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

Section 2: A Snapshot of ER Schemes Operating in England, Scotland & Northern Ireland - 2006-2008

Final 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.

- Elaine McNish, Physical Activity Specialist, Welsh Assembly Government.
- Suzanne Gardner, Regional Physical Activity Coordinator - West Midlands, PANWM
- Hazel Ainsworth, Health Development Officer, Mansfield District Council.
- Dr William Bird, Strategic Health Advisor, Natural England.
- Claire Flood, Physical Activity Coordinator, NHS Havering.
- Mary Hague, Senior Public Health Strategy Manager, Derbyshire County Primary Care Trust.
- Craig Lister, Public Health Manager, NHS Bedfordshire.
- Jean Ann Marnoch, Registrar, Register of Exercise Professionals.
- Niamh Martin, Senior Health Improvement Programme Officer, Physical Activity, NHS Health Scotland.
- Suzanne Mee, former Healthy Lifestyles Manager, London Borough of Tower Hamlets.
- Dr John Searle, Chief Medical Officer, Fitness Industry Association.
- Ruth Shaw, Programme Manager (Health Inequalities, PA Lead), NHS Greenwich.
- Martin Skipper, former Policy Officer, Fitness Industry Association.
- Steven Ward, Public Affairs and Policy Manager, Fitness Industry Association.
- Victoria Smith, Development Officer - Fitness, Skills Active.
- Jeannie Wyatt-Williams, National Exercise Referral Scheme Coordinator, Welsh Local Government Association.

We would like to extend special thanks to Elaine McNish for chairing the national working party and to Suzanne Gardner for her unquestionable commitment at the final stage of the production of the toolkit.

I would like to acknowledge Karen Milton, Research Associate, for her valuable contribution to the guide to evaluating exercise referral schemes.

A number of other individuals within have also contributed to the development of this toolkit in various ways and I would like to acknowledge these individuals for their valuable input.

- Sonia McGeorge
- Sandra Prickett
- Sarah Wortley

Finally I would like to thank Rob Adams for his assistance with the templates and graphics included in the toolkit.

Executive Summary

The purpose of this mapping exercise was to identify and survey existing exercise referral schemes in England, Scotland and Northern Ireland to ascertain the nature and extent of current practice.

A 50-item questionnaire was developed in consultation with the West and East Midlands Physical Activity Networks, this questionnaire was piloted with 4 exercise referral scheme coordinators before it was approved for use (see appendix). Questionnaires were sent to 198 named exercise referral professionals working in the North East, North West, West Midlands, East Midlands, South East, Eastern and Yorkshire and Humber regions. Questionnaires were also disseminated at 3 London region network meetings and through the existing Physical Activity and Health Alliance in Scotland.

In Northern Ireland two questionnaires were utilised for the mapping. One questionnaire specifically for healthcare professionals was sent to 370 GP practices in Northern Ireland. The second questionnaire specifically designed for leisure centre managers, was sent to contacts in 63 council-run leisure centres.

The audit was not conducted in Wales, as a review had been conducted as part of the development of the National Exercise Referral Scheme (NERS).

One-hundred and fifty-eight questionnaires were received for England and Scotland. Two-hundred and two questionnaires were received from GPs and forty-three questionnaires were returned by leisure centre managers in Northern Ireland.

Findings:

The results of this mapping show that there are various methods to delivering exercise referral schemes; it highlights that schemes operate at different capacities, with a range of different partners, operational structures and standards.

- A large geographical area of England, Scotland and Northern Ireland is covered by the schemes responding to the survey.

- There are some areas in England, Scotland and Northern Ireland which are not covered by schemes; however this may reflect a non-response rather than a lack of provision.

- The lead agencies responsible for schemes were in the public sector; the majority (75%) of schemes were developed and coordinated either by the PCT/NHS Health Board, the local authority or as a joint venture between local authorities and PCTs/NHS Health Boards.

- The majority of schemes in England and Scotland (69%) were fairly well established and had been operating for at least 4 years. In Northern Ireland schemes were slightly younger; the majority of schemes (72%) had been running for 4 years or less.

- The overall aim of the majority of schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities for increased physical activity.

- The referral inclusion criteria differed from scheme to scheme depending on scheme aims, exercise referral staff experience and qualifications and the range of health professionals referring into the scheme.

- The most predominant conditions included by schemes being delivered throughout England, Scotland and Northern Ireland were:

    - Mental health problems.
    - Weight problems.
    - Hypertension.
    - Asthma.
    - Diabetes.
    - Inactivity.
    - Osteoporosis.
    - Arthritis.
    - Raised blood cholesterol.
    - Chronic obstructive pulmonary disease.
    - Coronary heart disease risk factors, such as smoking, family history.

- General practice was the most frequently cited route for referral with 94% of schemes accepting referrals from GPs and 89% accepting referrals from Practice Nurses. Over two-thirds of schemes now accept referrals from a range of allied health professionals, such as physiotherapists, specialist nurses.

- The majority of schemes adopted a range of methods for recruiting patients. The most commonly reported recruitment methods were patient initiated requests for referral, followed by opportunistic health professional referrals.

- Local authority leisure facilities (including leisure trusts) were the most popular setting for the delivery of the exercise referral programme. Almost two-thirds of schemes were also utilising community or outdoor settings for a variety of activities.

- The wider range of settings being utilised has enabled many schemes to move away from traditional leisure centre-based activities and to expand the range of activity options available to referred patients. The majority of schemes (55%) in England and Scotland offered between 3-to-7 different activities, whereas the majority of schemes in Northern Ireland (64%) provided 1 or 2 activities.

- The typical length of the referral period in England and Scotland was 12 weeks. This data was not available for Northern Ireland.

- The number of patients referred to schemes on an annual basis varied from one scheme to another. Data for England and Scotland showed that referral numbers ranged from 20 patients up to 6500 patients per annum. The number of patients being referred to schemes in Northern Ireland also varied; however the majority of schemes (86%) had between 26 to 150 referrals per annum.

- Patient completion rates were recorded by the majority of schemes, however it was difficult to provide an accurate picture of these across schemes due to the variations in the way schemes measured completion.

- The analysis of exit strategies used by schemes in England and Scotland highlighted that a variety of exit routes were utilised, the most popular being an offer of a concessionary rate. This data was not captured for Northern Ireland.

- Ninety-three percent of schemes reported being evaluated, of these the majority were evaluated internally either by the scheme coordinator, health improvement manager, PCT/health board or local authority.

- Ninety-seven percent of schemes also reported that they collected data on a range of patient health, fitness and physical activity indicators at some point during the referral period.

- The majority of schemes in England and Scotland reported using the National Quality Assurance Framework to inform the development and delivery of their scheme.

- The majority of schemes (44%) stipulated that their exercise instructors must hold a recognised exercise referral qualification as a minimum and a further 22% stipulated that their exercise instructors must hold a minimum of an advanced level 3 qualification and a recognised exercise referral qualification.

It is clear from the evidence gathered in this audit that exercise referral schemes are not, and cannot be, delivered as a ‘one size fits all’. Schemes need to have some degree of flexibility to meet the needs, capacity and resources of the local situation.

Section 2: Current Practice

The purpose of this section is to give an overview of the characteristics, design and operating principles of exercise referral schemes in England, Scotland and Northern Ireland.

2.1. Current Practice

2.1.1. Methods

Questionnaires and a briefing paper,[i] explaining the rationale for the audit, were sent out via email during September 2006 to February 2008 to 198 named exercise referral professionals working in the North East, North West, West Midlands, East Midlands, South East, Eastern and Yorkshire and Humber regions. One-hundred and twenty-six questionnaires were returned, representing an overall regional response rate of 64% and individual regional response rates of between 33–94%. Questionnaires were also distributed to professionals with an interest in exercise referral during 3 consultation meetings held in the London region. Information was obtained from 10 schemes operating in the London region; however previous research[1] has indicated that there are 30 established schemes across Greater London, therefore the response rate represented exactly one-third of schemes known to be operating in the London region. In Scotland, the questionnaire and briefing paper was disseminated via email through the existing Physical Activity and Health Alliance database, information was obtained from 22 schemes. Due to the methods used for gathering data on schemes operating across Scotland it was not possible to calculate the response rate. A total of 158 responses were received across England and Scotland.

A similar approach was undertaken to gather data for Northern Ireland. The Health Promotion Agency identified 63 contacts working in council-run leisure centres. Questionnaires were sent to centre managers via post and telephone reminders were made to prompt a response. A total of 43 questionnaires were returned representing a 68% response rate.[2]

The audit was not conducted in Wales, as a review had been conducted as part of the development of the National Exercise Referral Scheme (NERS). NERS is a randomised controlled trial investigating whether self-reported physical activity (as well as depression, anxiety, quality of life and other physiological measures) at 12 months is different among those patients receiving an exercise referral programme compared to those receiving usual GP care and a leaflet on physical activity. The evaluation will also investigate the cost-effectiveness of the scheme. The final results of the trail will be available in the early autumn of 2010.

2.1.2. Limitations of the Mapping Exercise

The methodology of this mapping exercise is not without limitations. A central database of exercise referral schemes operating across the United Kingdom does not exist, thus the mechanism for identifying professionals responsible for the delivery,

[i] See sections 2.3.1. and 2.3.2. for a copy of the questionnaire and briefing paper

coordination or commissioning of schemes predominantly relied on the regional and national physical activity coordinator's knowledge of schemes operating in their area. Scotland and several English regions have established physical activity networks; consequently the procedures for identifying the relevant exercise referral professionals were much more straightforward and potentially more reliable, than in the regions where such networks did not exist. While every effort was made to ensure that the database included all relevant exercise referral professionals working across these regions, there is no guarantee that this was accurate. The individual responsible for developing the exercise referral contact lists in these regions relied upon secondary sources to obtain contact names and email addresses, such as receptionists within key agencies e.g., Local Authorities, Primary Care Trusts, websites and the regional coordinator's contacts, where appropriate and practical. The lower response rates in these regions may reflect the difficulties in trying to identify relevant exercise referral professionals. Due to timescales and difficulties in identifying relevant exercise referral professionals this mapping exercise was not completed in the South West of England.

Previous reports have estimated that there are around 600-800 exercise referral schemes in existence across the UK[3]; in contrast this mapping exercise has uncovered a significantly smaller number of schemes. Consequently, this raises the question whether the present mapping exercise has failed to capture the true extent of exercise referral scheme provision across the UK or whether previous reports have over-estimated the level of provision. However, there is a plausible explanation for the conflicting figures presented in this report and previous estimates; observations of the existing data reveal that many schemes operate across a number of provider sites with an overarching protocol or set of standards. For example, a recent evaluation of Eastern and Coastal Kent exercise referral scheme[4] reported that the programme takes place across a multitude of leisure centres, these centres have signed up to a core set of standards and one exercise referral scheme strategy. In the present report the Eastern and Coastal Kent exercise referral scheme would count as one scheme whereas previous reports would have counted each provider site as a unique scheme, hence the large discrepancy in the levels of provision presented in this report and previously.

The information presented in this section provides a snapshot of the nature and extent of exercise referral schemes operating in England, Scotland and Northern Ireland during 2006-2008 and is based on self-report data. A self-report questionnaire was used to gather information about schemes, however there are limitations to using questionnaires to collect data, which must be recognised and taken into consideration in this report. It is possible that there is a real difference between those who respond to surveys and those who do not, thus the problem of a self-selecting sample is particularly apparent in relation to questionnaire-based surveys. Resultantly, there may be a response bias which may over or under-represent the issue being investigated. Typically surveys have low response rates, sometimes as low as 10-20% which can threaten the validity and ability to generalise the findings; however with an overall response rate of 64% the findings presented in this report are likely to be representative of other exercise referral schemes.

The questionnaire used to capture information about schemes operating in Northern Ireland was slightly different to the one used in England and Scotland. Where possible, the findings presented in this section incorporate evidence from the mapping exercise undertaken in Northern Ireland, where such data is not available or where

there are slight variations in the data captured this has been stated in the respective sections.

2.1.3. Location of Schemes

Information was gathered from 158 schemes operating across England and Scotland, table 1 below shows a breakdown of the number of schemes responding to the survey by country and the number of schemes responding within each English region.

Table 1.Number of Responses by Country and Geographical Region

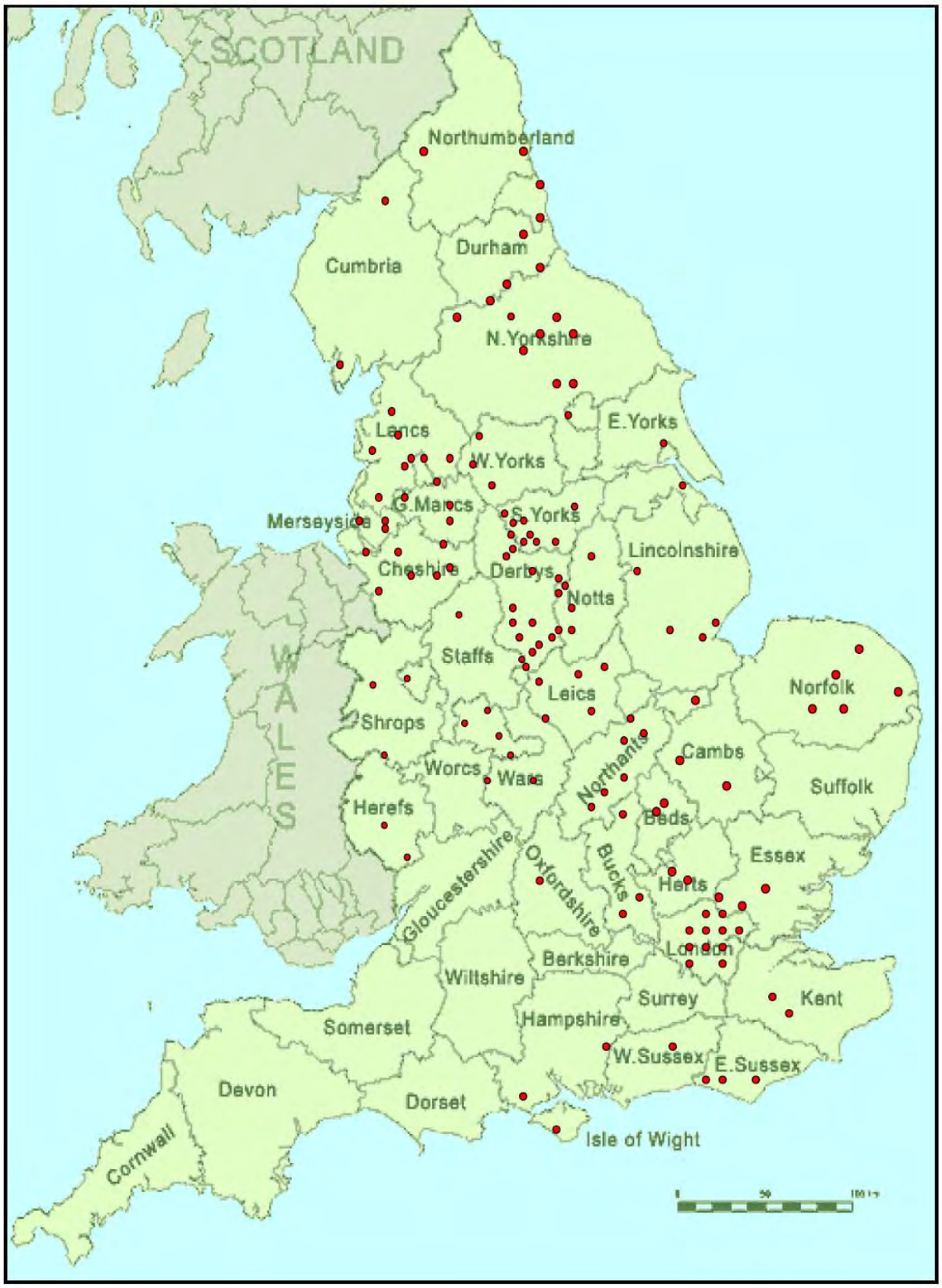
Geographical Area	No. of Schemes
Scotland	**22**
England	**136**
London Boroughs	10
North West	22
South East	11
Eastern Region	15
North East Region	15
Yorkshire & Humber Region	16
West Midlands	14
East Midlands	33
Overall	**158**

Respondents were asked about the area covered by the scheme, data highlighted that schemes are delivered in various sizes; some operate within district council boundaries, some cover full counties and others are city-wide. The scale of the survey and the varying sizes of schemes, e.g. town, district, county or city wide, made it extremely challenging to produce a summary of the number of schemes operating by boundary type; however a crude analysis of the data shows that the majority of schemes are district wide. Maps 1 & 2 on the following pages show the geographical distribution of schemes across England and Scotland respectively. As can be seen there are some areas in both England and Scotland which are not covered by schemes. However, it should also be noted that these maps are based on the responses to the survey, there may be some areas where schemes currently operate, but the information was not captured in this mapping exercise.

