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Optimising Exercise Referral Schemes

Recommendations from 3 PHIRST Evaluations

1. **Moving from in-person to remote delivery (Wales)**
2. **Targeted Exercise Referral Scheme for Equity (Bracknell Forest)**
3. **A hub-based model for exercise referral (Southwark)**

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Evaluation 1:

Adaptation of the Welsh National Exercise Referral Scheme (NERS) to virtual delivery

What is NERS?

- Operates across all of Wales supporting people, with (or at risk of) long-term conditions, to exercise (11 pathways)

- Until March 2020: Face-to-face classes
- March 2020 to March 2021: Virtual exercise classes (pre-recorded or live) and/or home exercise plan
- March 2021 onwards: Virtual or face-to-face depending on preference

What did we find?

- Attendance highest for flexible delivery
- Being older, or living with lower deprivation, increased uptake/adherence
- Estimated costs per person for face-to-face delivery was £65 vs £202 for virtual
- Offering a virtual version could increase accessibility for typically underserved
- Some lacked digital skills or confidence to get online, particularly older users

What does this mean for you?

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Evaluation2:

Targeted Exercise Referral Scheme for Equity (Bracknell Forest)

The Intervention:

- The service is based on the principle of proportionate universalism and is **available to all** (with very few exclusion criteria).
- The service is made **free of charge to those in receipt of benefits** and targets people from socially disadvantaged communities and those with protected characteristics.
- Referrals are made from **health professionals** but also from **social prescribers**, voluntary sector and via **self-referral**.
- Following an initial assessment with a **Health and Well-Being Physical Activity Coach**, users receive a **bespoke tailored exercise programme** that was intended not to be solely gym-based but which may include one-to-one or small group work and activities based in community settings.
- The service **lasts 6 months** (longer than the usual 12 weeks).
- Health and Well-Being Coaches were expected to refer to other community services where needs related to health are identified and addressed, e.g., housing, debt, loneliness.

Acceptable and accessible service to those with long term conditions AND those least likely to be active

What did we find?

Strong uptake but low adherence:

- 320 people referred; 80% uptake (in line with national ERS data) but only around 15% met the recommended attendance of 2+ sessions per week.
- Majority of users were women (59%), average age 51; 40% lived in the most deprived wards.

Who engaged:

- Participants typically had multiple health conditions (physical and mental), complex lives, and caring responsibilities.
- Engagement was supported by free/subsidised access, extended 6-month duration, and personalised coaching.

Systemic issues:

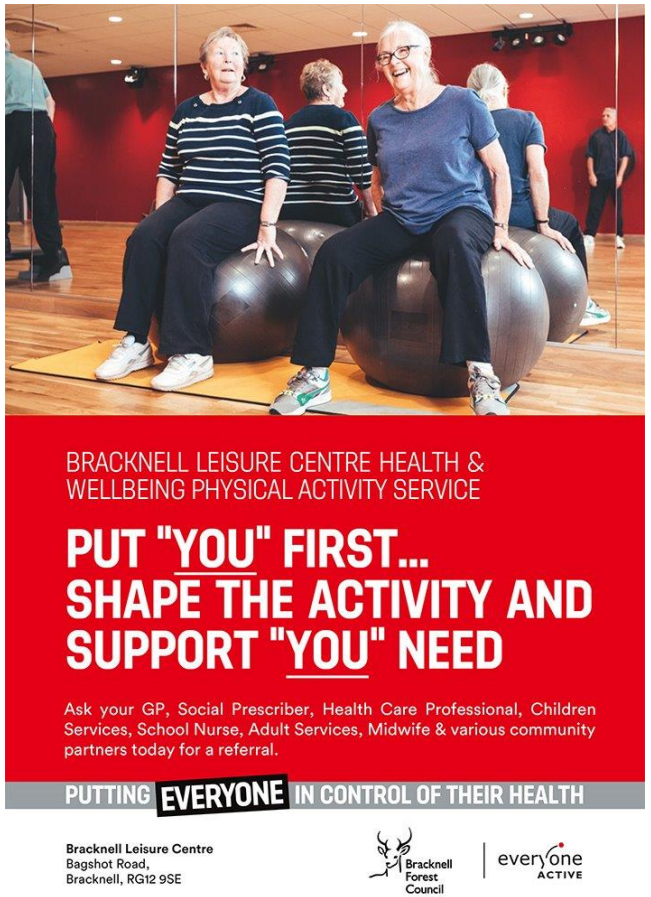
- Limited cross-sector links: health, social care, and voluntary sectors operated largely in silos.
- The offer remained mainly gym-based, not the broader community-embedded model originally intended.
- Referral was primarily through primary care and social prescribers.

Impact:

- Participants completing 6 months reported improved wellbeing (26%) and physical/mental health (68%).
- Reported small but meaningful lifestyle shifts: greater confidence, less isolation, better mood, and more routine physical activity.

Cost

- Average cost per participant £172.40



What does this mean for you?

