The role of healthcare professionals in supporting disabled people into physical activity

Research report

Activity Alliance

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Better Decisions Together

activity alliance disability inclusion sport

Contents

Executive summary

Healthcare professionals are known to play a role in positively impacting disabled people's health and wellbeing through promoting physical activity.

This research project explored the role of healthcare professionals in supporting disabled people to be more physically active.

A review of evidence found that the NHS and healthcare professionals are **trusted messengers:** a source of information and guidance on being physically active. The **exact roles or job titles** of trusted messengers were less clear, and there was little information on which healthcare professionals disabled people wanted support from.

The review also found that disabled people experience a **lack of guidance** on appropriate types or levels of activity, or suitable rehabilitation advice (impacting on pain or recovery). We also found that there may be **key moments** where interventions are more impactful (or where an individual's level of physical activity is more likely to decrease).

We looked at the above areas in our research, and explored what interventions worked for people, and whether these are scalable.

Good practice case studies

We wanted to research **areas of good practice**, and develop case studies of where healthcare professionals were successfully supporting disabled people into physical activity.

Six examples of good practice in local areas were developed into case studies (from a long-list of over 40 potential projects and approaches).

The projects featured in our good practice case studies were: Access to Exercise and Wellbeing (Cheshire); Health Improvement Practitioner in community stroke team (Greater Manchester); Move to Include (Somerset); Parkinson's Disease exercise group (Greater Manchester); Super Mash Up! at the Manchester Children's Hospital and the Middlesbrough Powerchair Football Club.

From these case studies, we identified **six key features of success**:

- Cross-sector collaboration.
- Lived-experience leadership.
- Commitment to inclusion.
- Community creation and mental wellbeing.

- Personalisation and staying in touch.
- Upskilling through education, awareness and training.

Disabled people's experiences of positive support

Sixteen disabled people attended focus groups to share their experiences of being supported by a healthcare professional to be more physically active.

Participants were supported by **various healthcare professionals**, including GPs, physiotherapists, occupational therapists and social prescribers.

Overall, there were five key features of successful support into physical activity:

- **Personalised support**, understanding individual needs while conveying an informed clinical understanding of their impairment or condition.
- **Trusted relationships**, built on common ground, with professional who demonstrated condition-specific clinical knowledge.
- A **multi-disciplinary** approach which reinforced positive messaging about physical activity.
- **Gradual, realistic progression** with a personalised plan.
- Connecting into the **community**: Most interactions took place within local **primary care** settings, acting as gateways to broader community activities.

For some participants, community-based and community-building activities were a key part of success.

Timing was important for the delivery of a successful intervention. People needed to be at a point of being open to taking action to improve or protect their physical and mental wellbeing. This was sometimes after they had had time to process a changed situation, or when they felt that their physical or mental health could be about to decline.

Opportunities for scaling up

Opportunities for scaling up include:

- **Working in collaborative 'physical activity' partnerships** across healthcare, the voluntary sector and sports and physical activity providers.
- Working in **local, place-based partnerships** where local people can benefit from professionals who have knowledge of local community needs, and can match these to local resources.
- Accessible and **streamlined referral systems** to facilitate efficient and seamless integration of physical activity services into clinical care pathways.
- Embedding **Physical Activity Champions** in neighbourhood teams through identifying and commissioning roles to enable patient transitions into activities and ongoing support.

Scaling-up of **funding** represents a challenge but is essential to move beyond pilot projects. Suggestions include exploring grants for one-off capital costs and commitment from local systems to work together to fund projects and evaluation.

Resources to help healthcare professionals and systems understand how to support disabled people into physical activity are also suggested: this report includes **Top Tips for healthcare professionals**, and a **checklist for Integrated Care Systems** for suggestions of 'what good looks like.'

Ideas for **action at a national level** includes working with respected key players in the sector to raise the profile of the work, establishing a standardised training framework for key professionals, and coordination of centralised support hubs and peer networks, alongside an awareness of the importance of a diverse workforce.

Overall, we conclude that our research shows that there are **reasons to be positive** about the tremendous potential within the current landscape for the scaling up of supporting disabled people into physical activity. These findings show that positive and collaborative change is possible, and will aligns well with current healthcare priorities.

1. Introduction

1.1. Background

Activity Alliance is the national charity dedicated to achieving fairness for disabled people in sport and activity.

Healthcare professionals (sometimes called HCPs) are known to play a role in positively impacting disabled people's health and wellbeing through promoting physical activity. Having identified a need for the healthcare professionals to work with sport, physical activity and leisure sectors, Activity Alliance planned a multi-phase research process to explore the role of healthcare professionals, and related opportunities and challenges.

Phase 1 was carried out in summer 2023, exploring literature and the experiences of a small sample of disabled people. The literature review highlighted that healthcare professionals play a key role, but there is limited insight into disabled people's experiences of support. Focus groups revealed mixed experiences of support from healthcare professionals. Trusted relationships, personalised approaches, and specialist services were highlighted as enablers, and physiotherapists and specialist nurses as potential key messengers.

Activity Alliance commissioned an **interim phase** in spring 2024. In this stage we held an Expert Stakeholder Workshop with representatives from key sports and physical activity organisations, to explore the more impactful areas of focus for the Phase 2 research. We also co-designed a Research Charter to guide future research and engagement.

In summer 2024, Activity Alliance commissioned **Phase 2** to shed light on how the health, and sport, physical activity and leisure sectors can work together in supporting disabled people to be more physically active.

1.2. Research objectives

The overall **aim** was:

> **To understand the role of healthcare professionals in supporting disabled people to be more physically active.**

This was to be achieved by demonstrating good practice, of what, how and where this is working well.

To deliver that aim, the research sought to achieve the following **objectives**:

- Focus and expand on Phase 1 and interim phase insights.
- Explore Activity Alliance's potential influencing role in the space.
- Engage disabled people, healthcare professionals, activity providers, and Activity Alliance.
- Work with the people who are the leading voice in this space.
- Explore what makes support work.

As such, the project aimed to answer the following **research questions**:

- Where is this working well?
- What are the barriers and enablers for supporting disabled people into sport and physical activity?
- What interventions work for disabled people?
- How do we facilitate large-scale change for disabled people in healthcare and physical activity?

1.3. How to read this report

Chapter 2 provides insight on how this research builds on previous phases, and **chapter 3** provides an overview of the method.

Chapters 4 and 5 present findings from the case studies and focus groups, while **chapter 6** brings together insights about the role of healthcare professionals.

Then we present suggestions for acting on the research insights (**chapter 7**) and conclusions (**chapter 8**).

1.3.1. Definitions

For this research, we used the Activity Alliance definition for **disability** (which follows that of the Equality Act 2010), where '**long-term**' means 12 months or more.

> **Having a physical or mental impairment that has a substantial and long-term negative effect on your ability to do normal daily activities.**

When we say '**Healthcare professional**' we mean anyone who works to help people with their health and care. This includes doctors, nurses, physiotherapists, Occupational Therapists, social prescribers, and lots of other jobs too.

We use the words '**sport, physical activity, and leisure**' to mean any activities we do to move our bodies. That might be team sports, walking, dancing, swimming, and other things we do to move our bodies to keep fit.

We use the words **patient, service user and client** in this report. They can be used interchangeably, but we generally use:

- 'patient' when referring to someone who is seeing a healthcare professional;
- 'service user' when referring to people who are using a service (which might not be a healthcare service); and
- 'client' when referring to an individual person who is interacting with a non-healthcare professional or user of a service.

1.3.2. Interpreting and extrapolating findings

As with any research method, it is important to consider what the approach means for interpreting or extrapolating findings.

A **qualitative** approach was used to allow participants to share their experiences in their own words, and enable in-depth exploration of views. We aimed to recruit people from different backgrounds to capture diverse views, but this approach did not aim to be representative of the population or any particular demographic group. As such, **findings are not statistically representative** of the wider public, **nor generalisable** (for example, it is not possible to say that because most participants held a certain view, that most disabled people hold that view). Nonetheless, this research approach enables us to see common themes and challenges which shed light on our research questions.

We faced several challenges in the process that may have impacted the findings. For example, due to other organisations' policies, we were unable to engage disabled people involved in the initiatives showcased in the case studies. These are discussed further in chapter 4, section 4.3.

2. Building on phase 1

Phase 1 highlighted four areas for further research to understand how to best further work which informed the design and focus areas of Phase 2.

Phase 1 included:

- a literature review; and
- focus groups with 18 disabled people about experiences (both good and bad) of healthcare professionals supporting them into physical activity.

Stakeholder insights led to Phase 2 focusing on examples of successful practice. Stakeholders were interested in where things are being done well, why those examples are working, how supporting activity can be the easy option in delivering positive health outcomes, why things are not changing, and the enablers and barriers for healthcare professionals in supporting disabled people.