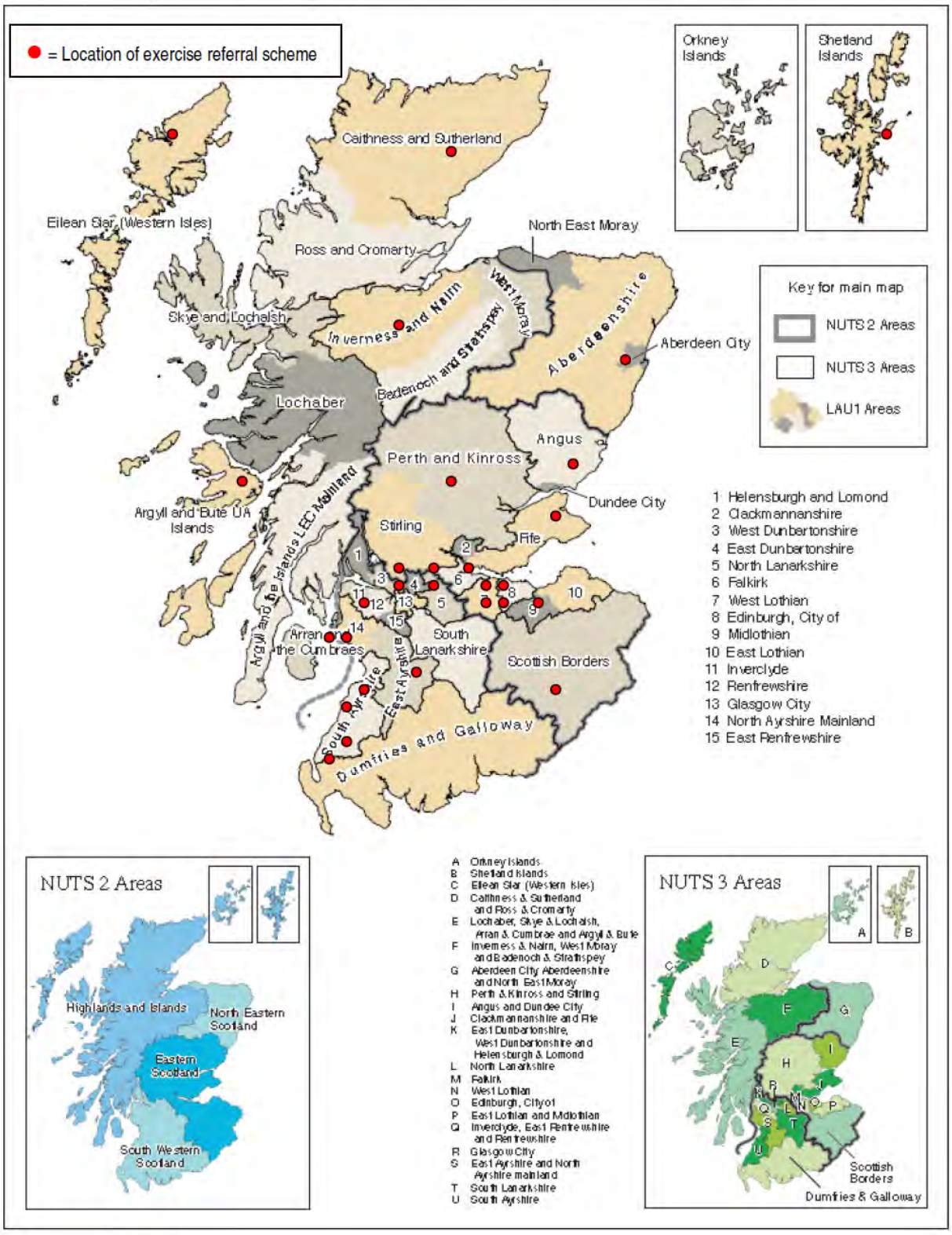
Sixty-five percent of respondents in Northern Ireland reported that their leisure centre was involved in a physical activity referral scheme to some level. Map 3 shows the geographical distribution of the schemes that GP practices currently refer patients to in Northern Ireland.

The maps showing the geographical spread of schemes within each region are included in section 2.3.3 of this document.

Map 1: Geographical distribution of exercise referral schemes across England



Map 2: Geographical distribution of exercise referral schemes across Scotland

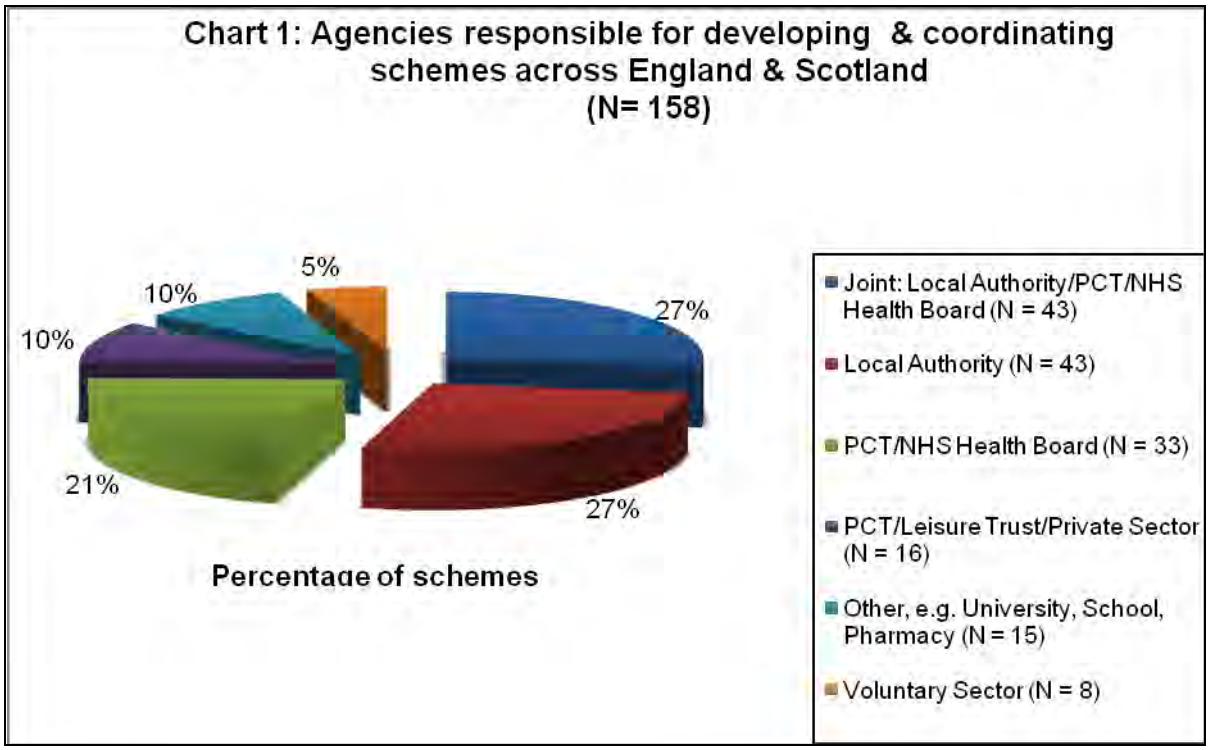


Map 3: Geographical distribution of exercise referral schemes across Northern Ireland

Reprinted with permission of Northern Ireland Health Promotion Agency.[2]

2.1.4. Responsibility for Schemes

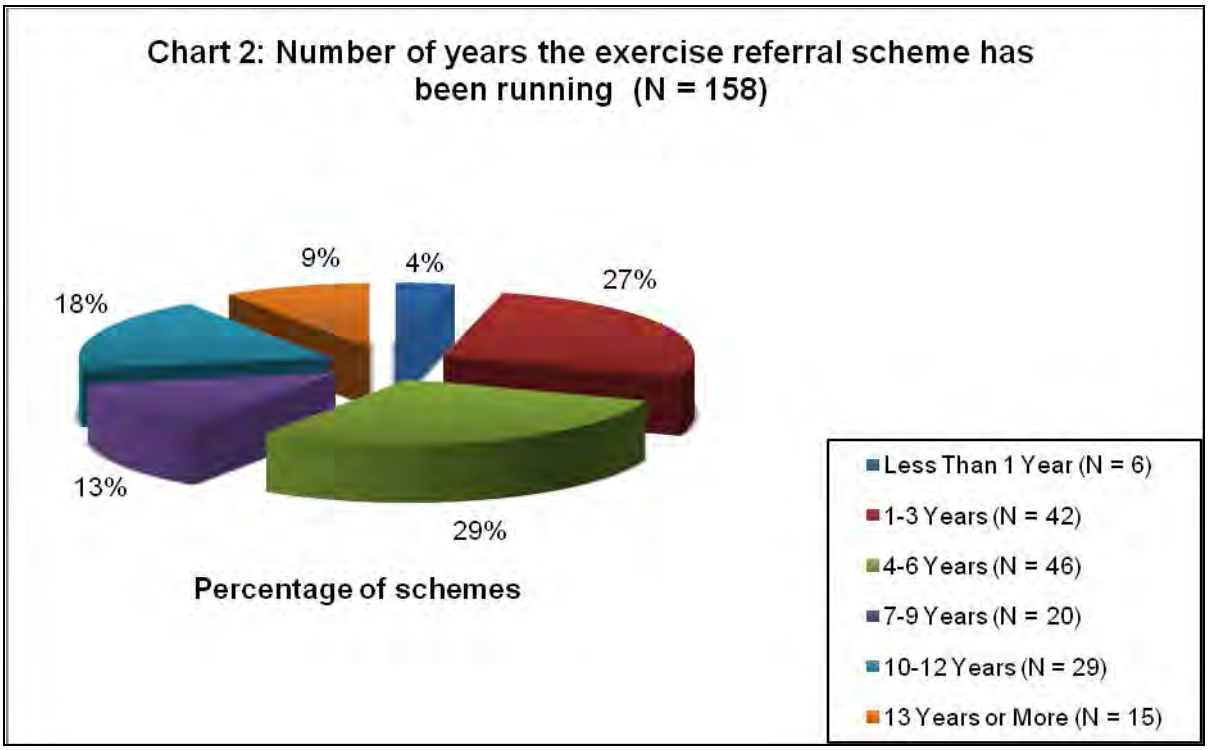
Respondents were asked to indicate who had the lead responsibility for the exercise referral scheme. Across England and Scotland, the lead agencies responsible for schemes were all within the public sector. While there were some slight variations in the lead agencies for schemes across the English regions; chart 1 below shows on the whole the majority of schemes in England and Scotland were developed and coordinated either by local authorities (27.2%) or as a joint venture between local authorities and Primary Care Trusts/NHS Health Boards (27.2%). The mapping exercise also found that PCTs/NHS Health Boards were named as the lead agency for a further 21% of schemes being delivered in England and Scotland. The remaining 24.8% of schemes were led by a range of agencies: of these 10.2% were delivered in partnership with leisure trusts or private sector providers; 9.6% were delivered as partnerships with no one lead agency and 5% were delivered by voluntary sector organisations such as the YMCA, Age Concern. Comparative data on the agencies responsible for the delivery and coordination of exercise referral schemes in Northern Ireland was not captured through their mapping exercise.



2.1.5. Length of Schemes

The first exercise referral scheme was set up in the early 1990'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. To gain a picture of the development of schemes over time respondents were asked how long the scheme had been in action. As can be seen from chart 2 below, the majority of schemes (69%) were fairly well established and had been operating for at least 4 years. Almost a tenth of schemes (9%) had been in existence for more than 13 years making them some of the longest running schemes in the UK. Several schemes (4%) had been established for less than 1 year or were in a pilot phase, indicating that in spite of the NICE guidance new schemes were still being launched.

In Northern Ireland the survey of leisure centre managers revealed that physical activity referral schemes were not as well established as those in England and Scotland. Twenty-nine percent reported that their leisure centre had been involved in the physical activity referral scheme for 1-to-2 years. A further 36% had been involved for 3-to-4 years and 24% had been involved in the scheme for over 4 years. A small number (7%) of leisure centre managers reported that they had been involved in running a referral scheme for less than one year.



2.1.6. Aim of Exercise Referral Schemes

Although the specific aim(s) of schemes varied from one scheme to another, the overall aim for the majority of schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities for increased physical activity.

More than half of the schemes had more than one aim; further aims for many schemes were to:

- Increase physical activity levels amongst the most sedentary groups.
- Provide opportunities for people with underlying medical conditions to become more active.
- Provide access to safe and effective exercise in a supervised environment.
- Equip patients with the knowledge and skills to become more active.
- Raise awareness of the benefits of physical activity.
- To promote long-term behaviour change.

2.1.7. Inclusion/Exclusion Criteria

The referral inclusion criteria differed from scheme to scheme depending on scheme aims, exercise referral staff experience and qualifications, and the range of health professionals referring into the scheme. Fifty percent of schemes stated they have inclusion criteria based on patients' physical activity levels; however the physical activity measures used to determine whether a patient would be eligible for the scheme varied. Some schemes specified levels of activity as the inclusion criteria, i.e. sedentary or limited mobility (less than 30 minutes of physical activity per week) or insufficiently active (less than 5 times 30 minutes of physical activity per week); other schemes used a physical activity questionnaire e.g. Godin & Shephard, or a pre-

screening tool e.g. GPPAQ to determine the patients physical activity levels. A few schemes did not define levels of physical activity and recommended the referring health professional used their professional judgement about the patients suitability for the scheme based on the scheme protocol.

