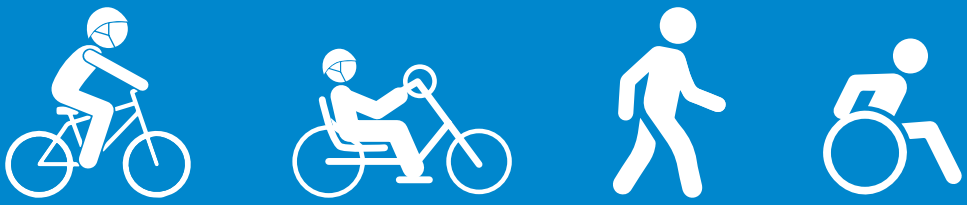
Funded by UK Government

CORNWALL COUNCIL | Healthy Cornwall

Active Travel Record

Daily movement and journey record.

Putting health and movement at the centre of your everyday journeys



Daily movement is good, more is better, but every minute counts

www.cornwall.gov.uk

What is active travel?

It simply means getting from A-B in more physical active ways – like walking, cycling, wheeling (using a wheelchair or mobility aid) or starting your journey by walking or cycling to catch the bus or train. It usually applies to short journeys, by including more movement in your day, like walking to the shops or cycling with friends. It could also involve using public transport as part of a longer journey for getting you from A-B.

Why engage in active travel?

Moving more has proven health benefits for both physical and mental wellbeing. Its healthier for you, better for the environment and may help you to meet new people and get to know your local area. It also might help to put some money back into your pocket by saving on fuel.

How do I start?

Make a commitment to making a change and set a goal today! Start small and increase if you feel you can. Reflect on your current travel choices using the chart below and see if you can make any changes however small. Think differently about your daily trips. Where possible rethink your journey and how you travel. Try something new or different like taking the bus or train, cycle or walk to visit friends or to work. Make it more fun and sociable by involving family and friends. This might help you to keep yourself more motivated. Record your active travel progress using the attached form and don't forget to reward yourself for your success.

Remember: Daily movement is good, more is better, every minute counts.

Goal setting may take a bit of planning. Maybe ask a friend, family member or the support of our Active Travel Social Prescribing Health Improvement Practitioner with this. Also, unexpected events can happen which make achieving your goal tricky. That's ok, just re-set the goal for another day instead.

Examples of goals could include the following:

- Learn to ride a bike.
- Access buses to travel more actively
- Use the Beryl bikes.

- Get about without using the car on short local journeys and to save money on fuel.
- Learn how to read and understand bus/train timetable in order to be able to use buses/trains as a mode of transport.
- Attend group walking and cycling sessions with like-minded people to increase confidence and social connectiveness.
- Try an e-bike and build up confidence to use one within my local community.
- Use the bus to attend a walking group in my local area.
- Improve fitness by walking and/or cycling local journeys in my community.

Analyse your current pattern of transport

Use the chart below to record your current travel choices then once completed look back and review to see if there are any changes or small opportunities to rethink your journey and travel choices. This can be all or part of a complete journey.

Remind yourself as to why you are making these changes. Consider what are the benefits to yourself, others and the environment. Then make a note below to keep yourself on track and motivated.

Key: X = not able to make a swap/essential
? = potential for change
Y = definitely a swap

	Walk	Cycle	Wheeling	Bus	Train	Car Share	Car	Combination	Review (X - ? - Y)	Comments
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

My active travel goal is?

Rate where you are now in achieving this goal on a scale between 0-10:

How close are you to reaching this goal? 0 = not at all - 10 = completely

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

How confident are you in achieving this goal? 0 = not at all - 10 = completely

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

How important is this goal to you? 0 = not at all - 10 = completely

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

What are the benefits of working towards this goal?

What will help me achieve this? What might stop me achieving this? What barriers, if any, may be in the way?

