



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

Guidance for exercise referral scheme
coordinators

Introduction

Welcome to the exercise referral toolkit - guidance for exercise referral scheme coordinators.

A critical success factor of any exercise referral scheme is the existence of a dedicated, knowledgeable and enthusiastic scheme coordinator. The aim of this guide is to provide advice to professionals responsible for the delivery and coordination of exercise referral schemes. The resource draws upon evidence from relevant exercise referral guidance^{1, 2} and outlines the key steps to developing and coordinating a high quality exercise referral scheme.

It is recommended that exercise referral coordinators familiarise themselves with the whole of the toolkit and do not just read this guide. There are implications for the development of schemes in all the accompanying documents that will support scheme co-ordinators in meeting the checklist and recommendations contained in this guide.

To accompany this resource, we have also developed:

- **Guidance for referring healthcare professionals** - a resource which provides background information on exercise referral schemes, detailing information about the referral pathway, clinical governance and scheme governance.
- **Guidance for exercise professionals** - a resource which outlines the roles and responsibilities of the exercise professional and includes some practical tips for working with referred patients.
- **Guidance for exercise referral scheme commissioners** - this resource provides an overview of the national guidance and protocols for developing and commissioning local exercise referral schemes.
- **A guide to evaluating exercise referral schemes** - this guide includes helpful hints on how to improve the evaluation of exercise referral schemes. It provides a checklist for evaluating schemes.
- **A guide to qualifications and training** - includes guidance on qualifications and training for professionals involved in the delivery, coordination and commissioning of exercise referral schemes.

Guidance for exercise referral scheme coordinators

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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.

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Supporting Partners



**East of England Regional
Physical Activity Alliance**



Executive Summary

A critical success factor of any exercise referral scheme is the existence of a dedicated, knowledgeable and enthusiastic scheme coordinator.



The aim of this guide is to provide advice to professionals new to the delivery and coordination of exercise referral schemes and to offer a checklist for reflection for those professionals already performing this role. It draws upon evidence from relevant exercise referral guidance^{1, 2} and information gathered from a number of existing scheme protocols which outlined the coordinator's role.

Tips for developing or redesigning schemes:

- Set up a multi disciplinary steering group who will be responsible for setting the aims and objectives of the scheme, its operating procedures, protocols and monitoring and evaluation processes.

- Develop clear aims and measurable objectives for the scheme.
- Identify the required and available resources for the delivery of the scheme.
- Design the scheme to meet the requirements of the local population whilst adhering to the National Quality Assurance Framework for Exercise Referral Systems.¹ Be clear about the size and scope of the scheme.
- Develop documentation outlining operational procedures, roles, responsibilities of, and lines of accountability for all partners.
- Develop robust monitoring and evaluation procedures and ensure these are implemented and utilised to inform future developments of the scheme.

Recommendations for exercise referral scheme coordinators:

This section makes a number of recommendations for exercise referral coordinators which aim to strengthen the development and delivery of schemes in the UK:

- Establish closer working relationships with primary care & other referring health professionals.
- Where possible, engage referring health professionals in the development of scheme protocols and operating procedures and consult with them regarding any proposed changes.
- Provide clear scheme protocols outlining roles and responsibilities of all partners engaged in the delivery and evaluation of the scheme.
- Map the characteristics of the local patient population against the competencies of local exercise professionals and local exercise opportunities to develop clear criteria regarding which patients the scheme can safely accommodate.

- Work with referrers to identify their training needs - provide specific training about the scheme - aims, protocols, operating procedures etc. and the benefits of the scheme to them and their patients, where necessary provide additional training about the benefits of physical activity for health.
- Work with referring practitioners to develop a more systematic approach to identifying suitable patients for referral, for example, targeting specific 'at risk' or underrepresented groups or link to other initiatives such as the NHS Health Checks and the 'Let's Get Moving' Physical Activity Care Pathway.
- Develop criteria for referral which take account of the patient's health status, activity status and readiness to change.
- Provide referring health professionals with access to appropriate risk stratification tools, e.g. see Irwin and Morgan sample risk stratification tool in appendix.5.
- Where possible provide opportunities for patients to sample a diverse range of activities which are facility and non-facility based and at convenient times.
- Ensure that monitoring and evaluation processes for the scheme are developed, implemented and utilized to determine further developments to the scheme.
- Develop appropriate exit strategies, which:
 - Establish links with other local exercise providers and identify other suitable exercise opportunities for patients to explore after the referral period.
 - Develop local exercise referral networks to offer support and opportunities for interaction during and beyond the referral programme.
 - Consider opportunities to provide subsidised physical activity options.
- Explore opportunities to develop a referral programme which is not time limited.

- Develop more thorough patient monitoring procedures which track patients from the point of referral and at each stage of the scheme to determine the profile of patients: i.e. who does/does not take up the offer of referral; drops-out through the referral period, who completes the scheme and who continues to be active.
- Where possible introduce more systematic monitoring procedures to record the number of sessions patients attend.
- Agree the purpose of, and methods for, evaluation with all stakeholders and agree budgets for conducting the evaluation.
- Provide regular feedback to referring health professionals about the benefits of the scheme for their patients via newsletters, e-bulletins.
- Regularly verify the qualifications and training of existing and new exercise professionals.



Guidance for exercise referral coordinators

A critical success factor of any exercise referral scheme is the existence of a dedicated, knowledgeable and enthusiastic scheme coordinator.



The National Quality Assurance Framework¹ highlights that National Occupational Standards for the role of the exercise referral scheme coordinator do not exist; generally guidelines about the roles and responsibilities of the individual coordinating the scheme are drawn up locally for each scheme. These roles and responsibilities may vary depending on: where the individual is employed (within a dedicated exercise setting or within a healthcare setting); their professional background (e.g. health promotion specialist, doctor, nurse or allied health professional, exercise scientist, advanced exercise instructor); and the status of the scheme (i.e. in-development, pilot stage, well-established, under-going review).

It is recommended that exercise referral coordinators familiarise themselves with the whole of the toolkit and do not just read this guide. There are implications for the development of schemes in all the accompanying documents that will support scheme co-ordinators in meeting the checklist and recommendations contained in this guide.

1.0 Setting up an exercise referral scheme

In setting up a scheme it is important that the coordinator recognises the key areas of the National Quality Assurance Framework¹ that relate to the development of a quality assured scheme and that they have an understanding of the wider physical activity context within which the scheme will be implemented e.g. Let's Get Moving Pathway³ NHS Health Checks.⁴

The following steps are recommended when developing a new scheme:

1.1 Set up a steering group

The planning of an exercise referral scheme should be undertaken by a multidisciplinary group. This group should consist of representatives from the relevant primary care trust, health board or health commission, a leisure provider, a general practitioner, other potential referrers and an exercise professional. It is also good practice to include a member of the clinical governance team from one of the relevant health partners and, if practical, a representative from a patient-user group.