Most schemes accept patients with a wide range of medical conditions, ranging from:

- CHD risk factors, for example hypertension, raised blood cholesterol; family history, smoker.
- Mental health problems, for example, anxiety, depression, stress.
- Musculoskeletal conditions, for example, back pain, arthritis, osteoarthritis, osteoporosis, multiple sclerosis.
- Respiratory conditions, for example, asthma, COPD.
- Neurological conditions, for example, epilepsy, Parkinson's disease.
- Metabolic/endocrine problems, for example, diabetes, thyroid disease.

Box 1 below; shows the most predominant conditions included in schemes being delivered throughout England, Scotland and Northern Ireland.

Box 1: Most predominant conditions

- Mental health problems
- Weight problems
- Hypertension
- Asthma
- Diabetes
- Inactivity
- Osteoporosis
- Arthritis
- Raised blood cholesterol
- Chronic obstructive pulmonary disease
- Coronary heart disease risk factors

Where schemes have appropriately qualified level 4 exercise instructors, e.g. phase IV cardiac rehabilitation, falls prevention they are offering an integrated physical activity referral service which includes activities for patients with current severe disease or disability. While the integration of services for patients with current severe disease or disability, such as coronary heart disease, chronic low back pain and osteoporosis is becoming common practice it should be recognised that such patients are not considered suitable for a general exercise referral scheme. Patients with more chronic and enduring medical conditions should only be referred to specialist physical activity/ exercise sessions with appropriately qualified level 4 exercise instructors or health care professionals. Refer to section 9 for further information on qualifications and training for professionals working with referred clients.

Seventy-one percent of schemes reported that they have defined exclusion criteria, the remaining twenty-nine percent either made no comment here (26%) or stated they do not have any exclusion criteria (3%). Of the schemes with defined exclusion criteria many based their exclusion criteria on a range of factors, for example: Age (less than 16 years of age); Physical activity (active at a moderate intensity on 3 or more occasions per week); ACSM contraindications to exercise testing[5]; BACR phase IV contraindications to exercise[6]; An unstable or uncontrolled medical condition such as diabetes, asthma, epilepsy, hypertension, psychotic illness; and severe medical conditions such as, heart disease, obesity (BMI greater than 40); osteoporosis or musculoskeletal disorders exacerbated by exercise.

The inclusion and exclusion criteria used by schemes are crucial as it enables referrers to assess patients' suitability for referral and should provide clear guidance about who is suitable for a particular scheme. Guideline 2 of the National Quality Assurance Framework (NQAF)[7] recommends:

> ***"each scheme should develop its own medically led selection criteria which is tailored to the health needs of the patient population, the competencies and qualifications of the exercise professionals and the exercise facilities and services available."***
>
> **p.18, NQAF, 2001**

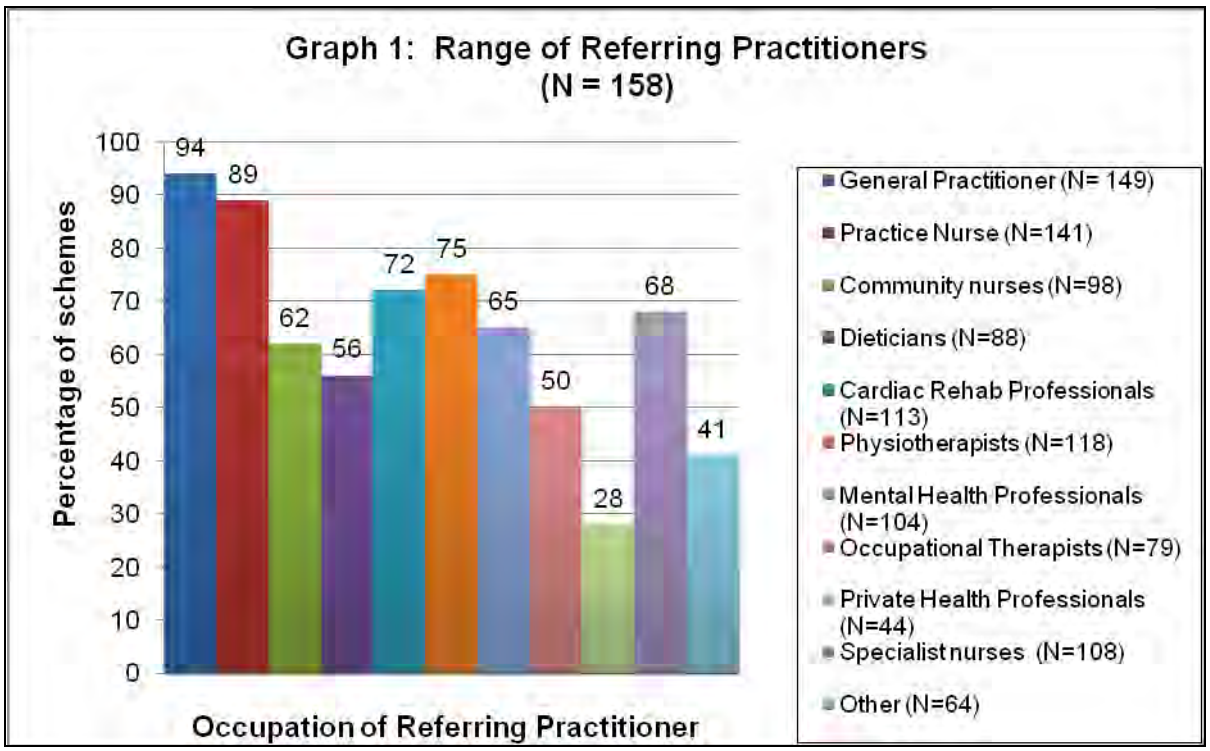
2.1.8. Referring Practitioners

Since the initial development of exercise referral schemes the range of healthcare practitioners referring into schemes has grown in England and Scotland. Schemes are now accepting referrals from a range of professional disciplines, including community nurses, health visitors, dieticians, physiotherapists, mental health professionals, occupational therapists and specialist diabetes, asthma and epilepsy nurses.

Graph 1 below, shows the range of professionals referring into schemes in England and Scotland. General practice is still the most frequent route for referrals with 94% of schemes accepting referrals from GPs and 89% accepting referrals from practice nurses. Over two-thirds of schemes now accept referrals from physiotherapists (75%), cardiac rehab professionals (72%), specialist nurses (68%) and mental health professionals (65%). Referral routes from dieticians, occupational therapists and private health professionals are less utilised.

Forty-one percent of schemes indicated that they accept referrals from a variety of other routes, such as hospital department staff, community psychiatric nurses and HIV clinicians. Of this 41%, a small number of schemes (6%) reported that they have an open referral route and will accept referrals from any health professional who has access to a patient's full medical history.

In Northern Ireland, exercise referral schemes are in their relative infancy (72% of schemes are under 4 years old) and referrals are mainly from general practice. Ninety-two percent of referrals are from GPs and seventy-two percent are from practice nurses. Eleven percent of referrals are from nurse specialists or nurse practitioners working within general practice or other professionals, role unspecified (4%).[2]



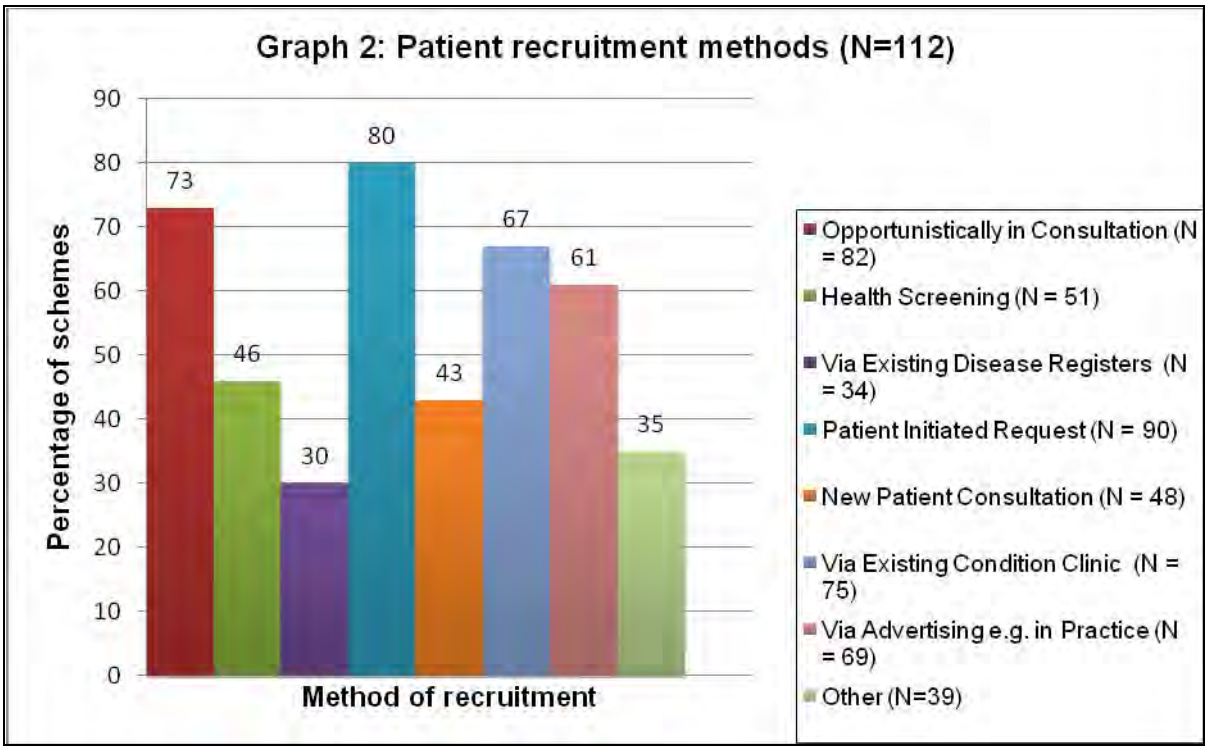
At their inception exercise referral schemes were called 'GP referral schemes' or 'Exercise on Prescription' which may reflect why general practice is still the most popular route for referrals and why many schemes have strong buy-in from general practices in their locality. While the percentage of GP practices that refer into schemes falls as low as 4% in some localities; the majority (62%) of exercise referral schemes across England, Scotland and Northern Ireland have at least two-thirds of practices in their locality signed up as refers. Approximately 30% of schemes have buy in from 95-100% of general practices in their locality.

2.1.9. Patient Recruitment Methods

The majority of schemes adopted a range of methods for recruiting patients, typically these included:

- Opportunistic recruitment during routine consultations, health screening clinics or new patient consultations.
- Targeted recruitment via existing disease registers or condition specific clinics.
- Open recruitment via advertising in practices and local health centres.
- Patient initiated requests for referral while visiting their GP.

Graph 2 below, shows a breakdown of the variety of recruitment methods being used by schemes. The most commonly reported recruitment methods were patient initiated requests (80%), followed by health practitioner initiated referrals either in routine consultations (73%) or via existing condition clinics (67%).

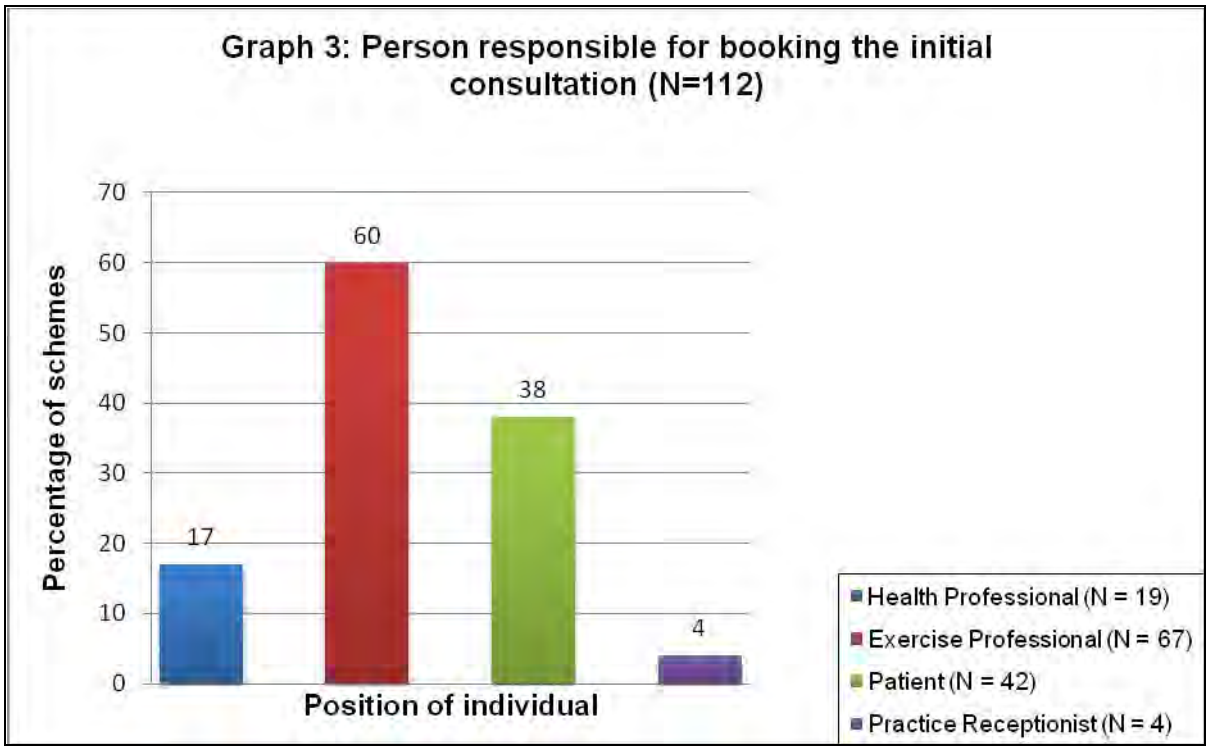


2.1.10. Referral Pathway

Respondents were asked about the referral pathway, specifically who is responsible for booking the initial exercise referral consultation and how information and paperwork is transferred between the health professional and exercise professional.

As can be seen in graph 3 below, the most commonly adopted referral procedure involved the exercise professional booking the initial consultation with the patient; over half of the schemes used this referral pathway. Approximately one-third of schemes passed the responsibility for booking the initial consultation to the patient and a further seventeen percent relied on the health professional to book the initial appointment. A small number of schemes (4%) utilised the practice receptionist as a conduit for booking the initial referral consultation. Fifteen percent of schemes used a combination of one or more of the above methods to arrange the initial patient consultation.

