A Toolkit for the Design, Implementation & Evaluation of Exercise Referral Schemes

Section 1: Background technical report

March 2010

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Terms of Use

The aim of this toolkit is to provide an easy-to-read, practical guide for all those professionals involved in the delivery, coordination, commissioning and evaluation of exercise referral schemes. These professionals include general practitioners, practice nurses, community nurses, allied health professionals (physiotherapists, dieticians etc), exercise professionals, health promotion/ public health specialists, commissioners and researchers.

The toolkit has been developed in consultation and collaboration with a range of professionals involved with exercise referral schemes and key national stakeholders.

It draws upon current Government policy for the design and delivery of quality assured exercise referral schemes; it is **NOT** a replacement for such national policy. Furthermore it **should NOT** be used in isolation from the National Quality Assurance Framework for exercise referral schemes (NQAF).

It is a tool to aid the design, delivery and evaluation of exercise referral schemes, but is **NOT POLICY**. It uses the evidence base and local scheme practice to support schemes in meeting the guidelines set out within the National Quality Assurance Framework and to raise standards within schemes.

This resource was written and produced by the British Heart Foundation National Centre for Physical Activity and Health. It was last updated March 2010.

Using the toolkit

It is recognised that capacity, resources and funding vary across schemes and that some schemes are struggling to implement elements of the National Quality Assurance Framework and consequently may struggle to adopt some of the recommendations set out within the toolkit.

The toolkit is not designed as a '**blueprint**' for how exercise referral schemes must be designed, implemented and evaluated; it offers some best practice principles for all those involved in the delivery, management and commissioning of exercise referral schemes. It is for individual schemes to consider whether the implementation of these principles will improve the design, delivery and effectiveness of their scheme, given the capacity and resources available.

Many schemes may already be meeting the recommendations outlined within the toolkit, in which case the toolkit can be used as a resource for professionals to take a fresh look at their scheme or as a guide for on-going reflection.

Some local health boards and primary care trusts may have developed an integrated system for the promotion of physical activity, which offers a range of physical activity opportunities for the local population, such as led-walks, green-exercise, exercise referral schemes and/or specialist condition specific whole exercise classes. This toolkit is predominantly concerned with exercise referral schemes designed for low to medium risk patients which involve the transfer of medical information from a healthcare practitioner to an appropriately qualified level 3, exercise professional.

Whilst it is recommended that, where appropriate, primary care professionals should advise patients to increase their physical activity it should be noted that recommending or sign-posting patients to local physical activity opportunities such as lay-led walking schemes is quite distinct from referring an individual to a dedicated service and transferring relevant medical information about this individual to this service.

Where schemes offer specialist condition specific whole exercise classes for patients/clients with any conditions covered by the level 4 national occupations standards these schemes should ensure they comply with the relevant governance arrangements and quality assurance guidelines.

Acknowledgements

This document could not have been completed without the assistance of many professionals involved in the delivery, coordination and commissioning of exercise referral schemes. We would like to thank all those professionals who responded to the audit questionnaire; kindly provided us with sample forms, scheme protocols and service level agreements and attended the consultation workshops to help shape the toolkit.

We would also like to extend our gratitude to Flora Jackson, Physical Activity Alliance Coordinator NHS Health Scotland; Nicola Brown, former Physical Activity Lead for the Health Promotion Agency Northern Ireland and the Department of Health Regional Physical Activity Leads for their assistance in identifying relevant professionals and convening the national and regional consultation workshops.

We would also like to acknowledge and thank those people and organisations who responded during the consultation phase, their comments have helped shape the final toolkit.

Following the consultation process a national exercise referral toolkit working party was established to assist in finalising the toolkit. We would, therefore like to acknowledge the following individuals and organisations for their contribution to the working party and for their support in ensuring the comprehensiveness of the toolkit.

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Executive Summary

This toolkit has been developed in response to concerns expressed by exercise referral professionals and regional physical activity leads following the initial release of the NICE public health intervention guidance.[14]

We have taken a bottom up approach to the development of the toolkit, its content and format have been shaped by a range of professionals who are currently responsible for, or who have experience of, delivering, coordinating, commissioning and/or evaluating exercise referral schemes.

The mapping exercise provided a snapshot of the nature and extent of exercise referral schemes in England, Northern Ireland and Scotland and allowed us to gain a more comprehensive understanding of how schemes are delivered and evaluated. The formative consultation seminars provided an opportunity to learn about the practical issues and real challenges of delivering, coordinating, commissioning and evaluating exercise referral schemes. Moreover, these seminars enabled professionals to identify what practical support and guidance they required to respond to these challenges. In addition, the views and opinions of key stakeholders were sought during the development of the toolkit.

The review of exercise referral research identified some key implications for practice, where appropriate, these have been used to develop some of the good practice guidelines and recommendations within the toolkit.

The six week consultation on the draft toolkit provided professionals and key stakeholders with a further opportunity to identify any keys issues which had been overlooked and to indicate where further clarification and/or guidance was needed.

Following the consultation phase a national working party was established to assist in finalising the toolkit. Although this process has delayed the release of the final toolkit it has resulted in a much more comprehensive resource with buy-in from key national stakeholders and relevant partners. It has also reduced duplication and allowed the maximum use of expertise and resources.

Section 1: Background Technical Report

The aim of this section is to provide the background rationale for the toolkit, specifically outlining how schemes have evolved over the last two decades. This section also provides a comprehensive outline of how the toolkit was developed and finishes with a summary of some key issues raised during the draft toolkit consultation exercise.

1.1. Rationale for the Toolkit

The benefits of a physically active lifestyle for health promotion and disease prevention are well documented.[1,2] The Chief Medical Officer's Report: '*At least five a week'* stated that:

> ***"Adults who are physically active have a 20-30% reduced risk of premature death and up to 50% reduced risk of developing the major chronic diseases such as coronary heart disease, stroke, diabetes and cancers."***
>
> **p1. CMO (2004)[2]**

However, there is a serious shortfall in the actual number of adults who engage in sufficient levels of physical activity to confer health benefits. In the United Kingdom physical activity levels are low[3], data for England, Scotland, Wales and Northern Ireland show that, on average only 38% of men and 27% of women meet the current physical activity guidelines suggested by the Government.[i] See section 1.4.1. for a breakdown of the percentage of adults, by age and sex, meeting the physical activity recommendations for England, Scotland, Wales and Northern Ireland.

There is increasing recognition, both globally and in the UK, of the need to promote healthier lifestyles and improve physical activity levels in order to reduce premature mortality and morbidity from chronic diseases.[2,4,5] The World Health Report (2002) estimated that 3% of all disease burden in developed countries was caused by physical inactivity.[6] In the UK, there is a considerable public health burden due to physical inactivity, in 2003-2004 researchers found that physical inactivity was responsible for 3.1% morbidity and mortality.[7] Given the high prevalence of physical inactivity in the UK today, Professor Jerry Morris's statement of almost two decades ago still retains it potency:

> ***"The potential health gain by increasing population physical activity levels is arguably today's best buy in public health."***
>
> **Morris (1994)[8]**

Primary care has been recognised as a potentially important setting for the promotion of physical activity. Primary healthcare professionals come into frequent contact with the general public. During 2007/2008[ii] it was estimated that there were 292.4 million consultations in primary care, with the average patient receiving 5.3 consultations.[9] Overall about 85% of the population visit their GP surgery on an annual basis.[10] Every

[i] CMO recommends that adults should do at least 30 minutes or more of moderate intensity physical activity at least 5 days a week.