2.1. Exploring the roles of 'trusted messengers'

The NHS and healthcare professionals are a trusted source of information and guidance on being physically active. Other key messengers include peers with impairments, community-based organisations, and social workers.

The **exact roles** or job titles of trusted messengers were less clear. This raised the possibility for further work to explore which healthcare professionals would be the best cohort to target, and what competencies were needed. Early indications were that key messengers could be Specialist Nurses and Consultants. While Social Prescribers are a key part of developing Primary Care Networks, they were not highlighted in phase 1.

Phase 1 highlighted a need for further exploration around underlying **reasons for key messenger preferences**, to help shape principles for healthcare professionals to strive toward.

2.2. Exploring forms of successful intervention

Disabled people experience a lack of guidance on appropriate types or levels of activity, or suitable rehabilitation advice (impacting on pain or recovery).

Some issues can only be dealt with on a case-by-case or personalised care plan approach. The role of motivation and encouragement was a key element countering barriers related to confidence and fear.

Phase 1 highlighted the potential to further explore whether there is an approach that might be suitable for a wider group of disabled people. Considering what type of intervention worked for different individuals, and whether it is **scalable**.

2.3. Exploring key moments for intervention

Findings suggested that there may be key moments where interventions are more impactful (or where an individual's level of physical activity is more likely to decrease).

These may be when conditions worsen or change, or with new diagnoses of degenerative conditions. There was very little evidence about the benefits of different types of interventions, or which interventions lead to successful outcomes. This is a complicated issue to evidence other than anecdotally, but there is value in asking if interventions by healthcare professionals make a difference to behaviour.

2.4. Examining the different needs of the disabled population

Disabled people whose activities were 'limited a little', men, people aged 18-24, and those living in London were less likely to agree that they have had useful advice on being active from healthcare professionals.

Further research would be valuable to explore these discrepancies. Such research could consider **the breakdown of the disabled population by ability to do physical activity, which healthcare professionals are seen more frequently by the different groups, and differences in trusted messengers**.

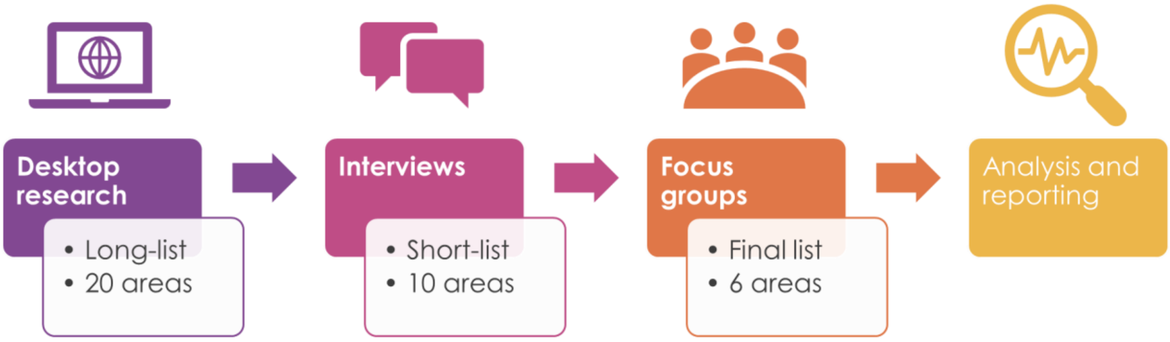
This research area was not deemed to be feasible to incorporate into this phase of the research, as it would require a quantitative approach that is beyond the scope of this research due to requiring a large number of patient data sets. However, some of our research findings may help shape potential hypotheses around these areas that could be tested in future research.

3. Method

3.1. Overview

Phase 2 of the '**Role of healthcare professionals in supporting disabled people into physical activity**' research initially focussing on the development of case studies, and included **four phases**, to refine the shortlist of case studies as the project progressed.

- Desktop research.
- Interviews with professionals.
- Focus groups with disabled people.
- Analysis and reporting.


Desktop research
- Long-list
- 20 areas

Interviews
- Short-list
- 10 areas

Focus groups
- Final list
- 6 areas

Analysis and reporting

3.2. Target audiences

The research aimed to involve four key audiences, each focussing on a different perspective of the wider research objectives.

- **Healthcare professionals:** Where is this being done well and how? How can I work in my system to improve this?
- **Disabled people:** What does good look like? Is it available near me?
- **Activity providers:** How can I maximise my reach and networks to improve this?
- **Activity Alliance:** How can we influence with impact?

3.3. Desktop research

We started with a call-out to stakeholders seeking examples of good practice, alongside a review of Phase 1 data for examples of good practice that disabled participants had shared with us.

This created a longlist of **47 potential projects** of which **20 were contacted** for further information to support short-listing the most relevant and feasible options for case studies. Ultimately, interviews spanned **twelve projects** of which **six were selected** for the final set of case studies.

3.4. Fieldwork

3.4.1. Engaging professionals: Interviews

We undertook **ten interviews** with professionals in health services, the Voluntary, Community and Social Enterprise (VCSE) sector, and the sport, physical activity and leisure sector, as well as volunteers. These interviews provided more detailed information to shape the case studies and assist in shortlisting.

3.4.2. Engaging disabled people: Focus groups

We initially planned to recruit 18 disabled people to take part in focus groups: three people for each of the six selected case study areas. Unfortunately, none of the case studies were able to put us in touch with participants due to issues such as GDPR constraints and exclusivity contracts with evaluation partners, and although some projects kindly contacted participants on our behalf, none got in touch.

We adapted our approach through an open call to networks, advertising for disabled participants who wanted to share positive experiences of support from healthcare professionals to be more physically active. This had a considerable response, and we selected 16 disabled people from a longlist of 71 who came forward.

We hosted **two** 90-minute focus groups online using **Zoom**, with the **16 participants**. Participants were offered an **incentive** of £40 for participating (equivalent to an hourly rate of £25 – in line with Activity Alliance's incentive policy).

3.5. Data processing and analysis

Facilitators took notes of discussions in focus groups and interviews, and recorded sessions (where consent was given), to support us in ensuring that the notes were an accurate reflection of participant contributions.

Our notes enabled thematic analysis across focus groups and interviews, allowing us to reflect on areas of good practice, consensus or divergence.

4. Findings: Case studies

Chapter summary

Six examples of good practice in local areas were short-listed for case studies from a long-list of over 40 potential approaches. This chapter presents an overview of the six case studies, and explores the key features of successful approaches, the common challenges they face, and our learning from the process.

The case studies shared several **key features of success**, most notably, **collaborating** and embedding practices across sectors and organisations. Inclusion was a central theme, supported by involving people with **lived experience** and committing to **accessibility**. Initiatives shared aims of supporting mental wellbeing and creating a sense of community. **Personalised** approaches were also key.

Initiatives seeking to support disabled people into physical activity through healthcare professionals faced several **common challenges**, such as declining **engagement** following initial interest from leaders and people using the services. Initiatives were often **hyperlocal** or small-scale, with limited **funding** and staff. There were continued **cultural** challenges within healthcare systems, and a lack of **readiness** among non-disabled activity services.

Reflecting on the **overall process**, a key challenge for this project was the lack of examples put forward. Most examples being publicised were in the **North West**. Many initiatives were very small or had **limited links** between healthcare and physical activity services. **Unresponsiveness** was a significant hurdle across long-listed and short-listed initiatives. This was believed to be due to a lack of time among healthcare professionals, and organisational **gatekeeping** (concerns about privacy and data protection, or wanting to protect access to contacts, particularly service-users).

For the detailed case studies, please refer to the accompanying document.

4.1. Case studies: Where this is working

4.1.1. Access to Exercise and Wellbeing (Cheshire)

This project, led by the Neuro Therapy Centre with a Lived Experience Steering Group, promotes exercise and wellbeing for people with neurological conditions. The project has improved participants' wellbeing and mobility, by partnering with a local leisure centre organisation to enhance accessibility in leisure centres. Referrals into the programme come from individuals, GPs, specialist nurses and physiotherapists.

4.1.2. Health Improvement Practitioner in community stroke team (Greater Manchester)

The Bolton-based stroke team employed a Health Improvement Practitioner to support people in integrating back into their community and maintain a healthy lifestyle. The stroke team healthcare professionals refer patients to the Health Improvement Practitioner. The patient then has a telephone call or face-to-face meeting, where the Health Improvement Practitioner explores their needs, offers advice and signposts them to relevant services.

