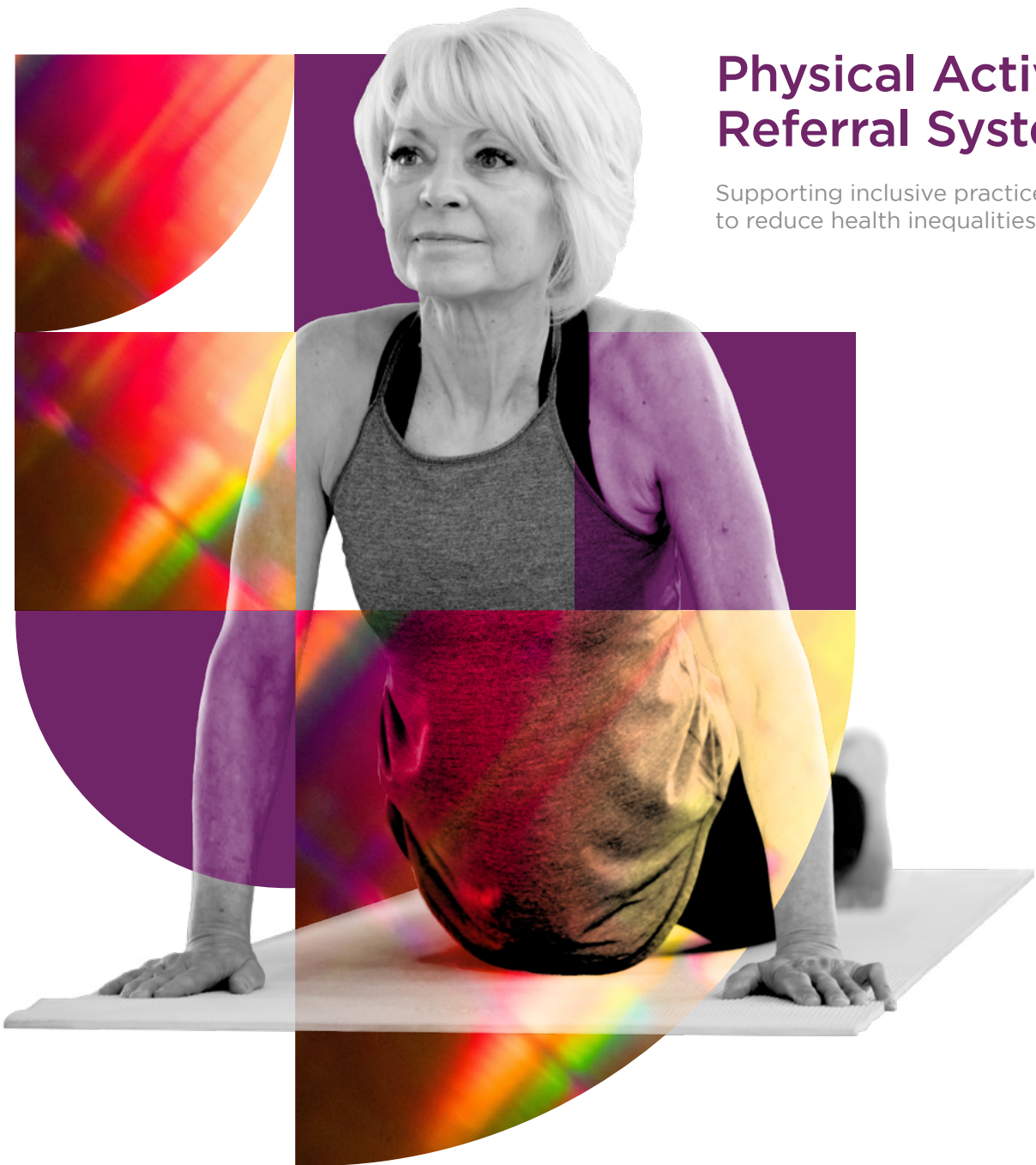




**Durham**  
University

Department of Sport  
and Exercise Sciences

Inspiring the extraordinary



## Physical Activity Referral Systems

Supporting inclusive practice  
to reduce health inequalities

# Overview

## Exercise and physical activity referral systems support a wide range of individuals to become active.

Created in the 1990s and now available internationally, schemes traditionally target those with specific health conditions or risk factors who might most benefit from increasing their physical activity. More recently, provision has diversified, becoming fully embedded within treatment pathways (e.g., cardiac rehabilitation), through tailored condition-specific routes

**Activity inequality-centric interventions could be up to 4 times more effective at reducing obesity prevalence than a population-wide approach.** Althoff et al. 2017. *Nature*.

(e.g., falls prevention, mental health), and with widened access opportunities (e.g., self-referral, referrals from social care or prescribers).

This diversity raises challenges in understanding what works, in what contexts, and for which types of people. Our research with patients, commissioners and providers has helped to understand who is benefitting, who is missing out, and why. We have designed and tested within-scheme innovations and shared best practices nationally.

Together, we want to ensure physical activity referral systems successfully address longstanding health inequalities by supporting those most in need.