[ii] This data pertains to the NHS financial year of 2007/2008.

consultation provides an opportunity to promote behaviour change or to refer patients to relevant support services.[11]

Lord Darzi[12] highlighted that the growth in the prevalence of many long-term conditions such as coronary heart disease, diabetes, hypertension, depression and chronic obstructive pulmonary disease, can be attributed not only to unhealthy lifestyle choices, but also to missed prevention opportunities. Many long-term conditions are commonly diagnosed, treated and monitored in primary care; however Darzi found that 54% of patients said that their GP had not provided advice on diet and exercise.[12] Furthermore, 65% of adults thought that it would be a good idea for GPs' to prescribe exercise instead of prescription drugs if the GP thought the exercise would remedy the patients condition.[13]

This emphasises the importance of primary care professionals in promoting health-related behaviours, such as physical activity, during routine consultations. Indeed NICE public health guidance[14] recommends that:

> ***"Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more)."***
>
> **p.4 NICE (2006)**

In the UK exercise referral schemes are one of the most popular interventions used by primary care practitioners to encourage sedentary individuals and individuals with long-term medical conditions, such as diabetes, hypertension, asthma, arthritis, obesity etc. to become more physically active.

According the National Institute for Health and Clinical Excellence (NICE)[14] an exercise referral scheme is a process whereby a health professional:

> ***"Directs someone to a service offering an assessment of need, development of a tailored physical activity programme, monitoring of progress and a follow-up. They involve participation by a number of professionals and may require the individual to go to an exercise facility such as a leisure centre."***
>
> **p.5 NICE (2006)**

The first exercise referral scheme was set up in the late 1980's and over the past two decades there has been a significant and sustained growth in the number of exercise referral schemes operating across the United Kingdom. The Royal College of General Practitioners credits GP Dr Derek Browne with being the first GP to promote exercise on prescription in the UK.[15] Exercise referral schemes provide patients with the opportunity to engage in a structured programme of physical activity or exercise under the guidance of a suitably qualified exercise professional. The objective is to provide a positive introduction to being active which may act as a catalyst to long-term behaviour change.

Whilst there are variations in the models and standards of exercise referral schemes across the UK, schemes typically involve a member of the primary care team or allied health professional opportunistically referring a patient to a dedicated exercise professional who develops an exercise programme based on the patient's goals and

preferences. Generally this exercise programme takes place within a leisure facility for between 10-16 weeks and is usually offered at a subsidised cost.
As a result of such rapid expansion of exercise referral schemes it has been suggested that there has been a consequential lack of quality assurance and a paucity of good quality evaluation.[16] Indeed, previous reviews have identified a lack of systematic evaluation of exercise referral schemes.[17]

In 2001, in a bid to improve the quality of delivery of schemes the Department of Health produced a National Quality Assurance Framework (NQAF) for Exercise Referral Systems.[18] The objective of the National Quality Assurance Framework was to provide guidelines for exercise referral systems, with the aim of improving standards among existing schemes and helping the development of new schemes. NQAF set out quality standards that exercise referral schemes should aspire to, these included measures to improve the evaluation of schemes.

In spite of the publication of the NQAF, capacity and resource constraints have largely dictated the extent to which the majority of schemes are meeting these standards. Furthermore, researchers have argued that the NQAF has failed to achieve consistency and comparability of standards, audit and evaluation mechanisms across the country.[19-21]

Although concerns about the quality and effectiveness of exercise referral schemes have been voiced by researchers and some policy makers for more than a decade, such concerns have been muted by Government policy, which has continued to promote the use of exercise referral schemes as a popular intervention for increasing physical activity levels.[22]

Following the publication of the White Paper 'Choosing Health' questions about the evidence of the effectiveness of exercise referral schemes were being raised by senior policy makers. Consequently in 2005, the Department of Health commissioned the National Institute for Health and Clinical Excellence (NICE) to undertake a review of the effectiveness of exercise referral schemes to increase physical activity levels. The review evidence was carefully scrutinised by the NICE Public Health Interventions Advisory Committee who determined that there was insufficient evidence to recommend the use of exercise referral schemes to promote physical activity, other than as part of research studies where their effectiveness can be evaluated.

Subsequent NICE guidance[14] recommended that:

> **"*Practitioners, policy makers and commissioners should only endorse exercise referral schemes to promote physical activity that are part of a properly designed and controlled research study to determine effectiveness. Measures should include intermediate outcomes, such as knowledge, attitudes and skills, as well as a measure of physical activity levels. Individuals should only be referred to schemes that are part of such a study."***
>
> **p6. NICE (2006)**

The NICE recommendation to halt further use of exercise referral schemes other than for controlled research caused deep anxiety among exercise referral schemes.[23] The subsequent publication of the NICE implementation advice and audit criteria resulted in further concerns and confusion among practitioners, policy makers and

commissioners.[24] On the one hand the NICE intervention guidance recommended that schemes should only be endorsed to promote physical activity if they are part of a controlled research study, on the other hand the NICE implementation advice[24] acknowledged that exercise referral schemes can involve partners from a number of sectors and suggested caution before withdrawing funding or other endorsements, so that good partnership arrangements are not damaged for the future.[24]

In the light of the NICE guidance, the future of exercise referral schemes started to look uncertain as many Primary Care Trusts began to question whether to continue funding their current schemes. In addition, many schemes which were deemed to be effective at a local level prior to the guidance were now under pressure to justify their existence and demonstrate their effectiveness. However, the cost implications of conducting a controlled research study to evaluate the effectiveness of exercise referral schemes meant this was an unrealistic objective for the majority of schemes.

The publication of the Department of Health statement on exercise referral schemes[25] offered a reprieve for some schemes by stating that the NICE requirement to be part of controlled study only applied to those schemes existing solely for the purpose of promoting physical activity in people with no underlying medical condition or risk factors. Exercise referral schemes which address the medical management of conditions, such as type 2 diabetes, obesity and osteoporosis or specifically designed to prevent or ameliorate individual health conditions (e.g. falls prevention) fall outside the scope of the NICE review and consequently are not affected by the NICE public health intervention guidance no 2.

> ***"The Department of Health urges commissioners, practitioners and policy makers to continue to provide high quality exercise referral schemes for their local population where appropriate."***
>
> **p1. DH (2007)**[25]

The NICE guidance clearly signalled the need to improve the evaluation of exercise referral schemes and to build a more comprehensive evidence base on the effectiveness of exercise referral schemes at a local and national level. However, for those schemes eager to respond to the NICE guidance, they found that it offered little practical direction on how to improve the delivery and/or evaluation of their scheme.

