



This is a peer-reviewed, post-print (final draft post-refereeing) version of the following published document, This is the accepted version of the following article, published by Emerald in March 2014: Jackson, C., Lewis, K., Conner, M., Lawton, R. and R.C. McEachan, R. (2014), "Are incremental changes in physical activity and sedentary behaviours associated with improved employee health? : A 12-month prospective study in five organisations", International Journal of Workplace Health Management, Vol. 7 No. 1, pp. 16-39. and is licensed under Creative Commons: Attribution-Noncommercial 4.0 license:

Jackson, Cath, Lewis, Kiara ORCID: 0000-0002-0142-7351, Conner, Mark, Lawton, Rebecca and R.C. McEachan, Rosemary (2014) Are incremental changes in physical activity and sedentary behaviours associated with improved employee health? International Journal of Workplace Health Management, 7 (1). pp. 16-39. doi:10.1108/IJWHM-03-2013-0013

Official URL: <http://dx.doi.org/10.1108/IJWHM-03-2013-0013>

DOI: <http://dx.doi.org/10.1108/IJWHM-03-2013-0013>

EPrint URI: <https://eprints.glos.ac.uk/id/eprint/9765>

Disclaimer

The University of Gloucestershire has obtained warranties from all depositors as to their title in the material deposited and as to their right to deposit such material.

The University of Gloucestershire makes no representation or warranties of commercial utility, title, or fitness for a particular purpose or any other warranty, express or implied in respect of any material deposited.

The University of Gloucestershire makes no representation that the use of the materials will not infringe any patent, copyright, trademark or other property or proprietary rights.

The University of Gloucestershire accepts no liability for any infringement of intellectual property rights in any material deposited but will remove such material from public view pending investigation in the event of an allegation of any such infringement.

PLEASE SCROLL DOWN FOR TEXT.

International Journal of Public Health

How do physical activity and sedentary behaviours in workers impact on their health? A 12-month prospective study --Manuscript Draft--

Manuscript Number:	
Full Title:	How do physical activity and sedentary behaviours in workers impact on their health? A 12-month prospective study
Article Type:	Original article
Keywords:	physical activity, exercise, sedentary, sitting, workplace, employee
Corresponding Author:	Cath Jackson, Ph.D University of York York, UNITED KINGDOM
Corresponding Author Secondary Information:	
Corresponding Author's Institution:	University of York
Corresponding Author's Secondary Institution:	
First Author:	Cath Jackson, Ph.D
First Author Secondary Information:	
Order of Authors:	Cath Jackson, Ph.D Kiara Lewis, MSc Mark Conner, Ph.D Rebecca Lawton, Ph.D Rosemary RC McEachan, Ph.D
Order of Authors Secondary Information:	
Abstract:	<p>OBJECTIVES: Explore the impact of incremental increases in physical activity and incremental decreases in sedentary behaviours on health outcomes in employees of five organisations. Investigate the association between physical activity and sedentary behaviours.</p> <p>METHODS: Self-reported physical activity and sedentary behaviours were recorded at four time points (baseline, 3, 6, 12 months). BMI, % body fat, waist circumference, blood pressure and resting heart rate were collected in health checks (baseline, 12 months). Well-being and health were collected via questionnaire. Participants were classified into five physical activity groups (n=308) and three sedentary groups (n=358). MANCOVAs explored the impact of activity and sedentary group on health. Spearman's correlation analysis investigated associations between behaviours.</p> <p>RESULTS: Low activity and high sedentariness were evident. More activity was associated with improved BMI, % body fat, resting heart rate, waist circumference and well-being. Sedentary behaviour was not associated with health. A weak positive association between physical activity and sedentary behaviours emerged.</p> <p>CONCLUSIONS: The low activity levels are of particular concern as linked to health outcomes. The weak association between behaviours suggests worksite interventions should target both behaviours.</p>

How do physical activity and sedentary behaviours in workers impact on their health? A 12-month prospective study

Cath Jackson*, York Trials Unit, Department of Health Sciences, University of York, YORK, YO10 5DD, UK. Email. cath.jackson@york.ac.uk. Tel. 0044 (0) 1904 32 1869

Kiara Lewis, Department of Clinical and Health Sciences, University of Huddersfield, HUDDERSFIELD, HD1 3DH. Email. kiara.lewis@hud.ac.uk

Mark Conner and Rebecca Lawton, Institute of Psychological Sciences, University of Leeds, LEEDS, LS2 9JT, UK. Email. m.t.conner@leeds.ac.uk; r.j.lawton@leeds.ac.uk

Rosemary R C McEachan, Bradford Institute for Health Research, Bradford Teaching Hospitals NHS Foundation Trust, BRADFORD, BD9 6RJ, UK. Email. Rosie.McEachan@bthft.nhs.uk

On behalf of the AME for Activity team

*Corresponding author

How do physical activity and sedentary behaviours in workers impact on their health? A 12-month prospective study

ABSTRACT

Objectives: Explore the impact of *incremental* increases in physical activity and *incremental* decreases in sedentary behaviours on health outcomes in employees of five organisations. Investigate the association between physical activity and sedentary behaviours.

Methods: Self-reported physical activity and sedentary behaviours were recorded at four time points (baseline, 3, 6, 12 months). BMI, % body fat, waist circumference, blood pressure and resting heart rate were collected in health checks (baseline, 12 months). Well-being and health were collected via questionnaire. Participants were classified into five physical activity groups (n=308) and three sedentary groups (n=358). MANCOVAs explored the impact of activity and sedentary group on health. Spearman's correlation analysis investigated associations between behaviours.

Results: Low activity and high sedentariness were evident. More activity was associated with improved BMI, % body fat, resting heart rate, waist circumference and well-being. Sedentary behaviour was not associated with health. A weak positive association between physical activity and sedentary behaviours emerged.

Conclusions: The low activity levels are of particular concern as linked to health outcomes. The weak association between behaviours suggests worksite interventions should target both behaviours.

How do physical activity and sedentary behaviours in workers impact on their health? A 12- month prospective study

BACKGROUND

Physical activity is important in the primary and secondary prevention of chronic diseases, in particular coronary heart disease, stroke, hypertension, breast cancer, colon cancer, type 2 diabetes mellitus and osteoporosis (Warburton et al. 2007). Globally, 5.3 million premature deaths are caused by physical inactivity each year (Lee et al. 2012). Indeed, the risk of dying prematurely is estimated to be 66% lower for the most physically active compared to the least active (Warburton et al. 2007). Yet physical activity levels remain low. In England, 60% of men and 70% of women do less than the recommended amount for health benefit (Craig et al. 2008) and these figures are consistent with other westernised countries (Cavill et al. 2006; Department of Health 2011; Department of Health and Ageing 2011). In 2010 the British Association of Sport and Exercise Sciences produced a consensus statement on the levels of recommended activity for health benefit (ABC of Physical Activity for Health; O'Donovan et al. 2010). Whilst broadly the same as previous national (Department of Health 2004) and international recommendations (Surgeon General 1996) this statement provides further guidance on the combination of moderate and vigorous activity levels required for adults (Figure 1).