4.1.3. Move to Include (Somerset)

Professionals, families or individuals nominate a disabled person who wants to join a sports club or participate in a physical activity. Somerset Activity Sports Partnership supports them to access opportunities aligned with their interests and needs, to help their mental, social, and physical wellbeing (like walking, tennis, multi sports or the local gym). This project differs from many others as it focuses on including disabled people in non-disabled activities, rather than finding a disabled sport for them to join.

4.1.4. Parkinson's Disease exercise group (Greater Manchester)

An 8-week exercise programme for recently diagnosed Parkinson's Disease patients, led by healthcare professionals, and followed up with education and advice. The team is working with Public Health to pilot a follow-on 'prescription' process – on completing the 8-week programme, patients are 'prescribed' physical community activity, and have a follow-up call 6 weeks later.

4.1.5. Super Mash Up! At the Manchester Children's Hospital (Manchester)

The Manchester Children's hospital national rehabilitation group organises an annual event for young people with spina bifida. The event (named 'Super Mash Up!' by the young people involved) brings together the hospital's clinical staff, sports and activity providers, children, siblings and parents. Funded by the hospital, it shows parents what is available and possible for their children, and connects them to local groups.

4.1.6. Middlesbrough Powerchair Football Club (Newcastle)

The multi-disciplinary muscular team at NHS Newcastle refers patients to the Middlesbrough Powerchair Football Club. The interaction between healthcare and the football club is organic, with patients championing the club to their healthcare professionals. The mental health benefits of being part of a team is significant for service users. Whilst not a specific healthcare initiative, this is an interesting example of relational awareness-raising among healthcare professionals.

4.2. Insights from across the case studies

4.2.1. Key features of successful projects

These good practice case studies have six key features.

1. Cross-sector collaboration
2. Lived-experience leadership
3. A commitment to inclusion
4. Community creation and mental wellbeing
5. Personalisation and staying in touch
6. Upskilling through education, awareness and training

4.2.1.1. Cross-sector collaboration

- **Partnership working:** Not sticking to organisational boundaries is a key feature. Successful projects involve partnerships across healthcare, voluntary organisations, and sport, physical activity and leisure providers. Building genuine long-term relationships is essential to ensure: a shared vision across all partners, an understanding of the conditions targeted, and long-term support for participants.
- **Early buy-in:** Partnership working that starts early, to get everything in place and to socialise the work.
- **Collaborative referral systems:** Streamlined referral systems and information sharing make it easier for healthcare professionals to connect patients to physical activity opportunities. For example, one project has a ‘one-click’ referral function on its website.
- **Embedding physical activity into clinical pathways:** In some case studies, physical activity is 'prescribed' as part of the rehabilitation process.

4.2.1.2. Lived-experience leadership

- **Involvement of people with lived experience: Projects** often include co-production through steering groups or involvement from people with experience of the conditions targeted, including carers and disability consultants. This helps ensure a continual process of informed quality improvement and leadership from disabled people and their families.

4.2.1.3. A commitment to inclusion

- **Inclusive design and accessibility:** As demonstrated in 'Super Mash Up!', keeping activities accessible but also inclusive works to draw in the wider support system of siblings and family.
- **Adaptations for mainstream activities:** Thinking beyond disability sport, looking at how to include disabled people in 'mainstream' sport (such as the Move to Include project) gives multiple benefits. It both expands opportunities for disabled people but also upskills people in the sport and physical activity sector to work in more inclusive ways.
- **Specialised and adapted equipment:** The Access to Exercise and Wellbeing project shows how specialised equipment can enable participation. It uses specific tools like the FES (Functional Electrical Stimulation) bike to help those with neurological conditions access physical activities (refer to the Access to Exercise and Wellbeing **Error! Reference source not found.**case study, for more information a bout the bike).

4.2.1.4. Community creation and mental wellbeing

- **Mental health focus:** Several case studies highlight the mental health benefits of physical activity, including improved social inclusion, reduced isolation, and enhanced self-esteem.
- **Rehabilitation and long-term health:** Some projects focus on integrating physical activity into rehabilitation. This has the benefit of potentially preventing the progression of conditions, offering a model for connecting activity with long-term health outcomes.
- **Building social networks:** Fostering social connections is a key element of some projects. This is done through bringing together people with similar conditions, creating a sense of community through a shared sport or interest, and fostering integration in sports clubs.

4.2.1.5. Personalisation and staying in contact

- **Personalisation:** Many projects are flexible, led by the specific needs and interests of clients. Offering messages around the individual benefits and evidence-base for physical activity is also important.
- **A focus on joy:** A key feature of personalising the approach is discovering and enabling activities that the individual enjoys.

- **Timely:** Successful initiatives know when to target their offer so the patient is receptive. This is particularly important for degenerative or acquired conditions, when patients and families are coming to terms with a new reality.
- **Keep checking-in:** Continuity of care, for example checking in at set times, ensures participants stay on track as they feel like their healthcare professionals are invested in their progress or journey and any emerging concerns can be addressed.
- **Offer digital options:** Projects adapted during the Covid-19 pandemic to offer virtual exercise sessions; this enables ongoing support to people who may not be able to attend in person.

4.2.1.6. Upskilling through education, awareness, and training

- **Upskilling across sectors:** Training around disabled participants' needs (including specific conditions) and how they can be supported through adaptations and inclusion, helps upskill all local partners and ensure that healthcare professionals act as skilled community connectors.
- **Raising awareness within healthcare teams:** Informal education through relationships with healthcare professionals who have a passion for sport or physical activity, helps raise awareness of available opportunities for disabled individuals.

4.2.2. Common challenges experienced by projects

Several challenges were common to many of the projects. Recognising these is helpful for considering potential obstacles when planning similar projects or upscaling initiatives.

1. Non-responsiveness of key stakeholders
2. Small-scale, hyperlocal projects
3. Resource constraints
4. Cultural resistance to system integration
5. Non-disabled sport, physical activity and leisure sector lacking readiness
6. Sourcing the right training
7. Intersectional inclusion

4.2.2.1. Non-responsiveness of key stakeholders

- **Difficulties in engaging participants and stakeholders:** A recurring barrier to engagement is non-responsiveness from both activity leaders and participants. Initial enthusiasm often wanes, leading to communication breakdowns (as seen in the process learning reflections, section 4.3). This suggests that projects may face difficulties in sustaining interest and commitment over time, especially when dealing with organisational or individual barriers.

4.2.2.2. Small-scale, hyperlocal projects

- **Small, localised initiatives:** Many projects operate on a small or local scale, often relying on the voluntary efforts of a few specific individuals. While these initiatives can be highly effective within their communities, their size and reliance on key change-makers can risk sustainability and make scaling up difficult.

4.2.2.3. Resource constraints

- **Challenges in securing long-term funding:** Securing consistent, long-term funding is a major challenge for many projects, making it difficult to embed them or scale them up. Many initiatives rely on short-term funding from organisations like Sport England or the NHS, especially when starting up. Some initiatives are excluded from certain funding streams due to the complexities of funding requirements.
- **Limited resources and staffing:** Many projects struggle with limited staff capacity and rely on goodwill and volunteers.

4.2.2.4. Cultural resistance to system integration

- **Silo working cultures:** A common challenge is the lack of strong connections between healthcare services and physical activity providers. While some projects succeed in building these links, others struggle with fragmented relationships, making it harder for healthcare professionals to refer patients to appropriate activities. A lack of formal referral pathways is a key challenge.
- **Complexity of embedding initiatives within healthcare systems:** Integrating physical activity into healthcare pathways can be complex and slow-moving, particularly when it comes to aligning objectives between different sectors. This often leads to long lead-in times for initiatives and potential to lose momentum.
- **Gatekeeping and data protection concerns:** Engaging with participants, particularly through healthcare providers, is sometimes limited by data protection issues or gatekeeping. This can prevent projects from reaching the right participants and receiving the feedback or insights necessary for improvement.

4.2.2.5. Mainstream (non-disabled) sport, physical activity and leisure sector lacking readiness

- **Specialist support versus mainstream inclusion:** Mainstream or non-disabled sports providers are not always equipped with the skills or confidence to adapt their activities for disabled people, despite training. While staff can be trained, the sports, physical activity, and leisure sector has a high staff turnover, and retaining skilled staff can be a challenge for initiatives that take time to establish.

4.2.2.6. Sourcing the right training

- **Challenges in accessing the right training and expertise:** Finding the right training courses is often a challenge. As noted in the Access to Exercise and Wellbeing case study, there can be gaps in available training for the sport, physical activity, and leisure workforce, and for healthcare professionals working with specific conditions.

4.2.2.7. Intersectional inclusion

- **Reaching marginalised or minority groups:** Some projects highlight the challenge of engaging less-represented demographic groups (like women or minority ethnic communities). While approaches often focus on the broader disabled community, there is a need for targeted efforts to ensure intersectional inclusion.