1.2. Development Process

In response to concerns expressed by exercise referral practitioners and discussions with several of the Regional Physical Activity and Health Coordinators a meeting was convened with the National Physical Activity Coordinator for Wales, the Physical Activity Lead for the Department of Health and several of the Regional Physical Activity and Health Coordinators to consider how we could best support exercise referral practitioners in implementing the NICE guidance. At this meeting it was agreed that:

a) **There was a need for coordinated and coherent approach to managing the effects of the NICE guidance.**

b) **A project would be undertaken to examine the feasibility of developing a toolkit for the design, delivery and evaluation of exercise referral schemes.**

The West Midlands Physical Activity Network had already started to consider how they could best support professionals in the region and shortly after the publication of the NICE guidance the network led a mapping exercise to establish how many schemes were operating in the West Midlands region. The aim of the mapping exercise was to ascertain current practice, i.e. aims, objectives of schemes, target population, who refers into the schemes, types of activities available, length of schemes, criteria for evaluating and monitoring schemes etc. The East Midlands Physical Activity Network also replicated the mapping exercise in their region. The mapping work undertaken in the West and East Midlands informed the basis for the further mapping of schemes across the UK.

1.2.1. Mapping Exercise

The questionnaire developed by the East and West Midlands Physical Activity Networks (see section 1.4.2.) was reviewed and modified in order to capture additional information about patient recruitment, transfer procedures, patient follow-up and evaluation activities. A copy of the questionnaire used for the mapping exercise can be found in section 1.4.3.

During 2007-2008 we worked, on a region by region basis, with the Regional Physical Activity and Health Coordinators in the North West, North East, Yorkshire and Humber region, South East and Eastern regions to identify professionals responsible for exercise referral schemes operating across their respective regions. Where there were gaps in the regional information, we made supplementary calls to Local Authorities and PCTs in an attempt to locate any professionals who might have been missed. A briefing paper, explaining the purpose of the mapping exercise (see section 1.4.4), and the questionnaire was then emailed to these professionals requesting information about their scheme. As a safeguard to ensure the questionnaire reached the relevant professionals, the email also asked professionals to inform us if they were not the key contact for the exercise referral scheme in their area. In Scotland, the questionnaire was sent out to all members of the Physical Activity Health Alliance and in the London regions the questionnaire was distributed via local networks and during several exercise referral toolkit consultation meetings. In parallel to the mapping exercise, the Health Promotion Agency of Northern Ireland also conducted an audit of physical activity promotion in primary care which captured data on existing exercise referral schemes.

Around 89% of primary care trusts in England are estimated to have an exercise referral scheme[26] and similar figures are quoted for the health boards of Scotland, Wales and Northern Ireland. However, little is known about the detailed characteristics of exercise referral schemes currently running in the UK. The mapping exercise was the first stage to developing a more comprehensive evidence base on the nature and extent of exercise referral schemes in the United Kingdom. It provided an overview of how schemes operate and enabled us to highlight strengths, gaps and challenges in practice.

1.2.2. Formative Consultation Seminars

Following the initial data collection, a series of consultation seminars were hosted to gain professionals views about
whether there was a need for an exercise referral toolkit and what the content of a

toolkit might look like. In total 10 consultation seminars were held across England and Scotland, involving approximately 180 professionals engaged in the delivery, management and commissioning of exercise referral schemes, for example, referring practitioners, scheme coordinators, exercise professionals and commissioners.

At the first seminar in the West Midlands region, formative ideas on what the toolkit might include were presented; these ideas were generated at the initial meeting held in Loughborough with the Regional Physical Activity and Health Coordinators and National Physical Activity Leads. At each subsequent regional seminar cumulative ideas were presented based on the information gathered at the preceding consultation seminar. The overriding goal of each consultation seminar was to give a voice to the exercise referral professionals and to locate the proposed exercise referral toolkit firmly within the realities of professionals' everyday experiences of exercise referral schemes. The formative consultation seminars ended when no new ideas were emerging from the successive groups.

In addition to the regional seminars meetings were held with key stakeholders e.g. Skills Active, the sector skills council, The Registrar for Register of Exercise Professionals (REPs), exercise referral training providers, professionals from the Royal College of Physicians and the Faculty of Sports Medicine. Further correspondence was exchanged with several GPs, practice nurses, physiotherapists and clinical exercise specialists.

The information gathered from the mapping exercise, exercise referral research literature, consultation seminars, meetings, email and telephone correspondence was collated and analysed. Similar issues were combined into more global themes, to form the framework of the draft toolkit; the resultant draft toolkit included:

- A summary of current practice, research and policy.
- Guidance for referring practitioners.
- Guidance for exercise professionals and exercise referral scheme coordinators.
- Guidance for commissioners.
- A guide to evaluation.

Five further seminars were held in Cambridge, London, Birmingham, Glasgow and Belfast to obtain professionals views about the proposed contents of the toolkit, and to gain feedback on the content, style, length and format of specific sections. Around 100 professionals attended these seminars and feedback was subsequently used to inform the final development of the draft toolkit.

1.2.3. Draft Toolkit Consultation Exercise

The draft toolkit and consultation questionnaire (see section 1.4.5 for a copy of the consultation questionnaire) were disseminated to all professionals who had responded to the mapping exercise and attended the formative consultation seminars. Electronic copies of the toolkit and questionnaire were also emailed to the Physical Activity Leads within UK Government, the Regional Physical Activity and Health Coordinators and the Coordinator of the Scottish Physical Activity and Health Alliance, the latter two were asked to cascade the documents throughout their physical activity networks. In addition electronic copies were sent to key organisations and stakeholders - Royal College of General Practitioners, SkillsActive, Fitness Industry Association's Exercise

Referral Forum, Register for Exercise Professionals, Chartered Society for Physiotherapists and the Royal College of Physician's Exercise for Life Working Party.

The consultation ran for six weeks during mid-February to the end of March 2009. Thirty-five responses were received from a range of individuals and organisations. It is difficult to give an accurate picture of the number of individual responses to the consultation exercise as the majority of responses (70%) were combined. For example, a combined response covering the whole of the North East region and its stakeholders was submitted. The region's PCTs and local authorities were invited to comment, views of the NE Green Exercise Forum and Regional Physical Activity Group were also sought and feedback from the North Tyneside Exercise Referral Scheme was included in a single response.

At the close of the consultation period all responses were collated and reviewed by the toolkit project manager. The consultation responses were also discussed with a number of key individuals and several major stakeholders in order to consider how the we could best respond to the feedback. Following these discussions we agreed to set up a working party to help take forward the exercise referral toolkit, to ensure the final version reflected the needs of all national, regional and local stakeholders involved in exercise referral schemes.