Figure 1

It is now acknowledged that sedentary behaviour is not merely the absence of physical activity but rather are 'activities that do not increase energy expenditure substantially above the resting level' and include sleeping, sitting, lying down and watching TV (Pate et al. 2008, p174). Individuals can therefore be both highly active and highly sedentary (British Heart Foundation 2012). There is increasing evidence that sedentary behaviour is a risk factor for poor health, independent of physical activity (Katzmarkzyk 2010; Thorp et al. 2011); specifically, moderate evidence exists for a relationship between sedentary behaviour and risk for type 2 diabetes; and strong evidence for all-cause and cardiovascular disease mortality (Proper et al. 2011). We also know that adults currently spend considerable time in sedentary behaviours in their leisure, travel and occupational time (Bauman et al. 2011); for example, in Europe, 64% reported sitting for more than 4 hours a day (Hallal et al. 2012). Currently there are no specific recommendations for the duration of sedentary time above which health may be at risk. It is simply recommended that adults minimise the amount of time being sedentary for extended periods of time (British Heart Foundation 2012).

1 Studies are increasingly assessing physical activity behaviours across different volumes and intensities with a view to
2 confirming the ‘dose-response relationship’ with health outcomes (O’Donovan et al. 2010). They are also exploring
3 *both* activity and sedentary levels (Biddle 2007). However, many studies are cross-sectional and also do not account for
4 age, sex, ethnicity and socioeconomic status (SES) variations (Bryan and Katzmarzy 2011; O’Donovan et al. 2010).
5
6 Studies need to be prospective and assess total energy expenditure from physical activity and sedentary behaviours
7
8 across all domains rather than focusing only on work or leisure time (Bryan and Katzmarzy 2011). In this paper we
9
10 address these limitations. We present prospective data collected from employees of five organisations in the UK over a
11
12 12 month period. Most adults spend half their waking hours at work, and many are in occupations which require low
13
14 levels of activity and prolonged bouts of sitting (van Uffelen et al. 2010) making the workplace an excellent setting for
15
16 understanding these health behaviours to inform interventions. We explore the impact of *incremental* increases in
17
18 physical activity and *incremental* decreases in sedentary behaviours on objective and self-reported health outcomes. We
19
20 also investigate the association between activity and sedentary behaviours.
21
22
23
24

25 **METHODS**

26 **Ethics approval**

27
28 Ethics approval was granted by the University of Leeds, Institute of Psychological Sciences and Sheffield East NHS
29
30 Local Research Ethics Committees in October 2007.
31
32
33
34

35 **Participants**

36
37 Participants were employees of five UK organisations who took part in the ‘AME for Activity’ study (McEachan et al.
38
39 2011). We present data from 467 participants who completed a postal questionnaire at four time points: baseline (T1),
40
41 3 months (T2), 6 months (T3) and 12 months (T4) and attended a health check at T1 and T4.
42
43
44

45 **Data collection and measures**

46 **Postal questionnaire**

47
48 *Participant demographics* were recorded at T1: gender, age, marital status, ethnicity, socio-economic status using the
49
50 self-coded UK National Statistics Socio-Economic Measure (SES; NS-SEC) and employer organisation.
51
52
53
54

55 *Self-reported physical activity and sedentary behaviour* were measured at all four time points using the short form of
56
57 the International Physical Activity Questionnaire (IPAQ; Craig et al. 2003) which has demonstrated validity and
58
59 reliability and performs similarly to the longer version of the questionnaire (Hagstromer et al. 2006). The IPAQ short
60
61
62
63
64
65

form exhibits moderate correlations with objectively assessed physical activity via pedometer or accelerometer data (Craig et al. 2003) performing similarly to other questionnaire physical activity indices (De Cocker et al. 2009).

The IPAQ short form assesses the duration (minutes) and frequency (days) an individual engages in three types of activity (walking, moderate and vigorous) over the previous seven days. Each type of activity is then weighted by its energy requirements defined in METs (a multiple of resting metabolic rate, walking = 3.3, moderate = 4, vigorous = 8). This results in a MET-minute score per week for the three types of activity.

Using the MET-minute scores per week we classified participants at each time point according to the ABC of Physical Activity for Health consensus statement (Figure 1). Participants were classified as **B**eginner if their MET-minutes per week were less than 600, as **A**ll healthy adults if their MET-minutes per week were between 600 and 1199; and as **C**onditioned if their MET-minutes per week were more than 1200. Where MET-minutes per week data were missing (T1 9%, T2 13%, T3 18%, T4 7%) participants were classified as **B**eginner. Little's MCAR test confirmed that these data (and the missing sitting data presented below) were missing completely at random ($\chi^2(8) = 13.22$; $p=0.11$).

In order to explore the impact of *incremental* increases in physical activity behaviour on health outcomes (as per the ABC classification), we created five independent *12-month physical activity* groups:

1. **B**eginner at all 4 time points
2. Either **B**eginner or **A**ll healthy adults across the 4 time points
3. **A**ll healthy adults at all 4 time points
4. Either **A**ll healthy adults or **C**onditioned across the 4 time points
5. **C**onditioned at all 4 time points

Group size was unequal across the five 12-month physical activity groups however we retained all five groups in the analyses as per the ABC classification. We excluded participants who had reported *non incremental*, mixed levels of activity over the 12 months (i.e. moved between **A**ll healthy adults, **B**eginner and **C**onditioned levels, $n=159$).

The IPAQ short form also assesses the duration (hours, minutes) an individual spends sitting on a week day during the previous seven days. Since there are currently no specific recommendations for the duration of sedentary time above which health may be at risk, we categorised participants at each time point using a classification of sitting time from a large survey of sedentary behaviour in workplace employees (Brown et al. 2003): Sitting more than 444 minutes (7.4

hours) a day, sitting 282 to 444 minutes a day or sitting 281 minutes (4.7 hours) or less a day. Where data were missing (T1 10%, T2 17%, T3 21%, T4 10%) participants were classified as Sitting more than 444 minutes a day.

To explore the impact of *incremental* decreases in 12 months sitting behaviour on health outcomes, we first created five independent *12-month sedentary* groups:

1. Sitting more than 444 minutes a day at all 4 time points
2. Either sitting more than 444 minutes or sitting 282 to 444 minutes a day across the 4 time points
3. Sitting 282 to 444 minutes a day at all 4 time points
4. Either sitting more than 282 to 444 minutes or sitting 281 minutes or less a day across the 4 time points
5. Sitting 281 minutes or less a day at all 4 time points

We excluded participants who had reported *non incremental*, mixed levels of sitting over the 12 months (i.e. moved between levels of sitting, n=109). We subsequently merged groups 3 to 5 as they were small (n=9, n=34 and n=21 respectively) creating three *12-month sedentary groups*: High (group 1 above), Moderate (group 2 above) and Low (groups 3 to 5 above).