The steering group will be responsible for: agreeing the aims and objectives of the scheme; developing the fundamental operating procedures

needed to implement the scheme (for example, protocols, quality standards) and deciding what monitoring and evaluation procedures will be used.

1.2 Agree Aims and Objectives of the Scheme

It is important to be clear about what the scheme intends to achieve and that these intentions are realistic and can be measured.

The aims (or aim) should describe in general terms what the scheme is trying to achieve. Whereas the objectives should be much more specific, they outline the desired end state (or result or outcome) to be achieved within a specified time period. Objective setting is a critical stage in the planning of an exercise referral scheme.⁵ Objectives should be attainable and expressed in ways that are as measurable as possible, for example specifying quantity, quality and a time when they will be achieved. The steering group will need to agree the aims and objectives of the scheme before any further planning can be undertaken.

Example: Yew Tree Exercise Referral Scheme aims to increase the physical activity levels of patients at risk of developing coronary heart disease.

The objectives are to:

- Screen the practice populations to identify all patients with a Framingham ten year predicted CHD risk of 20% or more.
- Invite 15% of all 'at risk' patients to take part in the exercise referral scheme within six months of being identified.
- Increase the physical activity levels of all patients attending the exercise referral scheme by 50% at the end of the 12 week scheme.

1.3 Identify Resources

The steering group should decide what resources are going to be used in order to deliver the exercise referral scheme. Identify what resources are already available, what resources will be needed, what additional resources will need to be acquired and what level of funding is required.

- Identify all the people who will be involved in the delivery of the scheme, referrers, leisure providers, exercise professionals, scheme administrator, evaluation specialists, others?
- Find out what local leisure facilities, exercise classes and groups already exist and whether these are fully utilised.
- Identify whether any relevant material resources are available, for example leaflets about local leisure opportunities, training packs.
- Ascertain what financial resources are available and determine what financial resources are needed. The cost of running an exercise referral scheme will depend on the type of scheme to be delivered and what existing staff and facilities are available. Costs that need to be considered include: training of exercise instructors and health professionals; facility charges; purchase of equipment; publicity/promotional and operational/administrative materials; other subsidies or payments such as transport, gym membership, GP enhancements; evaluation.

1.4 Design the Scheme

Each stakeholder may have a different view about how the scheme should operate. It is therefore essential, right from the start, to identify and reconcile as far as possible these differing views. The bottom line is the scheme must meet the requirements of the local population and the standards of the National Quality Assurance Framework.

The following steps should be considered in designing the scheme:

Determine the Size and Scope of the Scheme

The steering group will need to agree, as early as possible about the size and the scope of the scheme. This will depend on the local population (e.g. age, health profile, nature and extent of medical conditions) and the resources and capacity available locally (for example facilities, staff numbers and their qualifications) and any funding that may be acquired.

Determine Protocols

The protocols are perhaps **THE** most important element of an exercise referral scheme as they specifically relate to the operational procedures of the scheme, therefore it is

essential to make these clear. Furthermore to ensure schemes are operating efficiently and effectively it is important that established protocols are monitored and reviewed regularly.

Each scheme will develop its own protocols based on local priorities, however there are common themes which all exercise referral scheme protocols should address and whatever is developed locally, should reflect national quality standards.

Scheme protocols typically include information about:

1. Referral routes.
2. The inclusion and exclusion criteria.
3. The referral process.
4. Who is eligible to receive referrals.
5. The initial exercise referral consultation.
6. Exercise opportunities.
7. Monitoring patient attendance.
8. Programme review.
9. The exit strategy.
10. Follow up.
11. Medico-legal responsibilities.

1. Referral routes:

This section should include information about who can refer into the scheme and how referrals from allied health professionals will be managed, if applicable. Examples of the range of allied health professionals who might be suitable to refer into a scheme can be found in the relevant section on current practice. It should be noted that the NQAF explicitly states that:

“**ONLY** a medically qualified individual, or another allied health professional working within a protocol with delegated authority, can initiate a referral into an exercise referral scheme.”

p39 Guideline 6 NQAF (2001)¹

The term allied health professionalⁱ includes roles such as physiotherapists, occupational therapists, psychologists, dieticians, or other medically trained professionals who often have a remit regarding further diagnoses and determining treatments for patients. Non-Allied Health Professionals e.g. health trainers are not medically trained or qualified to diagnose and treat patients and as such the acceptance of referral forms directly from Health Trainers or other non-allied health professionals should not be initiated by schemes. Non-allied

ⁱ Further information on allied health professionals can be found at www.ahpf.org.uk.

health professionals can play an important part in facilitating referrals to schemes, working with primary care practitioners and allied health professionals. However the referral form needs to be completed and signed by a medically qualified individual or allied health professional.

2. The inclusion and exclusion criteria:

The decision, about which patients are suitable or not suitable for referral into a scheme, should be made on the basis of an agreed set of criteria. The NQAF recommends that schemes should establish medically-led selection criteria that relate to individual or community health needs.

To enable schemes to agree and develop clear criteria regarding which patients it can safely accommodate, it is good practice to map the characteristics of the patient population against the competencies of local exercise professionals and the exercise facilities and services available. This mapping should be guided by the NQAF contextual diagram for matching participant characteristics with exercise professional expertise (see appendix 1). Referral from specialist clinic and rehabilitation routes should only be initiated if the scheme's exercise professionals have the relevant expertise e.g. referrals from hospital

based cardiac rehabilitation should only be accepted if schemes have access to qualified Phase IV cardiac rehabilitation instructors. (See the [guide to qualifications and training](#)).

The exclusion criteria should clearly indicate which patients the scheme is not suitable for, while these may be based on a range of factors, most exclusions are due to medical reasons (refer to the [complete toolkit - snapshot of exercise referral schemes](#)). The outcomes of the mapping process recommended above can also be used to define which patient population groups cannot be accommodated within the scheme due to a lack of professional expertise.

In this section of the protocol it might also be useful to distinguish between patient suitability for referral and the actual need for referral. Given that the majority of the population are inactive, many patients are likely to be eligible for an exercise referral scheme. However, many of these patients may not require

supervised exercise in the guise of an exercise referral scheme. For the majority of the population general advice to become more active in order to gain health benefits may suffice. This also presents a good opportunity for health professionals to

sign-post these patients to other local schemes, such as led-walks.