Record Sheet – Keeping a track of my progress

Date	Type of transport	Distance or time taken	Journey type	Stop and reflect
	ie walk / cycle/ bus / car / liftshare etc.		Journey (J), leisure (L) or both (JL) - feel free to add location if helpful. Journey might be for: Work, shopping, attending medical appointment, family responsibilities etc.	Are there any possible changes that you could make? Car free day, moving something to another day, arrange to walk with friends, is it a short journey I could walk to?
	Walk	10 mins	Home to local Spar - J - shopping	

Record Sheet – Keeping a track of my progress

Date	Type of transport	Distance or time taken	Journey type	Stop and reflect
	ie walk / cycle/ bus / car / liftshare etc.		Journey (J), leisure (L) or both (JL) - feel free to add location if helpful. Journey might be for: Work, shopping, attending medical appointment, family responsibilities etc.	Are there any possible changes that you could make? Car free day, moving something to another day, arrange to walk with friends, is it a short journey I could walk to?
	Walk	10 mins	Home to local Spar - J - shopping	

Record Sheet – Keeping a track of my progress

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	Walk	10 mins	Home to local Spar - J - shopping	

Active travel record review - 1/3/6 months review

Analyse your current pattern of transport

1 Month review
Date completed:

	Walk	Cycle	Wheeling	Bus	Train	Car Share	Car	Combination	Review (X - ? - √)	Comments
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Key: X = not able to make a swap/essential
? = potential for change
Y = definitely a swap

3 Months review
Date completed:

	Walk	Cycle	Wheeling	Bus	Train	Car Share	Car	Combination	Review (X - ? - Y)	Comments
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Key: X = not able to make a swap/essential
? = potential for change
Y = definitely a swap

6 Months review
Date completed:

	Walk	Cycle	Wheeling	Bus	Train	Car Share	Car	Combination	Review (X - ? - Y)	Comments
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Key: X = not able to make a swap/essential
? = potential for change
Y = definitely a swap

My notes:
What's working well, what changes have I made, what still needs to be tackled, barriers, enablers, where am I now in achieving my goal? What benefits am I noticing etc. Write your reflections here.

You may want to have a look at the following websites for advice/guidance and apps to track your progress:

Cornwall Council | Healthy Cornwall

Offering healthy lifestyle information, tools and support to help you live healthier and happier life. Supporting you with: Active Travel Social Prescribing, Stop Smoking, Physical Activity, Weight Management, Healthy Eating, Healthy Pregnancy.

Go Cornwall bus

Go Cornwall bus app helps you plan your journeys and has information about the £2 single fare cap. Plan your journey - Go Cornwall Bus or **www.gocornwallbus.co.uk/plan-your-journey**

£2 single fare cap find out more:
"it's time to travel more for less!"

NHS

NHS Better Health Get active - Better Health - NHS (www.nhs.uk)
www.nhs.uk/better-health/

Active 10

The **Active 10** app anonymously records every minute of walking you do. Just pop your phone in your pocket and away you go!
The app: tracks your steps, helps you set goals, shows you your achievements and gives you tips to boost your activity.

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sustrans JOIN THE MOVEMENT

Sustrans.org.uk
Making it easier for everyone to walk, wheel and cycle.

Fitness tracker apps that allows you to record your activity/distance and share your effort with friends such as apps like Strava or Komoot.

Have your say: ATSP Community Mapping Tools

The Active Travel Social Prescribing (ATSP) pilot has been funded by Active Travel England. As part of the pilot, we are collecting views on what helps or hinders people to get from A to B by walking, cycling, wheeling or using public transport. Your comments and suggestions will help us understand some of the local barriers and facilitators to active travel.

We are collecting information on three areas. Please use the following maps to provide information about your local area. The maps are open to feedback until July 2025.

Penzance: **https://communitymap.uk/project/223**

Bodmin: **https://communitymap.uk/project/224**

St Austell & China Clay: **https://communitymap.uk/project/225**

Please use the links to access the maps and make a note of an issue and to propose a solution. Please be aware that you may not receive a direct response to your comment. The information you provide will help us create an evidence base for Transport to use to inform future development work.

You can comment on:

- Lack of safe route for walking
- Lack of bike parking
- Poor air quality
- Speeding
- Heavy traffic
- Narrow pavement
- Physical barriers
- Pavement parking
- Hard to cross the road
- Poor lighting
- Behaviour of road users
- Lack of safe route for cycling
- Poor signage
- Other (please describe)

For more information see our project website: **https://www.cornwall.gov.uk/health-and-social-care/public-health/public-health-campaigns/active-travel-social-prescribing-atsp-pilot/**

If you would like this information in another format or language please contact:

Cornwall Council, County Hall,
Treyew Road, Truro, TR1 3AY

e: customerservices@cornwall.gov.uk
t: 0300 1234 100

May 2024 jn54563

Cornwall recycles
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