Self-reported mental well being and health:

At all four time points participants completed the GP-CORE (Evans et al. 2005). This 14-item scale records subjective well-being (e.g. I have felt OK about myself), problems/symptoms (e.g. I have felt anxious or nervous) and functioning (e.g. I have felt able to cope when things go wrong) over the past week. It is designed for use in non-clinical settings and has shown acceptable reliability and validity within a student sample (Evans et al. 2005). Items were scored 1 ('not at all') to 5 ('all the time') and divided by 14 to yield a mean item score between 1 and 5.

Self-reported health was measured at all four time points using the standardised visual analogue scale from the EQ-5D, where 0 = worst imaginable health and 100 = best imaginable health (The EuroQol Group 1990).

The T1 and T4 data for both measures were used in the analyses for this paper as these were time points where objective health data were collected.

Health check

Objective health data were collected in a health check at baseline (T1) and at (T4) which took place in the participants' worksite and was conducted by a trained health technician following a detailed protocol. The following data were recorded: body mass index (BMI) and per cent body fat (using OMRON BF306 body fat monitor), waist circumference

(mean of three tape measurements), diastolic and systolic blood pressure (lowest of two measurements using OMRON M7 blood pressure monitor), and resting heart rate (RHR, using OMRON M7).

Data analysis

Descriptive statistics were used to summarise participants' demographic characteristics across the independent 12-month physical activity and sedentary groups. Chi-squared analyses explored the associations between these characteristics and the 12-month physical activity and sedentary groups. One way ANOVAs compared mean age across the 12-month physical activity and sedentary groups.

Means and standard deviations were calculated for the objective and self-reported health outcomes across the five 12-month physical activity and three 12-month sedentary groups. Two MANCOVAs explored the impact of 12 months physical activity and sedentary behaviour on objective and self-reported health outcomes. Demographic characteristics, employer organisation; and baseline health measures were entered as covariates. Where significant between-subjects effects were identified pairwise comparisons investigated where these differences occurred. To correct for multiple testing, a Bonferroni correction was carried out.

Spearman's correlation analysis explored the association between participants' physical activity (A, B or C) and sitting (> 444 minutes a day, 282 to 444 minutes a day, 281 minutes or less a day) classifications at each time point. All 467 participants were included in these analyses.

RESULTS

Participants

The majority of participants were White British (89%), married (71%), and in intermediate and managerial/professional roles (91%). Just over half were female (59%) and just under half worked for the council organisation (44%). The mean age was 40 years. Demographic characteristics for participants by the 12-month physical activity and sedentary groups are presented in Tables 1 and 2 respectively.

Approximately one third of participants were categorised as Beginner (30%), one third as **Beginner or All Healthy Adult** (31%) and just 7% as **All Healthy Adult**; 16% were **All Healthy Adult or Conditioned** and 15% as **Conditioned**. No demographic characteristics were statistically significantly associated with 12-month physical activity group.

1 Over one third of participants were categorised as High sitting (37%), nearly half as Moderate sitting (45%) and 18% as
2 Low sitting over the 12 months. SES (χ^2 (2, N=358) = 7.46; p=0.02) and employer organisation (χ^2 (8, N=358) =
3 28.85; p<0.001) were significantly associated with 12-month sedentary group. Participants classified as lower SES were
4 more likely to be in *both* the Low sitting group and the High sitting group and less likely to be in the Moderate sitting
5 group; the reverse pattern was evident for high SES participants. Employees of the bus company and the government
6 organisation were more likely to be in the High sitting group, council employees were less likely to be in this group.
7
8
9
10
11
12
13

14 Table 2

15 **What is the impact of physical activity behaviour over 12 months on health?**

16
17
18
19 The objective and self-reported health outcomes across five 12-month physical activity groups (n=308) are presented in
20 Table 3. MANCOVA revealed statistically significant multivariate effects for 12-month physical activity group (F(32,
21 788)=1.22, p=0.02). Between subjects effects for 12-month physical activity group are presented in Table 3. These were
22 statistically significant for BMI, per cent body fat, waist circumference, resting heart rate and mental well-being. In
23 general, as activity levels moved from **B**eginner to **C**onditioned all five health outcomes improved i.e. more activity
24 was associated with lower BMI, lower per cent body fat, smaller waist circumference, lower resting heart rate and better
25 mental well-being.
26
27
28
29
30
31
32
33
34
35
36

37 Table 3

38
39
40
41 Pairwise comparisons revealed that the two lowest 12-month physical activity groups (**B**eginner; **B**eginner or **A**ll
42 healthy adult) had statistically significantly higher BMI and per cent body fat than the **A**ll healthy adult (p<0.05), **A**ll
43 healthy adult or **C**onditioned (p<0.05) and **C**onditioned (p<0.01) groups. These two lowest 12-month physical activity
44 groups also had statistically significantly larger waist circumference than the **C**onditioned group (both p<0.05). In terms
45 of resting heart rate the **B**eginner group had a statistically significantly higher mean score than all the other 12-month
46 activity groups (p values range from <0.001 to <0.05). Mean resting heart rate for the **B**eginner or **A**ll healthy adult
47 group was also significantly higher than the **C**onditioned group (p<0.05). Finally, the **B**eginner group had statistically
48 significant poorer mental wellbeing than the two highest 12-month physical activity groups. The **B**eginner or **A**ll
49 healthy adult group had statistically significant poorer mental wellbeing than the **A**ll healthy adult or **C**onditioned group
50 (all Mean, SD and p values are presented in Table 3).
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65

1 Health outcomes did not vary as a function of marital status, ethnicity, SES or employer organisation. A near
2 statistically significant multivariate effect emerged for age ($F(8, 194)=1.99, p=0.05$). Between subjects effects for age
3 are presented in Table 3. There were no statistically significant interactions between 12-month physical activity group
4 and any of the demographic characteristics. Statistically significant multivariate effects emerged for all the objective
5 and self-reported T1 health outcome covariates which were significant in the predicted direction, for example those with
6 the highest BMI at baseline also had the highest BMI at 12 months.
7
8
9

10 11 12 **What is the impact of sedentary behaviour over 12 months on health?**

13 The objective and self-reported health outcomes across three 12-month sedentary groups ($n=358$) are presented in Table
14 4. There was no effect for 12-month sedentary group. In other words, as sitting levels decreased from high to low there
15 was no improvement in objective or self-reported health outcomes.
16
17
18
19
20
21

22
23 Table 4
24
25

26 Two significant interactions with 12-month sedentary group did emerge: sedentary group by gender ($F(16, 534)=2.06,$
27 $p=0.009$) and sedentary group by SES ($F(16, 534)=1.80, p=0.03$). The significant between subjects effect for sedentary
28 group by gender was for self-reported health (see Figure 2). For sedentary group by SES, significant between subjects
29 effects emerged for self-reported health and mental well-being (see Figures 3 and 4). However for all three effects, there
30 were no statistically significant differences in any pairs of mean scores.
31
32
33
34
35
36
37
38