This section should also consider how potentially eligible disabled patients, who may require 1:1 supervision, can be accommodated in a scheme. The Disability Discrimination Act⁶ would expect each scheme to anticipate how it would accommodate a disabled patient if the above scenario should arise. Schemes should have a contingency plan in place which would need to show a willingness to make reasonable adjustments to accommodate disabled patients who require 1:1 support, i.e. provide an alternative service or funding for an additional instructor/ support worker for the individual patient. According to the law schemes cannot offer a lesser service for disabled individuals.⁶ Each scheme will need to review this at a local level in relation to what is considered to be reasonable and may want to seek advice from HM Government Office of Disability Issues.ⁱⁱ

There are significant benefits from investing time in developing clear inclusion and exclusion criteria in consultation with medical professionals and scheme providers, it:

- Provides an opportunity to clarify the purpose of the scheme.

ⁱⁱ Further information on the Office of Disability Issues can be found at www.odi.gov.uk

- Reduces the number of inappropriate referrals.
- Clarifies whether the scheme is suitably equipped to accept high risk patients.

The Medical Protection Society⁷ stated that: *"It would be helpful for there to be either national or local guidelines which set out specific conditions for which referral for a structured exercise programme is appropriate."*

3. The referral process:

This section of the protocol should include information about how each element of the referral process will operate or be managed, and specifically cover the following issues:

- How patients will be recruited, e.g. opportunistically through routine consultations; targeted via existing disease registers or via the vascular risk check programme; patient initiated/self referral.
- Who is responsible for booking the patient's initial exercise referral consultation, e.g. referrer, patient, exercise professional, central administrator.
- How information and paperwork will be transferred between the referring practitioner and the exercise professional.
- What information will be transferred and where, if essential information is not

provided or accessible how this will be managed. For example, some referring allied health professionals might not have full knowledge of, or access to a patient's medical information and therefore, may be unable to complete all sections of a referral form, how this is managed needs to be agreed in the protocol. It may require the exercise professional to send a letter to the patient's GP informing them of the referral or it may require the referral form to be signed-off by the GP when essential information is not available.

- How inappropriate referrals will be managed.
- How the patient's progress will be fed back to the referring practitioner.
- How information concerning any changes in the patient's health status will be transferred to the exercise professional.
- How long a referral is valid for.

In order to encourage GPs and other allied health professionals to become involved in referring patients for exercise it is important that guidelines are simple and they do not feel that they are being asked to take on responsibilities for which they are ill equipped.⁷

4. Who is eligible to receive referrals:

This section should specify what qualifications and professional competencies are required of those professionals who can receive referrals. According to the NQAF the minimum qualifications recommended for exercise professionals devising exercise programmes for referred patients are:

- Level 3 advanced instructor.
- Recognised exercise referral qualification.
- Relevant CPR qualification.

In addition, the exercise professional should have current status of Level 3 on the Register of Exercise Professionalsⁱⁱⁱ (REPs)⁸ and possess appropriate insurance.

In February 2005, the General Medical Council (GMC) and Medical Defence Union(MDU)⁷ issued a statement which said:

“The MDU advises doctors that it goes against GMC guidance to refer a patient to a professional not registered with a statutory body. One notable exception are exercise professionals registered with the Register of Exercise Professionals (REPs) as this organisation is a Department of Health recognised

ⁱⁱⁱ 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.

body and the GMC has indicated it would have no concerns about a doctor referring a patient to someone on that register.”⁷

There is a need to reassure health professionals of the competencies of the staff who are receiving referrals, therefore procedures for verifying and monitoring the qualifications and training of existing and new exercise referral instructors could be included in this section of the protocol.

It is recommended best practice that all staff working on the scheme have a CRB check undertaken due to the potential for staff to be working with adults who could be considered to be vulnerable.

5. Initial exercise referral consultation:

Details of key elements of the initial exercise referral consultation should be outlined in this section of the protocol, this might include information on:

- Reviewing referral paperwork - transfer form, patient consent.
- Pre-exercise screening - PAR-Q⁹ or equivalent.
- Pre-exercise assessments - procedures for conducting tests, how to interpret the results, how to present results to the patient.
- Motivational interviewing - assessment of readiness to

exercise, barriers, activity goals and preferences.

- Criteria for risk stratifying the patient.
- Development of the exercise programme - patient centred.
- Patient's responsibilities - attendance, following programme advice.
- Programme monitoring - how to keep a record of the exercise programme, monitor exercise intensity.
- Relevant leisure facility protocols - evacuation, emergency.

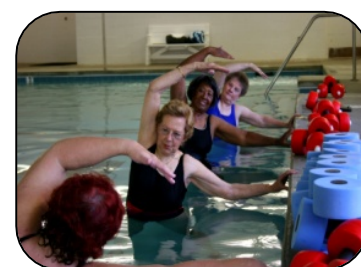
6. Exercise opportunities:

The location and accessibility of the scheme is a key factor in its potential success. Travel distance, cost and the time involved are significant barriers to using recreational facilities; research shows that the rate of use of a recreational facility falls progressively as the distance grows between the user's home and the facility.⁹ Also opportunities for physical activity should be at convenient times for potential participants; for that reason consideration should be given to the differing needs of the patient population, i.e. single parents, full-time workers, unemployed, retired.

As previously noted in the guide for exercise professionals, some patients entering an exercise referral scheme will not find traditional, structured

activities based at leisure facilities, such as gyms desirable or convenient for initiating and/or maintaining an increased level of physical activity.¹⁰

In order to improve short-term adherence to the referral programme and increase the likelihood of long-term behaviour change, where possible, patients should be provided with a range of activities (including home-based and unstructured activity) which cater for different needs and preferences.¹¹ However, this needs to be balanced against the facilities, activities and staffing available locally.



This section of the scheme protocol should clearly describe the programme components, what is to be provided and what standards of performance, outputs and outcomes are expected. For example:

- Exercise opportunities, for example the range and location of activities available to referred patients.
- Model of delivery - the frequency and duration of the referral period.
- The costs to the patient.
- Regulations and procedures for transferring patients to another exercise professional, i.e. when and if this is appropriate, responsibilities of the other professional.
- Operational requirements for exercise facilities: health, safety and insurance requirements, risk assessment of the exercise environment.

Please refer to the guide to qualifications and training for further information on the process for widening the activities available for exercise referral clients and the qualifications that staff will require to enable this to happen effectively.

7. Monitoring patient attendance:

Adherence to exercise programmes has been shown to average from 50 to 80% for the first 5 to 6 months of a programme. The majority of people dropout of an exercise programme during the first 12 weeks.¹² Given this, patient monitoring is going to be crucial; schemes need to have clear guidelines about how they will monitor patient attendance and follow-up patients who either do not attend the initial consultation meeting or during the referral period.