# Globally 3.2m

deaths per year are attributed to inactivity (WHO)



© Obesity Action Coalition.

## The Challenge of Inequalities

### Practice Challenges

Physical activity referral schemes operate in difficult and dynamic contexts. Schemes have to support individuals with a wide range of often complex needs. Navigating resource (time and money) pressures has led to creativity 'on the ground', but there is limited capacity for evaluation and data collection. We support practitioners and scheme coordinators by publishing and sharing good practice. To ensure feasibility, we work with them to prototype new interventions, before these are scaled up.

### Evidence Challenges

Generating high-quality evidence about schemes is challenging, due to varying data collection, data sharing restrictions, and a lack of long-term follow up (especially of health outcomes).

We are improving the evidence base by developing easy-to-use classification systems (with Hanson, Edinburgh Napier) and using advanced modelling to consider localised populations and health needs when examining uptake and adherence.

### Policy Challenges

Our work responds to policy calls for research focused upon factors encouraging uptake and adherence, and barriers preventing participation (e.g., The National Institute for Health and Care Excellence, UK). We are supporting policy development and implementation by identifying areas for prioritisation, and finding new ways to broker understanding and co-working across multiple stakeholders including healthcare and leisure professionals, local authorities and charitable partners.

## Why the Research is Important

**Inactivity is costly in terms of people's lives, health, and public spending, accounting for 1.5% - 3.0% of developed countries' direct healthcare costs.<sup>1</sup> However, inactivity is not evenly distributed; those living with greater disadvantage are less likely to be regularly physically active.<sup>2</sup>**

In addition to wider health inequalities, access to services supporting individuals to become active may not be equitable. Some participants face increased barriers including cost, accessibility, managing co-morbid health conditions, or complex social circumstances.

To avoid widening health inequalities, we need to find ways to help everyone to become active.

1 Oldridge NB. Economic burden of physical inactivity: Healthcare costs associated with cardiovascular disease. *Eur J Prev Card*. 2008;15(2):130-9.

2 Ball K, Carver A, Downing K, Jackson M, O'Rourke K. Addressing the social determinants of inequities in physical activity and sedentary behaviours. *Health Promotion International*. 2015; 30(2): ii8-ii19.

3 Farrell L, Hollingsworth B, Propper C, Shields MA. The Socioeconomic Gradient in Physical Inactivity in England: Evidence from One Million Adults in England. *Soc Sci Med*. 2014; 123: 55-63.

**Socio-economic gaps in activity levels suggest that current campaigns may not be reaching those who need them most.<sup>3</sup>**

## Featured Research

With **Active Northumberland and Momenta Weight Management**, we've tested new packages of behaviour change support in particular for those referred for excess weight. We have also explored the impact of referral on widening or reducing existing inequalities.

With **UKActive**, we've modelled inequalities in engagement and outcomes across schemes nationally, highlighting best practice for inclusive provision.

With the **National Exercise Referral Scheme Wales**, we've tested the feasibility of technological innovations to support engagement and adherence.

With **participants and patients** we've highlighted how their wider health, financial, and social circumstances can impact on engagement and experience.



# Key Findings and Recommendations

Schemes and services should *regularly monitor, report and review* uptake by key sociodemographic characteristics, as our work has shown that recruitment and retention is biased by gender, age, affluence and ethnicity. We recommend using the Cochrane's PROGRESS-Plus model to do this.

*Technological interventions should be used cautiously*; our work has shown that uptake is skewed towards those with higher social economic status, and experiences and use can be undermined by a lack of digital literacy, home-based technology, and concerns about cost.

Funding systems should explicitly *incentivise engagement of hard-to-reach groups* and consider more *nuanced evaluation*. For example, we recommend including distance travelled as an indicator of effectiveness - a small change at the extremes of poor health may be very meaningful for an individual.

Providers should *enhance triaging* at entry to enable effective *tailoring of provision*. This may include light-touch services for those who are 'nearly active' alongside *complementary service provision* (e.g., welfare advice, counselling) for those requiring additional support.

For healthcare providers, *raising conversations* around physical activity and expectations is important, especially for those least likely to access schemes (e.g. men). Commissioners should ensure stakeholders are aware of service options, engaged with scheme development, and able to contribute to ongoing scheme refinement.



## Our Research Partners

For further information, please contact **Dr Emily Oliver** or **Dr Caroline Dodd-Reynolds**, who are both members of the Department of Sport and Exercise Sciences and Co-Directors of the Wolfson Research Institute for Health and Wellbeing's Physical Activity Special Interest Group at Durham University.

The featured and ongoing work was conducted with and supported by key research partners and organisations including Dr Coral Hanson, Dr Jemma Hawkins, Dr Paul Kelly, the Welsh National Exercise Referral Scheme, Active Durham, UKActive, Active Northumberland and Fuse - The Centre for Translational Research in Public Health.



## Contact us

- [Click to learn more](#) about our Department's research
- or follow us [@WolfsonResearch](#) [@DUSportExSci](#)