In Northern Ireland the situation was reversed; in most cases (86%) the GP made contact with the leisure centre to arrange the referral, followed by the practice nurse (29%) and the patient (29%). Seven percent of schemes received referrals from practice managers or receptionists.[2]



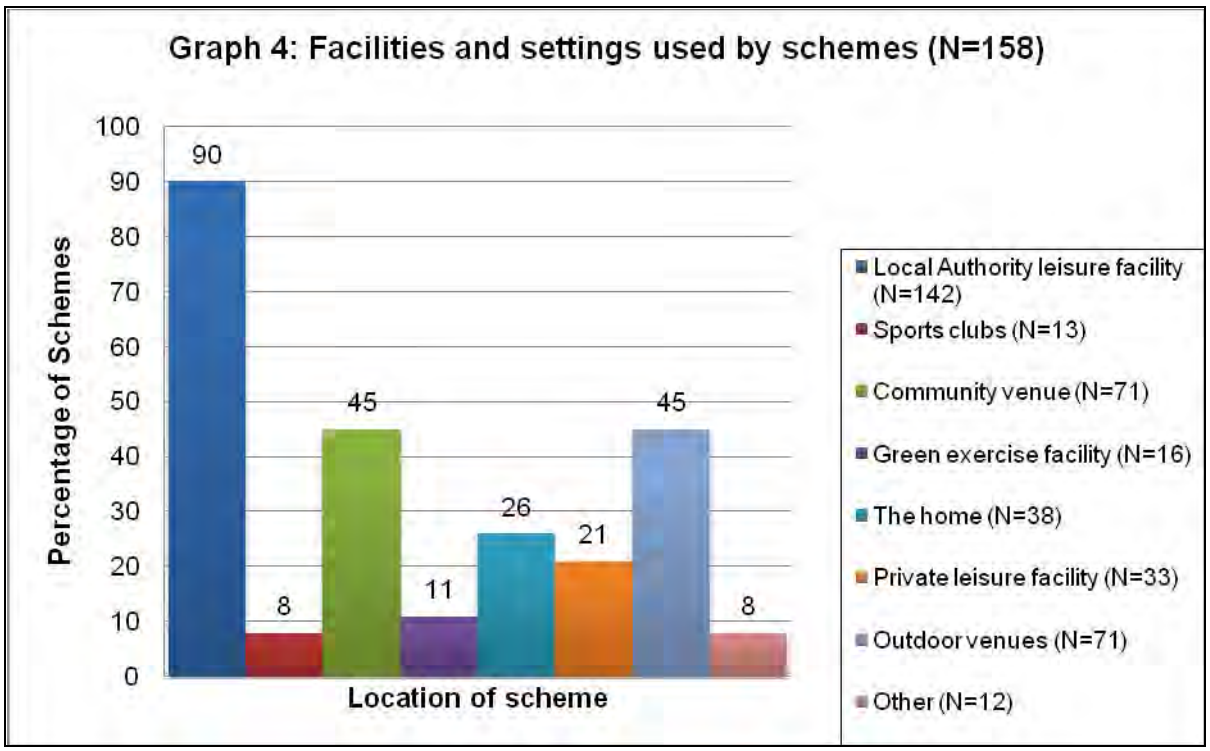
The vast majority of schemes in England and Scotland (58%) stated that paperwork is transferred between the referring practitioner and the exercise professional via post. A further 20% of schemes reported that the patient hands the relevant paperwork to the exercise professional at the initial consultation. Other schemes transferred paperwork by fax (17.5%), by email (12%), by phone (10%), and by personal delivery and/or collection (9%). Twenty percent of schemes used a combination of the above methods to transfer paperwork between the referring practitioner and the exercise professional, the most popular combination being by post and in person via the patient. The combined methods enable schemes to keep an audit trail of the number of patients referred and the number of patients attending the initial consultation. A similar pattern was found in Northern Ireland, the majority of schemes reported that they receive referrals on paper (93%), in person (11%), by telephone (4%) and via email (4%).

In addition to the varied methods employed to transfer information between the referring practitioner and the exercise professional, the paperwork being used to transfer patient information differed from scheme to scheme. Some schemes used a referral letter, other schemes used a tailor-made exercise referral transfer form, and others used referral cards. Example referral letters, transfer forms etc. were collected during this mapping exercise, analysis of these revealed that the majority of forms gathered standard demographic (gender, age, ethnicity) and health information (height, weight, BMI, blood pressure, resting heart rate); the reason for referral and information about the patients prescribed medication. A sample transfer form has been produced based on the SIGN best practice guidelines for referral documentation and the common themes taken from the examples gathered, return to the downloads page for a word version of the sample transfer form.

2.1.11. Characteristics of Schemes

Facilities:

In previous reviews it has been found that schemes centred activities mainly within local leisure facilities, with some exceptions. While this mapping exercise found that local authority leisure facilities are still the most popular setting for the delivery of exercise referral schemes (90%), it also revealed that many schemes are now delivering activities in a number of settings. Today, almost two-thirds of schemes are utilising two or more settings for the delivery of their exercise referral programme, these other settings include sports clubs (8%); community venues (45%); green exercise facilities (11%); private leisure facilities (21%); outdoor venues (45%) and the home (26%). A number of schemes (8%) also reported using other settings for the delivery of their programme; these included schools, colleges, universities, GP surgeries, a day centre and a football stadium. Graph 4 below, shows the range of facilities and settings being utilised by exercise referral schemes across England and Scotland.



In Northern Ireland, the exercise referral activities were predominantly located in the leisure centre, with a few schemes offering activities in the community.[ii]

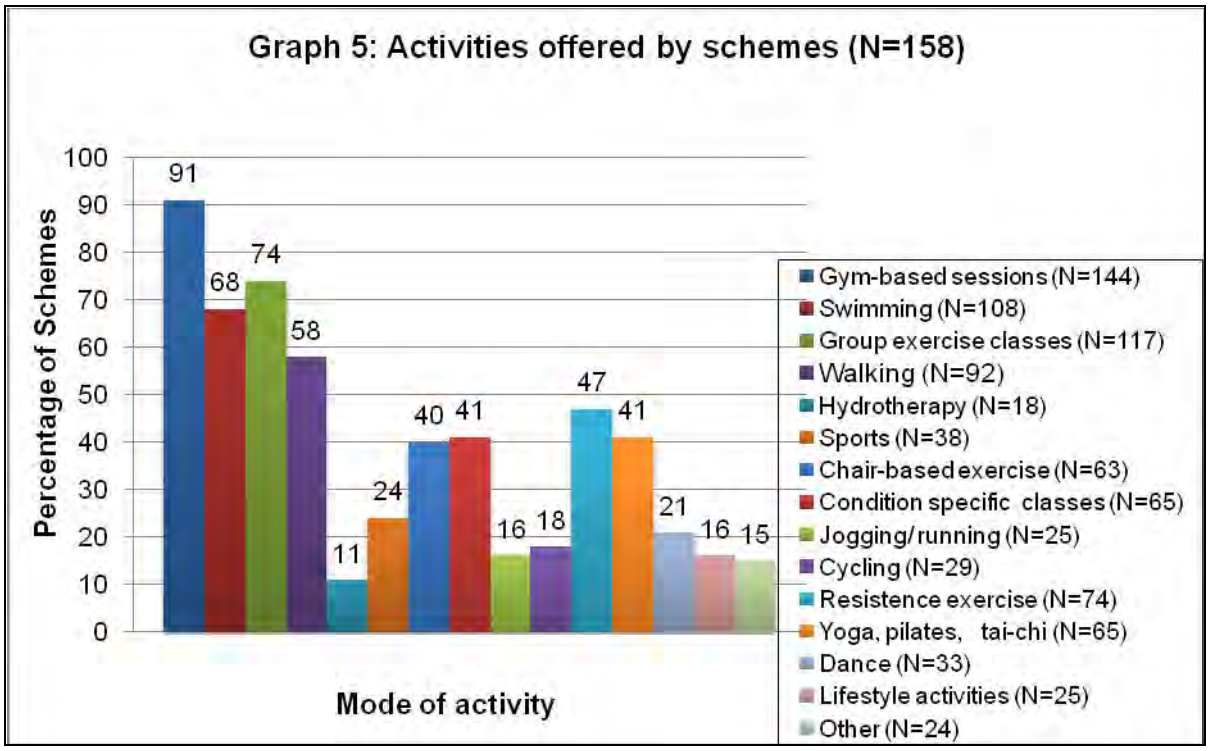
Activities:

The wider range of settings being utilised has enabled many schemes to move away from traditional leisure centre-based activities and to expand the range of activity options available for referred patients. In England and Scotland activity options differed from scheme to scheme, ranging from the provision of only one or two activities[iii] (e.g. gym based activities or group exercise classes) to the provision of a wide range of

[ii] Actual numbers were not available from the Northern Ireland audit.
[iii] 13.3% of schemes provided 1 or 2 activities.

activities. The majority of schemes offered between 3-7 activities (55%). A small number of schemes (13%) offered 10 or more different activities for patients involved in the exercise referral programme. In Northern Ireland fewer activity options were provided for referred patients, with the majority of schemes (64%) providing only one or two activities.

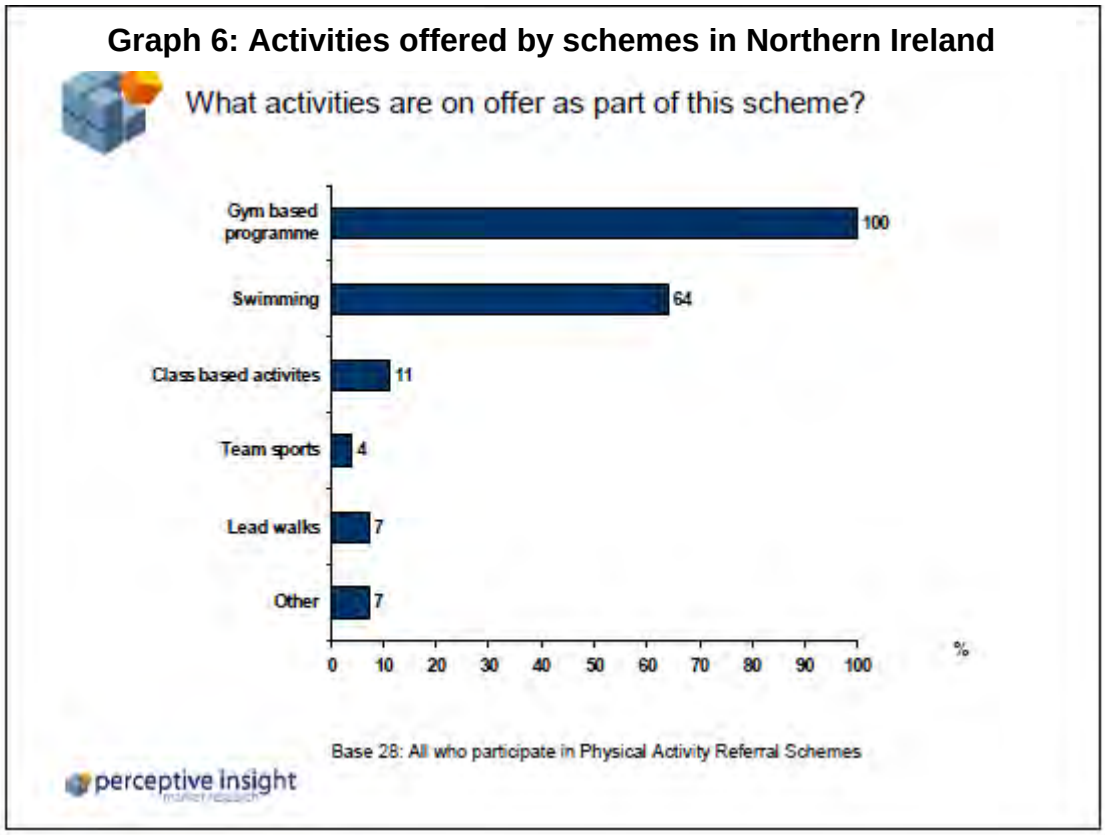
Graph 5 below, shows the type of activities offered by schemes in England and Scotland: gym- based sessions, group exercise classes, swimming and walking were the most common activities. Ninety-one percent of schemes offered gym-based activities; seventy-four percent offered group exercise classes, sixty-eight percent offered swimming and a further fifty-eight percent offered led-walks. Two-fifths of schemes also offered chair-based activities, condition specific exercise classes, resistance exercise sessions, yoga, Pilates and tai-chi. A small number of schemes also offered alternative activities such dance, hydrotherapy, sports, lifestyle activities and cycling.



Schemes offered either exclusive activity sessions for referred individuals and/or the opportunity to exercise in suitable mainstream activities established in a leisure centre or local community. Exclusive activity sessions tended to be in leisure facilities at 'off-peak' times and therefore operated during the daytime.

In Northern Ireland, the activities offered as part of the exercise referral scheme were less diverse. As can be seen in graph 6 below, the most common activities were gym-based and swimming sessions: all schemes reported that they offered gym-based activities as part of their referral programme and almost two-thirds offered swimming. The provision of other activities was less widespread; however a small number of schemes reported that they offered class-based activities (11%), led-walks (7%) and team sports (4%) as part of their exercise referral scheme.

Graph 6: Activities offered by schemes in Northern Ireland



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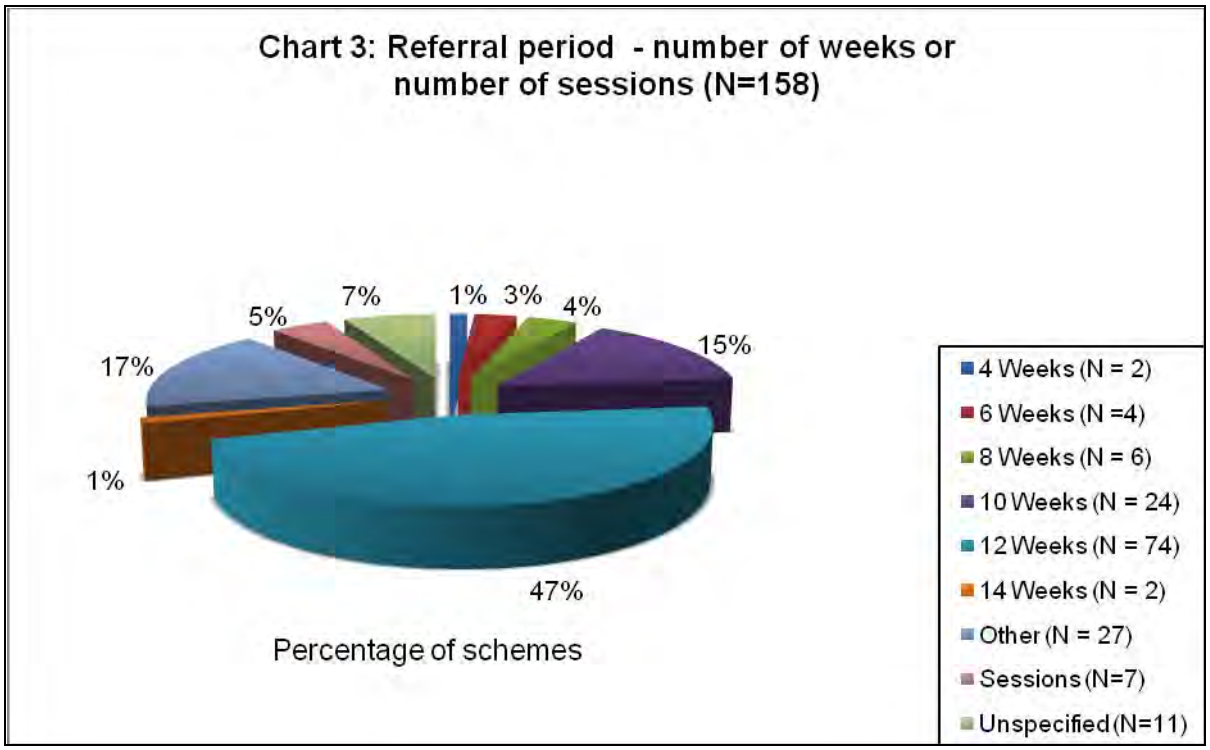
Length of Referral Period:[iv]

Respondents were asked to indicate how long the 'referral period' lasted for their scheme. Chart 3 below, shows that the typical length of the referral period was 12 weeks for most schemes (47%), however the referral period ranged from 4 weeks to 1 year in some areas. Almost a quarter of schemes operated a referral period of 10 weeks or less and a slightly less than one-fifth of schemes operated a referral period of 14 weeks or more.