The NQAF provides guidance on timelines and processes for following up patients and what to do about patients who drop-out. In this section of the protocol, schemes might also want to outline how they plan to capture data on the reasons why patients fail to attend a programme.

Schemes should consider developing protocols to enable patients who have dropped out of the scheme to return to their programme under the original referral, providing that their health status has not changed. Implementing such a policy would enable schemes to support patients back into activity, without creating pressure on the capacity of schemes that may occur if patients are frequently re-referred for initial assessments. Such a policy would ensure that patients are not caught in a loop of constant re-referrals. Some current schemes allow

patients to re-enter a scheme up to 12 weeks after they have dropped out of the activities, under the initial referral, providing that there has been no change to their health status. The time period is often linked to policies on how long a referral form is valid for once it has been signed by the health professional. It is recommended that scheme coordinators ensure that there is some flexibility in the protocols for returning patients due to the nature of certain chronic health conditions which may hinder a patient's ability to adhere to their programme e.g. mental health, rheumatoid arthritis.

8. Programme review:

The NQAF recommends that all referred patients should be offered a programme review at some point during the referral period and at the end of the referral period. The details of how and when this will occur, what this involves and who is responsible for this should be outlined in the scheme protocols. In addition, this aspect of the protocol should also identify how, when and in what format this information will be fed back to the patient and the referring practitioner.

9. Exit strategy:

There comes a point when a patient will have to exit the referral programme and this aspect of the protocol should outline how this is to

be managed. A good quality exit strategy is going to be crucial if physical activity behaviour is to be maintained over the longer-term.

A quality exit strategy might include:

- Information about similar activities taking place elsewhere in the community and circulating details.
- Opportunities for patients to sample a variety of activities - some activities will be more appealing to some than others.
- The undertaking of an updated PAR-Q and a letter confirming completion of the Exercise Referral Scheme to aid the patient in moving onto other activities.
- Strategies for helping patients to adhere to long-term goals.
- Information about sources of social support - make use of existing networks such as walking groups, activity motivators or buddy systems.
- Dedicated opportunities for patient support from time to time - regular contact with an exercise professional tends to encourage sustained changes in physical activity, simple follow-up call or a welcome back day can promote long-term adherence.¹³

10. Follow Up:

It is recommended that schemes implement systems to monitor and

evaluate the physical activity levels of clients up to 1 year after completion of the referral programme to determine longer term behaviour change. This should be agreed in the service specification and can be undertaken through a variety of means e.g. phone calls, face-to-face consultations or questionnaires.

11. Medico-legal responsibilities:

All parties involved in exercise referral schemes need to be clear about the medico-legal aspects of referrals for exercise. This aspect of the exercise referral protocol should outline what these are and the need for professionals to regularly update their knowledge in this area.

Different aspects of the scheme protocol will be more relevant to one partner than another; therefore it is good practice to have an overarching protocol for the scheme coordinator and specific protocols for the referring practitioners, leisure providers and exercise professionals.

1.5 Agree legal requirements for data protection, disclosure of information and ensuring confidentiality of patient information

Exercise referral processes require the disclosure, accumulation and maintenance of medical information.

The NQAF states that:

“It is essential that the personnel delivering exercise to referred patients on an exercise referral scheme are bound by confidentiality.”
p15 NQAF (2001)¹

All organisations that handle personal information are required by law to adhere to the Data Protection Act.¹⁴

The Act covers the way in which organisations process personal information and the disclosure of information to individuals regarding computer and paper records that are held regarding them.

The Act works around eight key principles to ensure that personal information is:

- Fairly and lawfully processed.
- Processed for limited purposes.
- Adequate, relevant and not excessive.
- Accurate and up to date.
- Not kept for longer than is necessary.
- Processed in line with your rights.
- Secure.
- Not transferred to other countries without adequate protection.

This effectively means that clients can request access to their records and any correspondence such as emails and letters regarding them. It should be made clear to all staff on schemes that patients can request to

see the records that are held on them and as such staff should ensure that all information is recorded in a professional and factual manner.

The Freedom of Information (FOI) Act¹⁵ gives the public a general right of access to official information held by most public authorities. The Act sets out a number of requirements that public authorities must adhere to including: an approved publication scheme for documentation; processes for dealing with information requests and when these requests are exempt from the Law.

Due to the potentially sensitive nature of the information that exercise referral schemes may hold on their clients it is imperative that schemes are adhering to the Data Protection Act.

As such it is recommended the exercise referral scheme coordinators know their organisation's data protection and FOI policies^{iv} and ensure that all staff receive training on and adhere to the procedures regarding this.

Procedures must be followed to ensure that all patient information is securely stored with access limited to authorised personnel only. Staff

^{iv} Further information on compliance with the Data Protection Act and Freedom of Information Act can be found at www.ico.gov.uk

should be trained in the legal framework covering the disclosure of confidential patient information. They should also be provided with the procedures for obtaining explicit consent and guidance on where to seek advice if they are unsure whether they should disclose such information.

Consideration must be given to the security measures required for databases of information gathered by schemes, the use of computer equipment away from secure bases, for example the use of lap tops in outreach settings, and the secure storage of patient information by outreach instructors. No members of staff employed by leisure providers or the exercise professionals working on the scheme should discuss individual patient details with other customers or other staff members who are not trained or designated to work with exercise referral scheme patients.

1.6 Plan Evaluation

It is vital that evaluation is planned before any work starts, as this will avoid misunderstanding and false expectations. All stakeholders need to agree on the evaluation methods and it is imperative that the resources (people, finances) necessary for systematic evaluation are built in from the inception of schemes. Further information on how to

evaluate exercise referral schemes see the guide to evaluation.

1.7 Engage Partners

An exercise referral scheme can only be delivered through partnerships between healthcare professionals and exercise providers. The scheme coordinator is likely to be responsible for engaging the delivery partners; therefore they will need to have good communication and influencing skills.

Engage referrers:

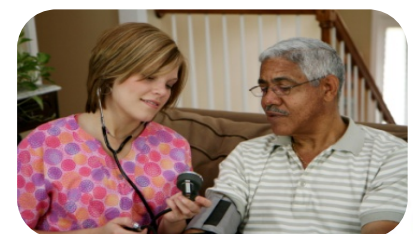
Healthcare professionals are the main access point for entry to an exercise referral scheme, thus securing their involvement will be a critical factor in setting up a scheme; without the referrers the scheme is a non-starter. Physical activity may not be seen as a priority for many health professionals; therefore the way information about the exercise referral scheme and the associated operational procedures is presented at the primary care level may have implications for practitioners' involvement.¹⁶

Presenting information about how the scheme has been developed and shaped in partnership with other healthcare professionals may increase a prospective referrer's confidence in the efficacy of the scheme for them and their patients. It is recommended that the guidance for referring healthcare professionals is used in

preparation for meetings with potential referrers.

