NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

CENTRE for PUBLIC HEALTH

Equality impact assessment

PH54 Exercise referral

NICE has a duty to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. The purpose of this form is to document the consideration of equality issues in each stage of the guideline production process. This equality impact assessment is designed to support compliance with NICE's obligations under the Equality Act 2010 and Human Rights Act 1998.

Table 1 below lists the protected characteristics and other equality factors NICE needs to consider, i.e. not just population groups sharing the 'protected characteristics' defined in the Equality Act but also those affected by health inequalities associated with socioeconomic factors or other forms of disadvantage. The table does not attempt to provide further interpretation of the protected characteristics.

This form should be initiated during scoping for the guidance, revised after consultation and finalised before guidance is published. It will be signed off by NICE at the same time as the guidance, and published on the NICE website with the final guidance. The form is used to:

- record any equality issues raised in connection with the guidance by anybody involved
- demonstrate that all equality issues, both old and new, have been given due consideration, by explaining what impact they have had on recommendations, or if there is no impact, why this is.
- highlight areas where the guidance should advance equality of opportunity or foster good relations
- ensure that the guidance will not discriminate against any of the equality groups.

Table 1: NICE equality groups

Protected Characteristics

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage and civil partnership (protected only in respect of need to eliminate unlawful discrimination)

Additional characteristics to be considered

- Socioeconomic status

Depending on policy or other context, this may cover factors such as social exclusion and deprivation associated with geographical areas, or inequalities or variation associated with other geographical distinctions (for example, the North-South divide; urban versus rural).

- Other

Other groups in the population experience poor health because of circumstances often affected by, but going beyond, sharing a protected characteristic or socioeconomic status Whether such groups can be identified depends on the guidance topic and the evidence. The following are examples of groups that may be covered in NICE guidance:

- Refugees and asylum seekers
- Migrant worker
- Look-after children
- Homeless people.

1. Scoping

1.	Have any potential equality issues been identified during the scoping process (development of the scope or discussion at the Committee meeting), and, if so, what are they?

The age cut off point outlined in the scope which focuses the guidance on those aged 19 years old and above (thus excluding those aged 18 and under) was raised as a potential equality issue by stakeholders.

Stakeholder raised the need to consider and acknowledge the potential for any health intervention to exacerbate health inequalities. Reference is made to the lack of evidence on how ERS interacts with disability, gender identity, ethnicity, religion and belief or sexual orientation.

Stakeholders raised the issue of the need to consider the appropriateness of the ERS format and subsequent activity referred to and specific populations for example those with a disability

Stakeholders raised the issue of those with primary responsibility for referral, such as GP's, and the potential for inequalities. Reference is made to socio-economic status, gender and age and its influence on doctor-patient relationship and the potential to exacerbate inequalities.

2.	What is the preliminary view as to what extent these potential equality issues need addressing by the Committee? (If there are exclusions listed in the scope (for example, populations, treatments or settings), are these justified?)

The following was noted by Committee.

Age of 19 years was to match the age used in CMO physical activity guidelines for the broad adult population (people age 19 to 64 years).

Issues related to inequalities and appropriateness of exercise referral format and subsequent activity referred to for different groups were explored in the evidence reviews – particularly the 'context, barriers and facilitators' work commissioned from

SURE.

3.	Has any change to the scope (such as additional issues raised during the Committee meeting) been agreed to highlight potential equality issues?
No. The above points raised by the stakeholders were all felt to be considered by the scope. The key questions outlined in the scope sought to explore the evidence regarding all items raised by stakeholders regarding equality, and does not restrict on the basis of equality.	

4.	Are there any language or communication needs
None specific to this topic or stakeholders, experts or Committee members.	

2. Consultation document

1.	Have the potential equality issues identified during the scoping process been addressed by the Committee, and, if so, how?
The issues regarding potential inequalities from 'inappropriate exercise referral', 'those with responsibility for referral' and 'a lack of evidence' have been considered in the development of the consultation document. The consultation document acknowledges the lack of identified evidence to fully elucidate all ERS scenarios on page two and three and in the considerations section of the guideline. The draft guideline and its underpinning reviews (based on the scope questions) did seek to understand the impact of items relating to referral to exercise referral, but as outlined in the consultation document a lack of evidence regarding how these items impacted effectiveness meant that little comment could be made (this is outlined in the considerations section in more detail). The research recommendations in the consultation document further highlight the need for more research in the area to elucidate the factors that impact effectiveness and cost effectiveness and for which	

groups. It specifically highlights the need for greater research on support for primary care professionals and what factors encourage under-represented groups to take part in exercise referral schemes.

2.	Have any other potential equality issues been raised in the draft Guidance, and, if so, how has the Committee addressed these?