4.3. Process learning (What we learnt from doing this research)

In addition to insights from the six case studies, we found that the process of researching initiatives for long-listing and liaising with stakeholders for short-listing, presented further insights to the healthcare-and-physical-activity landscape. Key learning from across the full process is presented here, as it may support stakeholders engaging in this space.

There were a few key reasons as to why approaches in the long-list were discounted from further investigation.

- Initiatives where **information was not available** (including contact information of involved stakeholders) or where a single initiative was reported differently by different stakeholders (appearing as though it were several different projects).
- Initiatives that were too **small** (including examples of personal service provision), with limited opportunities for scaling-up or replication (for example, due to prohibitive costs).
- **Specialist** healthcare service provision (such as rehabilitation for specific injuries).
- Initiatives supporting disabled people into physical activity, but without a specific and meaningful **healthcare link**.
- Initiatives where healthcare professionals were supporting people into physical activity, but without a specific **link to disabled people**.
- Services where disabled people had experienced good practice, but where there were no clear examples of **organisational approaches** to healthcare professionals supporting disabled people into physical activity.
- Initiatives where healthcare professionals had supported disabled people into physical activity but were **no longer delivered** due to an end in funding.

There appeared to be a greater prevalence of initiatives in the **North West**. This may be because organisations in the region are more active in communications about their work and services, or it may reflect a more developed culture of collaborative working in the north-west, for example with historical initiatives such as devolution in Greater Manchester.

Across all the initiatives we explored (including those in the final case studies), we faced a general challenge with **non-responsiveness from key stakeholders**. For many initiatives in the long-list, this was the first barrier, and key reason for not being short-listed. We believe that the failure of initial communications was potentially due to a lack of continuity of key contacts in those initiatives, and sector-wide issues of high workloads and demands on healthcare staff.

The intention was to speak to healthcare professionals, activity providers, and disabled service users for each case study, however non-responsiveness made this not viable. For case studies where positive stakeholder relationships were established and initiative leads confirmed they could connect us with other stakeholders and service-users, we believe the non-responsiveness that followed was due to **organisational barriers**. For example, **gatekeeping** within organisations due to data protection policies, concerns about connecting external organisations with service-users, or where initiatives were in the process of evaluation, wanting to prevent competition for service-user access or publication. Concerns about external communications may also have played a role.

4.4. Key take-aways

The case studies show that good practice is happening in local areas to support disabled people to be more physically active. The core components of these case studies are **collaborative partnerships**, **inclusive** and **lived-experienced-led** approaches, **personalisation**, a **holistic approach** and **upskilling of cross-organisations teams**. We explore these in more detail – and ask what these case studies tell us about opportunities for scaling up – in chapter 7.

5. Findings: Focus group insights

Chapter summary

Sixteen disabled people attended focus groups exploring their positive experiences of being supported by a healthcare professional to be more physically active. This chapter explores the findings from these focus groups.

Who provided support in healthcare?

Participants were supported by **various healthcare professionals**, including GPs, physiotherapists, occupational therapists and social prescribers. **Physiotherapists** were mentioned as providing both rehabilitative exercises and connections to activities. **Trust** and long-term relationships played a role in encouraging people to take action to be more active.

What support was provided?

Personalised, **tailored** support was essential to success. Participants benefited most when healthcare professionals took time to understand their needs and interests, while conveying a clinical understanding of their impairment or condition. Participants highlighted the importance of **gradual progression** and starting with small, manageable goals. Having multiple professionals reinforce positive messages about physical activity helped participants build confidence and overcome self-doubt. Community-based activities (including walking groups, Pilates, and disability-specific sports) were another key success element for some participants (in contrast to physical activity alone).

Where was the support provided?

Most interactions took place within local **primary care** settings, such as GP surgeries, acting as gateways to broader community activities.

When did this happen in a person's journey?

Timing was crucial in delivering support effectively. For some participants this was **after an adjustment period** following an acquired impairment or diagnosis, when they were ready to receive help but before their physical or mental health declined. For others it was when they felt that they were at a 'low point' where **their physical or mental wellbeing was at risk of declining**. These themes suggest that support should be offered proactively, at a point where individuals feel mentally and emotionally prepared to engage with it.

5.1. Key features of good experiences

1. Personalised support
2. Trusted relationships
3. A multidisciplinary approach
4. Gradual, realistic progression
5. Connecting into the community

5.1.1. Personalised support

Mirroring insights from the case studies, participants responded to **personalised or tailored** advice and routines, reflecting the clinician's thorough understanding of their specific conditions and impairments. Focusing on what activities the patient would **enjoy** was also important, as well as them feeling as though the suggested activity was **realistic and achievable**. This personalised support was critical in motivating them to start and maintain physical activity.

A key part of personalised support was taking the time to "**sit down with me**" and develop a shared understanding of the participant's condition, needs, and interests and create a plan that would specifically address them.

> **"The social prescriber was very understanding and took the time to explore different options that could fit into my lifestyle and address my concerns, giving me options specifically tailored for people with joint and back issues. I wouldn't have known anything about it if not for them."**

5.1.2. Trusted relationships

Several respondents mentioned that they acted on their healthcare professional's advice because of a **long-standing relationship**. For example, one person trusted their GP, because they had known them for over 30 years and felt the GP was familiar with their medical history.

Another element that developed trust was where the healthcare professional had demonstrated **sound clinical knowledge** of the participant's condition, and explained how exercise could help (articulating evidence-based practice). One participant felt that their physiotherapist understood and explained the reasons behind their symptoms, reassuring them that the physiotherapist 'knew what they were talking about' and helping them to trust the advice.

A further element is that of cultural competency and connection, for example, a shared cultural background or a love of the same sport or team. This is explored more in section 5.2.5.

5.1.3. A multidisciplinary approach

Participants mentioned the involvement of different types of healthcare professionals (including GPs, physiotherapists, occupational therapists, and social prescribers) and there was no one healthcare professional who stood out from the research as a key trusted messenger by virtue of their role.

Some participants had positive support from one key healthcare professional, where others had positive support from several healthcare professionals. While some of this reflected the necessity of healthcare referral pathways, **consistent positive messaging** and encouragement from all healthcare professionals along the pathway was a common theme. This consistent positive reinforcement helped participants by **addressing doubt** about their ability to progress along their physical activity journey.

> **"The (physio) therapist and instructor were really nice to me and encouraged me a lot, even when I doubted myself and wasn't sure I could do it (following an acquired disability) – telling me about different recovery stories and checking up on me, sharing with me the impacts of what would happen if I did it consistently."**

5.1.4. Gradual, realistic progression

Several participants mentioned the importance of **starting small and making achievable progress**. Manageable routines and a gradual approach allowed individuals to regain movement and strength without overwhelming them.

5.1.5. Connecting into the community

A key element of the learning from the focus groups was that **people do not know what is available**. Participants were unaware of local services or activities until they were suggested by healthcare professionals. This role of the healthcare professional as a **community connector** was key to many of the participants' positive experiences.

Respondents mentioned being introduced to group activities or community-based initiatives, such as walking groups, swimming, or Pilates classes. The social support and accountability of group activities such as this were key motivators. Many participants felt encouraged by follow-up communication from healthcare professionals.

One participant reflected that their local surgery was 'a training surgery' and a lot of the healthcare professionals were on rotation from other areas. They felt this raised challenges because staff lacked knowledge of local groups and activities, which helps disabled people understand what services were available in their area.

> **"I felt my GP surgery was always too busy, trying to rush through as many patients as possible, while when I was with the physio it felt like they had time to sit down with me and discuss what was in my area, which I wasn't previously aware of. Once I understood what was available to me it reassured me and encouraged me to find out more and get involved."**

5.2. What does positive support look like practically?

5.2.1. Who: The healthcare roles involved

The question of **who** is key when considering this area: which healthcare professional specifically is best placed to offer support to become more physically active?

Firstly, it is important to note that some participants were unclear about the healthcare professionals that they had been dealing with. For example, one participant spoke of 'a nurse' at the surgery without any indication of what role the nurse might have in the surgery; another mentioned that a 'doctor' visited them at home after a stroke, although this may be a specialist stroke rehabilitation physiotherapist rather than a GP. This is a key challenge for research in this area, as members of the public may not be aware of (or interested in) the specific roles or qualifications of the healthcare professionals looking after them.

When reflecting on the healthcare professionals who had supported them into physical activity, participants mentioned their GP, physiotherapists, surgery nurses, social prescribers and occupational therapists.