Once onboard, a health professional's confidence to make referrals will be increased when they have a greater understanding of the processes, aims, objectives and benefits of the scheme.¹⁶ Training sessions and practical resources to assist healthcare professionals will need to be provided. The exercise referral coordinator will need to:

- Explain the scheme protocols and relevant paperwork.
- Ensure all referring health professionals understand the terms and conditions of their involvement.
- Verify that all referring practitioners have signed the declaration of commitment which ratifies their adherence to the scheme protocols and operational procedures (sample sign-up forms for GPs and allied healthcare professionals are presented in appendix.3. and 4. respectively).
- Arrange training for all designated referrers.
- Provide copies of all relevant promotional and administrative resources.
- Provide regular monitoring and evaluation reports.
- Manage any problems



which arise and respond to correspondence in a timely manner.

- Be accessible as a source of support and information.

Sharing Practice:

Insisting referrers attend training as a pre-condition to involvement in the exercise referral scheme has been shown to improve the quality of referrals and the whole system.

Identifying which patient groups are more likely to take up the referral offer and which patient groups are more likely to drop out enables referrers to make more informed decisions on the appropriateness of a referral for different patients and increases the likelihood of programme compliance.

Tips for engaging referrers:

1. Develop a referral champion in each practice-based commissioning group to promote the scheme and discuss the merits of the scheme from a medical perspective.
2. Make contact with the practice managers in the surgeries and offer to provide a brief session on the scheme at a future practice meeting.
3. Develop a referrers' newsletter/briefing to keep them up to date on the scheme's progress, use case studies of patients etc to give real life

examples of the difference the scheme has made to individuals and include brief interviews with referrers who regularly refer to the scheme.

4. Ask specialist referrers such as Physiotherapists, Mental Health Specialists etc to support staff on the scheme by providing an annual training session relevant to the patients that they will be referring through to the exercise professionals.
5. Offer to set up outreach sessions at appropriate surgeries such as chair based sessions and health walks

Engage service providers:

The exercise referral scheme concept may have to be sold to some prospective leisure and fitness service providers who cannot see the benefits of investing time and staff to a scheme which may appear unlikely to make a profit. The advantages of a scheme should be highlighted, these include: attracting a previously 'untapped' market into centres during predominantly off-peak hours; attracting increased occasional use of a facility during other times by referred patients and their friends and family; the possibility of referred patients taking up centre membership after the referral period and providing a good public relations opportunity.

Once the leisure and fitness providers have agreed to be involved in the scheme, the exercise referral coordinator will need to agree

business plans for the particular services for which each provider is responsible. The coordinator will be responsible for ensuring these plans align with the scheme protocols and operating procedures.

The exercise referral coordinator will need to provide regular training for the service providers and the exercise referral instructors regarding:

- Scheme protocols and their role in receiving referred clients.
- Procedures for ensuring confidentiality of patient data.
- Legal responsibilities.
- Monitoring patient attendance.
- Recording and analysing activity data.
- Health and safety requirements at facilities receiving referred clients.

In addition, the exercise referral coordinator will be responsible for ensuring the leisure providers understand the arrangements for recruiting and selecting appropriately qualified exercise and fitness staff to work with referred clients at their facilities. The exercise referral coordinator needs to be accessible as a source of support and information for all providers engaged in the delivery of the referral programme.

Good links with the leisure providers and exercise instructors are important if suitable, attractive and high-quality activity sessions are to be timetabled within leisure facilities at convenient times for referred patients.

1.8 Implement the Scheme

Putting the scheme into action is the most exciting part and it is always worth making a final check to ensure that no significant changes have occurred during the development process. For example, if the only qualified level 4 cardiac rehabilitation exercise instructor has decided to take up a new appointment, then a plan to provide an integrated phase IV cardiac rehabilitation service as part of the scheme will need to be reviewed. It is likely that a lot of effort will have gone into the development of the scheme and it may be difficult to redesign parts or all of it, however the need to adapt and be flexible is essential even after the scheme has been developed. If evaluation is built into each step of



the scheme then changes can be integrated and the scheme revised.

1.9 Monitor and Evaluate the Scheme

According the National Quality Assurance Framework:

“All exercise referral systems should have an integral auditing system, which focuses upon agreed outcomes between the GP and exercise professional, or service commissioner and provider. A mechanism for information exchange and collection should be clearly established.”

p46 NQAF (2001)¹

Previous reviews have identified a lack of systematic evaluation of exercise referral schemes.¹⁷ In order to ensure that schemes are sustainable all exercise referral schemes should have procedures and resources in place to evaluate and demonstrate the efficacy of their scheme. Further information on how to evaluate exercise referral schemes is provided in the accompanying resources: [A guide to evaluating exercise referral schemes](#).

Sharing Practice: *activeSTART*- Central and East Cheshire PCT Leisure Providers / Exercise Professionals Quality Standards

All leisure providers, activity and exercise professionals involved with the *activeSTART* scheme will have access to the Operational Procedures Manual and a commitment to comply with the scheme guidelines and protocols.

All leisure providers or a representative on behalf of a leisure provider, and exercise and activity professionals will have read and signed the Declaration of Commitment form confirming their adherence to the protocols of the *activeSTART* scheme.

Identified leisure providers, activity and exercise professionals will be sensitive to the needs of the *activeSTART* patients and will provide appropriate support and advice if and when needed.

All leisure providers, activity and exercise professionals who have agreed to accept *activeSTART* patients will do so at the discounted rate upon presentation of the *activeSTART* ID card.

All leisure providers, activity and exercise professionals will assist in the recording and provision of information to the *activeSTART* scheme co-ordinator of *activeSTART* patient attendance to activities or facilities.

All activity and exercise professionals employed by leisure providers, and especially those with direct contact with

activeSTART patients will be encouraged to join the National Register of Exercise Professionals and work towards achieving Level 3 Advanced Instructor status, as well as attending local training and information events organised by the *activeSTART* scheme coordinator.

It will be the responsibility of the leisure providers to inform the *activeSTART* co-ordinator of any training requirements or service problems that may arise through staff turnover, leave or sickness.

New members of staff should not be involved in the *activeSTART* scheme unless they have the necessary qualifications and access to the appropriate information.