A small number of schemes (5%) offered patients a set number of sessions (ranging from 8 to 36) which were not time limited. Seven percent of schemes did not specify either the length of the referral period or the number of sessions offered to exercise referral patients.

The mapping exercise in Northern Ireland did not capture data on the length of the referral period.

[iv] The 'referral period' represents the amount of time patients access the scheme for supervised and sometimes subsidised, physical activity with qualified exercise referral staff.



Patient Charges:

The charges made to patients accessing exercise referral programmes across the country varied considerably, from scheme to scheme. Just over a tenth of schemes (11%) reported that they do not charge patients anything during the referral period. The remaining 89% of schemes reported charging patients either a one-off fee for the referral period or a discounted rate per activity session during the referral period. The one-off charges differed across schemes starting from £6.70 for a 10 week programme to £67.50 for an 8 week programme. The charge to patients, per session during the referral period also varied from scheme to scheme, ranging from 50p to £7.50 (the average charge levied by schemes, per session was between £1.50 and £2.00). The costs patients' incurred also varied depending on the activities they were accessing within a scheme, for example some schemes offered free swimming, cycling or walking and charged for gym-based sessions and group-based exercise classes. Almost a fifth of schemes (18%) charged patients for the initial consultation or assessment, these charges ranged from £2.90 to £35.00. The charges patient incurred during the referral period were variable depending on whether the patient was entitled to free prescriptions or other concessions.

Data on costs patients may or may not have incurred during the referral period were not captured through the mapping exercise in Northern Ireland.

2.1.12. Referral Numbers and Uptake

The number of patients referred to schemes on an annual basis varied from one scheme to another. Data for England and Scotland showed that the number of referrals[v] ranged from between 20 patients per year to 6500 patients per annum. It should be noted here, that it would be erroneous to assess the quality of a scheme

[v] Number of referrals is also commonly referred to as 'patient throughput'.

simply by patient throughput, the scope and size of the scheme is clearly a determining factor in the number of referrals each scheme receives on an annual basis.

The numbers being referred to schemes over the course of the year also varied in Northern Ireland. The majority of schemes (86%) had between 26-150 referrals and approximately a tenth of schemes (11%) had more than 150 referrals over the year.[2]

Following the referral the next step in the exercise referral process is the 'uptake' of the referral. While the research literature highlights that there are variations in the way 'uptake' is determined by schemes, for the purpose of this mapping exercise 'uptake' was determined by whether the patient attended the initial exercise referral consultation. In England and Scotland, rates of uptake varied across schemes, ranging from 30% to 98% of patients attending the initial exercise referral consultation. A third of schemes (33%) indicated that more than 80% of patients referred attend the initial exercise referral consultation (range 80-98%). A further 28% indicated that patient uptake was around 71-80% and 18% of schemes reported that uptake ranged from 61-70%. Ten percent of schemes indicated that between 30-60% of patients took up the offer of referral and the remaining ten percent of schemes did not know what percentage attended the initial consultation. Rates of uptake reported in the research literature are between 43-79% hence for the majority of the schemes (60%) included in this report uptake rates compare favourably.

The majority (82%) of schemes indicated that they have systems in place to follow-up patients who do not attend the initial exercise referral consultation. These systems varied depending on who was responsible for booking the initial appointment, typically follow-up involved between 1-3 phone calls, a letter/postcard or a combination of these.

Data on uptake rates and information regarding systems to follow-up patients who do not attend the initial consultation was not available for Northern Ireland.

2.1.13. Programme Attendance

Ninety-five percent of schemes reported that they collect routine data on patient attendance during the referral period either electronically at the point of entry to a leisure facility or via patient registers at each exercise session. Data on levels of attendance across schemes was not reported in this mapping exercise. However, given that the majority of schemes use predominantly objective systems to record patient attendance it might be worth exploring whether it is feasible to track attendance at the individual patient level.

A small percentage of schemes (5%) used vouchers as a way of monitoring patient attendance. Some schemes used a combination of electronic monitoring, patient attendance registers, patient activity logs and vouchers. It was also interesting to note that schemes offering a diverse range of activities i.e. leisure facility, community exercise classes, walking, outdoor activities, home-based programmes had introduced a range of systems which enabled to them to capture patient attendance or patient activity levels. For example, registers in community based exercise classes and walking groups, step-o-meters to capture activity levels for patients following home-based activities and patients pursuing independent lifestyle activities were contacted

by a Lifestyle Officer at set points throughout the programme to assess progress and update activity plans.

Almost 90% percent of schemes indicated that they have systems in place to follow-up patients who fail to attend during the referral period. These systems typically followed the recommendations outlined in the National Quality Assurance Framework, which states exercise professional should telephone patients who fail to attend to determine the reason for non-attendance and if no contact is made this should be followed up by a letter.

2.1.14. Scheme Completion Rates

Patient completion rates were recorded by the majority of schemes, however it is difficult to provide an accurate picture of these across schemes due to the variations in the way schemes measured 'completion'. Some schemes calculated completion rates by the number of patients who finished the designated referral period (i.e. 10/12/14 weeks); others based it on the number of patients who attended the end of referral period assessment; others based it on the number of sessions attended and others calculated it on the number of patients who attended follow-up consultations.

Data collected for England and Scotland showed that completion rates ranged from between 20-90%, however it is unclear whether these completion rates relate to the percentage of all patients who were referred to the scheme or the percentage of all patients who took up the initial exercise referral consultation. Consequently the completion rates reported here should be interpreted with caution.

For Northern Ireland completion rates were reported as the proportion of referred patients who made it to the end of the referral period. Completion rates for schemes varied considerably. Twenty-two percent of respondents (n=5) reported that over eighty percent of referrals completed the referral period, a further twenty-two percent (n=5) reported that between sixty-one to eighty percent of referrals were successful. Thirteen percent of respondents (n=3) reported that twenty percent or less of those referred to the scheme made it to the end. The remaining schemes (n=10) reported completion rates of between 21-to-60%. Only 23 responses were obtained for this question, therefore care should be taken when interpreting these results.

2.1.15. Exit Strategies

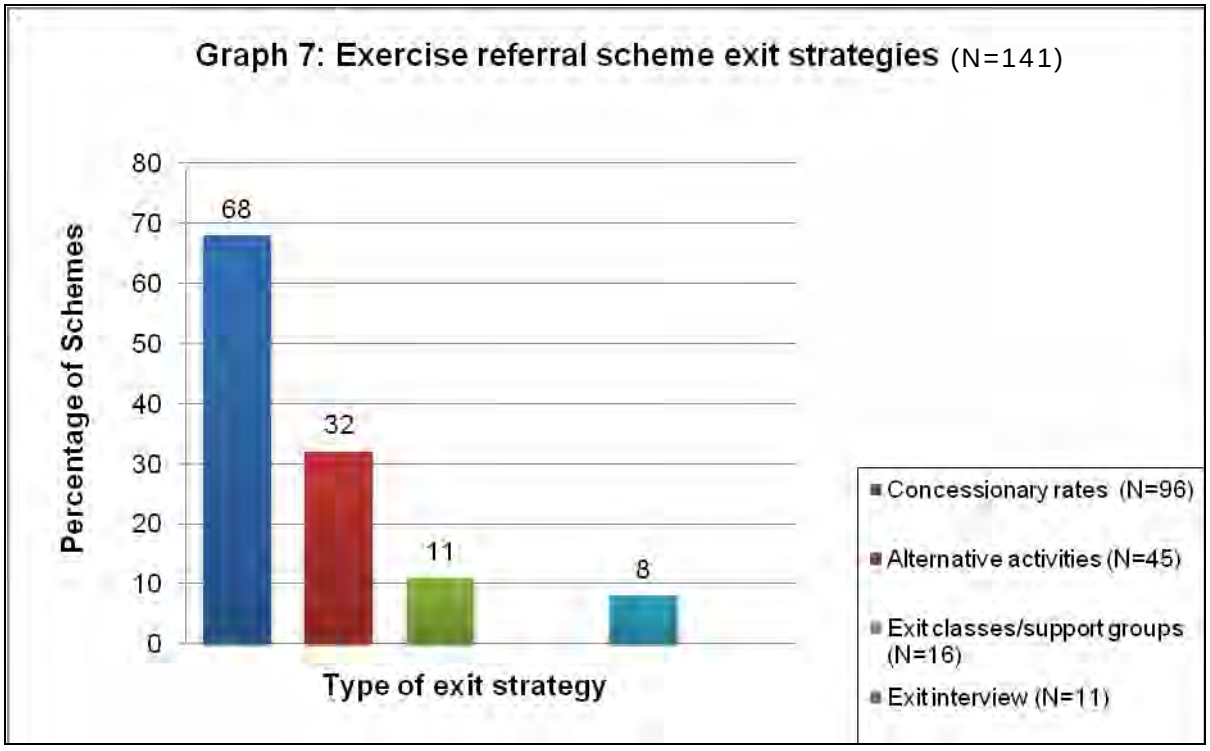
The primary objective of an exercise referral scheme is to provide patients with a positive introduction to physical activity as a way of encouraging them to adopt and maintain a physically active lifestyle. In order to support this long-term change in physical activity behaviour, the majority of schemes (89%) have introduced a range of strategies to make the transition from the exercise referral scheme into mainstream activities easier. Eleven percent of schemes reported that they did not have an exit strategy, either because resources did not allow this or because programmes were continuous.

Of those schemes (n=141) who had introduced an exit strategy, the offer of a concessionary rate was the most popular method used to encourage patients to continue to exercise. As can be seen in graph 7 below, 68% of schemes offered reduced rates for referred patients after the referral period. The next most popular exit

strategy involved sign-posting patients to other local exercise opportunities: 32% of schemes promoted alternative activities.

Eleven percent of schemes reported that they: Phased out the referral programme with graduate classes, which typically followed the format of the referral scheme, but group sizes are much bigger and patients are encouraged to take more responsibility for their exercise choices; Or offered patients continued support and motivation; Or provided opportunities for patients to join support groups. A small number of schemes (8%) offered patients' an exit interview at the end of the referral period to discuss options to maintain an active lifestyle.

The procedures followed after an individual completed the designated referral period varied widely and depended upon the availability of facilities, staff, funding and the activity programme completed by the referred individual.

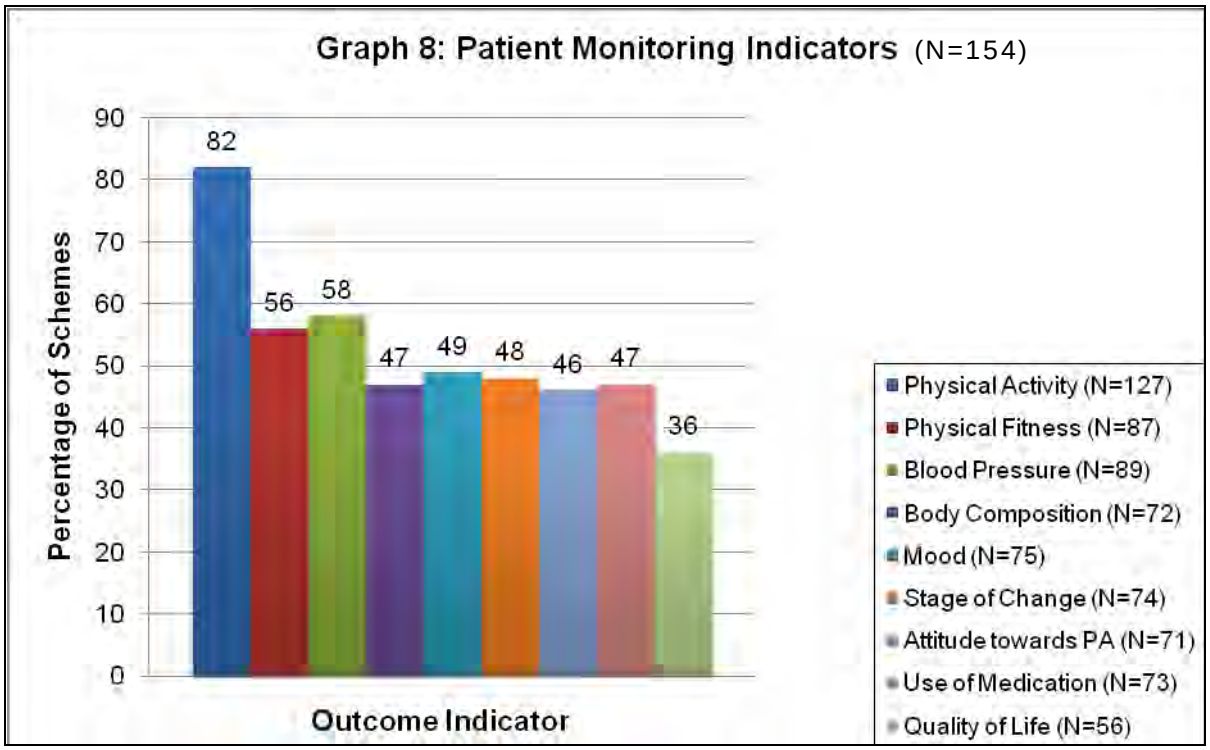


Information regarding scheme exit strategies was not available for Northern Ireland.

2.1.16. Patient Progress and Feedback

Ninety-seven percent of schemes (N=154) reported that they collected data on a range of health and fitness indicators and physical activity at some point during the referral programme. Across these schemes there were variations according to when data was collected and what data was collected: 74% of schemes indicated that they collected data on various indicators at the start of the programme; 79% collected data at the end of the referral period and 55% collected data at some point during the referral period. Approximately 65% of schemes collected data on a variety of patient indicators at the start and end of the referral period which allowed pre-post comparisons of the patients' progress. A further 45% of schemes collected data prior to, at some point during the referral period and at end of the referral period.

As mentioned above a combination of patient indicators were monitored either prior to, during or at the end of the referral programme. Graph 8 below, shows the range of, and the most popular indicators assessed by exercise referral schemes in England and Scotland (N=154). As expected the majority of schemes measured physical activity (82%). Physical fitness and blood pressure were the next most commonly assessed indicators (56% and 58% respectively) and between 46-49% of schemes collected data on body composition, mood, stage of change, attitudes towards physical activity and use of medication. Finally a third of schemes collected data on quality of life at some point during the scheme.