The most common group mentioned was **physiotherapists**. Their role extended beyond providing physiotherapy interventions and rehabilitative exercises (although for some, this was key to moving on to other activities). It extended into **signposting** people into community-based activities, including groups for disabled people like football, cycling classes, and leisure centres, and private classes such as Pilates.

Healthcare professionals who were mentioned least favourably were often **GPs**, who participants noted were very busy and lacked the time to properly advise about non-medical interventions. One participant, however, felt that newer doctors had a different approach and took more time to listen to patients, which was very positive.

> **"I felt that some of the new doctors that are now coming through seem to take the time to understand. They ask: What can we do to help you?"**

5.2.2. Where: The location of positive experiences

Notably, all healthcare professionals mentioned were (most likely) from primary care, with participants' **local** surgeries being key for support and signposting.

Again, it is not possible to be entirely clear about this because of participants' lack of clarity over roles and the complexities of health service commissioning and service structures. For example, participants who had seen 'a doctor' or an 'OT' at home may have been receiving support from a secondary care team. However, all roles appeared to be based locally to the participants.

5.2.3. When: The best time for intervention

5.2.3.1. Too early

No participants felt that they had received support too early.

5.2.3.2. The right time

Most participants felt that they had received support at the right time for them. There was a theme of participants feeling that they were at a 'crossroads' in their life, where proactive action needed to be taken to put them 'on the right path' to physical and mental wellbeing.

Some participants found that the right time for intervention was often **after an adjustment period**, for example following an acquired impairment or diagnosis, when they were ready to receive help but before their physical or mental health declined.

For some participants there was a theme of needing time to come to terms with new circumstances – and complete initial treatment – before intervention was effective. It may reflect how participants also felt ready to establish new routines at this point in their lives. (The length of time of an 'adjustment period' was not discussed in detail, and is largely subjective, but this concept was raised by both individual disabled participants and also case study interviewees.)

Some participants felt that they were starting to **struggle with mental health challenges**, isolation and depression. They saw this as the right time for them to be supported into physical activity, to help improve both their physical health and their mental wellbeing.

> **"It wasn't too late or too early, I was just in between where I didn't know how to start coping with my new situation, my new life, and I was just starting to go down a road of depression."**

Some participants felt that the timing was crucial because they were **on the verge of health deterioration**. They were conscious that their physical health was declining, and this spurred a sense of recognition that the time was right to improve their physical health to prevent further decline.

> **"It was the right time because I didn't want to get to a point in my life where I would get really sick with my disability. It would be a very difficult point for me if I was to lose my health in addition to my impairment. […] So I quickly jumped on it, so I could try to recover [...] so it wouldn't get to a point where I had to be dependent."**

It should be noted that data was not collected on whether people's disability was acquired, congenital or degenerative, but these themes suggest that support should be offered proactively, at a point where individuals feel mentally and emotionally prepared to engage with it.

Participants felt that intervention helped prevent further physical or mental decline, allowing them to regain control over their health and life.

5.2.3.3. Too late (but appreciated)

Several participants mentioned they would have **preferred earlier support** to avoid deteriorating health or a loss of motivation. While they felt it was positive once it was given, they felt that the **delays exacerbated their pain**, frustration, or emotional difficulties.

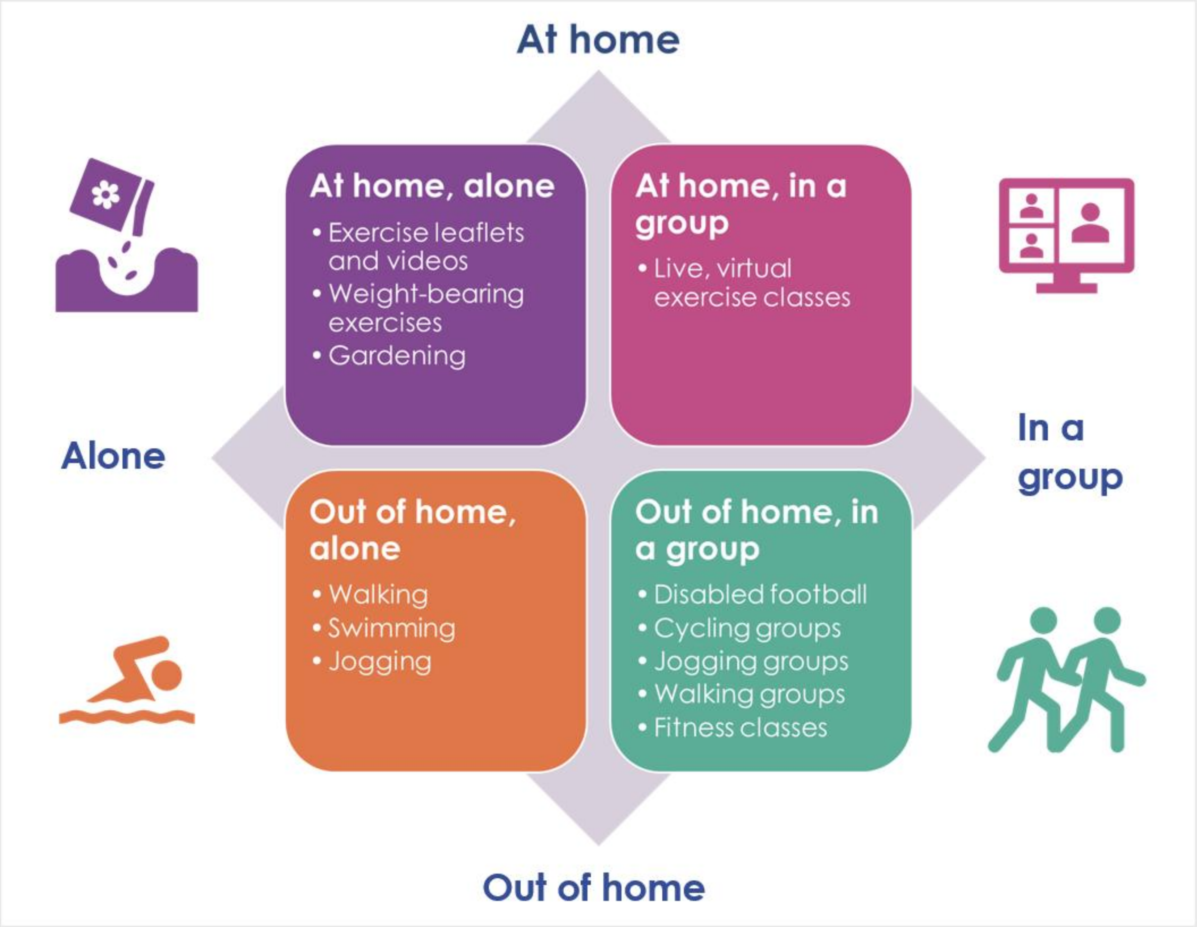
Several participants highlighted frustration with needing to **persistently ask for help** or rely on their own initiative.

> **"If my doctor had brought it up, when I was going to get medication or something else, recommended the website to explore or people to contact, I would've accessed it six months earlier, before I was in a great deal of pain."**

5.2.4. What: The types of activity

Participants had a wide range of different activities that they were supported to do. These were generally either exercises that they did at home on their own or, more often, community-based classes or organised groups. The common themes in these exercises were that they were often group-based or community activities in the local area.

One participant, who was being supported for mental health reasons, had been recommended cooking and computer classes at a local community centre. These were not perhaps what we think of when we talk about physical activities. However, this participant had not been able to leave their house due to their mental health condition and was conscious that walking to the venue to take part in such classes was considerably more activity than they were currently undertaking. This shows that thinking about what 'physical activity' might mean for different people may necessitate thinking outside the box of what we usually think of as 'exercise' or sport and physical activity.



5.2.5. How: Person-centred support and intersectionality

Participants were asked to reflect on whether there were **aspects of their identity** or personal circumstances that affected the support they received. A few key themes emerged.

5.2.5.1. A shared connection with healthcare providers

Participants who had **a long-standing relationship** with their GP or other professionals felt more comfortable and were more likely to receive personalised support. In contrast, some individuals who saw multiple different doctors or lacked continuity in their care felt that this hindered their experience and created a sense of disconnect.

As well as familiarity, participants raised other areas where sharing common ground helped in building rapport with a healthcare professional. These included having **personal connections in common**, like following the same football team.

Another key area was sharing a **cultural connection** or having a **shared ethnic background**. Several respondents indicated that this made it easier to open-up and feel understood. This shared identity helped establish rapport and trust, leading to better communication and more culturally sensitive care.