1.2.4. National Toolkit Working Party

A working party was established with a cross-section of professionals involved in the delivery, coordination and commissioning of exercise referral schemes; and representatives from key national and regional stakeholders. The working party included the Department of Health, the Welsh Assembly Government, NHS Health Scotland, Welsh Local Government Association, Skills Active, Register of Exercise Professionals, Fitness Industry Association, Natural England and several professionals with a variety of skills; knowledge and expertise in exercise referral (for further details of how these professionals were selected see section 1.4.6 & 1.4.7).

At the first meeting, the working party terms of reference were ratified and a project plan outlining the process for finalising the toolkit was discussed and approved. It was agreed that the starting point for the working party was to analyse the consultation responses to identify what issues this had raised.

All of the consultation responses were anonymised and collated into one large document, which was circulated to the working party. A sub-group of the working party volunteered to review the consultation document. To aid this process members of the sub-group examined the consultation responses in relation to a specific area of their expertise e.g. commissioning, scheme coordination, qualifications, evaluation etc and summarised key issues for consideration. These key issues were discussed by the wider working party and an action plan, outlining who would take responsibility for sourcing additional information, guidance and making revisions to the toolkit, was agreed. At this meeting the working party also agreed how the toolkit would be segmented and presented as a web-based resource.

Six small sub-groups were formed and each sub-group was assigned responsibility for revising a specific section of the toolkit in line with the action plan. Prior to the next meeting the amended sections of the toolkit were circulated to all working party members for review. At the final working party meeting each section of the toolkit was reviewed and any further changes/actions were approved. Following this meeting each sub-group revised their respective section and sent their final version to the chair of the working party, regional physical activity and health coordinator and the project manager. Upon receipt of the revised sections the chair, regional coordinator and project manager met to review the amendments and to sign-off the content of each section. After this meeting all sections of the toolkit were handed over to the project manager for final editing, formatting and production.

1.2.5. Working Party Response to Specific Consultation Comments

The working party have attempted to address most of the comments submitted during the consultation exercise within the different sections of the toolkit. However, it has not been possible to resolve all of the issues raised either because these fell outside the scope of the toolkit or were not within the remit or expertise of the working party. Below is a list of some of the key issues and questions raised during the consultation exercise and a summary of the working party's response.

- A few respondents expressed concerns that their schemes did not have the resources, capacity and funding to adopt some of the recommendations set out within the toolkit.

    - The working party acknowledged that capacity, resources and funding vary across schemes and that some schemes are struggling to implement elements of the National Quality Assurance Framework. The toolkit is not designed as a '**blueprint**' for how exercise referral schemes must be designed, implemented and evaluated. It **offers some best practice principles** for all those involved in the delivery, management and commissioning of exercise referral schemes. It is for individual schemes to consider whether the implementation of these principles will improve the design, delivery and effectiveness of their scheme, given the capacity and resources available.

- A number of respondents wanted a definitive list of headline outcome indicators that all schemes should be encouraged to adopt.

    - The working party felt this requires further debate at a national policy level. Furthermore, the working party were of the opinion that to provide such a definitive list could be interpreted as national policy, which the toolkit is not. ***A recommendation that this should be addressed at a national policy level has been made to the Department of Health and devolved administrations.***

- Several respondents requested clarification about the qualifications and training necessary for working with referred patients.

    - Firstly, it should be made very clear that the toolkit is not, by any means, recommending a reduction in the qualifications and standards of exercise professionals responsible for designing, agreeing, adapting and reviewing a physical activity programme for referred patients. We hope that by working in partnership with SkillsActive and the Register of Exercise Professionals that

these issues have been clarified. ***A recommendation will be put forward to Government and the devolved administrations to look at the medical legal implications for schemes referring clients on to 'other instructors' in order to offer a wider range of activities.***

- Some respondents had expressed concerns over the level of detail required in the sample referral form and felt that GPs would refer less if too much information was requested.

    - To some extent, the working party have taken on board these concerns and modified the sample referral form where feasible. However it must be noted that a referral form should comply with the standards outlined in NQAF and the sample in the toolkit also complies with SIGN best practice guidelines for primary care referrals.

Finally, a number of respondents questioned where exercise referral sits in relation to 'Lets Get Moving', walking schemes and other physical activity interventions. In addition some individuals wanted clarification about recommendation and referral.

- 'Lets Get Moving' represents an integrated care pathway for the promotion of physical activity in primary care in England, Exercise referral schemes which follow the Department of Health policy[25] are regarded to be one part of the delivery chain within this pathway and should, where appropriate, be considered for individuals with clinical needs.
- Even though exercise referral schemes are popular throughout the UK, it is important to recognise that such schemes represent only one type intervention that can be used by primary care professionals to promote physical activity for health gain. Self-directed unsupervised activities such as free swimming, gardening or lay led activities such as health walks, green gyms or supervised structured activities such as dance, tai-chi etc. all contribute to the wider concept of physical activity promotion for disease prevention.
- Recommending or sign-posting a patient to any of these broader physical activity opportunities is quite distinct from referring an individual to a dedicated service for the development of a tailored physical activity programme i.e. an exercise referral scheme. With the former the responsibility for taking part in any of these activities is up to the patient who is also responsible to act within the boundaries of the health professional's recommendation. The latter, exercise referral, requires the transfer of relevant medical information about an individual in order to develop a tailored physical activity programme; furthermore the exercise professional takes responsibility for the safe and effective design, delivery and management of this individual's physical activity programme.

Summary:

The level of interest and engagement from professionals, key stakeholders and partners involved in exercise referral schemes has shaped the toolkit into a resource far beyond our original ideas.

Although its development has been slow, the process has been worthwhile since it has resulted in a much more comprehensive resource with buy-in from key national stakeholders and relevant partners.

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26. Crone, D., Johnston, L. & Grant, T. (2004) Maintaining quality in exercise referral schemes: a case study of professional practice. Primary Health Care Research and Development 5 (2): 96-103. Cited in: C. Gidlow, L. Johnston, D. Crone and D. James (2008) Methods of evaluation: Issues and implication for physical activity referral schemes. American Journal of Lifestyle Medicine (2): 46-50.

1.4. Appendices relevant to this section

- **Physical Activity Patterns of UK Adults**
- **East/West Midlands Exercise Referral Mapping Questionnaire**
- **Exercise Referral Mapping Questionnaire**
- **Background Briefing Paper**

1.4.1. Physical Activity Patterns of UK Adults

Percentage of adults, by age and sex, meeting the physical activity recommendations for England, Scotland, Wales and Northern Ireland

	All ages %	16-24 %	25-34 %	35-44 %	45-54 %	55-64 %	65-74 %	75+ %
ENGLAND								
Men	40	53	52	46	38	35	21	9
Women	28	33	36	35	34	27	16	4
SCOTLAND								
Men	42	59	57	45	40	35	23	13
Women	30	36	40	39	35	28	16	6
WALES								
Men	36	49	41	42	38	31	23	15
Women	23	29	29	29	27	21	17	6
NORTHERN IRELAND								
Men	33	33	40	39	29	28	26	17
Women	28	26	35	35	33	26	20	11

Notes: Recommended level of physical activity 30 minutes or more of moderate intensity physical activity at least 5 days a week
Sources:

Health Survey for England (2008) http//www.ic.nhs.uk/statistics-and-dat-collections/health-and-lifestyles-related-surveys/health-survey-for-england/health-survey-for-england-2007-latest-trends-[ns]

Health Survey for Scotland (2003) http://www.scotland.gov.uk/Resource/Doc/924/0019811.pdf

Welsh Health Survey (2007) http://new.wales.gov.uk/statsdocs/health/hs2007/hs2007ch4e.xls

Northern Ireland Health and Social wellbeing Survey (2005/06)
http://www.csu.nisra.gov.uk/Physical%20activity.pdf

1.4.2. East/West Midlands Exercise Referral Mapping Questionnaire

This form is to be completed by the Coordinator or Manager of the ER Scheme

Background information

1. Title of the Scheme:

……..