39 Figures 2 to 4
40
41
42

43 MANCOVA revealed a statistically significant multivariate effect for gender ($F(8, 266)=2.88, p=0.004$) which had not
44 emerged in the physical activity group analysis presumably because of the different sample sizes in the two analyses (a
45 difference of $n=50$). Females ($M=31.57, SE=0.46$) had statistically significantly higher per cent body fat than males (M
46 $= 26.61, SE=0.51; (F(1, 273)=10.67, p=0.01)$ and lower systolic blood pressure (Females $M = 115.45, SE=1.63$; Males
47 $M = 121.17, SE=1.78; F(1, 273)=3.76, p=0.05$). Finally, as reported above there were statistically significant
48 multivariate effects for all the T1 objective and self-reported health outcome covariates in the predicted direction.
49
50
51
52
53
54
55
56

57 **Are physical activity and sedentary behaviours associated?** 58 59 60 61 62 63 64 65

1 Spearman correlation analysis revealed weak positive correlations between activity and sitting behaviours at all four
2 time points (T1: $r_s=0.21$; $p<0.001$; T2: $r_s = 0.22$; $p<0.001$; T3: $r_s = 0.23$; $p<0.001$; T4: $r_s =0.17$; $p=0.001$). In summary,
3 high activity was weakly associated with high sitting at each time point.
4
5

6 **DISCUSSION**

7
8 The aim of this study was to explore how *incremental* increases in physical activity as per the recent ABC classification
9 (O'Donovan et al. 2010; Figure 1) and *incremental* decreases in sitting (High to Moderate to Low) over a 12-month
10 period impact on health outcomes in employees of five organisations. We also investigated the association between
11 physical activity and sedentary behaviours. The participating employer organisations represent large UK employers
12 (Health and Social Care Information Centre 2012; Office for National Statistics 2011) and our findings provide
13 important insight into the activity and sedentary behaviours of employees as well as their health which has implications
14 for the design of effective interventions across different types of workplaces.
15
16
17
18
19
20
21
22
23
24

25 Two study limitations are acknowledged. We used a self-report measure of physical activity and sedentary behaviour
26 which is open to potential bias and measurement issues (Heesch et al. 2011). That said this method is pragmatic and
27 reliably associated with health outcomes (Heesch et al. 2011). Second, there were missing IPAQ data. However these
28 were confirmed to be missing completely at random. To address this we imputed the lowest activity (Beginner) and
29 highest sedentary (sitting more than 444 minutes a day) classifications at each time point. As such we are confident that
30 we have not over-estimated the positive effect of physical activity or low sitting on health outcomes. Indeed we may
31 have diluted their impact.
32
33
34
35
36
37
38
39
40

41 **How physically active and sedentary are these employees?**

42
43 Less than half (38%) of employees met the levels of physical activity recommended for health benefit at all four time
44 points. These activity levels, whilst captured over 12 months, are consistent with cross-sectional national adult surveys
45 (Cavill et al. 2006; Craig et al. 2008; Department of Health and Ageing 2011) and with the UK Well@Work study (Bull
46 et al. 2008). Differences in activity levels across the organisations were not statistically significant. Our measure of
47 activity included all types of physical activity, within and outside work, meaning any differences in workplace physical
48 activity would be hard to pick up if employees compensated for high or low activity levels outside of work.
49
50
51
52
53
54
55
56

57 The lack of a specific recommendation for the duration of sedentary time above which health may be at risk means that
58 studies which categorise sitting time use different cut off points as well as measure different domains of sedentary
59 behaviour e.g. TV viewing, occupational sitting; making comparison across studies difficult (Bauman et al. 2011). Over
60
61
62
63
64
65

1 a third (37%) of employees reported sitting for more than 7.4 hours on weekdays and a further 45% sat for more than
2 4.7 hours a day at each time point. This is noticeably less than the 82% of men and 55% of women reported by Brown
3 et al. (2003) in their study of Australian workers (whose classification of sitting behaviour we used) but is in line with
4 levels of *total sitting* reported in Dutch workers (Jans et al. 2007). Consistent with previous workplace studies (Bull et
5 al. 2008, Jans et al. 2007) we found statistically significant associations between levels of sedentary behaviour,
6 employer organisation and SES (using a measure based on occupation). Because of our use of a single index of
7 sedentary behaviour, we cannot be sure that these differences are due to the nature of the work of employees, although
8 it would seem likely. For example, council employees, found to be less sedentary, included a broad range of
9 occupations (including teachers, social workers, refuse collectors) compared to the highly sedentary bus drivers and
10 government organisation office workers. This explanation assumes that employees are not compensating for high or low
11 sedentary levels outside of work (Jans et al. 2007), which is in contrast to our interpretation of the physical activity
12 patterns reported above. In westernised countries many people have occupations that require long periods of sitting (van
13 Uffelen et al. 2010); if our interpretation of these findings is correct it suggests that those who cannot reduce their work
14 sitting time need to be prompted to reduce sitting in their travel and leisure time.
15
16
17
18
19
20
21
22
23
24
25
26
27
28

29 **What is the impact of physical activity behaviour over 12 months on health?**

30 As 12-month physical activity levels increased, four (of six) objective and one (of two) self-reported health outcomes
31 improved. More activity was associated with lower BMI, per cent body fat and RHR, smaller waist circumference and
32 better mental well-being. This was observed after controlling for demographic characteristics, organisation and baseline
33 health outcomes. Specifically, the two highest activity groups (**All healthy adult** or **Conditioned, Conditioned**) had
34 statistically significantly better scores on these health outcomes compared to the two lowest activity groups (**Beginner,**
35 **Beginner** or **All healthy adult**). Across all five groups systolic and diastolic blood pressure was within the normal range
36 (NICE, 2011) and self-reported health was marginally below UK adult population norms (Kind et al. 1999).
37
38
39
40
41
42
43
44
45
46

47 Health data by 12-month physical activity group and gender are presented in Appendix 1. In terms of *clinical*
48 significance, mean BMI and waist circumference scores for men in the two lowest activity groups placed them into the
49 ‘overweight’ and ‘high waist circumference’ categories (NICE, 2006) resulting in a classification of ‘increased health
50 risk’. Mean body fat percentage for these two groups defined them as ‘obese’ (Gallagher et al. 2000). High RHR is a
51 risk factor for both cardiovascular and all-cause mortality (Palatini and Julius 2004). Men in the two highest activity
52 groups had ‘good’ resting heart rate (RHR) levels compared to ‘average/below average’ for the two lowest activity
53 groups (YMCA 1989). Mean RHR scores placed women in the ‘average’ category, with the exception of the
54 **Conditioned** group who would be classified as ‘good/excellent’. The differences across activity groups for mental well-
55
56
57
58
59
60
61
62
63
64
65

being did not equate to a clinically significant benefit. Mean scores were marginally higher (reflecting poorer mental well-being) than norms for a non-clinical student population (Evans et al. 2005).