> **“I had a GP that was not the same ethnicity as me and I did not feel like she paid attention to my needs until about three months after my accident when I saw a new nurse practitioner and she understood my background, she understood the emotional and mental stress as a black woman. Sometimes I believe the quality of support I was able to get from her was because she could relate to my ethnicity and skin colour and was sensitive to my needs.”**

5.2.5.2. Inequality in access to support

A common theme was frustration over **unequal access** to healthcare resources. Some participants felt that those who “shout the loudest” receive more help, while others are overlooked. This may add an additional layer of inequality to accessing support, for example for people who are unable to advocate for themselves (or who do not have a supportive advocate).

Participants’ experiences of support pathways varied, including in terms of whether they had consistent care from a healthcare professional that knew them well. One participant felt that they lacked continuity of care due to the high number of student healthcare professionals that were taken on by their surgery. These findings may be considered a **geographical inequality**, or indication of a ‘postcode lottery’.

5.2.5.3. Lack of parity of care for mental health needs

Several respondents pointed out that their **emotional needs** were not initially addressed, with clinicians only focusing on physical symptoms. Only after further insistence or changing providers did they feel that someone understood the emotional and social aspects of their care.

Additionally, some felt **pushed toward medication** instead of being offered other supportive services, which they believed was due to time constraints or a lack of resources on the part of healthcare professionals.

> **“Because GPs see a lot of people they will push you towards antidepressants rather than providing the (support) services that are available: they are not telling the patient because they don’t have the time or resources.”**

5.3. Scaling up: Ideas for large-scale change

Participants were asked to reflect on their experiences and consider whether what worked for them would work for other people, and how they large-scale change could be brought about.

Although there were clear themes in the positive experiences shared, many participants shared **doubts** that what worked for them would work for others. There was an awareness that everyone's situation is different and therefore approaches needed to be individualised, specific, and tailored to both people's impairments and their personal journey.

This reflects the challenges of addressing a situation that is complex and individual with a simple universal offer.

However, despite doubts about the efficacy of a universal roll-out, participants made the following suggestions.

5.3.1. Scaling up: Campaigns to raise awareness

A recurring theme was the **need to address a lack of awareness** about local resources and activities available to people, through conveying that physical activity was suitable for people with impairments, and raising awareness of how to access support.

Suggestions included national campaigns and raising awareness through social media, leaflets, websites, and advertisements. (Participants were not aware of existing campaigns that raised awareness of the benefits of physical activity to disabled people.)

> **"I think there are a lot of people who don't know there is help out there, don't know how to ask for it, and don't know it will be personalised for them. If they can approach their GP, or district nurse, there is something for everyone to be active."**

5.3.2. Scaling up: A central source of access to information

Suggestions included creating a **centralised source of information**, such as a national helpline, website, or forum where people could both find resources and speak to others with similar experiences. **A national coordinating organisation** was suggested, or something with a hub-and-spoke model, with national advice but local information.

A **national telephone line** was suggested, where people could call for information about what was suitable for them and locally available. A telephone line was felt to be accessible for people who did not access social media or online information. Suggestions included having a messaging facility so that local information could be given to people via telephone, or through the post.

> **"There needs to be a national centre with a freephone telephone number where you could ring up and tell them your issues or they would provide you via email or the post with organisations in your area that you might be interested in joining."**

5.3.3. Scaling up: Leveraging peer support and inspiration

Participants suggested that the **voices of disabled people** who had benefited from physical activity would be helpful as both **inspiration and a source of evidence-based practice.** Participants felt that this should be a key element of communications for national campaigns (peer testimonials, for example), and also a source of practical mentoring or peer support.

Participants also felt that **peer mentors and support** would be beneficial and were willing to be mentors for others. In order to get in touch with other people in a similar situation, participants suggested **website chat forums** or similar.

> **"A forum where you can speak to like-minded people in your local area, because you are vulnerable at this stage and the thought of making that step (to physical activity) is hard – so maybe some testimonials and a forum so you can see how it has helped them."**

5.3.4. Scaling up support from Healthcare professionals: Accessible, personalised, compassionate and with continuity of care.

Participants felt that for the approach to work, there needs to be personalised care and **consistent communication** between the healthcare professional and the patient. This includes **tailoring the support** to individual needs and ensuring that the patient understands why certain activities are important. This is largely to address individuals' doubts that exercise is for them, or can benefit them.

> **"I didn't realise that was possible for me (to exercise). There should be an awareness that disabled people can do exercises for their conditions and encouraged to speak to their health professionals."**

Participants suggested that some people may need more proactive, accessible or flexible support, such as **home visits, physical help, or video calls** for those who cannot easily access services. Ensuring that the support is adaptable and available through various means was seen as critical to reaching more people.

A key element of the healthcare professionals' successful interactions was that they were compassionate, **took the time to develop a rapport** with their patient and also **connected via shared experiences**. This very human level of compassionate care is not easy to 'scale up' but was something that participants felt was key.

In a time where the 'family doctor' providing consistent care has become a thing of the past, it is reassuring to note that **shared experiences** can create that rapport, developing a fast-track to the human connection in the clinician-patient relationship.

> **"If my GP what he did applied to all disabled people, the way we connected on different levels […] It was like he cared genuinely for me and could relate to what I was going through. Showed me the benefits of what he was trying to preach. Some medical professionals are not ready to explore all that, but he was."**

Participants felt that **continuity of care** was important, to ensure **feedback loops** with patients, so healthcare professionals can check that activities are working and advise **adjustments** as needed.

5.3.5. Scaling up support from Healthcare professionals': getting the timing right.

Several participants pointed out that not every approach would work for everyone due to varying conditions and stages of disability and emotional acceptance. It was noted that individuals have different levels of determination and readiness to start activity, which could affect how well they respond to guidance from healthcare professionals.

However, most positive experiences seemed to happen when people had time to process a change of circumstance, including a loss of their 'past life' and what they used to be able to do, but before they entered a period of decline. For participants with long-term conditions or impairments, the right time was when they felt concerned that their physical and mental health was potentially about to decline. This is the key time for successful interventions.

> **"It takes a whole lot of time to process that you are a disabled person now and it takes a lot of determination and decision-making (to be active). If the person isn't determined enough to do what the health professional says they should do, then it's going to be a huge problem."**

5.4. Key take-aways

The need to talk to people about physical exercise when they are ready and receptive needs to be met with advice that is trusted, reflects the individual's physical impairments or diagnoses, and is part of an overall treatment plan.

The **key timing for intervention** seemed to be as early as possible, after processing any change in circumstances, or when a person is starting to experience mental health challenges, but before their physical and mental wellbeing starts to decline.

Participants acted on advice from trusted professionals – particularly physiotherapists – who conveyed a **compassionate but clinically competent understanding of their condition**, who took them through a **gentle and gradual progression** of physical activity, and who provided encouragement through the journey.

A key driver in making interactions impactful was a **shared cultural experience**. This is an area where the **diversity of healthcare staff** needs to be supported and properly understood for the resource that it is.

Information about community opportunities is key to success, although rehabilitation and physiotherapy was an important stepping stone to this for some people. Healthcare professionals have a key role in being **community connectors**: showing and telling disabled people about what is available locally. Healthcare professionals who are themselves using local sport, physical activity and leisure services may be best placed to do this, as they will know what is available and can link individuals who might have shared connections or experiences.

6. Findings: Healthcare professionals as trusted messengers

For many patients, the advice and support from trusted healthcare professionals can be the difference between a sedentary (or perhaps even a hope-less) lifestyle and regular physical activity that improves both physical and mental wellbeing.

This research reinforces our understanding that healthcare professionals can play a pivotal role as trusted messengers in promoting physical activity among disabled people – this has been known for some time.

But how can healthcare professionals be trusted messengers? This chapter explores the **competencies** that healthcare professionals need, as well as the **system enablers** that need to be in place, to ensure that they are trusted messengers who encourage disabled people to get active.

6.1. Personal and professional competencies

This research shows us the key competencies that healthcare professionals can cultivate to be trusted messengers.

6.1.1. Use common ground to build relationships

Trust is often built through **long-term relationships**, and participants in the focus groups mentioned how having a long-standing relationship with a professional such as a physiotherapist or GP made them more likely to follow advice.

However, long-term relationships are not always realistic in a modern healthcare setting. This research shows that **shared interests** and **common ground** can be a fast-track way to build trust. This involves active listening, and considering what human connections you can make: it may be a love of a shared sport or team, or something more significant such as a shared ethnicity or cultural background. That demonstration of common ground can help embed a sense of trust and understanding.

6.1.2. Demonstrate condition-specific clinical knowledge

Healthcare professionals need **condition-specific knowledge** about the impairments or diagnoses they are supporting. While this may sound obvious, the case studies have shown that this specialist training is actually hard to come by (for example, training in specific neurological conditions for specific clinical roles, such as physiotherapists).

