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With over 2 million cancer survivors in the United Kingdom and the rate rising by as much as 3% per annum, rest, as a cancer patient (CP) intervention, is challenged.

Physical activity (PA) supports improved patient outcomes and reduces treatment side effects. Whilst potential cost effectiveness of PA in cancer care is recognised, practical mechanisms for integrated delivery are sought. “Get Active Feel Good” (GAFG) aims to provide an integrated pathway approach to support CPs maintaining or initiating PA.

Underpinned by “Let’s Get Moving” PA pathway and an evidence-based pilot, GAFG is now embedded within cancer care, steered by a multi-disciplinary group and funded by Shropshire Public Health/Macmillan. Post-diagnosis screening and PA behaviour change (BC) intervention precedes referral of CP to GAFG Advisor (GAFGA) from clinicians. GAFGA contacts CP, and follow-up motivational interviewing (MI) sessions support PA BC. Activities and CP concerns, beliefs, goals and options are explored alongside readiness/confidence to engage. Wellness and PA measures are included as appropriate and Macmillan PA resources incorporated. CPs define their own goals and requirements for safe/effective activity. Progress is reviewed at 3/6 months if required by CP. GAFGA is an experienced exercise science postgraduate with MI, cancer-specific training and clinical liaison skills. 250 CPs engaged with GAFG, 80% of these referred during or post-treatment and breast, lung, colorectal and 15 other cancer designations engaged via nine referral routes. Clinical nurse specialists referred 60% of all CPs. About 55%–60% of CPs instigated attendance at review. Health, well-being and PA indicators reflected fluctuations in condition/treatment.

... before, I was scared and didn’t know what or how to do it. Now I take regular exercise and feel better for it.

I always thought exercise was part of the treatment, like taking a tablet every day.

Multidisciplinary working has created referrals and clinical recognition of the role of PA. Follow-up appointment procedures now enable GAFGA to proactively arrange sessions. PA intervention opportunities are now available for all CPs. Collaboration with clinicians/stakeholders is essential to sustainable delivery. GAFG relies upon generating referrals and high-quality delivery. GAFG demonstrates how integrated pathway delivery supports PA BC opportunities. Activity throughout the cancer journey has positive impacts that are reported at a patient level.

As expected, CP engagement cycles with condition and treatment status. Commissioners and funders have responded to results with continued support.

D2.P9. Passive movement training improves one-legged stance but no other measure of functional ability in older females

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Physical activity can delay the deleterious effects of ageing. Motorised passive movement gyms, typically marketed at older individuals, use a circuit of machines to passively move the limbs. Little is known, however, about the beneficial effects of passive movement on the functional fitness of older individuals. The aim of the study was (i) to determine whether a 12-week programme at a motorised passive movement gym provided any benefit to the functional fitness of healthy older females and (ii) to compare the functional fitness ability of long-term passive movement gym participants to normative values. With institutional ethical approval, nine healthy females (mean (*s*) age 73.6 (6.1) years), new recruits to a motorised passive movement gym, were measured for functional fitness pre- and 12 weeks post-initiation of the passive gym programme. A total of 13 females (aged 76.0 (6.7) years) acted as a control group. Between group comparisons were conducted using Mann–Whitney U test. Pre- to post- programme comparisons were conducted using Wilcoxon test. Statistical significance was set at $P < 0.05$. Effect size (ES) was calculated. Additionally, 36 females (aged 71.0 (7.3) years), long-term passive movement gym participants, also completed the functional fitness tests and were compared to age-matched normative values (Rikli and Jones, 1999, *Journal of Aging and Physical Activity*, 7, 162–181). Measurements of functional fitness were one-legged stance, timed 8-foot up-and-go, chair stand, handgrip, chair sit-and-reach and back scratch. Performance in the timed 8-foot up-and-go, chair stand, handgrip, chair sit-and-reach and back scratch did not change following the 12-week programme; however, the one-legged stance duration increased from 11.2 ± 8.6 s to 16.7 ± 8.5 s ($P < 0.01$, ES = 0.89). In comparison with the normative data, motorised passive gym participants were considered “above average” for one-legged stance, “average” for chair stand, handgrip, chair

sit-and-reach and back scratch while “below average” for timed 8-foot up-and-go. Findings suggest that motorised passive movement can be an effective exercise to improve static balance in older women, but not to improve muscle function, flexibility and mobility. Stimulation of the proprioceptive sensory

afferents from the passive movement may have increased kinaesthetic awareness, resulting in an improved static balance. This form of exercise, however, should not be relied upon to train other forms of fitness, as no benefits were seen in the other components of functional ability.