If attending the fitness suite facilities, all *activeSTART* patients will receive a fitness suite induction with identified and appropriately qualified instructors (GP referral), and follow recommended amendments for individual patients and their condition(s) provided by the *activeSTART* scheme advisors/co-ordinators. It is recognised by the *activeSTART* scheme that the supervision of a patient during their attendance to the facility and during their programme may not always be done by the identified instructors. During such times, patients should be able to have access to staff, although not exclusive access, who are trained to a minimum

standard of emergency first aid and with a recognised gym instructors qualification denoting competence in the operation of fitness equipment and client safety.

At the fitness suite induction and / or class attendance the leisure centre staff will inform the *activeSTART* patient of any facility protocol (such as evacuation procedures, dress code etc) and make them aware of safe use of the equipment and facility.

All activity and exercise professionals in the recommended facilities used by *activeSTART* patients will be first aid trained.

Confidentiality: All *activeSTART* patient information provided by the scheme co-ordinator and advisors or by the patient will be kept secured, with access limited to staff working with the *activeSTART* scheme and *activeSTART* patients.

Confidentiality: No members of staff employed by leisure providers or exercise and activity professionals should discuss individual patient's details with other customers or other staff members not trained or designated to work with *activeSTART* patients.

Summary

The information above aimed to provide background guidance on the roles and responsibilities of the exercise referral coordinator in developing and implementing a new exercise referral scheme. It also provides a mechanism for exercise referral coordinators to review the design and delivery of existing schemes.



Recommendations for exercise referral coordinators

Based on the information above, this section makes a number of recommendations for exercise referral co-ordinators to strengthen the development and delivery of schemes in the U.K.:

Establish closer working relationships with primary care & other referring health professionals.

Where possible, engage referring health professionals in the development of scheme protocols and operating procedures and consult with them regarding any proposed changes.

Provide clear scheme protocols outlining roles and responsibilities of all partners engaged in the delivery and evaluation of the scheme.

Map the characteristics of the local patient population against the competencies of local exercise professionals and local exercise opportunities to develop clear criteria regarding which patients the scheme can safely accommodate.

Work with referrers to identify their training needs - provide specific training about the scheme - aims, protocols, operating procedures etc and the benefits of the scheme to

them and their patients, where necessary provide additional training about the benefits of physical activity for health.

Work with referring practitioners to develop a more systematic approach to identifying suitable patients for referral, for example, targeting specific 'at risk' or underrepresented groups or link to other initiatives such as the NHS Health Checks and the "Let's Get Moving" Physical Activity Care Pathway.

Develop criteria for referral which takes account of the patient's health status, activity status and readiness to change.

Provide referring health professionals with access to appropriate risk stratification tools e.g. see Irwin and Morgan sample risk stratification tool in appendix 5.

Where possible provide opportunities for patients to sample a diverse range of activities which are facility and non-facility based and at convenient times.

Ensure that monitoring and evaluation processes for the scheme are developed, implemented and utilised

to determine further developments to the scheme.

Develop appropriate exit strategies, which:

- Establish links with other local exercise providers and identify other suitable exercise opportunities for patients to explore after the referral period.
- Develop local exercise referral networks to offer support and opportunities for interaction during and beyond the referral programme.
- Consider opportunities to provide subsidised physical activity options.

Explore opportunities to develop a referral programme which is not time limited.

Develop more thorough patient monitoring procedures which track patients from the point of referral and at each stage of the scheme to determine the profile of patients: i.e. who does/does not take up the offer of referral; who drops-out through the referral period, who completes the scheme and who continues to be active.

Where possible introduce more systematic monitoring procedures to record the number of sessions patients attend.

Agree the purpose of, and methods for, evaluation with all stakeholders and agree budgets for conducting the evaluation.

Provide regular feedback to referring health professionals about the benefits of the scheme for their patients via newsletters, e-bulletins.

Regularly verify the qualifications and training of existing and new exercise professionals.

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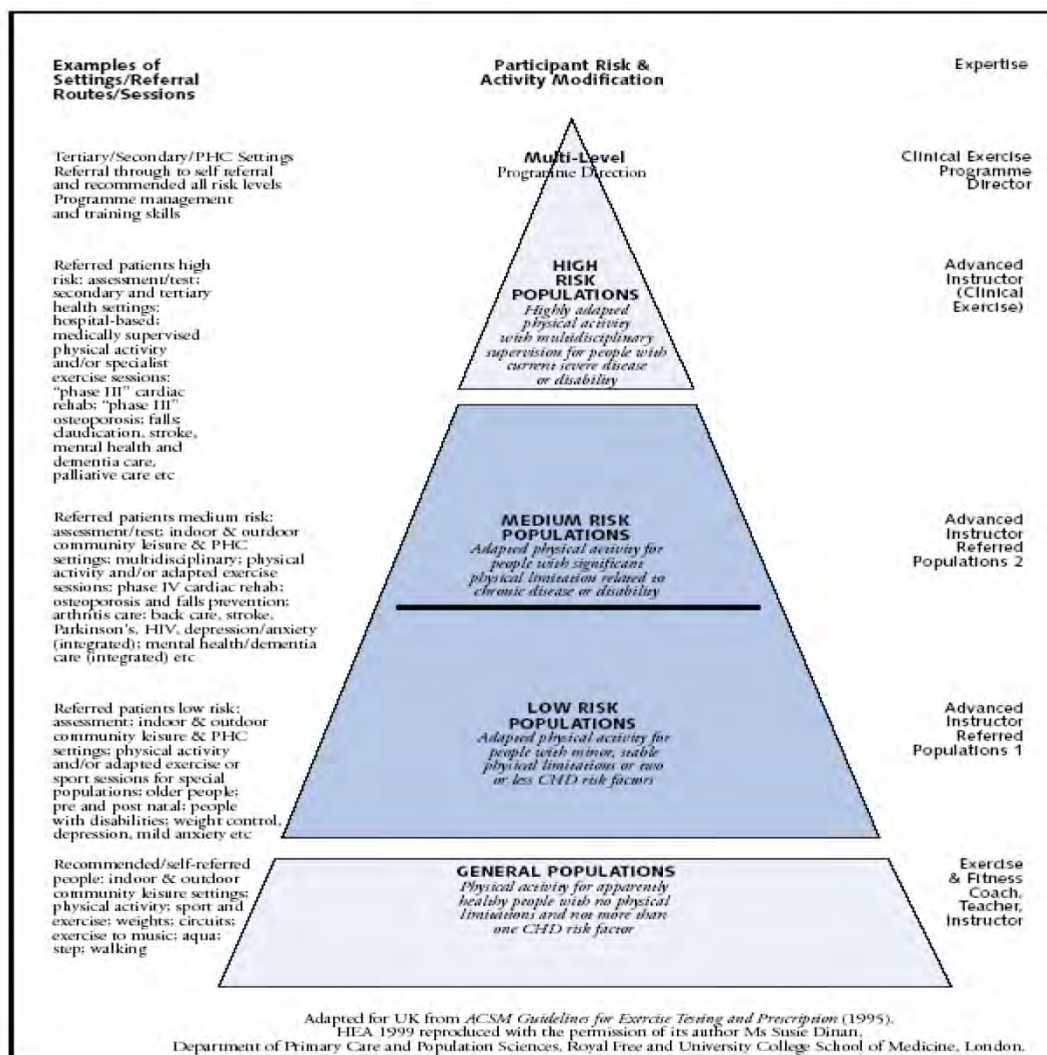
Appendices

1. NOAF Patient Characteristics & Exercise Professional Expertise Pyramid.
2. Physical Activity Readiness Questionnaire (PAR-Q).
3. Sample GP practice sign-up form.
4. Sample sign-up form for Allied Health Professionals.
5. Irwin and Morgan Sample Risk Stratification Tool.