Equality items were discussed in both PHAC 1 and 2 but this was mainly with regard to the lack of evidence to say anything specific to exercise referral.

PHAC 1 meeting outlined a number of issues regarding the evidence and economic modelling and its consideration of all participants including groups within the protected characteristics. In particular the barriers and facilitators review highlighted a number of aspects related to protected characteristics which stimulated conversations regarding: cultural tailoring of schemes; facilitating access to exercise referral schemes across protected characteristics; lack of black and minority ethnic representation and understanding barriers to access; uptake and adherence; disabilities and access to facilities; a lack of provider skills to deliver appropriate physical activity, and subsequent reluctance to teach and need for specialist skills; the challenge faced by those from lower socioeconomic groups in the uptake and adherence to exercise referral schemes, subsequent drop out and lower likelihood of attendance; and what prevents attendance at exercise referral schemes in hard to reach/under-represented groups. The evidence provided on the effectiveness and cost effectiveness of exercise referral led to the development of conditional recommendations on the commissioning of and referral to exercise referral schemes. A gap in the evidence was identified regarding exercise referral and the protected characteristics for consideration as a potential research recommendation.

At the PHAC 2 meeting the underpinning economic modelling was discussed. Research recommendations were discussed and drafted that considered greater research into those with learning difficulties; specifics regarding populations that might benefit and appropriate comparators for these populations; specific consideration of equalities and those from lower socioeconomic groups. Discussions were had regarding partial payment and free schemes and impact on adherence in lower socioeconomic groups. In the development of the draft

recommendations, discussion were had regarding conditional recommendations (given the effectiveness of exercise referral being marginal and the economic modelling demonstrating ICER's in excess of the NICE threshold), 'appropriate referrals' which included discussion on 'hard to reach' populations and specific protected characteristics such as gender, disability, age and culture/ethnicity. Barriers and facilitators to participation were discussed in relation to the 'content' of an exercise referral scheme, for example the location at 'gyms/leisure centres' and impact on access.

3.	Do the preliminary recommendations make it more difficult in practice for a specific group to access any recommended services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?
No. The consultation guideline outlines that exercise referral schemes should not be commissioned for the sole purpose of promoting physical activity.	

4.	Are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access identified in question 3, or otherwise fulfil NICE's obligation to promote equality?
Not applicable	

5.	Have the Committee's considerations of equality issues been described in the consultation document, and, if so, where?
Yes. Issues regarding exercise referral schemes as an intervention to increase 'affordable access to facilities' and a 'tool for engagement' have been highlighted in Considerations 2.20 and 2.4 respectively. Research recommendation 3.4 outlines a focus on greater research on factors that encourage groups that fall into protected characteristics and factors that encourage participation in exercise referral schemes.	

3. Final Public Health Guidance document

1.	Have any potential equality issues raised in section 2 been addressed by the Committee and if so, how?

The committee discussed the potential issues regarding inequalities and exercise referral schemes in terms of access to physical activity intervention in the development of the draft consultation guideline. There was limited information to elucidate the impact of exercise referral intervention and the impact on the identified protected characteristics. The committee have made reference on page 2 of the guideline to the potential benefit of exercise referral schemes in terms of providing 'affordable access to facilities'. Consideration 4.23 further acknowledges that there may be groups for whom exercise referral schemes are a cost effective intervention for example 'those who would not have otherwise accessed supervised exercise programmes'.

The committee acknowledged the findings of the fieldwork report which highlighted the potential for 'draft recommendations to increase inequalities in health, as many schemes focus on overcoming social isolation and improving people's general participation in the local community, rather than physical activity alone. There was no evidence identified that captured these points raised.

The lack of evidence regarding the impact of exercise referral schemes and aspects pertaining to the protected characteristics lead the committee to specifically call for the research recommendations to 'identify the differences in effectiveness among under-represented groups (5.3).

2.	Have any additional potential equality issues been raised during the consultation, and, if so, how has the Committee addressed these?

The stakeholder consultation on the draft guideline highlighted a number of items.

Across all protected characteristics there was a feeling that 'access, affordability and tailoring should be considered'. The evidence reviews and preceding scope questions sought to investigate and understand these issues in the context of exercise referral schemes. The committee discussed these issues with respect to protected characteristics based on the evidence reviews and economic modelling. There was limited information to elucidate the impact of exercise referral intervention and the impact on the identified protected characteristics.

Age: The issue of age cut off at 19 was raised again with additional points raised regarding the provision of advice on exercising safely to older people. The issue of age cut off was already addressed at the scoping stage. The committee considered the issue of exercising safely. Changes to the final guidance reflect this in a broader item of the incorporation of behaviour change techniques (see recommendation 2 of the final guideline) which highlights examples related to tailoring and social support which must be in place as a prerequisite in the commissioning ofexercise referral schemes.