Eighty-two percent of schemes in Northern Ireland reported that they carried out routine monitoring and evaluation. The type of information gathered included patients BMI, blood pressure, health and physical ability, general feelings and well-being and other medical statistics.

Approximately 70% of schemes provided feedback to the referring health professional on the progress that had been made by the patient as a consequence of the scheme. Data was not collected regarding how and when this information was fed back to the referrer. In addition, 77% of patients also received feedback about the progress they made while participating in the scheme.

The incidence of schemes providing reports to referrers varied in Northern Ireland. Thirty-six percent reported that they always provided the GP with a report and a further twenty-five percent reported that they did this sometimes. Eighteen percent of schemes did not provide any reports as they were not requested by the GP. The remaining 21% stated that they either did not provide a report to the referring GP or they were unsure if a report was provided. Of those schemes providing reports, the majority provided them at the end of the scheme (65%).

2.1.17. Monitoring and Evaluation

Ninety-three percent of schemes (N=147) reported being evaluated, of these almost 20% reported that this included both internal and external evaluation activities (N=28). The majority of schemes were evaluated internally (N=134; 91%) either by the scheme coordinator, health improvement manager, PCT/NHS health board or local authority. Twenty-two percent of schemes (N=32) indicated that they were externally evaluated and of these evaluations, three-fifths were undertaken by universities or external evaluation consultants.

Despite the theory that evaluation should be planned and agreed by all stakeholders, less than one fifth of schemes engaged stakeholders in planning the scheme's evaluation activities.

The timelines for evaluation varied across schemes, some schemes conducted evaluation at a single point in time, for example quarterly or bi-annually; other schemes conducted evaluation at multiple time points for example, monthly, quarterly, bi-annually and annually. The percentages reported here reflect that some schemes completed evaluation activities at more than one point in time. Of those schemes that undertook evaluation activities, 48% (N=71) indicated that they provided quarterly monitoring and evaluation reports; 12% (N=18) provided bi-annual reports and a further 47% (N=69) provided annual monitoring reports. Almost seventeen percent of schemes (N=24) undertook both quarterly and annual monitoring and evaluation. Of those schemes (N=13; 9%) that responded to the other category these mainly reported on a monthly basis.

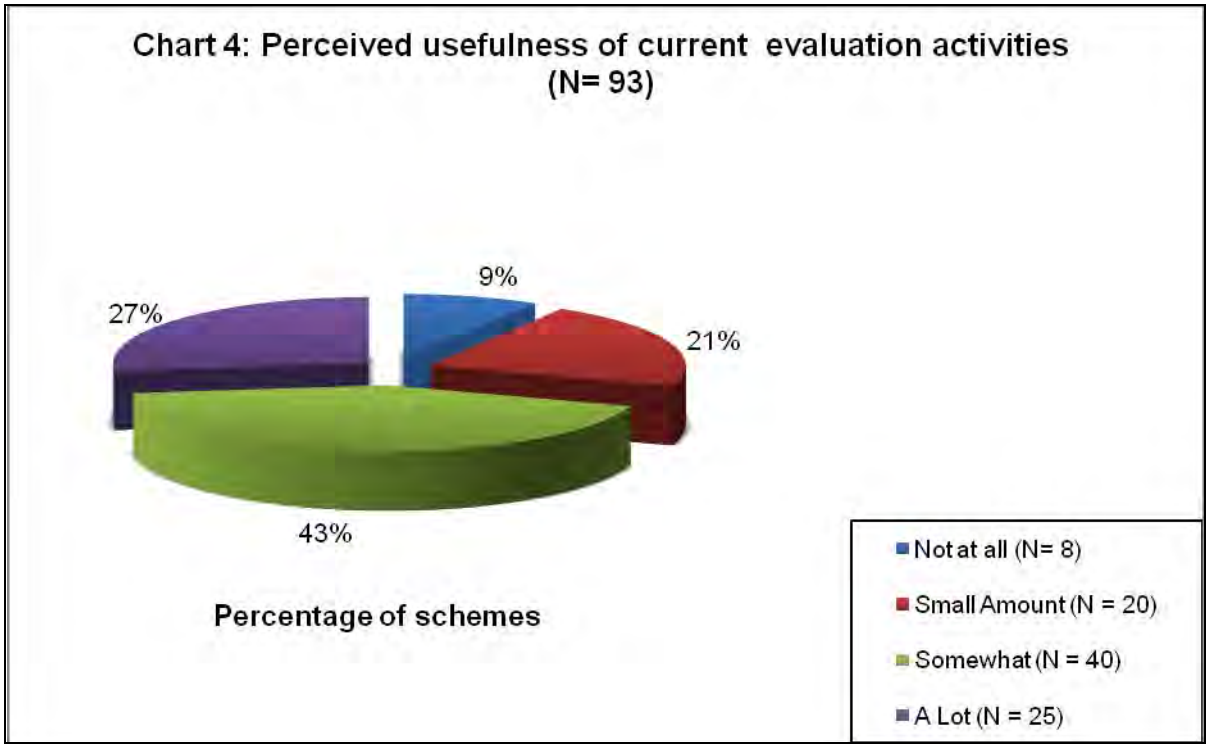
Schemes were asked a number of specific questions about their evaluation activities, i.e. whether activities offered within the scheme were implemented as planned and whether the scheme reached the target population. Eighty percent of schemes assessed whether the activities offered within the scheme were implemented as planned and seventy-one percent of schemes assessed whether the scheme reached its target population. Although these observations provide some reassurance that scheme targets and operational plans are being monitored, no details were provided as to how schemes were assessing these factors or to what extent they were doing this. Furthermore, these figures also show that one-fifth of schemes were not tracking whether schemes were being implemented as planned and almost thirty percent were not assessing whether the scheme reached its target audience.

Approximately 40% of schemes reported that they evaluated the cost-effectiveness of their scheme; however details of what this entailed was not captured in this study.

Of the 93% of schemes who reported that they engaged in evaluation: 97% of these schemes assessed patient outcomes, the majority of these focused on short-term outcomes of the patients who adhered to the exercise programme.

Respondents were asked to rate to how well they thought their evaluation activities helped to assess whether the scheme was meeting its specified aims and objectives. Only 93 responses were received for this question, of these, 70% thought that their current evaluation activities enabled them to assess the delivery of their scheme against its aims and objectives 'a lot' or 'somewhat'. However, chart 4 below shows

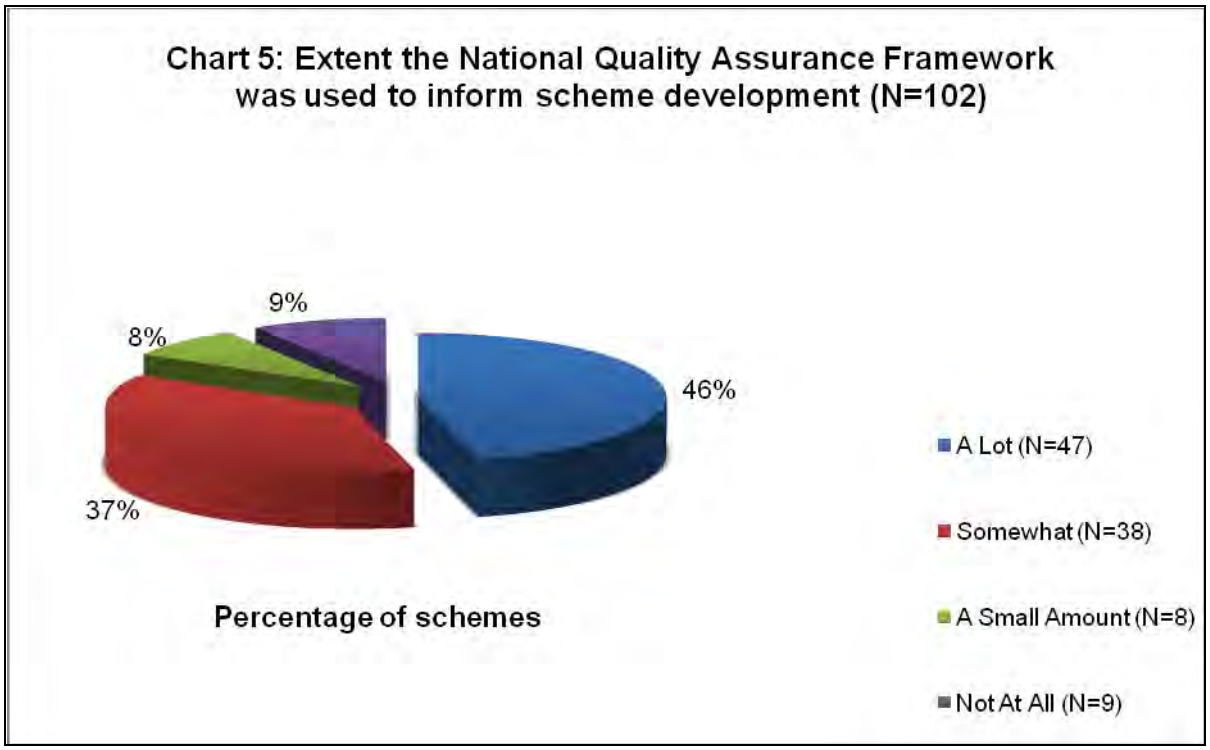
that the remaining 30% of respondents thought that their current evaluation activities did not or only to a small extent enabled them to assess whether their scheme was meeting its aims and objectives.



The analysis of scheme monitoring and evaluation activities revealed that the majority of schemes are mainly monitoring patient throughput, patient attendance and patient completion rates rather than long-term behaviour change. When interpreting this monitoring and evaluation data, readers should take into account that the majority of scheme evaluation has been conducted in-house by scheme coordinators or providers, with limited resources and capacity for robust evaluation, which tends to bias findings.

2.1.18. Quality Assurance

The National Quality Assurance Framework was introduced in 2001 by the Department of Health as a means to improving the quality and delivery of exercise referral schemes across the UK. At the time of its release some researchers and practitioners voiced concerns that the impact of the NQAF would be mininimal without appropriate systems to monitor or audit its application. One hundred and two shcemes responded to this question and it is interesting to note that more than 80% of schemes reported that they had used the NQAF ‘a lot’ or ‘somewhat’ to inform the development and delivery of their scheme (see chart 5 below).



Respondents were also asked to rate how useful they had found the National Quality Assurance Framework in the:

- Initial planning and design of the scheme.
- Implementation and delivery of the scheme.
- Evaluation.
- Ongoing scheme development.

On the whole responses were positive; respondents felt that the NQAF was very useful in the scheme planning, design and implementation phases and useful in designing the scheme evaluation.

Data regarding the use of NQAF was not captured in the Northern Ireland mapping exercise.

2.1.19. Qualifications

According to the NQAF the minimum level of qualification recommended for exercise professionals responsible for devising exercises programmes for low-to-medium risk referred patients is a level 3 advanced instructor with a recognised exercise referral qualification.

Respondents were asked whether their scheme has a minimum level of qualification for instructors working with referred patients. The majority of schemes (44%) stipulated that their instructors must have a recognised exercise referral qualification as a minimum; a further 22% stipulated that the instructor must have a minimum of an advanced level 3 qualification and a recognised exercise referral qualification. A fifth of schemes reported that instructors required a level 2 exercise qualification as the minimum (some specified this should be with a recognised exercise referral qualification). The remaining respondents either left this question blank or did not

specify what qualifications were required or indicated that this was flexible depending on the activities being offered and the patient's risk.

The responses to this question must be interpreted with some caution – taking the best case scenario from the data above, one can infer that two-thirds of exercise referral instructors working in schemes across England and Scotland are meeting the recommended qualifications stipulated in the National Quality Assurance Framework. This inference is made on the basis that an exercise instructor must hold a level 3 advanced instructor qualification before they can qualify for a place on a recognised exercise referral course.

In Northern Ireland respondents indicated that any fitness instructors involved in delivering schemes had received training in exercise referral. The majority (79%) also reported that the fitness instructors involved in the scheme are registered on the Register of Exercise Professionals (REPS).[vi]

[vi] REPS is an independent public register which recognises the qualifications of exercise and fitness professionals in the UK. REPs provides a system of regulation for instructors and trainers to ensure that they meet the health and fitness industry's agreed National Occupational Standards.

Summary:

This mapping exercise provides a snapshot of the nature and extent of exercise referral schemes in England, Scotland and Northern Ireland during 2006-2008. The results highlight that there are various methods to delivering exercise referral schemes; it shows that schemes operate at different capacities, with a range of different partners, operational structures and standards. It is clear from the evidence gathered in this mapping that exercise referral are not, and cannot be, delivered as a “one size fits all”.

2.2. References

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2. Northern Ireland Health Promotion Agency (2008) Mapping physical activity referral schemes in Northern Ireland. Belfast: Perceptive Insight Market Research.

3. Wright Foundation (2004) National GP referral conference. Birmingham: NEC.

4. Milton, K. (2008) Evaluation of the Eastern and Coastal Kent exercise referral scheme. Loughborough: BHF National Centre for Physical Activity and Health.

5. American College of Sports Medicine (2006) Guidelines for Exercise Testing and Prescription: 7th Edition. Philadelphia: Lippincott, Williams & Wilkins.

6. British Association of Cardiac Rehabilitation (2006) Phase IV Exercise Instructors Cardiac Rehabilitation Manual. Leeds: Human Kinetics.

7. Department of Health (2001) Exercise referral systems: A national quality assurance framework. London: Department of Health.

2.3. Appendices relevant to this section

- Mapping Questionnaire
- Background Briefing Paper
- Geographical distribution of schemes by region

2.3.1. Mapping Questionnaire

This form is to be completed by the Coordinator or Manager of the Exercise Referral 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

2.3.2. 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 a meeting was held with the Regional Physical Activity and Health Coordinators to consider how we can best support exercise referral practitioners in implementing the NICE guidance.

At this meeting it was agreed that a project would be undertaken to examine the feasibility of developing a framework for the design, delivery and evaluation of exercise referral schemes.

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.

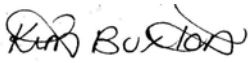
If possible, please could you base responses to evaluation related questions on the most recent annual report.