- The free/subsidised offer, extended timeframe, and health coach support are important enablers for participation
- Build strong referral networks and feedback loops between services
- Targeted awareness-raising in deprived wards and among referrers
- Move beyond gyms – include community, outdoor, and social options
- Integrate peer support and opportunities for social connection
- See ERS as part of a wider physical activity system, not a stand-alone scheme
- Commission for equity, inclusion, and sustainability, not just attendance numbers

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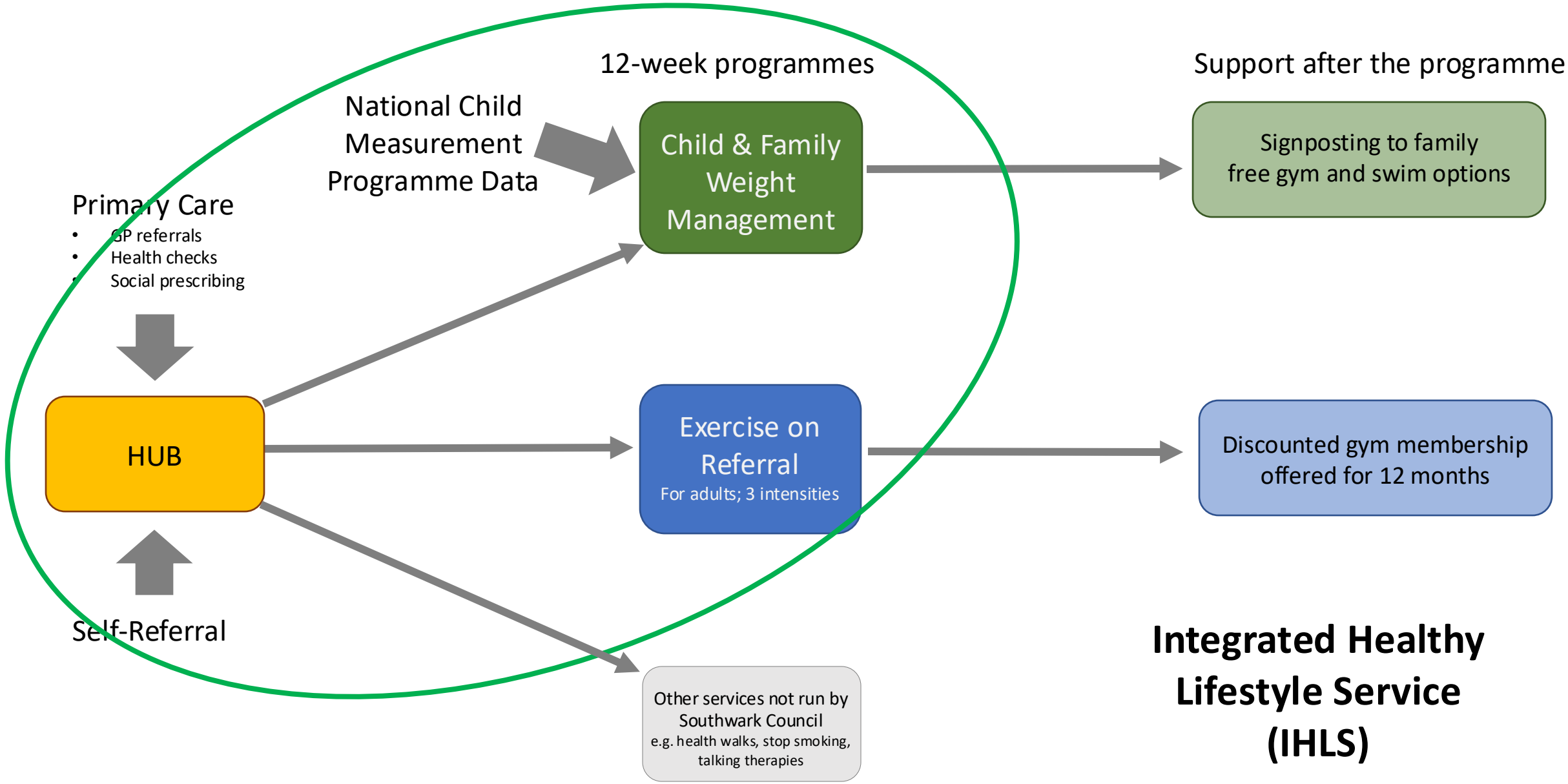
Evaluation 3

A hub-based model for exercise referral (Southwark)

What is the intervention?



Integrated Healthy Lifestyle Service (IHLS)

What did we find?

The Hub improves access for some

The way the hub engages with service users could be smoother

The role of the hub is not always clear for service users

The hub needs to be better integrated with other parts of the service

- Data
- Post-programme support

What does this mean for you? Recommendations…

For the Hub

- Define the exact *role* of the Hub and the services included under its umbrella
- Streamline access times and clarify inclusion criteria
- Communicate more clearly with service users (e.g. programme details, wait times)

For health behaviours & outcomes

Expand and promote post-progamme options

Service user involvement

Create a public involvement, community engagement or service user group

Data

- More consistent data collection
- Linked data sets (Hub – programmes - leisure centre)

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