2. Coordinator/Lead Contact Name:

……..

3. Coordinator/Lead Contact details:

Email:	Telephone:
Address:	

4. What is the area covered by the scheme: i.e. Name of town, city, county covered by the scheme.

……

5. Who is the lead agency in the scheme?

……

6. How long has the scheme been running for?

Length of time	Tick
Pilot phase	
1 - 3 years	
4 - 6 years	
7 – 9 years	
10 years +	

Details of the scheme

7. What is the overall aim of the scheme? i.e. a vision statement or overarching aim?

……

……

……

8. What are the specific target groups for the scheme?

- People who are sedentary
- People with CHD
- People at risk of CHD
- People who are overweight or obese
- People with Diabetes
- People with musculoskeletal conditions
- People with Chronic fatigue/ME etc
- People at risk of falling
- People with Mental Health conditions
- Other (please state)

……

9. Please state or attach your inclusion or exclusion criteria for the scheme?

……

……

……

……

10. What activity settings are available through your scheme and give examples of the activities available in the setting? Please tick the appropriate ones

Setting	Tick	Number of facilities involved	Type of activities
Local Authority Leisure Facility			
Private Leisure Facility			
Sports Club			
Outdoor settings			
Community settings			
Other (please state)			

11. What is the length of referral period? E.g.10 weeks, 12 weeks etc

- 4 weeks
- 6 weeks
- 8 weeks
- 10 weeks
- 12 weeks
- 14 weeks
- Other (please state)……

12. If known, please give an indication of the average number of activity sessions that clients attend during the exercise referral period

……

13. Who can refer onto the scheme?

- GP
- Practice Nurse
- Community Healthcare (Health Visitors, Community Nurses etc)
- Dieticians
- Cardiac Rehabilitation professionals
- Physiotherapists
- Occupational Therapists
- Private health professionals
- Specialist Nurses
- Hospital Department Consultant
- Community Psychiatric Nurses
- Mental Health professionals
- Other (please state)

……

14. How many GP practices are there in the area covered by the scheme?

……

15. How many of these practices refer to the scheme?

……

16. Which health professionals are the most frequent referrers? e.g. GP's, etc

……

……

17. What is the charge to patients/clients during the referral period?

Assessment charge: ……. ……..

Re-assessment charge: ……

Activity Session charges: please give the range of approximate charges for different activities if known e.g. *Free walks – community sessions £2.50 – gym session £3.50*

……

……

……

18. Please state any other charges implemented by the scheme

……

……

19. Is the scheme run inline with the National Quality Assurance Framework for Exercise Referral Systems?

- ☐ Yes
- ☐ No
- ☐ Partly
- ☐ Unsure

20. If you answered partly to the question above please state which parts of the NQAF the scheme adheres to

……

……

……

……

21. Is feedback on the client/patient's progress given to the referrer? If you answer yes, at what point is the feedback given?

- ☐ Yes……
- ☐ No
- ☐ Unsure

22. Do referrers make follow up appointments with patients once they have completed the referral period?

- ☐ Yes
- ☐ No
- ☐ Don't know

23. What happens after the referral period? Where do people go next?

……

……

Staff Training

24. What exercise referral qualifications do your instructors have? (please tick)

- ☐ CYQ Exercise Referral
- ☐ Wright Foundation Exercise Referral
- ☐ Cardiac Rehabilitation Phase IV
- ☐ Gayton Group Exercise Referral
- ☐ Other (please state)

……

……

……

25. Are your instructors registered on the Register of Exercise professionals?

- ☐ Yes
- ☐ No
- ☐ Unsure

26. Do you organise any in house training for continuing professional development or the advancement of staff knowledge?

- ☐ Yes (please state)….....
- ☐ No
- ☐ Unsure

Cost implications of the scheme

27. What are the core costs (if known) of running the scheme per annum?

Core Costs	**Amount Spent**
Co-ordination	
Training Staff	
Promotion	
Delivery	
Evaluation	

Partnerships and Scheme Management

28. Please name the partners in the scheme and identify funding contributions that are made by each partner, please also give details of what resources the partners provide i.e. expertise, venues, training etc

Partner	**Funding contributed**	**Resource contributed**

29. Does the scheme have a steering group to manage and develop it?

- ☐ Yes
- ☐ No
- ☐ Unsure

30. Please outline the team responsible for the delivery of the scheme, including a brief description of their role, employing body and contracted hours?

Post	Organisation	Role	Contracted hours for the scheme per week
Example: Coordinator	*PCT*	*Scheme Coordinator*	*21 hours*
Fitness Assessor (x6)	*Local authority leisure services*	*Assessment & programming*	*10 hrs x 6*

Monitoring and Evaluation

31. Is the scheme monitored and evaluated?

- ☐ Yes
- ☐ No
- ☐ Unsure

32. Is the evaluation completed internally or externally?

- ☐ Internally (please state who by);

  _____
- ☐ Externally (please state who by);

  _____
- ☐
- ☐ Scheme not evaluated

33. How often is the scheme evaluated?

- ☐ Quarterly
- ☐ Every six months
- ☐ Annually

34. Are any particular software packages to monitor the scheme?

- ☐ Yes (please state) ……..
- ☐ No
- ☐ Unsure

35. Do you have any specific targets/objectives set for the scheme? If so please identify these targets.

- ☐ Yes
- ☐ No
- ☐ Unsure

……

……

……

36. Please give an indication of the key aspects of the scheme that you evaluate and monitor i.e. throughputs, adherence, satisfaction, physiological and psychological measures etc

……

……

……

……

37. Have you undertaken a cost effectiveness evaluation of your scheme?

- ☐ Yes
- ☐ No
- ☐ Unsure

38. Is your scheme currently part of a research programme? If yes please give brief details of this research.

- ☐ Yes
- ☐ No
- ☐ Unsure

……

……

……

Current statistics

39. If known please give an indication of the overall number of clients/patients that participate in the scheme per annum.

……

……

40. If known please give an indication of the adherence rates for your scheme (i.e: % of clients completing full period of the programme and if known the longer term adherence rates past this period.

……

……

Long Term Sustainability

41. What is the status of the scheme? If your scheme is in a pilot phase or short term funded please indicate when the funding expires.