However, participants expressed confidence in healthcare professionals who showed a **clear clinical understanding** of their condition. Those that were able to articulate information about their **symptoms** and **how physical activity could help** to alleviate symptoms, improve their physical health or slow progress of progressive conditions.

6.1.3. Articulate an evidence-based understanding why physical activity can help

This ties into another factor that gave patients confidence and motivation to continue physical activity: **evidence-based arguments**. Healthcare professionals who understand a patient's condition and can give evidence-based reasons why physical activity can improve their wellbeing are more likely to be perceived as trusted messengers. This type of message helps instil a belief that 'physical activity is for people like me'.

Emphasising that physical activity also has a holistic role as part of a **broader approach to health and wellbeing**, helps patients see it as integral to their overall recovery or condition management. Several projects in our case studies highlight the importance of healthcare professionals encouraging physical activity not just as a stand-alone intervention, but as part of a holistic plan for recovery and improving quality of life. This broader framing can make patients more receptive to the idea and trust in its importance.

6.1.4. Personalisation – focussing on joy and realistic goals

Personalising referrals and recommendations based on what a patient is going to **enjoy** is key. Patients are more likely to engage with the recommendations if they are based on something that they think might be fun or enjoyable, and aligns with their interests.

Physical activity that patients perceive as aligning with their **capabilities** is also important – it has to be realistic, which is why gradual approaches have been shown to be more successful. Patients fear that activity is 'not for me' or might make their condition worse – a slow and steady approach at their own pace, with a fun activity, is more likely to result in a positive reception.

6.1.5. Be a community connector

To connect patients into services outside primary care, healthcare professionals need to be **well-informed about local activities and resources**. Several projects in our case studies demonstrated how important it is for professionals to have a strong understanding of what is available in their community, like adapted sports clubs, disability sport and rehabilitation, or specific exercise programmes.

A key way that healthcare professionals can improve their understanding is to be an **active participant** themselves in sports and physical activity in their own local area. Healthcare professionals who actively participate in or have experience with local programmes are often more trusted, as they can provide practical advice based on first-hand knowledge.

6.1.6. Reinforce messaging and follow-up

Successful programmes often include **regular check-ins** from healthcare professionals to ensure that patients stay on track with their physical activity goals, to address concerns, and to motivate them to keep going. This continuity of care reassures patients that they are not being left to manage alone, and reinforces the message that physical activity is going to be beneficial.

Providing consistent, **positive messaging at various stages**, helps build patients' confidence, addresses self-doubt and offers encouragement. Consistent positive messages from different clinical colleagues will also reinforce the importance of physical activity.

6.2. System competencies

For healthcare professionals to effectively encourage physical activity among disabled people, supportive systems and processes must be in place.

We have focused on the role of healthcare professionals, but systems also have an enabling role. To make physical activity the ‘easy option’, this research shows that we need systems that are collaborative, committed to co-production, embed physical activity into clinical pathways, enable referrals, value workforce diversity, and commission specialist training.

6.2.1. Collaboration between partners

Moving away from silos and **working together as partners** is crucial to ensuring consistent messaging and support for disabled people. In many of the case studies, the involvement of a wide range of professionals – clinicians, rehabilitation specialists, and community sports providers – created a holistic approach, **reinforcing messaging** around the benefits of physical activity from multiple angles. A multidisciplinary approach helps ensure that patients receive consistent encouragement throughout their healthcare journey and can easily transition between different parts of the system.

6.2.2. Committed to co-production

Many of the successful projects have **co-production** or **user-leadership** as a foundation of their governance and practice. A commitment to co-production should be a system-wide value that underlies all commissioning work and service provision. Embedding this value in vision statements and strategies – as well as leading by example – are key roles of system leaders. System leaders need to demonstrate their commitment to centring the experience of their communities by making sure that they involve communities in all aspects of commissioning and service provision. **Commissioning disabled-led organisations and lived-experience consultants** can help demonstrate their commitment to 'nothing about us, without us.'

6.2.3. Embedding physical activity into clinical pathways

For physical activity to become 'business as usual' for disabled people's clinical care, it needs to be embedded into clinical pathways – 'built-in, not add-on'. In some case studies, physical activity was 'prescribed' as **part of the rehabilitation process**. Integrating physical activity recommendations into **standard care plans** ensures that healthcare professionals consistently promote it as an essential component of overall health and wellbeing, rather than an optional extra.

For some clinical pathways, enabling **access to resources and equipment** should be a key commissioning commitment. For example, specialist tools like the Functional Electrical Stimulation bike which enabled patients with neurological conditions to engage in physical activity through electrical muscle stimulation (Access to Exercise and Wellbeing case study).

Systems should also allocate sufficient time for healthcare professionals to **follow-up** with patients after the initial referral, helping to maintain motivation and overcome barriers that arise. Building this into pathways is one way of supporting this approach.

6.2.4. Enabling easy system-wide referral mechanisms

To enable healthcare professionals to be community connectors, **easy referral pathways** are needed to quickly refer patients from primary care into the community. Clear and simple referral mechanisms, such as online forms, are essential to efficiently direct disabled people into sport, physical activity and leisure providers in the community.

In several case studies, referrals between healthcare teams and community activity programmes have been simplified, making it easier for patients to access support. This involves not inconsiderable work around information governance and sharing between partners, but this work is essential to save resources in the longer term.

6.2.5. Supporting and valuing a diverse workforce

To make the human connection, healthcare professionals need common ground with patients. A non-negotiable element of this is a **culturally competent workforce** that **reflects the diversity of our communities**. The focus group insights showed that shared cultural experiences between healthcare professionals and patients can foster better communication and trust, especially for **ethnically diverse** patients.

6.2.6. Commissioning specialist training for all system partners

Healthcare professionals need to be well-trained in the specific conditions they are working with and how these relate to physical activity. Specialist training is hard to come by, and hard to disseminate across system partners. Systems could **commission specialist training** and offer it to all partners in the physical activity pathway: sport, physical activity and leisure providers, health and social care staff, and the voluntary sector. Training led by patients and carers would be even more impactful.

6.3. Key take-aways

To be trusted messengers, healthcare professionals need to **build trust**, whether through long-term relationships or by establishing common ground, such as shared interests or cultural backgrounds. Patients feel more confident when professionals demonstrate **condition-specific knowledge** and provide **evidence-based reasons** for how physical activity can enhance their health. **Personalising** recommendations through focusing on joy and achievable goals helps patients feel that physical activity aligns with their capabilities and is realistic.

Professionals should serve as **community connectors**, directing patients to accessible local activities and groups. First-hand experience in these activities further enhances credibility.

System-wide support is also needed. Collaborative systems that embed physical activity into clinical pathways help make physical activity part of a wider, holistic approach, while streamlined referrals and diverse, well-trained teams ensure every patient has access to supportive, culturally competent care.

7. Next steps: Acting on research insights

This chapter explores next steps, considering the insights from the case studies and focus groups. We look at opportunities for scaling up, and suggest creating further resources, including a ‘Top tips for healthcare professionals’ and a framework or checklist for Integrated Care Systems, as well as ideas for national campaigns.

7.1. Opportunities for scaling up

The majority of these opportunities would apply to Integrated Care Systems and to stakeholders at this level of the service provision and commissioning landscape.

Working in collaborative ‘physical activity’ partnerships: Unsurprisingly, each case study relies on robust working partnerships across healthcare, the voluntary sector and sports, physical activity and leisure providers. Scaling these initiatives requires replicating these partnerships, Integrated Care Systems are designed to foster such collaboration and alliances, and this opportunity aligns with ICS priorities, enabling a collaborative and more holistic approach to care.

Local, place-based partnerships designed to promote physical activity: The case studies benefit from local people and knowledge connecting patients to local services. ICSs operate through ‘place-based partnerships’ that respond to local needs. These are ideal for building the cross-sector networks required to support and sustain physical activity programmes at the local level, tailoring each programme to community need and local resources, and liaising with local multi-disciplinary teams.

Identifying local community needs: Programmes are most effective when local needs are connected into local assets. Understanding community needs is essential for service planning, as is understanding local assets, like centres of excellence (such as Neuro Therapy Centres) or proactive sport, physical activity and leisure providers.

Accessible and streamlined referral systems: Programmes like Access to Exercise and Wellbeing, and Move to Include use streamlined online or easy-to-access referral forms, facilitating seamless integration into clinical care pathways. Expanding such referral systems would enable healthcare professionals across the country to efficiently connect patients with local activity programmes. Enabling self-referrals in addition to healthcare professional referrals ensures broad access and empowers patients to seek out opportunities independently (‘patient activation’).