Disability: there was a suggestion that the consultation recommendations could mean that people with 'medical conditions' might lose out on a physical activity opportunity. The issues of transport as a barrier to engagement for those with disabilities or 'confidence issues' was raised. The committee considered the lack of clarity of the consultation guideline (which was a key theme of the stakeholder comments) as an issue that has contributed to a potential misinterpretation of whom this guideline is for. Changes throughout the final guideline were made to address this. The issues of transport as a barrier were considered in a broader item in recommendation 2, where it outlines the incorporation of behaviour change techniques (see recommendation 2 of the final guideline) as a prerequisite to the commissioning of any exercise referral scheme.

Socioeconomic status: Stakeholders highlighted that the 'negative recommendations' could mean that those groups at greatest risk (who are also those most likely to benefit from increasing physical activity) may lose out. A comment (not underpinned by any submitted references or evidence) was made that incentives should be offered to providers and those who cater for vulnerable groups. It was also highlighted that those from lower socioeconomic groups have limited opportunities for physical activity and that exercise referral schemes were one of those limited opportunities. Stakeholder also highlighted that exercise referral schemes were about more than just physical activity promotion and also served as an intervention to increase community engagement and help with social isolation. The committee considered all of the raised items in their deliberations. With regard to those at greatest risk losing out, the guideline is clear that evidence and economic modelling demonstrates that exercise referral is more expensive and less effective than other physical activity interventions and that these other physical activity interventions, for example brief physical activity advice, should be considered. The final guideline makes conditional recommendations regarding the commissioning of and referral to exercise referral schemes and does not restrict by any of the protective characteristics. The clarity of the consultation guideline was highlighted by stakeholders and considered by the committee as a key reason for a number of the issues raised regarding the status of exercise referral schemes and who will and won't be eligible for example those with medical conditions. This has been considered by the committee (PHAC 3) and changes in the final guideline reflect this. The point regarding incentives was discussed by the committee and the final guideline addresses it in an in broader item regarding the incorporation of behaviour change techniques (see recommendation 2 of the final guideline) as a prerequisite of the commissioning of and referral to an exercise referral scheme. The use of incentives might be a way to achieve this aspect of the recommendation and is dependent on the individual nature of the exercise referral scheme and the

participant (but no effectiveness evidence was outlined regarding the additional impact of incentives on referral to, uptake of and adherence to exercise referral schemes). The committee considered the point raised regarding exercise referral as community engagement and social isolation intervention in the introduction section and in the considerations section of the final guideline

The fieldwork raised the same issues regarding equality and the protected characteristics as the stakeholder consultation. Clarity was seen to be the main issue for a number of the points raised regarding access, cost and the potential negative recommendation of exercise referral scheme. The committee considered the fieldwork report and changes were made to the guideline to increase clarity and resolve the issues pertaining to perceived equality issues – this included clarification regarding the evidence of effectiveness and economic modelling assumptions, outlining the other physical activity interventions already recommend by NICE and also where NICE recommends structured exercise programmes for specific disease conditions (see final guideline). The considerations also emphasise the concerns regarding the prioritisation of physical activity in primary care, the conditional recommendation around exercise referral and access to opportunities to be physically active.

3.	If the recommendations have changed after consultation, are there any recommendations that make it more difficult in practice for a specific group to access any recommended services compared with other groups? If so, what are the barriers to, or difficulties with, access for the specific group?

No. The changes to the recommendations post consultation focus on the reason for commissioning of and referral to exercise referral scheme. They do not exclude on the basis of any of the protected characteristics.

4.	If the recommendations have changed after consultation, are there any recommendations or explanations that the Committee could make to remove or alleviate barriers to, or difficulties with, access identified in questions 2 and 3, or otherwise fulfil NICE's obligations to promote equality?

Changes have been made to the recommendations that consider barriers and facilitators outlined in questions 2 and 3. Recommendation 2 makes reference to the incorporation of core techniques from the behaviour change: individual approaches (NICE public health guidance 49) which highlight agreeing goals and developing action plans (which could include incentives and provision of advice on exercising

safely)

5.	Have the Committee's considerations of equality issues been described in the final Public Health Guidance document, and, if so, where?
Yes. Issues regarding exercise referral schemes as an intervention to increase 'affordable access to facilities' and a 'tool for engagement' have been highlighted on page 2 under 'Other benefits of exercise referral schemes'. Issues pertaining to a lack of evidence regarding those groups that fall into protected characteristics and the effectiveness and cost effectiveness of exercise referral are discussed in Considerations 4.23. Further, the research recommendations (section 5) focus on more research on the differential effectiveness of exercise referral schemes in populations that fall into the protected characteristics.	

Approved by Centre or Programme Director: Professor Mike Kelly

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