Following the initial paper audit, we will be hosting a consultation seminar 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,

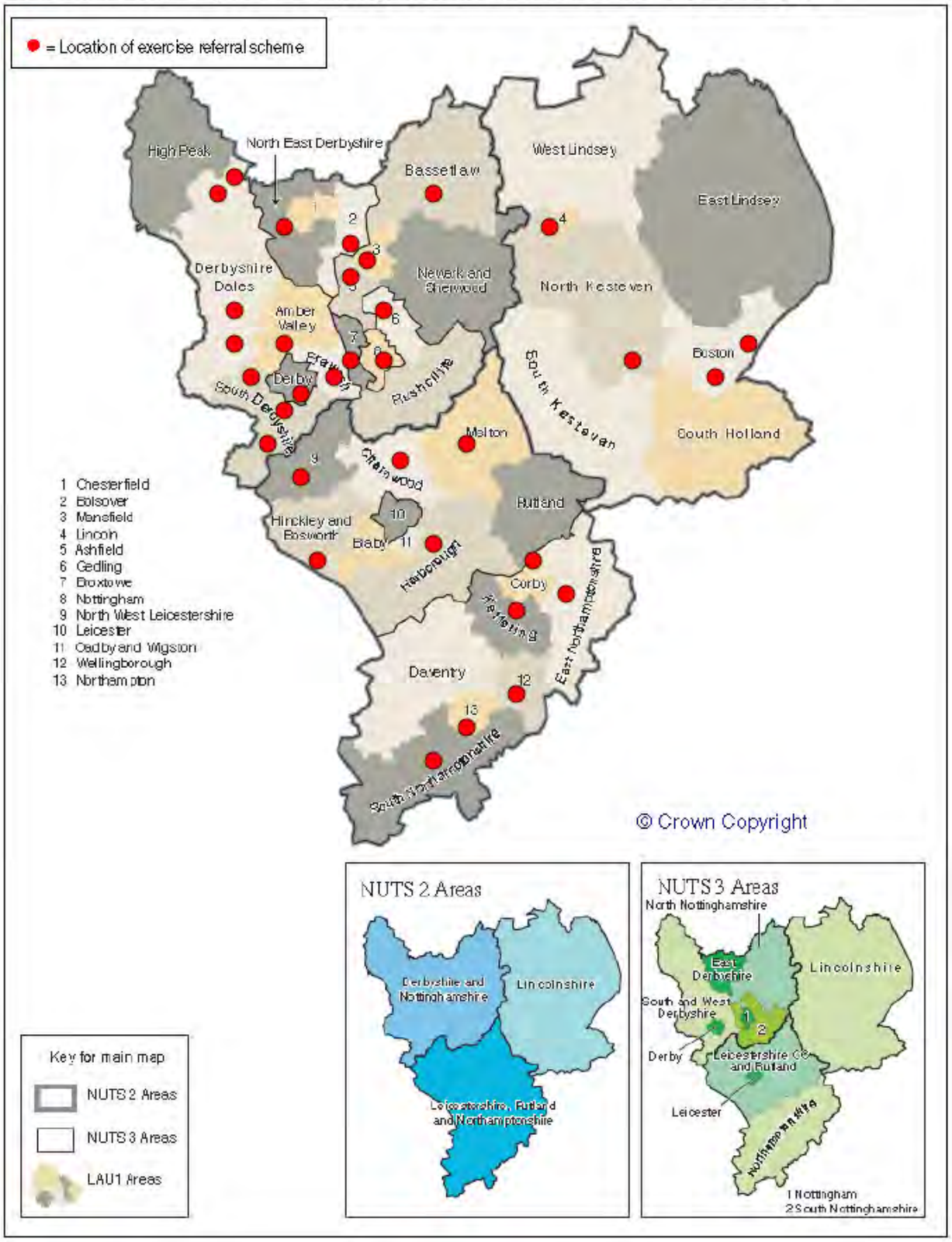


Kim Buxton,
Assistant Director - Project Manager Primary Care.

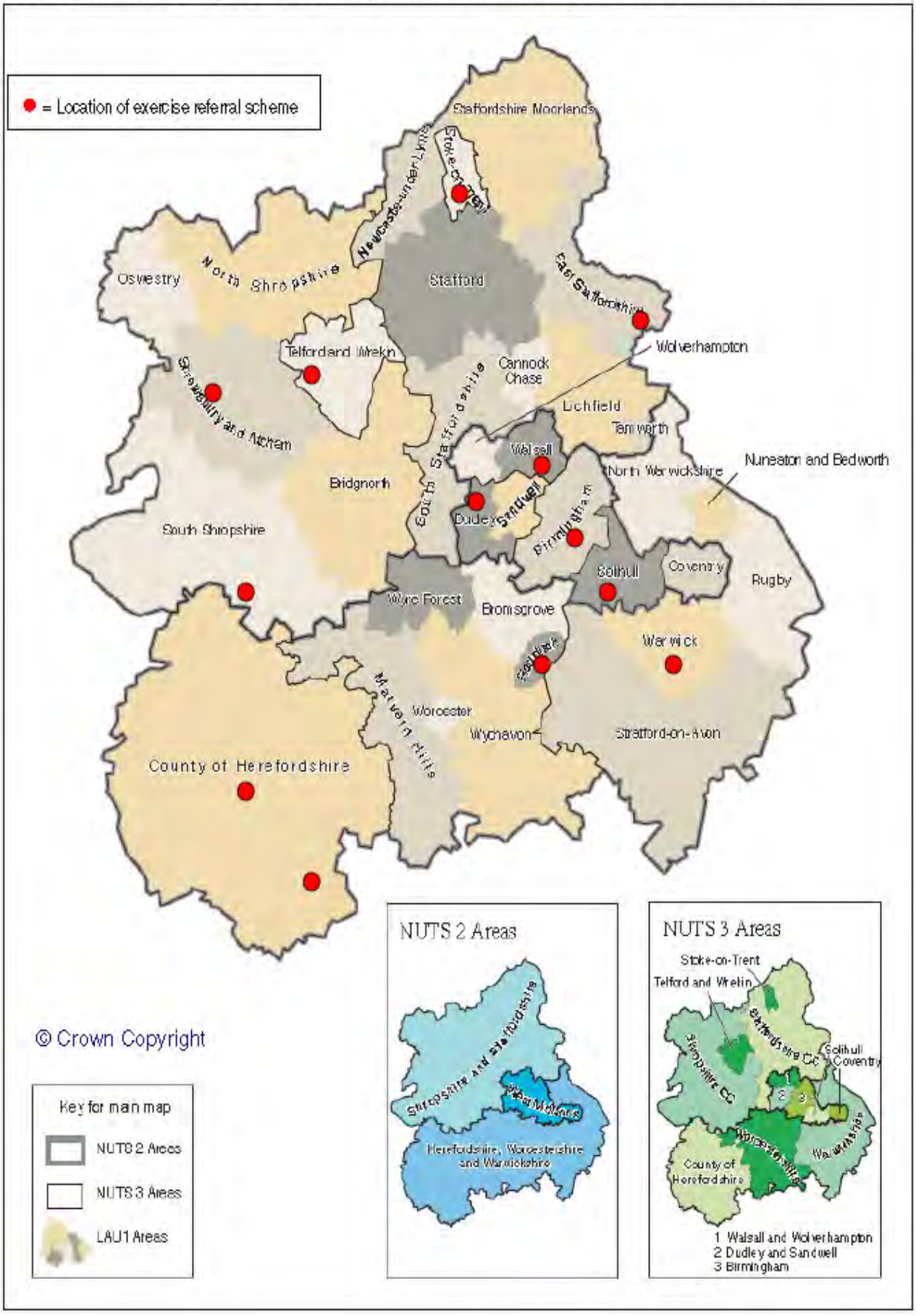
Paul Jarvis
S.E. Regional Development Manager - Physical Activity.

2.3.3. Geographical distribution of schemes by region:

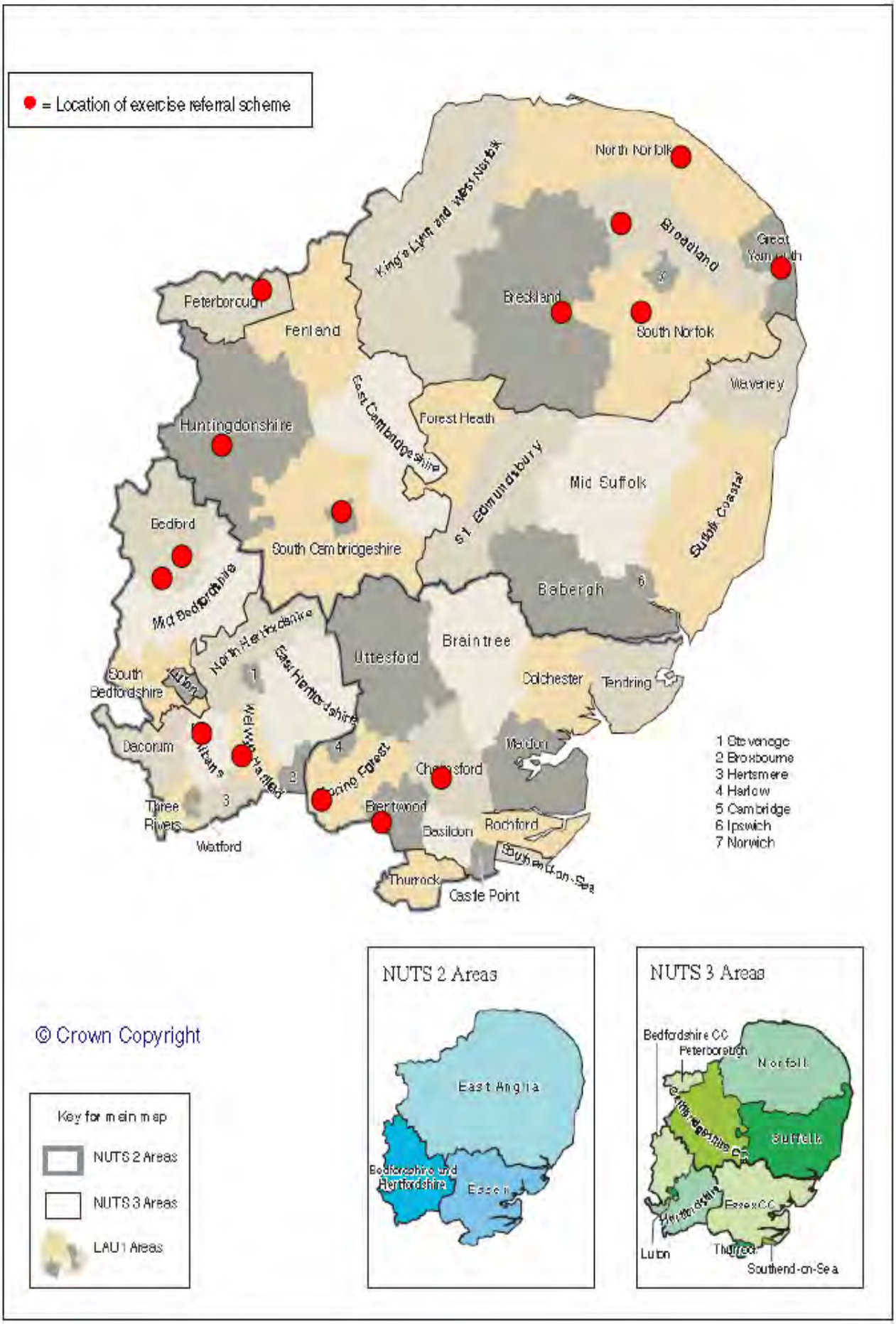
Map 4: Geographical distribution of exercise referral schemes across the East Midlands



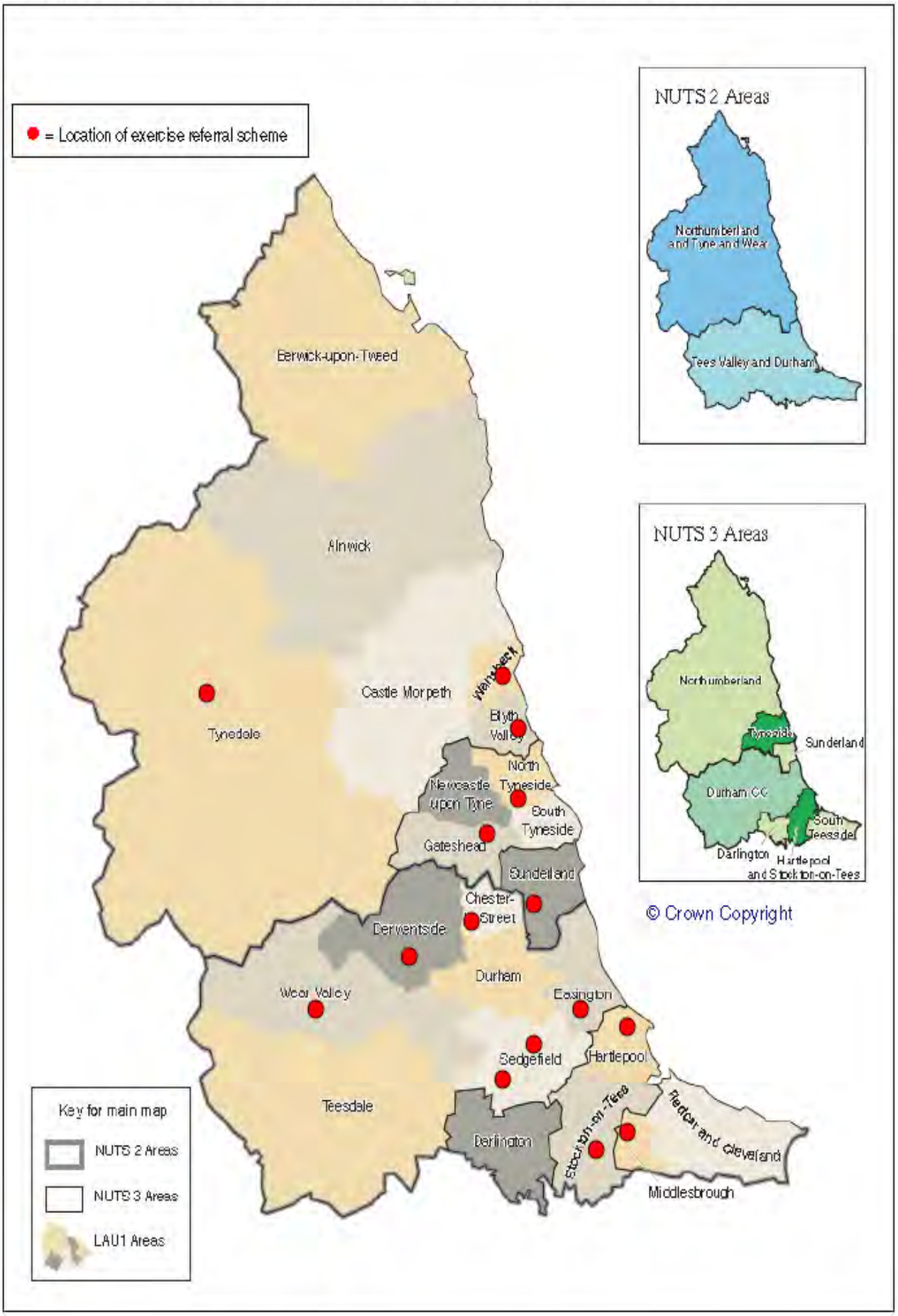
Map 5: Geographical distribution of exercise referral schemes across the West Midlands