- ☐ Pilot phase,
  ending……....
- ☐ Short term funded,
  ending…….
- ☐ Funded from mainstream budgets
- ☐ Other (please state)
  ……..

42. Please identify three successful elements of your scheme

1. ……
   ……
2. ……
   ……
3. ……
   ……

43. Are there any planned future developments for your scheme? If yes please describe

- ☐ Yes
- ☐ No
- ☐ Unsure

……
……
……
……

44. In your opinion what improvements could be made to the scheme?

……
……
……
……

Print Name:……

Signature:……..

Date:……..

Thank you for taking the time to complete this questionnaire. All individual scheme data will remain anonymous for reporting purposes. The data collated during the mapping exercise will be used to form a report on exercise referral in the West Midlands. This report will be used to inform the development of appropriate support for exercise referral schemes in the region and the cross regional discussions into exercise referral research to meet NICE guidelines.

Please return this form to Suzanne Gardner, Regional Physical Activity Co-ordinator, c/o Sport England West Midlands, 5th Floor, No 3 Broadway, Five Ways, Birmingham, B15 1BQ or fax to 0121 633 7115

1.4.3. Exercise Referral Scheme Mapping Questionnaire

This form is to be completed by the Coordinator or Manager of the ER Scheme

Section 1: Scheme coordinator contact information

1. Scheme coordinator contact name	
2. Scheme coordinator contact details	
E-mail	
Telephone	
Address	

Section 2: Details of the scheme

3. Title of the scheme			
4. What is the area covered by the scheme? i.e. name of town, city, county			
5. Who is the lead agency for the scheme? *Please tick the relevant box*			
Local authority		Voluntary sector	
Primary care trust		University	
Acute trust		Voluntary sector	
Private sector		Joint local authority and PCT	
Other (please specify)			
6. How long has the scheme been running?			
7. What is the overall aim of the scheme? i.e. a vision statement or overarching aim			
8. What are the objectives of the scheme? e.g. to provide more opportunities for physical activity for people with medical conditions			
9. Do you have a visual diagram which shows the conceptual framework of the scheme? *Please tick the relevant box*			
Yes		*If yes, please attach*	**No**		*If no, please go to Q10*

10. Do you have any inclusion criteria for the scheme based on physical activity (PA) levels? *Please tick the relevant box*					
An example of an inclusion criteria based on physical activity levels might be: sedentary – less than 30 minutes of PA per week; insufficiently active – less than 5x30 minutes moderate intensity PA per week; regularly active – 5 or more 30 minute sessions of moderate intensity PA per week.					
Yes		*If yes, please see below*	**No**		*If no, please go to Q11*
Please specify how you measure physical activity:					

11. Do you have any exclusion criteria for the scheme? e.g. unstable blood pressure *Please tick the relevant box*					
Yes		*If yes, please specify below*	**No**		*If no, please go to Q12*

12. How are participants recruited to the scheme? *Please tick all that apply*			
Opportunistically in a consultation		New patient consultation	
Health screening		Via existing condition clinic e.g. asthma	
Via existing disease registers e.g. CHD		Via advertising e.g. in practice	
Patient initiated request			
Other (please specify)			

13. Who can refer onto the scheme? *Please tick all that apply*			
General practitioner		Physiotherapists	
Practice nurse		Mental health professionals	
Community nurses, health visitors		Occupational therapists	
Dieticians		Private health professionals	
Cardiac rehabilitation professionals		Specialist nurses e.g. diabetes, epilepsy	
Other (please specify)			

14. Approximately what percentage of GP practices in your locality refer to the scheme? *Please tick the relevant box*			
Less than 33%		More than 66%	
34%-66%		If known please give exact percentage ____	

15. Who is responsible for booking the initial exercise referral consultation? *Please tick the relevant box*			
Health professional		Patient	
Exercise professional		Practice receptionist	
Other (please specify)			

16. How is any information and paperwork transferred between the health professional and exercise professional?

17. How many patients are referred into your programme on an annual basis?

18. What percentage of patients fails to attend the initial exercise referral consultation?

19. Are any systems in place to follow up patients who do not attend the initial exercise referral consultation? *Please tick the relevant box*					
Yes		*If yes, please specify below*	**No**		*If no, please go to Q20*

20. What settings are used for the scheme? *Please tick all that apply*			
Local authority leisure facility		Home-based	
Sports club		Private leisure facility	
Community venue, e.g. church hall		Outdoor settings	
Green exercise, e.g. green gyms			
Other (please specify)			

21. What types of activities are available via the scheme? *Please tick all that apply*			
Gym-based sessions		Condition specific exercises classes	
Swimming		Jogging/running	
Group exercise classes		Cycling	
Walking		Resistance exercise	
Hydrotherapy		Yoga/Pilates/Tai-chi	
Sports		Dance	
Chair-based exercises		Lifestyle activity e.g. gardening	
Other (please specify)			

22. What is the length of the referral period? *Please tick the relevant box*			
4 weeks		6 weeks	
8 weeks		10 weeks	
12 weeks		14 weeks	
Other (please specify)			

22a. Does the patient incur any costs during the referral period? *Please tick the relevant box*					
Yes		*If yes, please go to Q22b*	**No**		*If no, please go to Q23*

22b. What is the charge to patients during the referral period? *Please tick all that apply and give the cost to the patient*		
Charge	✓	**Cost**
Single overall charge		
Assessment charge		
Re-assessment charge		
Activity Session charges (please list): *e.g. Gym*		*e.g. £2.50 per session*

23. How is patient attendance monitored during the referral period? e.g. patient register, activity vouchers, etc.

24. Are any systems in place to follow up patients who drop out during the referral period? e.g. phone call, letter etc. *Please tick the relevant box*					
Yes		*If yes, please specify below*	**No**		*If no, please go to Q25*

25. How do you define patient adherence to the scheme?

26. What percentage of patients complete your programme?

27. Is information about the patients' progress fed back to the patient, referrer or any other stakeholders? *Please tick all that apply*			
Patient		Referrer	
Other (please specify)			

28. Is there a patient 'exit strategy' in place? e.g. concessionary rates after completion of the referral period *Please tick the relevant box*					
Yes		*If yes, please see below*	**No**		*If no, please see below*
Please could you provide details of the exit strategy			Please could you provide the reason(s) why your scheme does not have an exit strategy		

29. Are patients followed-up after they have completed the referral period? *Please tick the relevant box*					
Yes		*If yes, please see below*	**No**		*If no, please see below*
At what time points are patients followed-up? e.g. 3, 6, 12 months			Please could you provide any reason(s) why patients are not followed-up		

Section 3: Resources

30. To what extent did you use the National Quality Assurance Framework (NQAF) to inform the scheme? *Please tick the relevant box*							
Not at all		**A small amount**		**Somewhat**		**A lot**	

31. How useful did you find the NQAF in the following aspects of the scheme? *Please tick the relevant boxes*				
	Very useful	**Useful**	**Slightly useful**	**Not useful**
Initial planning and design				
Implementation/ delivery				
Undertaking evaluation				
Continued scheme development				