Appendix 1 NQAF Patient Characteristics & Exercise Professional Expertise Pyramid^v

Figure 1. A contextual diagram for matching participant characteristics with exercise professional expertise within the UK National Occupational Standards (NOS)

Note: the expertise in this diagram can be determined for an individual instructor by matching with the Professional Register for Exercise and Fitness (England) described in Section C7 of this document, whose structure is illustrated in Appendix 11.



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^vDiagram taken from Department of Health (2001) Exercise Referral Systems: A National Quality Assurance Framework. London: Department of Health

Appendix 2 Physical Activity Readiness Questionnaire (PAR-Q)^{vi}

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	1. Has your doctor ever said that you have a heart condition <u>and</u> that you should only do physical activity recommended by a doctor?
<input type="checkbox"/>	<input type="checkbox"/>	2. Do you feel pain in your chest when you do physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	3. In the past month, have you had chest pain when you were not doing physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	5. Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?
<input type="checkbox"/>	<input type="checkbox"/>	6. Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
<input type="checkbox"/>	<input type="checkbox"/>	7. Do you know of <u>any other reason</u> why you should not do physical activity?

If you answered

YES to one or more questions

Talk with your doctor by phone or in person **BEFORE** you start becoming much more physically active or **BEFORE** you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active — begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal — this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever — wait until you feel better; or
- if you are or may be pregnant — talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

No changes permitted. You are encouraged to photocopy the PAR-Q but only if you use the entire form.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction.

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT _____ WITNESS _____
(or GUARDIAN (for participants under the age of majority))

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

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continued on other side...

To download PDF version of PAR-Q visit: <http://www.csep.ca/>

^{vi} Printed with permission of Canadian Society of Exercise Physiology

Appendix 3 Sample GP practice sign-up form

To register your practice and each primary care practitioner who will be authorised as a referrer to the **XXX** Exercise Referral Scheme, please complete details below and return to:

<<Insert Exercise Referral Coordinators Name & Full Postal Address>>

I/we have read the "Exercise on Referral Protocol for GPs and nurses" and agree to comply with the stated referral criteria and patient enrolment process.

PRACTICE NAME.....

LEAD GP.....

SIGNED.....

ADDRESS.....

.....

TELEPHONE NO......

EMAIL ADDRESS.....

	Name of Practitioner	Job Title	Date

Please continue on additional sheet if necessary.

New staff may be added using this form at a later date.

Include details of where electronic copies of this form and further details can be obtained from **XXX**

Appendix 4 Sample sign-up form for Allied Health Professionals

Registered <<Physiotherapists, Occupational Therapists, Community Dieticians, Physiotherapists etc, delete as appropriate >> employed by <<insert appropriate details of the relevant secondary or tertiary care services >> may refer patients to the Exercise on Referral Scheme if they agree to:

- retain clinical responsibility for patients while they are on the scheme
- complete ALL required information on the Exercise Referral form
- be available to the exercise professional to answer queries relating to the patients they have referred to the scheme
- inform the patients GP via letter that they have referred a patient for exercise on referral

In addition:

Healthcare professionals referring patients to the Exercise on Referral scheme must be registered with the relevant professional body and have appropriate qualifications and accreditation for the role they perform.

NHS employed healthcare professionals referring patients to the Exercise on Referral scheme must be professional and competent to make referrals and should follow the stated terms and conditions in this document. NHS employees who meet these requirements are covered by vicarious liability.

I have read the "Exercise on Referral Protocol for Allied Health Professionals" and agree to comply with the stated referral criteria, patient enrolment process and accept clinical responsibility for the patients I refer.

Signed:

NAME.....

DEPARTMENT.....

WORK ADDRESS.....

.....

TELEPHONE NO.....

EMAIL ADDRESS.....

Please complete, sign and return this form to the address below:
<<Insert Exercise Referral Coordinators Name & Full Postal Address>>

Include details of where electronic copies of this form and further details can be obtained from **XXX**

Appendix 5 Irwin and Morgan sample risk stratification tool

HEALTH PROMOTION



By Dawn Irwin MSc and Oliver Morgan BEng (Hons) MSc

SCHEME DEVELOPMENT

In the central London borough of Kensington and Chelsea, the local Primary Care Trust has been working in collaboration with two existing exercise referral schemes and the local authority, to develop a new exercise referral scheme. The aim was to increase the number of people participating in regular exercise.

Our first step was to establish a working group, which included scheme managers, health professionals and representatives from the Primary Care Trust and local authority. Following an assessment of the existing schemes, the group identified the referral process as the most problematic stage of successful exercise referral schemes. The group decided to look at how patients are currently referred. To do this we conducted telephone interviews with general practitioners and general practice nurses to find out what they needed to refer a patient to an exercise referral scheme. It was overwhelmingly implied that they wanted referral guidelines that they could use during a clinical consultation.

THE RISK STRATIFICATION TOOL

The group used the National Quality Assurance Framework (4) as the basis of the development process and also looked at examples of several different schemes across the UK. These schemes largely took the form of a referral form, which included health conditions as high, medium and low risk. While we thought this provided a clear and easy way to consider risk, none of the examples contained sufficient

Exercise referral schemes exist in an evidence-free wilderness. The results from existing studies are inconclusive; a review by the Health Education Authority of physical activity promotion in primary care (5) suggested only limited evidence to support the use of exercise referral schemes. However, a recent review (6) has concluded that home-based activities may be better. So when can we claim on evidence in order to improve the effectiveness of existing schemes? This article looks at how one primary care trust developed its own risk stratification tool to improve the referral process to the existing referral schemes.

spends to the risk level that it can take. Finally, we have re-designed the referral forms so that clinicians can indicate the risk level of the condition for which they are referring.