Of interest, is whether adults consistently meeting the All healthy adult level of physical activity over 12 months confer greater health benefit than those not meeting it. Only 22 participants fell into this group so it is difficult to draw meaningful conclusions. A benefit was evident for men in terms of BMI and per cent body fat. Those achieving these levels would no longer be classified as having an ‘increased health risk’ (NICE 2006). To our knowledge there are no other prospective studies in workplace or general population samples that present adults’ activity levels using the ABC classification. Physical activity and fitness surveys (Cavill et al. 2006; Department of Health 2011) and workplace studies (e.g. Bull et al. 2008) often compare **Beginner** with **All Healthy Adult** only. Given the body of evidence demonstrating additional health benefits of higher frequency and intensity of activity (O’Donovan et al. 2010; Lee et al. 2012; Warburton et al. 2007) evident also in our data; classifying adults across the full ABC spectrum would seem sensible.

We found no effect for 12-month sedentary behaviour. As sitting levels decreased from high to low there was no statistically significant or clinically meaningful improvement in health. Evidence for an association of sedentary behaviours with three of the health outcomes we explored (BMI, waist circumference, mental health) whilst considered ‘plausible’ (British Heart Foundation 2012, p3) remains mixed (Teyenne et al. 2010; Thorp et al. 2011; van Uffelen et al. 2010). Indeed, the precise dose-response relationships between sedentary behaviours and different health outcomes remain unknown (Katzmarzyk 2010). Furthermore, it may be that some health outcomes require high energy expenditure (i.e. increased physical activity) for improvement rather than reduced sedentariness.

Are physical activity and sedentary behaviours associated?

Finally, sitting and physical activity behaviours at each time point were weakly associated. This further confirms that physical activity and sedentary behaviours can be independent and co-exist, rather than one displacing the other (Biddle 2007). The implication is that in designing worksite interventions one cannot assume that strategies to increase physical activity will also reduce sedentary behaviours or vice versa. Yet public health guidance for worksites (e.g. NICE 2008) commonly focus exclusively on increasing physical activity rather than *also* targeting reducing sitting. Worksite interventions that have been evaluated have also tended to target physical activity alone or if both behaviours, sedentary behaviour is a secondary outcome (Chau et al 2010). More research is needed to understand the impact of workplace layout and policy on *both* increasing physical activity and breaking up sedentary behaviours across different types of employer organisations.

REFERENCES

- 1 Bauman A, Ainsworth BE, Sallis JF, Hagstromer M, Craig CL, Bull FC, Pratt M, Venugopal K, Chau J, Sjostrom M,
2 the IPS Group (2011) The Descriptive Epidemiology of Sitting A 20-Country Comparison Using the
3 International Physical Activity Questionnaire (IPAQ). *Am J Prev Med* 41:228-235
4
5
6 Biddle SJH (2007) Sedentary Behavior. *Am J Prev Med* 33:502-504
7
8
9 British Heart Foundation (2012) Sedentary behaviour–Evidence Briefing. BHF National Centre, Loughborough
10
11 Brown WJ, Miller YD, Miller R (2003) Sitting time and work patterns as indicators of overweight and obesity in
12 Australian adults. *Int J Obesity* 27:1340-1346
13
14 Bryan SN, Katzmarzky PT (2011) The association between meeting physical activity guidelines and chronic disease
15 among Canadian adults. *J. Phys. Act. Health* 8:10-17
16
17
18 Bull F, Adams E, Hooper P (2008) Well@Work: Promoting Active and Healthy Workplaces. Final Evaluation Report.
19 Loughborough University, Loughborough
20
21
22 Cavill N, Kahlmeier S, Racioppi F (2006) Physical activity and health in Europe: evidence for action. World Health
23 Organisation, Europe
24
25
26
27 Chau JY, van der Ploeg HP, van Uffelen JGZ, Wong J, Riphagen I, Healey GN, Gilson ND, Dunstan DW, Bauman AE,
28 Owen N, Brown WJ (2010) Are workplace interventions to reduce sitting effective? A systematic review. *Prev*
29 *Med* 51:352-356
30
31
32
33 Craig CL, Marshall AL, Sjostrom M, Bauman AE, Booth ML, Ainsworth BE, Pratt M, Ekelund U, Yngve A, Sallis JF
34 et al. (2003) International physical activity questionnaire: 12-country reliability and validity. *Med Science*
35 *Sports Exer* 35:1381-1395
36
37
38
39 Craig R, Mindell J, Hirani V (2008) Health Survey for England 2008. Volume 1: Physical activity and fitness. The NHS
40 Information Centre, Leeds
41
42
43 De Cocker KA, De Bourdeaudhuij IM, Cardon GM (2009) What do pedometer counts represent? A comparison
44 between pedometer data and data from four different questionnaires. *Public Health Nutr* 12:74-81
45
46
47 Department of Health (2004) Chief Medical Officers Report: At least five a week; evidence on the impact of physical
48 activity and its relationship to health. HM Government, London
49
50
51 Department of Health (2011) Chief Medical Officers Report: A report on physical activity for health from the four
52 home countries. HM Government, London
53
54
55 Department of Health and Ageing (2011) National Health Survey–Australia 2009. Australian Government, Canberra
56
57
58 Evans C, Connell J, Audin K, Sinclair A, Barkham M (2005) Rationale and development of a general population well-
59 being measure: Psychometric status of the GP-CORE in a student sample. *Brit J Guid Couns* 33:153-173
60
61
62
63
64
65

- Gallagher D, Heymsfield SB, Heo M, Jebb SA, Margatroyd PR, Sakamoto Y (2000) Healthy percentage body fat ranges: an approach for developing guidelines based on body mass index. *Am J Clin Nutr* 72:694-701
- Hagstromer M, Oja P, Sjostrom M (2006) The International Physical Activity Questionnaire (IPAQ): a study of concurrent and construct validity. *Public Health Nutr* 9:755-762
- Hallal PC, Andersen LB, Bull FC, Guthold R, Haskell W, Ekelund U, for the Lancet Physical Activity Series Working Group (2012) Physical Activity 1. Global physical activity levels: surveillance progress, pitfalls and prospects. *The Lancet* 380:247-257
- Health and Social Care Information Centre (2012) Monthly NHS Hospital and Community Health (HCHS) Workforce Statistics in England – August 2012, Provisional Statistics. Health and Social Care Information Centre, London
- Heesch KC, Burton NW, Brown WJ (2011) Concurrent and prospective associations between physical activity, walking and mental health in older women. *J Epidemiol Commun H* 65:807-811
- Jans MP, Proper KI, Hildebrandt VH (2007) Sedentary Behavior in Dutch Workers. Differences Between Occupations and Business Sectors. *Am J Prev Med* 33:450-454
- Katzmarzyk PT (2010) Physical Activity, Sedentary Behavior, and Health: Paradigm Paralysis or Paradigm Shift? *Diabetes* 59:2717-2725
- Kind P, Hardman G, Macran S (1999) UK Population Norms for EQ-5D. The University of York, York
- Lee I-Min, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk for the Lancet Physical Activity Series Working Group (2012) Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *The Lancet* 380:219-229
- McEachan RRC, Lawton RJ, Jackson C, Conner M, Meads DM, West RW (2011) Testing a workplace physical activity intervention: a cluster randomised controlled trial. *Int J Behav Nutr Phy* 8:29
- NICE (2006) Obesity. Guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE, London
- NICE (2008). Workplace health promotion: how to encourage employees to be physically active. NICE, London
- NICE (2011) Hypertension. Clinical management of primary hypertension in adults. NICE, London
- Office for National Statistics (2011) Public Sector Employment, Q2 2011. Office for National Statistics, London
- O'Donovan G, Blazeovich AJ, Boreham C, Cooper A, Crank H, Ekelund U, Fox KF, Gately P, Giles-Corti G, Gill JMR et al. (2010) The ABC of physical activity for health: a consensus statement from the British Association of Sport and Exercise Sciences. *J Sport Sci* 28:573-591
- Palatini P, Julius S (2004) Elevated heart rate: a major risk factor for cardiovascular disease. *Clin Exp Hypertens* 26:637-644
- Pate RR, O'Neill JR, Lobelo F (2008) The Evolving Definition of "Sedentary". *Exercise Sport Sci R* 36:173-178