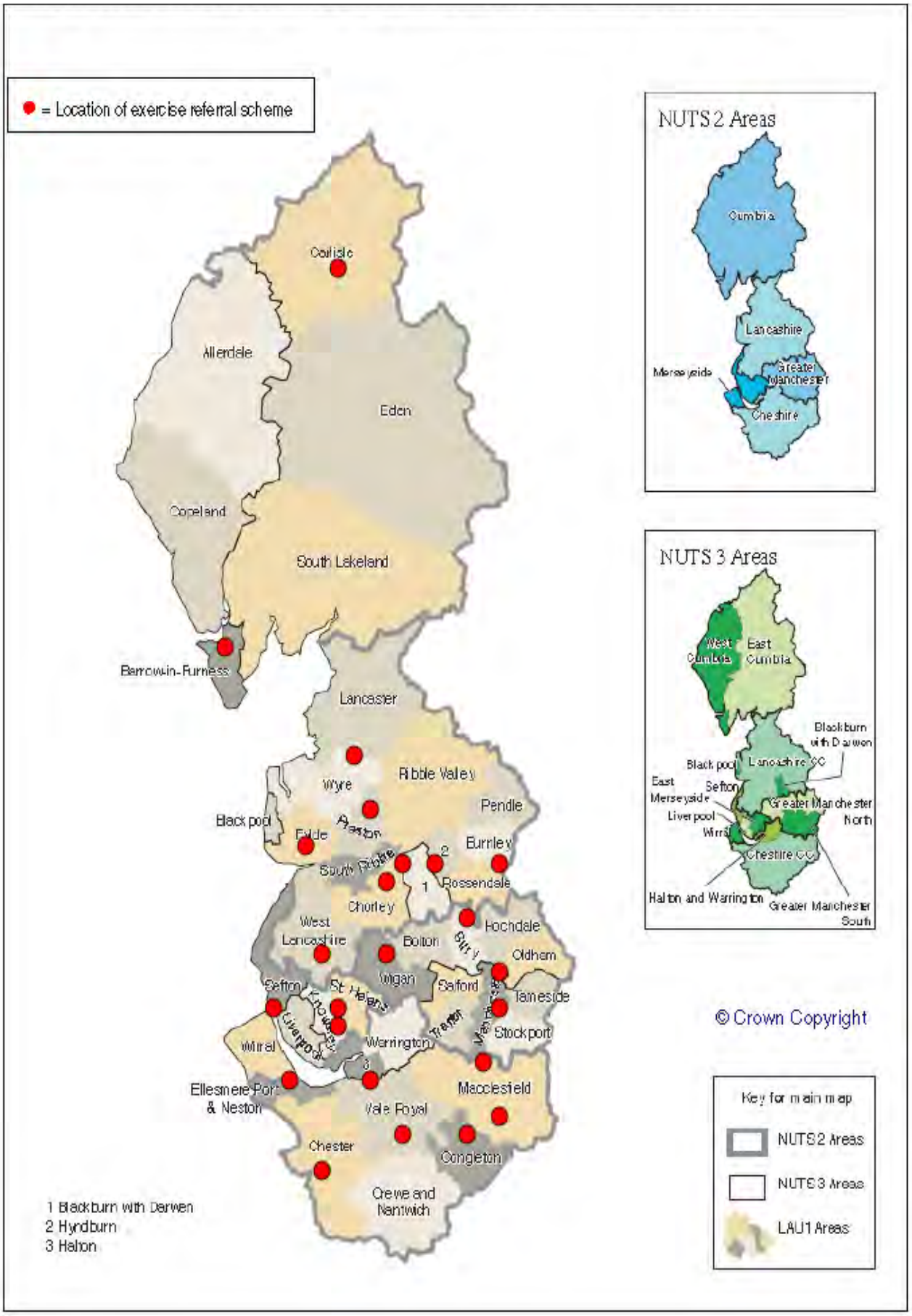
Map 6: Geographical distribution of exercise referral schemes across the East of England



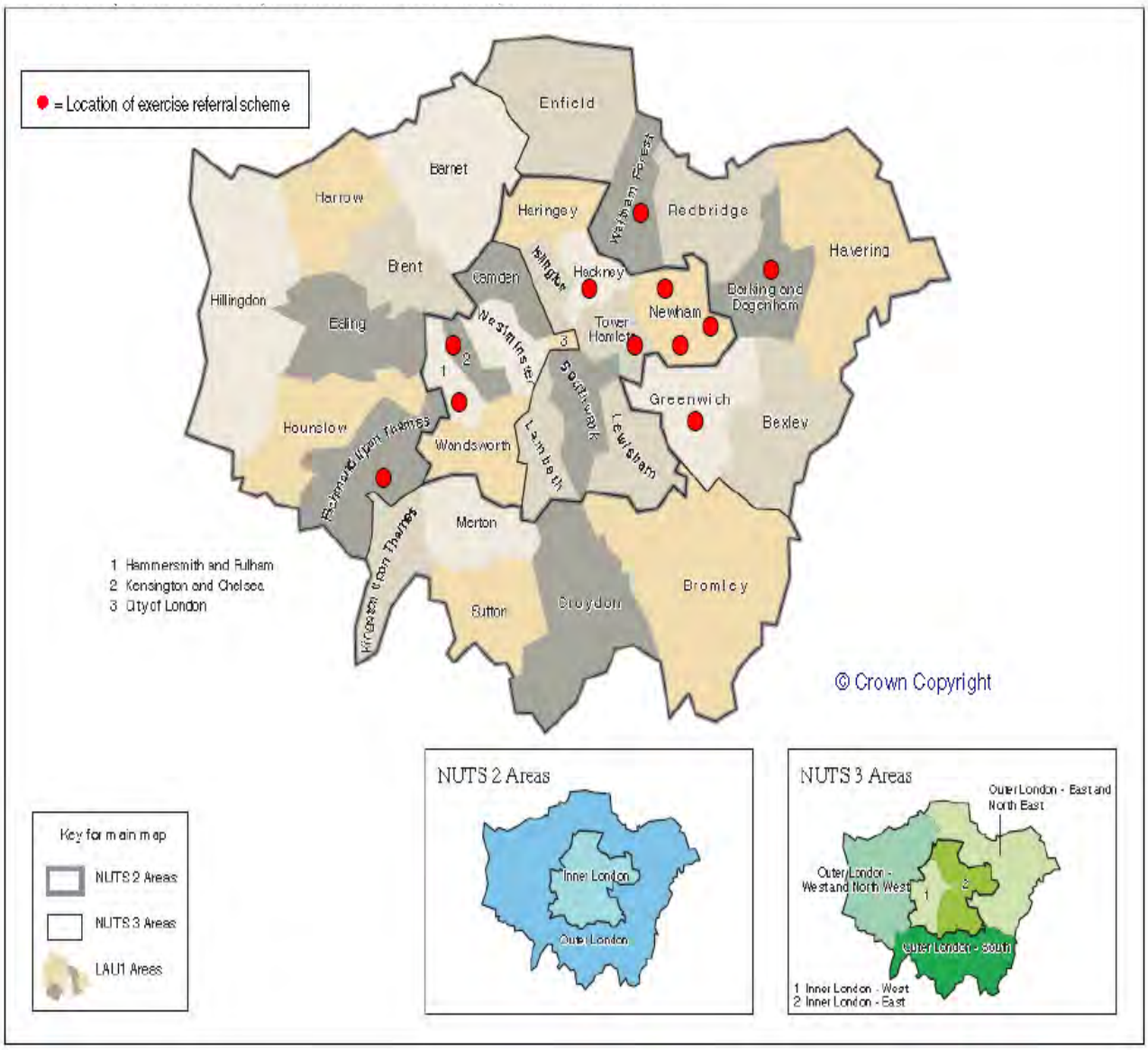
Map 7: Geographical distribution of exercise referral schemes across the North East of England



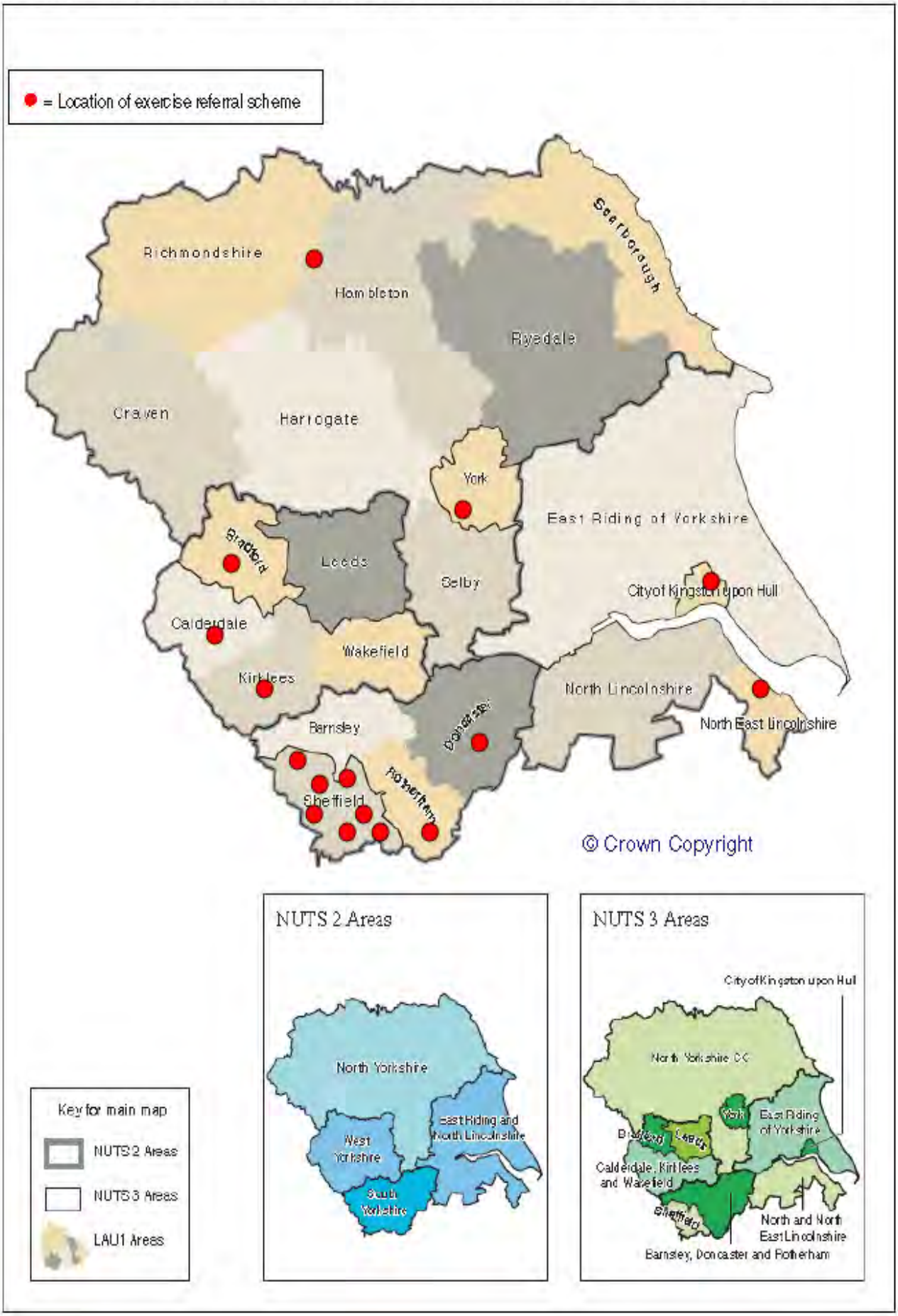
Map 8: Geographical distribution of exercise referral schemes across the North West



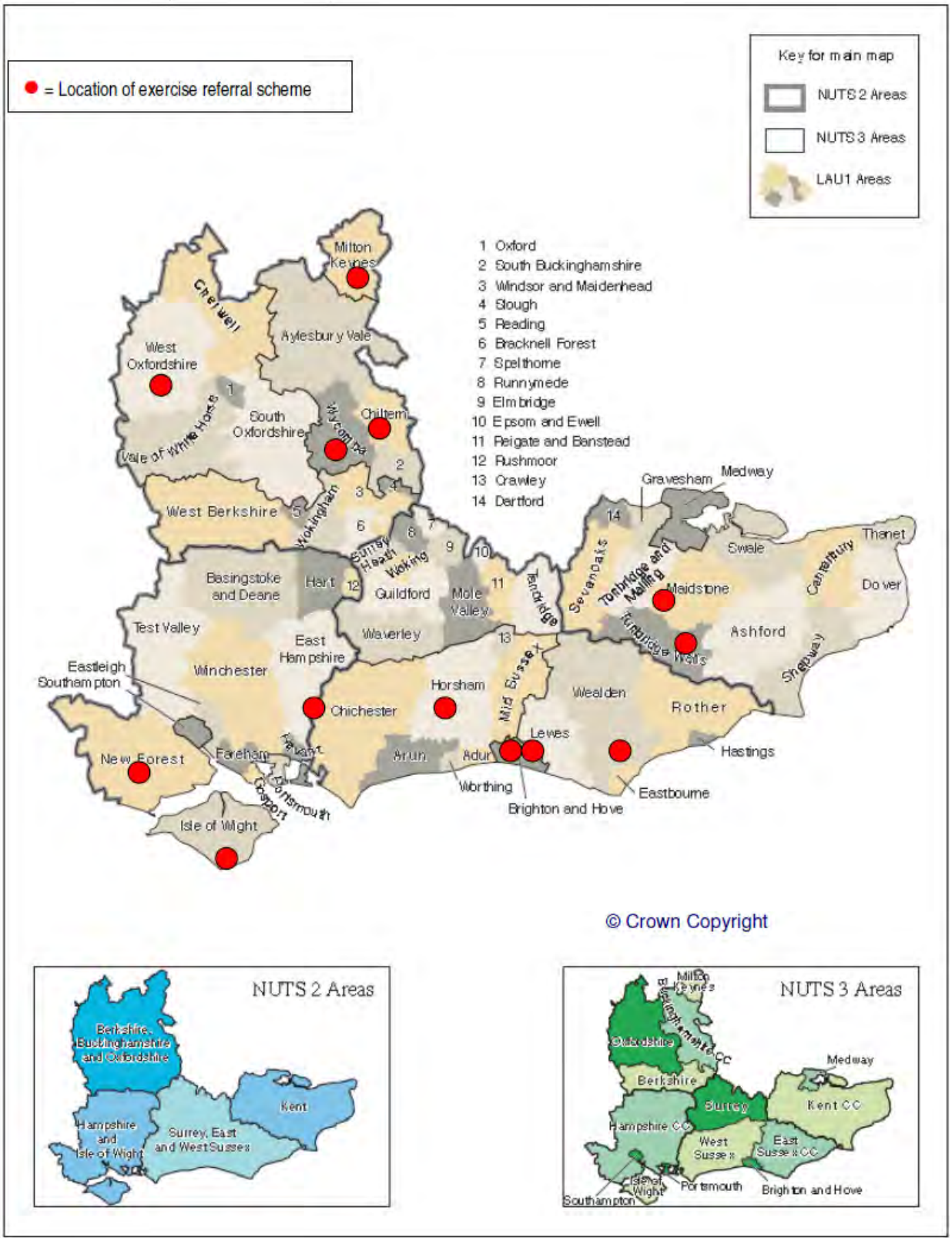
Map 9: Geographical distribution of exercise referral schemes across London



Map 10: Geographical distribution of exercise referral schemes across Yorkshire and the Humber



Map 11: Geographical distribution of exercise referral schemes across South East



Published by:

The British Heart Foundation National Centre for Physical Activity and Health
Loughborough University
www.bhfactive.org.uk

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