Embedding Physical Activity Champions in neighbourhood teams: The Health Improvement Practitioner role shows the value of embedding a specialist community connector in a multi-disciplinary local team (at a Primary Care Network level). The Disability Projects Officer role in Move to Include exemplifies the value of having a community connector in a social prescribing role. Identifying and commissioning such roles can facilitate patient transitions into new activities and ensure ongoing, localised support.

7.2. Resourcing the work: Ideas for scaling-up funding

Leveraging health and local authority funding: Dedicated funding for this work is essential to move beyond pilot projects and to properly embed the work in local pathways. This needs commitment from local systems to fund the core costs of key roles that will facilitate the work.

Grants and sponsorships: Funding from sports bodies, national or charitable organisations, and community grants can enable programmes to pilot projects, or pay for capital costs (like the FES (Functional Electrical Stimulation) bike or powerchairs).

Evidencing the work – Monitoring and evaluation: To make the case for long-term funding for this work, consistent data collection and progress tracking is key. Projects mentioned the challenges with this, including keeping in touch with service users, data sharing across organisations, and challenges of demonstrating cause and effect in long-term outcomes. However, feedback mechanisms like surveys, focus groups and other long-term patient evaluation is essential.

7.3. Developing resources

Drawing all our findings together suggests top tips, ideas and inspiration for healthcare professionals and systems that want to work together to encourage disabled people to be more physically active.

7.3.1. Five top tips for healthcare professionals

Know the right time: The key time to support a patient into physical activity may be when they have had time to come to terms with a change in their condition or impairment. Give time and support for this process, but bring in conversations about physical activity in a timely way, before they start to decline.

Build relationships through common ground: Provide culturally-sensitive care through making a human connection with your patient, whether through a shared cultural background, love of sport, or something else.

Be a community connector: Find out what is available in your local area, so you can connect people into physical activity and communities that are accessible and right for them. Taking part in physical activity yourself can help you understand what is available locally.

Demonstrate condition-specific clinical knowledge: Show the patient that you understand their specific condition, the symptoms, and how physical activity can help in this context. Articulate an evidence-based understanding of why physical activity can help ‘someone like them’ – explain how exercise has helped other people with their condition, and what positive impacts they can expect.

Build a personalised support plan with gradual progression: Find out what they enjoy and direct them to ideas and activities that will be fun for them. Make a manageable plan that is realistic and starts slowly, so they won't be discouraged. Follow-up to ask about progress and give advice and encouragement to continue.

7.3.2. Checklist for local integrated care systems

Integrated Care Systems (ICSs) and partners working at this level may lack ideas and frameworks for measuring and understanding ‘what good looks like’. The following suggested checklist may provide a starting point for ICSs wanting to start or measure this journey. A more detailed framework could be developed for measuring progress, maturity and developing accountability mechanisms in local areas.

- **Governance:** The ICS has structures in place for collaborative working between healthcare; the sport, physical activity, and leisure sector; and the VCSE sectors.
- **Shared vision:** There is an agreed shared vision for increasing physical activity in the system, which explicitly includes disabled people.
- **Referrals:** There are easy system-wide referral mechanisms in place for physical activity.
- **Information:** There are information sharing agreements and mechanisms between different partners.
- **Clinical pathways:** Physical activity is embedded into clinical pathways, and prescribed as part of the rehabilitation process.
- **Collaboration:** Clinical pathways cross organisations and enable easy transitions between different providers.
- **Community connectors:** Community connectors or similar roles are commissioned and embedded in neighbourhood teams.
- **Care plans:** Being more active is included in standard care plans.
- **User-leadership:** Users are centred through Steering Groups.
- **Co-production:** Co-production is highlighted in vision statements and strategies.
- **Feedback:** Mechanisms are in place for a continuous process of listening to and acting on patient and carer feedback.
- **Lived-experience commissioning:** Disabled-led organisations and lived-experience consultants are commissioned in this space.
- **Accessible support:** There are different ways to access physical activity support, including home visits, telephone consultations, and video calls.

- **Equipment:** Staff can access the necessary specialist equipment and services and this is considered in commissioning decisions.
- **Follow-up:** Patients are routinely followed-up once on their physical activity plan.
- **Training:** Specialist training and condition-specific training is commissioned and available to all system partners, across health, social care, sport, physical activity and leisure partners and the VCSE sector.
- **Workforce:** The rehabilitation and clinical workforce represents and values the diverse communities that you serve, and is evidenced through workforce measurements.

7.4. Ideas for national action

The following ideas for national-level action for key stakeholders, could support scaling up and ensuring momentum.

7.4.1. Work with respected key players with a national profile to facilitate scaling up

Involving national organisations like the MS Society or Parkinson's UK would build awareness and provide credibility. These organisations also offer toolkits and expert training resources that can be valuable for new regions.

7.4.2. Specialist training for activity leaders and clinicians

Scaling up requires a standardised training framework for physiotherapists, coaches, and volunteers, enabling them to confidently support disabled participants. This is a complex issue, as the training programmes highlighted by the case studies are condition-specific, and it is this condition-specific knowledge that participants felt built trust in their healthcare professional. As such, specific training could cover a large range of conditions and impairments, so this would need careful consideration. Nonetheless, online modules or certification programmes, accessible to various regions, could go some way to address gaps in training, making non-disabled sports and general physical activities more inclusive.

7.4.3. Continue awareness-raising campaigns

Continue or develop national campaigns aimed at raising awareness of the benefits of physical activity for disabled people. Challenge misconceptions held by both disabled people, their families and professionals, and highlight success stories, emphasising the accessibility and suitability of physical activity for disabled people.

7.4.4. Create a centralised resource hub

Establish a national helpline, website, or forum where disabled people can find information on services, support options, and community activities for people with different conditions. This should provide easy access to tailored resources, as well as opportunities to connect with others who have similar experiences in their local area.

7.4.5. Develop peer support networks

Introduce a national peer support system where disabled people who have successfully engaged in physical activity can mentor others. This could include online forums, local mentorship programmes, and peer testimonies to motivate and inspire others.

7.4.6. Encourage and celebrate diversity

Work to support, celebrate and showcase the diversity of the healthcare, sport, physical activity, and leisure workforce, ensuring a wide range of cultural backgrounds and lived experience. This diversity will help foster stronger connections and better understanding between people and professionals, particularly in terms of cultural sensitivity.

8. Conclusion

We know that healthcare professionals can play a vital role in positively impacting disabled people's health and wellbeing through promoting physical activity. However, this is not happening consistently, and disabled people often have to seek out their own support – and often lose hope that physical activity is achievable for them.

Through exploring best practice projects and hosting focus groups with disabled people, this research explored in more detail where this is working well, what enablers and interventions can support disabled people, and how we can facilitate large-scale change.

One of the standout findings was the importance of **collaboration across sectors**. This reinforces much of the current intent in the direction of healthcare, in particular systems working in collaborative alliances across organisational boundaries.

Successful approaches often centre on **lived-experience leadership**, **co-production** and **cultural competency**. This is further reflected through **personalised** approaches (involving the patient in developing their own journey) and supported by emphasising the **holistic benefits** of physical activity for community-building and good mental wellbeing.

This research emphasises the role of healthcare professionals as trusted messengers. **Demonstrating competency** in understanding conditions or impairments, and articulating **evidence of the benefits** that physical activity can have for an individual are important in building rapport as a trusted messenger. This detailed knowledge can be bolstered by specialist training – which can also help meet the needs of the sports, physical activity, and leisure sector, particularly where organisations and individuals are keen to welcome more inclusive practices.

Challenges raised by this research are the need to target **advice at the right time**, when people are receptive. This is often once they have had time to process a change in circumstance, but before they start a physical or mental decline (or when they start showing signs of this). This helps us understand more about successful interventions and the need to build this into pathways.

Challenges include the often hyperlocal nature of these initiatives, limited resources, and cultural resistance to integration within healthcare systems. This reinforces the need for scaling up these successful models by approaches such as **embedding physical activity into clinical pathways**.

The role of **lived-experience leadership** and **inclusion** within these initiatives cannot be overstated. Involving people directly in shaping services ensures that solutions are targeted effectively and meet the needs of communities.

This report sheds light on the **tremendous potential within the current landscape**. There are many projects that demonstrate good local practice and can serve as a blueprint for larger-scale change. Overall, the scaling up of good practice is achievable and sits well with current healthcare priorities and governance.

Ultimately, our findings call for **greater awareness and action at the systemic level**, both nationally and in terms of integrated care systems. The challenge of raising the profile of this important issue is significant, particularly in systems with limited resources where so many other competing priorities are also seeking to be a central part of the agenda. Key systemic challenges include siloed cultures and governance, in competition with a need to work in collaborative alliances. Only by addressing these challenges head-on can we ensure that all disabled people have equal access to the health-creating benefits of physical activity.

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