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65

Proper KI, Singh AS, van Mechelen W, Chinapaw MJ (2011) Sedentary behaviors and health outcomes among adults: a systematic review of prospective studies. *Am J Prev Med* 40:174-182

Teychenne M, Ball K, Salmon J (2010) Sedentary Behavior and Depression Among Adults: A Review. *Int. J Behav Med* 17:246-254

The EuroQol Group (1990) 'EuroQol-a new facility for the measurement of health related quality of life'. *Health Policy* 16:199-208

Thorp AA, Owen N, Neuhaus M, Dunstan DW (2011) Sedentary Behaviors and Subsequent Health Outcomes in Adults. A Systematic Review of Longitudinal Studies, 1996-2011. *Am J Prev Med* 41:207-215

Surgeon General (1996) Physical activity and health: a report from the Surgeon General. US Department of Health and Human Services, Rockville

van Uffelen JGZ, Wong J, Chau JY, van der Ploeg HP, Riphagen I, Gilson ND, Burton NW, Healy GN, Thorp AA, Clark BK et al. (2010) Occupational Sitting and Health Risks. A Systematic Review. *Am J Prev Med* 39:379-388

Warburton DER, Katzmarzyk PT, Rhodes RE, Shephard RJ (2007) Evidence-informed physical activity guidelines for Canadian adults. *Appl Physiol.Nutr Metab* 32:S16-S68

YMCA (1989) Y's Way to Physical Fitness (3rd edition). Human Kinetics Publishers, Champaign.

Appendix 1: Objective and self-reported health of participants by 12- month physical activity group and gender

	All				Beginner				Beginner or All healthy adult				All healthy adult				All healthy adult or Conditioned				Conditioned			
	Males		Females		Males		Females		Males		Females		Males		Females		Males		Females		Males		Females	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD
Body mass index	25.59	3.17	24.40	4.44	26.12	3.72	24.61	4.69	25.73	3.31	24.80	4.87	26.11	2.96	23.93	3.15	25.29	2.81	23.46	4.29	24.88	2.76	23.97	3.09
% body fat	24.84	5.63	34.58	6.84	27.00	6.10	35.33	6.74	25.70	5.56	24.80	4.87	24.35	4.67	32.80	5.05	24.33	5.13	32.94	6.99	21.98	5.03	33.15	7.00
Waist circumference	92.62	9.70	82.64	11.78	96.76	12.69	84.06	12.56	93.50	8.69	83.18	11.37	91.97	8.20	80.79	9.20	90.77	7.13	81.60	12.62	88.85	8.45	79.07	10.70
Systolic BP	125.92	12.28	113.37	13.71	124.34	9.53	114.17	16.05	126.94	16.80	114.03	12.70	125.10	7.71	111.92	7.98	126.88	11.67	113.32	15.11	125.69	10.21	109.86	9.42
Diastolic BP	79.54	9.00	76.16	9.86	79.48	8.16	77.38	9.97	81.86	10.44	76.56	10.12	81.20	6.60	74.08	8.27	78.72	9.04	76.28	10.96	76.62	8.13	72.33	7.74
Resting heart rate	65.63	10.98	70.17	9.77	72.93	10.73	73.20	10.38	68.09	9.14	70.15	8.71	58.20	10.35	69.75	12.48	63.20	8.70	68.00	7.26	59.38	10.26	63.86	8.70
Mental well-being ^a	3.78	0.63	3.80	0.62	3.56	0.64	3.71	0.75	3.77	0.58	3.80	0.52	3.60	0.69	3.89	0.47	4.01	0.59	3.84	0.51	3.88	0.65	3.97	0.64
Self-reported health ^b	74.12	16.50	73.66	17.34	67.97	19.21	71.02	19.46	72.34	14.54	71.89	17.79	74.20	20.71	73.50	15.71	81.84	7.77	78.36	13.17	75.92	18.05	81.38	11.35

^aN = 308 (125 male, 183 female): n = 93 Beginner (29 male, 64 female), n = 96 Beginner/All healthy adult (35 male, 61 female); n = 22 All healthy adult (10 male, 12 female), n = 50 All healthy adult/Conditioned (25 male, 25 female); n = 47 Conditioned (26 male, 21 female).

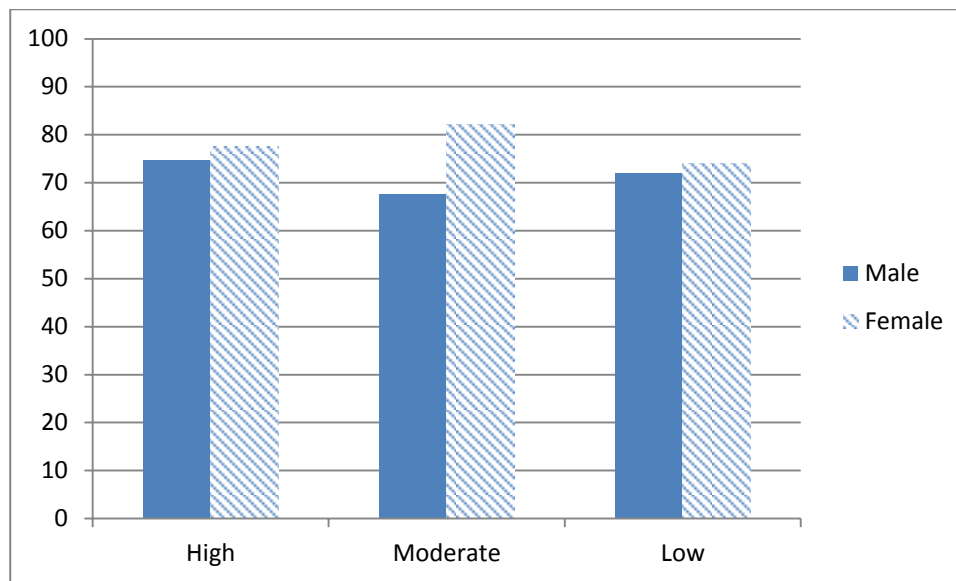
^bScores range from 1 (worst mental wellbeing) to 5 (best mental wellbeing); ^bScores range from 0 (worst imaginable health) to 100 (best imaginable health).