OTHER DEVELOPMENTS

Currently a set of evidence based exercise protocols is being developed. These will form the basis of an exercise resource that will be available to all GPs and supported by the fitness instructors, when programming exercise for referred patients. The success of these interventions will be assessed through the scheme's monitoring systems and periodic evaluations within general practice.

CONCLUSION

We expect that this risk stratification tool will help increase the confidence of clinicians to refer their patients to exercise referral schemes. The tool is evidence based risk stratification tool is likely to make referrals safer and more effective.

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www.sportex.net

RISK TOOL

LOW RISK	MEDIUM RISK	HIGH RISK
<p>Overweight (BMI 30/35/40) not medication controlled No other risk factors Diet controlled No more than 2 CHD risk factors and NOT AT RISK OF FALLS No symptoms of pre-stroke/TIA or history of miscarriage Provided 6/52 check complete and no complications Mild when physical activity will provide symptomatic relief No other CHD risk factor & no known impairment of respiratory function. Asymptomatic</p>	<p>Hypertension Stage 1 Type 2 diabetes Type 1 diabetes Physical disabilities Osteoarthritis COPD Clinical diagnosis Osteoporosis Surgery - Pre and Post: Intermittent claudication Stroke/TIA Asthma COPD Neurological conditions Early symptomatic HIV Chronic Fatigue Syndrome Depression Fibromyalgia</p>	<p>HIGH RISK Older people >65 years at risk of falls Frail older people with osteoporosis and history of fracture Unstable and uncontrolled Osteoarthritis Classification with cardiac dysfunction Orthostatic hypotension Stroke/TIA Severe Osteoarthritis/ Rheumatoid arthritis Moderate to severe asthma COPD/emphysema AIDS Psychiatric illness/cognitive impairment/dementia AMT score < 8</p>
<p>No complications (130/130/95/90) not medication controlled No other risk factors Diet controlled No more than 2 CHD risk factors and NOT AT RISK OF FALLS No symptoms of pre-stroke/TIA or history of miscarriage Provided 6/52 check complete and no complications Mild when physical activity will provide symptomatic relief No other CHD risk factor & no known impairment of respiratory function. Asymptomatic</p>	<p>(140/150/90/90) Medication controlled Medication controlled With adequate instructions regarding modification of insulin dosage depending on timing of exercise, and warning signs No other risk factors Diet controlled No other risk factors BMD >2.5 at spine, hip or forearm or ≥ 4 on FRACTURE index, with no history of previous low trauma fracture. General or Orthopaedic, NOT DAD/DAC No symptoms of cardiac dysfunction Mild when physical activity will provide symptomatic relief Without ventilatory limitation, but would benefit from optimisation of respiratory system mechanics and correction of physical deconditioning. E.g. young onset Parkinson's Disease (stable), Multiple Sclerosis Moderately diminished CD4 cells, intermittent or persistent signs and symptoms S.e.g. fatigue, weight loss, fever, lymphadenopathy Mild or moderate Associated impaired functional ability, poor physical fitness, social isolation, neuroendocrine and autonomic system regulation disorders.</p>	<p>REFER DIRECT TO FALLS SERVICE (BMD) >2.5 at spine, hip or forearm in the presence of one or more documented low trauma or fragility fractures) REFER DIRECT TO FALLS SERVICE Fall SSP/27 mph or less >30 mph/1g within 3 mins of standing Recent 3 months and With activity of previous 3 months With 50% or more of maximum strength, advanced retinopathy With severe asthma or moderate to severe asthma With true ventilatory limitation With accompanying neuromuscular complications, severe depletion of CD4 cells, malignancy or opportunistic infection. AMT score < 8</p>

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Source: American College of Sports Medicine (2007), Guidelines for Exercise Testing and Prescription, Sixth Edition (2000); American College of Sports Medicine Position Stand: Osteoporosis (1995); Osteoporosis (1995); Hypertension 1995; Older Adults 1996; Type 2 Diabetes; RCP Guidelines for the Prevention and Treatment of Osteoporosis (1999)

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HEALTH PROMOTION

EXERCISE REFERRAL SCHEME - RISK STRATIFICATION

LOW RISK POPULATIONS			
Definition:	People with minor, stable physical limitations or 2 or less CHD risk factors (see below).		
Exercise Setting:	Exercise Referral Schemes or other community leisure setting		
MEDIUM RISK POPULATIONS			
Definition:	People with significant physical limitations related to chronic disease or disability.		
Setting:	Exercise Referral Schemes or other community leisure setting.		
HIGH RISK POPULATIONS			
Definition:	People with current severe disease or disability. Not suitable for Exercise Referral Schemes.		
Setting:	Secondary and Tertiary Health Care settings ONLY		
EXERCISE REFERRAL SCHEMES			
Low	Medium	Kensington Leisure Centre	Walmer Road, W11 4PQ Tel: 020 7727 9747
Low	Medium	Chelsea Sports Centre	Chelsea Manor St SW7 5PL Tel: 020 7352 6985
Low	Medium	Portobello Green Fitness Centre	3-5 Thorpe Close W10 5XL Tel: 020 8960 2221
REHABILITATION AND TERTIARY EXERCISE SERVICES			
High Risk		Cardiac Rehabilitation*	Kensington & Chelsea PCT
		Established Osteoporosis **	Tel: 020 8237 2535
		Falls Risk ***	
CHD RISK FACTORS			
Family history	<55 male; <65 female		
Cigarette smoking	Current or given up within past 6/12		
Hypertension	≥ 140/≥ 90		
Hypercholesterolaemia	Total > 5.2 mmol/L OR HDL <0.9 mmol/L OR LDL > 3.4 mmol/L		
Sedentary lifestyle	Not meeting minimum recommendation ≥ 30 mins moderate physical activity every day		
Obesity	BMI ≥ 30 kg/m ² or waist girth > 100 cm		
Impaired Fasting Glucose	≥ 6.1 mmol/L		
CONDITIONS INDICATING CARDIAC REHABILITATION - PHASE IV			
Angina	Stable and controlled with no pain at rest		
CABG	If successful operation and has been discharged from Phase III		
Arrhythmias	Provided full cardiologist screening and approval		
Valvular Heart disease	Provided full cardiac screen and approval		
Congestive Cardiac Failure	Stable, on medical therapy without absolute contraindications (particularly obstruction to left ventricular outflow, decompensated CHF or threatening arrhythmias and have an exercise capacity of > 3 METs)		

* At present there is no provision within K&C PCT for Phase IV Cardiac Rehabilitation Exercise Services. Patients who present with any of the conditions overleaf who have associated cardiac problems require special consideration.

** See FRACTURE Index Screening Tool

*** See Falls Risk Assessment Screening Tool

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