Section 4: Staff qualifications

32. Do you have a minimum level of qualification for your instructors? e.g. CYQ Exercise Referral, Cardiac Rehabilitation Phase IV etc. *Please tick the relevant box*					
Yes		*If yes, please specify below*	**No**		*If no, please go to Q33*

33. Do you offer any opportunities for continuing professional development (CPD) for exercise referral staff? *Please tick the relevant box*					
Yes		*If yes, please specify below*	**No**		*If no, please go to Q34a*

Section 5: Monitoring and evaluation

34a. Does the scheme include any evaluation activities? *Please tick the relevant box*					
Yes		*If yes, please go to Q34b*	**No**		*If no, please go to Q48*

34b. Are the evaluation activities completed internally (e.g. by you) or externally (e.g. by a university)? *Please tick the relevant box and specify by whom*		
	✓	**By whom**
Internally		
Externally		

35. Do you involve any stakeholders in planning the scheme's evaluation? *Please tick the relevant box*					
Yes		*If yes, please see below*	**No**		*If no, please go to Q34*
Please specify which stakeholders are involved in the evaluation					

36. How often do you collate evaluation data and prepare a report on the scheme? *Please tick the relevant box*			
Quarterly		Every six months	
Annually		Bi-annually	
Other (please specify)			

37. Do you assess whether the activities offered within the scheme are implemented as planned? *Please tick the relevant box*					
Yes		*If yes, please see below*	**No**		*If no, please go to Q38*
Please briefly describe					

38. Do your evaluation activities assess whether the scheme reaches the target population(s)? *Please tick the relevant box*					
Yes			**No**		

39. Do you evaluate cost effectiveness? *Please tick the relevant box*					
Yes			**No**		

40. Do you assess any patient outcomes? *Please tick the relevant box*					
Yes		*If yes, please go to Q41*	**No**		*If no please go to Q45*

41. What patient outcomes do you monitor? e.g. physical activity, blood pressure, mood, attitude to physical activity, satisfaction with the scheme etc. *Please tick all that apply and specify the method of measurement for each outcome*

Outcome	✓	Method of measurement
Physical activity		
Physical fitness		
Blood pressure		
Body composition		
Mood		
Stage of behavioural change		
Attitude to physical activity		
Use of medication		
Quality of life		
Other (please specify)		

42. Which patients do you collect data from? *Please tick the relevant box*			
All who are referred		All who attend at least one session	
All who attend initial consultation		All who complete the programme	
Other (please specify)			

43. Who is responsible for collecting outcome data? *Please tick all that apply*			
Health professional		Exercise professional	
Other (please specify)			

44. When is data collected on patient outcomes? *Please tick all that apply*			
Initial patient consultation		During the referral period	
At the end of the referral period			
Other (please specify)			

45. How well do you think your current evaluation activities help assess whether the scheme is meeting the specified aims and objectives?							
Not at all		**A small amount**		**Somewhat**		**A lot**	

46. What, if any, changes or additions do you think need to be made to the scheme's evaluation?

47. What, if any, are the barriers to conducting your evaluation activities?

Section 6: Scheme development

48. Please could you list up to three successful elements of the scheme and state why you feel these element are successful
1.
2.
3.

49. How useful would you find guidance on the following aspects of exercise referral schemes. ? *Please tick the relevant boxes*				
	Very useful	**Useful**	**Slightly useful**	**Not useful**
Initial planning and design				
Implementation/ delivery				
Undertaking evaluation				
Continued scheme development				
Other, please specify				

50. Are there any developments planned for the scheme? *Please tick the relevant box*					
Yes		*If yes, please specify*	**No**		*If no please go to Q51*

Section 7: Permission to use information

51. Would you be happy for this project to be used as an example of good practice? *Please tick the relevant box*					
Yes			**No**		
52. Would you be happy for us to contact you for further information about the scheme? *Please tick the relevant box*					
Yes			**No**		
Signature			**Date**		

Thank you for taking the time to complete this questionnaire

Please return your completed questionnaire to Kim Buxton at:
K.E.Buxton@lboro.ac.uk

1.4.4. Background Briefing Paper

Dear Colleague,

Since the publication of the NICE guidance about physical activity interventions, specifically exercise referral schemes, there has been some uncertainty about the future of exercise referral schemes and concerns about how professionals will ensure their schemes are complying with NICE guidance. Late last year the a meeting was held with the Regional Physical Activity and Health Coordinators to consider how best to support exercise referral practitioners in implementing the NICE guidance.

Over the last 10 months we have been working in partnership with the regional physical activity and health coordinators on this project. Initial groundwork has required professionals working in exercise referral schemes to complete a questionnaire detailing what their scheme involves and how their scheme is evaluated. This audit has enabled the identification of schemes taking place across the Midlands and Northern regions, highlighting strengths, gaps and challenges in practice.

We are now working in partnership with the regional physical activity coordinators in the South East and Eastern region to continue gathering evidence about existing schemes.

Why is it important for you to be involved?
An audit of current schemes will enable us to benchmark what schemes are doing across England, aid in the identification of strengths and weaknesses in various approaches to exercise referral and provide us with a rationale for the development of the framework. It is hoped that the framework will assist professionals in designing and implementing exercise referral schemes based on evidence of best practice and help identify resources to ensure schemes are evaluated adequately.

What does this audit involve?
We are asking scheme coordinators to spare 30 minutes to complete the attached questionnaire, this will allow us to gather evidence about schemes and to benchmark what's happening around design, delivery and evaluation.

Please email your completed questionnaire to: K.E.Buxton@lboro.ac.uk Alternatively you can return your completed questionnaire to Kim Buxton, School of Sport, Exercise and Health Sciences, Loughborough University, Leicestershire, LE11 3TU.

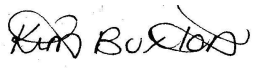
If possible, please could you base responses to evaluation related questions on the most recent annual report.

Following the initial paper audit, a consultation seminar will be hosted to gain your views about the content and design of the framework.

This seminar is provisionally booked for Thursday 31st January 2008, between 10-1pm in London; please could you let me know your availability for this seminar.

If you have any questions about the questionnaire or indeed any part of the proposed project, please do not hesitate to contact me on 01509 223267.

Yours faithfully,



Kim Buxton,
Assistant Director - Project Manager Primary Care.

Paul Jarvis
S.E. Regional Development Manager - Physical Activity.

1.4.5. Toolkit Consultation Questionnaire

Draft Exercise Referral Toolkit

The purpose of the consultation exercise is to gain professionals' views on the content, design and practical utility of the toolkit and to obtain views about how best to present the final version of the toolkit.