Figure 1: Key recommendations in the ABC of Physical Activity for Health

- All healthy adults should take part in at least 150 min of moderate-intensity aerobic activity each week, or at least 75 min of vigorous-intensity aerobic activity each week, or equivalent combinations of moderate- and vigorous-intensity aerobic activities.
- **B**eginners should steadily work towards meeting the physical activity levels recommended for all healthy adults.
- **C**onditioned individuals who have met the physical activity levels recommended for all healthy adults for at least 6 months may obtain additional health benefits by engaging in 300 min or more of moderate-intensity aerobic activity each week, or 150 min or more of vigorous-intensity aerobic activity each week, or equivalent combinations of moderate- and vigorous-intensity aerobic activities.
- All adults should minimise the amount of time spent being sedentary (sitting) for extended periods.

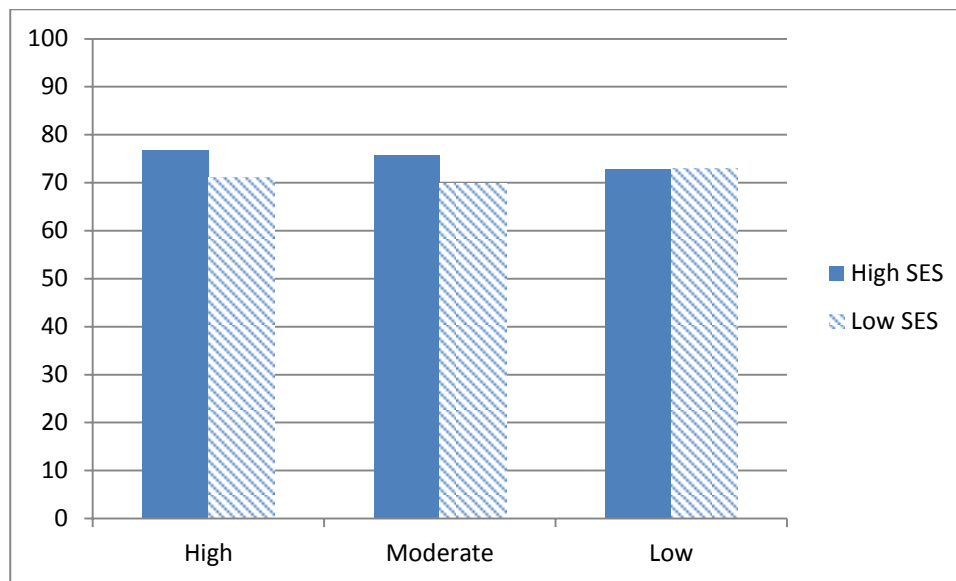
Adapted from O'Donovan et al. (2010)

Figure 2: Mean Self-reported Health State^a by 12-month sedentary group x gender



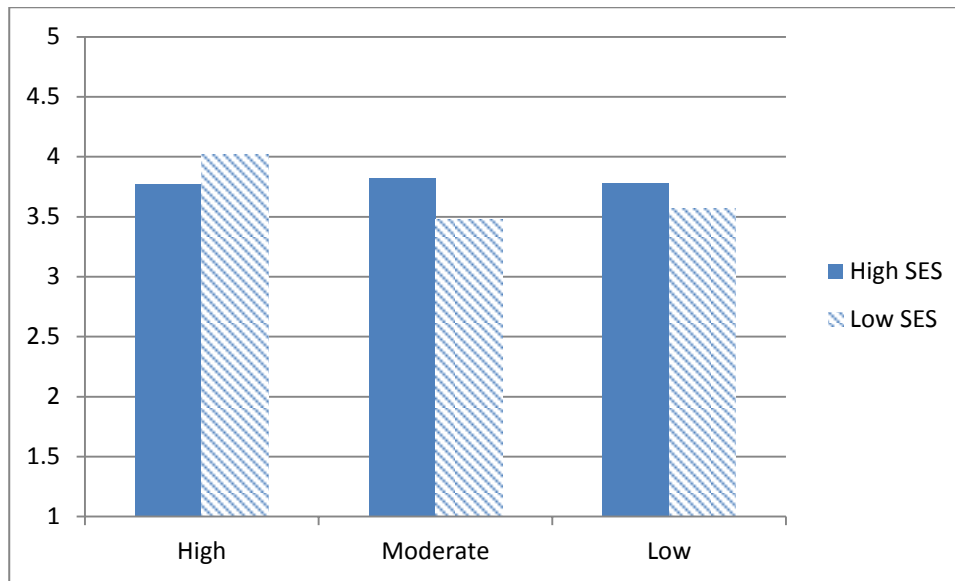
^aScores range from 0 (worst imaginable health) and 100 (best imaginable health)

Figure 3: Mean Self-reported Health State^a by 12-month sedentary group x SES



^aScores range from 0 (worst imaginable health) and 100 (best imaginable health).

Figure 4: Mean Self-reported Mental Well-being^a by 12-month sedentary group x SES



^aScores range from 1 (good mental well-being) to 5 (poor mental well-being)

Table 1: Demographic characteristics of participants across 12-month physical activity groups

		All		Beginner		Beginner or All healthy adult		All healthy adult		All healthy adult or Conditioned		Conditioned	
		n	%	n	%	n	%	n	%	n	%	n	%
	All ^a	308	100	93	30	96	31	22	7	50	16	47	15
Gender	Male	125	41	29	31	35	36	10	45	25	50	26	55
	Female	183	59	64	69	61	64	12	55	25	50	21	45
Marital Status ^b	Married	219	71	58	62	71	74	17	77	39	78	34	72
	Single	89	29	35	38	25	26	5	23	11	22	13	28
Ethnicity	White British	274	89	85	91	85	89	19	86	46	92	39	83
	Other	34	11	8	9	11	11	3	14	4	8	8	17
NSSEC ^c	Higher SES	280	91	80	86	90	94	20	91	48	96	42	89
	Lower SES	28	9	13	14	6	6	2	9	2	4	5	11
Employer Organisation	Council	136	44	33	35	41	43	10	45	28	56	24	51
	Hospital	58	19	24	26	18	19	3	14	6	12	7	15
	Bus company	23	8	13	14	6	6	0	0	2	4	2	4
	Government	70	23	17	18	25	26	7	32	11	22	10	21
	University	21	7	6	6	6	6	2	9	3	6	4	9
	Age (years; M, SD)	40.47, 9.77		40.73, 9.70		40.06, 9.13		38.77, 9.56		39.76, 10.02		42.34, 11.01	

N=308. ^aPercentages across for 'All' are calculated across physical activity groups. Percentages for demographics and employer organisation characteristics are calculated within physical activity groups. All percentages are presented to the nearest full number and may not total 100.

^bMarried/Civil partnership/living together; Single/in relationship. ^cHigher SES=Intermediate, Managerial/Professional; Lower SES=Lower Supervisory, Semi-routine/Routine.

Table 2: Demographic characteristics of participants across the 12-month sedentary groups

		High sitting		Moderate sitting		Low sitting	
		n	%	n	%	n	%
	All ^a	134	37	160	45	64	18
Gender	Male	59	44	66	41	26	41
	Female	75	56	94	59	38	59
Marital Status ^b	Married	96	72	119	75	52	81
	Single	38	28	41	25	12	19
Ethnicity	White British	122	91	137	86	58	91
	Other	12	9	23	14	6	9
NSSEC ^c	Higher SES	115	86	150	94	53	83
	Lower SES	19	14	50	6	11	17
Employer Organisation	Council	42	31	80	50	35	55
	Hospital	22	16	28	18	12	19
	Bus company	20	16	7	4	1	2
	Government	40	30	29	18	10	16
	University	10	7	16	10	6	9
	Age (years; M, SD)	40.95, 10.71		40.80, 10.19		42.13, 9,.27	

N=358. ^aPercentages across for 'All' are calculated across sedentary groups. Percentages for demographics and employer organisation characteristics are calculated within sedentary groups. All percentages are presented to the nearest full number and may not total 100.

^bMarried/Civil partnership/living together; Single/in relationship. ^cHigher SES=Intermediate, Managerial/Professional; Lower SES=Lower Supervisory, Semi-routine/Routine.

Table 3: Objective and self-reported health (mean, SD) of participants across 12-month physical activity groups

	All		Beginner		Beginner or All healthy adult		All healthy adult		All healthy adult or Conditioned		Conditioned		Between-subjects effects	
	M	SD	M	SD	M	SD	M	SD	M	SD	M	SD	12-month physical activity group	Age
Body mass index	24.88	4.01	25.08 ^{1,2,3}	4.45	25.14 ^{4,5,6}	4.37	24.93 ^{1,4}	3.19	24.38 ^{2,5}	3.70	24.47 ^{3,6}	2.92	F(4)=2.44, p=0.04	F(1)=4.31, p=0.04
% body fat	30.63	7.97	32.73 ^{7,8,9}	7.58	31.81 ^{10,11,12}	8.02	29.00 ^{7,10}	6.42	28.63 ^{8,11}	7.47	26.97 ^{9,12}	8.16	F(4)=2.48, p=0.04	F(1)=4.04, p=0.04
Waist circumference	86.48	10.62	88.02 ¹³	13.86	86.94 ¹⁴	11.56	85.87	10.27	86.18	11.15	84.48 ^{13,14}	10.62	F(4)=5.32, p<0.001	F(1)=2.23, p=0.14
Systolic BP	118.46	14.51	117.34	15.05	118.74	15.55	117.91	10.20	120.10	15.01	118.62	12.59	F(4)=1.18, p=0.32	F(1)=4.20, p=0.04
Diastolic BP	77.53	9.65	78.03	9.45	78.49	10.50	77.32	8.23	77.50	10.02	74.70	8.16	F(4)=1.25, p=0.29	F(1)=5.95, p=0.02
Resting heart rate	68.33	10.50	73.12 ^{15,16,17,18}	10.43	69.40 ^{15,19}	8.88	64.50 ¹⁶	12.73	65.60 ¹⁷	8.29	61.38 ^{18,19}	9.56	F(4)=2.94, p=0.02	F(1)=0.25, p=0.62
Mental well-being ^a	3.79	0.62	3.66 ^{20,21}	0.72	3.79 ²²	0.54	3.76	0.58	3.93 ²⁰	0.55	3.92 ^{21,22}	0.64	F(4)=3.37, p=0.01	F(1)=0.13, p=0.72
Self-reported health ^b	73.85	16.98	70.07	19.33	72.05	16.60	73.82	17.70	80.10	10.84	78.36	15.51	F(4)=0.78, p=0.54	F(1)=2.46, p=0.12

N = 308: n = 93 Beginner, n = 96 Beginner/All healthy adult; n = 22 All healthy adult, n = 50 All healthy adult/Conditioned; n = 47 Conditioned.

Statistically significant pairwise comparisons:

Pairwise comparisons: 1,2,4,5,7,8,10,11,13,14,15,19,21,22 all p<0.05; 3,6,9,12,16,17 all p < 0.01; 18,20 p<0.001.

^aScores range from 1 (worst mental wellbeing) to 5 (best mental wellbeing); ^bScores range from 0 (worst imaginable health) to 100 (best imaginable health).

Table 4: Objective and self-reported health (mean, SD) of participants across 12-month sedentary groups

	All		High sitting		Moderate sitting		Low sitting		Between-subjects effects		
	M	SD	M	SD	M	SD	M	SD	Gender	12-month Sedentary Group by gender	12-month Sedentary Group by SES
Body mass index	24.96	4.08	25.10	4.50	24.87	3.72	24.87	4.08	F(1)=0.40, p=0.53	F(2)=1.49, p=0.23	F(2)=0.92, p=0.40
% body fat	30.74	7.76	30.67	8.21	30.64	7.54	29.67	7.37	F(1)=4.60, p=0.03	F(2)=2.05, p=0.13	F(2)=0.43, p=0.65
Waist circumference	87.11	12.54	87.88	13.66	86.96	11.50	85.86	12.64	F(1)=2.50, p=0.12	F(2)=0.40, p=0.67	F(2)=0.96, p=0.39
Systolic BP	119.32	15.14	119.91	15.68	119.65	14.76	117.28	15.00	F(1)=4.08, p=0.04	F(2)=1.97, p=0.14	F(2)=0.58, p=0.56
Diastolic BP	77.78	9.94	78.01	9.40	78.04	10.10	76.63	10.67	F(1)=1.61, p=0.21	F(2)=1.31, p=0.27	F(2)=0.80, p=0.45
Resting heart rate	67.98	9.94	66.99	10.01	67.71	10.09	66.56	9.29	F(1)=2.65, p=0.11	F(2)=1.25, p=0.29	F(2)=0.10, p=0.91
Mental well-being ^a	3.82	0.59	3.84	0.59	3.76	0.58	3.94	0.60	F(1)=0.35, p=0.55	F(2)=0.85, p=0.43	F(2)=3.19, p=0.04
Self-reported health ^b	75.34	15.09	74.22	16.34	75.21	14.16	78.03	14.48	F(1)=2.15, p=0.14	F(2)=7.04, p=0.001	F(2)=5.92, p=0.003

N = 358: n = 134 High sitting, n = 160 Moderate sitting; n = 64 Low sitting.

^aScores range from 1 (best mental wellbeing) to 5 (worst mental wellbeing); ^bScores range from 0 (worst imaginable health) to 100 (best imaginable health).

ACKNOWLEDGMENTS

The AME for Activity study was funded by the Bupa Foundation Medical Charity (ref: 33a05Lawton). The contribution of RL, RRCM, MC and CJ to the study was funded by this Bupa Foundation grant. All five authors' employer organisations have funded the preparation of this manuscript. The Bupa Foundation Medical Charity had no role in this manuscript.

The authors would like to acknowledge the AME for Activity steering group: David Fishwick, Jennifer Lunt and Bronwen Ley for the Health and Safety Laboratory; the health technicians who conducted the health checks; Kate Thompson, Ben Green and Natalie Taylor for their assistance with data collection. Sara McDermott for assistance with recruitment in one organisation; all the participating organisations and employees who took part in the study.