Consultation Response Form

Part 1 – Information about you –
Leave this section blank if you would prefer to send in comments anonymously

Name	
Address	
Postcode	
Email address	
Organisation	
Position	
If you are responding on behalf of an organisation or interest group, how many members are you representing and how did you obtain their views:	

Part 2 – Overall comments about the toolkit

1. Do you think the toolkit is useful as a single source of reference?	Yes ❒	No ❒
If no, please explain your reasons or add any additional comments you wish to make:		

2. Do you think you will use the toolkit?	Yes ❒ **Go to 2a**	No ❒ **Go to 2b**
2a. Please tell us how you think you might use the toolkit		
2b. Please explain your reasons or add any additional comments you wish to make		
3. Are there any sections of the guidance which you particularly agree or disagree with?		
Please explain your reasons or add any additional comments you wish to make:		

4. Are there any additional issues which you feel should have been included in the toolkit?	Yes ❒	No ❒
If yes, please state what these are and explain your reasons or add any additional comments you wish to make:		
5. What did you like *best* about the toolkit?		
6. What did you like *least* about the toolkit?		

7. Please indicate how useful YOU have found each section of the toolkit. Please tick the relevant box.				
	Very Useful	Useful	Not Useful	Not sure
Section 1: Background and rationale for the toolkit				
Section 2: Current research and practice				
• Overview of current practice				
• Overview of research				
• National recommendations				
Section 3: Guidance for referring practitioners				
• The exercise referral pathway				
• Clinical governance				
• Governance arrangements				
• Recommendations for referring practitioners				
Section 4: Guidance for exercise professionals and exercise referral coordinators				
• Exercise professionals roles and responsibilities				
• Professional competencies				
• Exercise referral coordinators - setting up a scheme				
• Training				
• Recommendations for exercise professionals				
• Recommendations for scheme coordinators				
Section 5: Guidance for commissioners				
• Towards world class commissioning				
• Commissioning steps				
Section 6: A guide to evaluating exercise referral schemes				
• Importance of evaluation				
• Evaluation design				
• Evaluation expectations				
• Evaluation planning				
• Evaluation hierarchy				
• Process evaluation				
• Outcome evaluation				
• Suggested timeline for evaluation of ERS				
• Evaluation recommendations				
Appendices				

8. Are there any sections that could be improved?	Yes ❒	No ❒
If yes, what sections of the guidance do you think could be improved and how? **Section 1** **Section 2**		

Section 3

Section 4

Section 5

Section 6

9. Did the toolkit contain an adequate depth of information?	Yes ❒	No ❒
If no, please explain your reasons or add any additional comments you wish to make:		

10. Was the language set at an appropriate level?	Yes ❒	No ❒
If no, please explain your reasons or add any additional comments you wish to make:		

11. In what format would you like to see the final version of the toolkit?		
Downloadable as one document similar to draft version	Yes ❒	No ❒
Downloadable as separate sections:	Yes ❒	No ❒
• technical report: background, overview of current practice and research	Yes ❒	No ❒
• guidance for referring practitioners	Yes ❒	No ❒
• guidance for exercise professionals, commissioners	Yes ❒	No ❒
• guidance for commissioners	Yes ❒	No ❒
CD-rom	Yes ❒	No ❒
Internet micro site with downloadable mix and match resources	Yes ❒	No ❒
Please use this space to identify any other format you think would be appropriate for the final toolkit		
12. Are there any existing elements from the current presentation which you like?	Yes ❒	No ❒
If no, please explain or add any additional comments you wish to make		
13. Do you have any comments on the sharing of good practice features?	Yes ❒	No ❒
If yes, please add any additional comments:		
14. Do you think the toolkit should contain images of ERS in practice?	Yes ❒	No ❒
If yes, do you have any images/photographs that you can share?		

15. Please use the space below to provide any additional comments.

Thank-you for taking the time to provide feedback on the draft version of the toolkit.

Please return your consultation responses by 27th March 2009

Please send to:
Kim Buxton,
School of Sport, Exercise and Health Sciences, Loughborough University,
Loughborough, Leicestershire. LE11 3TU

Or
Email: K.E.Buxton@lboro.ac.uk

1.4.6. BACKGROUND PAPER FOR WORKING PARTY

EXERCISE REFERRAL TOOLKIT WORKING PARTY

Background:
Following the consultation on the Exercise Referral (ER) toolkit the we are setting up a working party to help take forward the exercise referral toolkit in order to ensure the final version reflects the needs of all national, regional and local stakeholders involved in the commissioning, management and delivery of ER schemes and where feasible responds to the issues raised during the consultation exercise.

We are looking for volunteers to assist in this process and are keen to engage professionals who are currently responsible for, or who have experience of delivering (referrers, exercise instructors, operators), coordinating, commissioning or evaluating ER schemes.

What will this involve?
The final drafting of the ER toolkit will be overseen by a working party comprised of national stakeholders and local or regional professionals with experience of ER schemes. The working party will be responsible for reviewing the consultation responses, summarising the key findings and developing an action plan for how the toolkit will be revised and presented.◆

There will also be several working party sub-groups; members of these sub-groups will have responsibility for revising specific sections of the ER toolkit according to the agreed action plan.

Professionals will be required to:
- Attend at a maximum of 5 meetings either working party or working party sub-groups;
- Respond and comment on relevant papers within a timely manner;
- Contribute to re-writing /revising relevant sections of the toolkit;
- Appraise the Exercise Referral resources
- Contribute to the production of an ER toolkit executive summary, technical report and national priorities briefing document.

Nature and Extent of Commitments
The deadline for completion of the final version of the ER toolkit is 31st October 2009. The project will have periods of intense work, particularly when sections of the toolkit are being revised by working party sub-group members and also when working party members are being asked to review documents within relatively narrow windows of time.

Involvement in the working party is on a voluntary basis, we do not have the funds to reward or reimburse professionals for either their time or travel costs, however all contributions will be fully acknowledged within the toolkit. We will endeavour to keep face-to-face meetings and travel to a minimum and where possible, will communicate via email and/or conference calls.

◆ Note: Revisions to the toolkit will primarily be based on the consultation feedback

1.4.7. WORKING PARTY EXPRESSION OF INTEREST FORM

EXERCISE REFERRAL TOOLKIT WORKING PARTY
EXPRESSION OF INTEREST

We would be grateful if you would complete and return this form to help us build up a clearer profile of the expertise amongst ***potential members*** of the exercise referral toolkit working party.

Name	
Position	
Organisation	
Address	
Telephone No.	
Fax No.	
Email	

MAIN AREAS OF EXPERTISE

Please indicate below your **main** area of exercise referral expertise

Referring Practitioner	☐	ER Scheme Commissioner	☐
Exercise Referral Instructor	☐	ER Training Provider	☐
Operator	☐	Academic/Researcher	☐
ER Scheme Coordinator	☐	Evaluation Specialist	☐

Other, please specify below

Please outline relevant exercise referral experience:
Please list any other skills or subject expertise that may be of value/relevance:

Potential working party members **must disclose the existence and nature of any prejudicial interests in Exercise Referral, for example a personal or non-personal pecuniary interest***

Have you any prejudicial interests in exercise referral? ***If yes,*** please give details below.

*Information about any prejudicial interests will be made publicly available in the exercise referral toolkit working party technical report.