Public Health Guidelines

Exercise referral schemes - Consultation on Draft Guidelines
Stakeholder Comments Table

19 March - 2 May 2014

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Stakeholder Organisation	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
British Heart Foundation	General		The British Heart Foundation (BHF) is the nation's leading heart charity. Our vision is of a world in which no one dies prematurely of heart disease. There are over 2.3 million people in the UK living with coronary heart disease. We are working to raise awareness of the benefits of a healthy lifestyle and recognise physical activity is a key component to preventing coronary heart disease and a number of other long term conditions. Advocating the benefits and encouraging members of the UK public to be physically active is a key part of this. The BHF fund the BHF National Centre for Physical Activity. (BHFNC)	Thank you and we welcome BHF's contribution
British Heart Foundation	General		The role of the BHFNC based at Loughborough University is to provide leadership and advocacy to raise the profile of physical activity, call for greater investment in health promotion and physical activity and improve the infrastructure and services provided to support more active lifestyles. We are committed to developing and promoting resources, training, information and guideline that will help professionals encourage people to be more physically active. Our primary aim is to develop, translate and disseminate research and practice-based evidence to expand and improve effective practice of physical activity promotion in the UK. The BHF and the BHFNC welcome the opportunity to comment on the draft guideline on exercise referral schemes. If you require any further information regarding this response please contact Amy Smullen, Policy Officer smullena@bhf.org.uk	Thank you for your comments
British Heart Foundation	General		When compared to the previous NICE public health guideline 2, on four commonly used methods to increase physical activity which included a clear recommendation on exercise referral schemes this draft guideline does not appear as clear-cut. We would welcome clarification on whether this guideline is recommending that exercise referral schemes	Thank you for your comments. Changes have been made to the guideline based on PHAC's consideration of your comment

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			should NOT be commissioned at all or recommending that exercise referral schemes should ONLY be commissioned with the caveats regarding minimum data collection? If it is the latter, Public Health Advisory Committee (PHAC) might wish to consider re-wording this recommendation to reflect the tone and style of recommendation 5 in PH2.	
British Heart Foundation	General		We feel there would be benefit in including a short section on the literature which was reviewed for this update with details of the study inclusion/exclusion criteria.	Thank you for your comment. Additional information on the evidence reviewed has been included in the preamble to the recommendations.
British Heart Foundation	General		We know that primary care professionals are under considerable pressures and many feel that they do not have the time and or resources to promote physical activity in routine consultations. We therefore have some concerns that the current emphasis on brief advice in primary care as 'the' alternative to exercise referral might result in physical activity not being given the priority, attention and investment that it merits. We would like PHAC to give some consideration to the practical implementation of the alternatives which are being highlighted in this guideline.	Thank you for your comment. The guideline has been changed to reflect PHAC discussions regarding brief advice and exercise referral schemes. Existing considerations have been amended and an additional consideration has been added to reflect these discussions.
British Heart Foundation	What is the guideline about?	1	We think this section needs further clarification, in particular PHAC might want to consider including a definition of the overarching purpose of an exercise referral scheme which relates specifically to the scope of this guideline, i.e., exercise referral schemes designed to increase physical activity of inactive adults.	Thank you for your comment. This section of the guideline has been changed based on PHAC's consideration of stakeholder feedback and fieldwork.

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British Heart Foundation	What is the guideline about?	1	Exercise referral schemes are often commissioned for the medical management of a number of long-term conditions i.e., diabetes, obesity, lower back pain, mental health problems. Therefore PHAC might wish to consider how, and where, these schemes fit within this guideline as some commissioners and/or providers might perceive this guideline is not relevant to them.	Thank you for your comment. PHAC considered this comment further and have made changes to clarify what types of exercise referral schemes are included as part of this guideline.
British Heart Foundation	What is the guideline about?	1	We are aware that there is a wealth of NICE guideline which includes recommendations on exercise to support people with specific clinical conditions and wonder whether PHAC might consider making reference to the guidelines that relate to the most prevalent long-term conditions.	Thank you for your comment. PHAC have made changes to the guideline to reflect where NICE guidelines recommends structured exercise programmes to support people with specific conditions.
British Heart Foundation	1 Draft Recommendations	5	We are concerned that some commissioners and policy makers may see this guideline as an opportunity to disinvest in physical activity, we would therefore like to see reference to NICE's other physical activity guideline and request that further commentary is included to urge public health commissioners and policy makers to continue to invest in a range of physical activity interventions.	Thank you for your comment. PHAC have made changes to the guideline to reflect this.
British Heart Foundation	Recommendation 1	5	Some commissioners, policy makers and practitioners might not be familiar with the guideline and recommendations which are cited. We would recommend a summary of complimentary guideline is included as an appendix.	Thank you for your comment. Due to template restriction we are unable to provide summaries of all the related guidelines. Changes have been made to provide some details regarding the most relevant published NICE

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				guidelines and section 6 outlines all the NICE guidelines of relevance with hyperlinks to the full guideline documents
British Heart Foundation	Recommendation 1	5	We recommend that if scope allows, that NICE public health guideline on workplace health is added to this section.	Thank you for your comment. Reference to 'Physical activity in the workplace' guideline has been added.
British Heart Foundation	Recommendation 1	5	We find the recommendation 'Not commission exercise referral schemes for the sole purpose of getting people to be more active' a little ambiguous. Many exercise referral schemes are not set up for the sole purpose of getting people more active they are often commissioned for the medical management of conditions and physical inactivity is considered to be one of the inclusion criteria for referral. Would it be possible to commission an exercise referral scheme for the sole purpose to improve another issue, for example mental well-being? Strength building etc?	Thank you for your comment. PHAC have made changes to the guideline to reflect the points you have raised.
British Heart Foundation	Recommendation 1	5/6	We welcome the recommendation for exercise referral schemes to improve evaluation mechanisms and fully endorse the recommendation for schemes to be collecting physical activity data at baseline, during the scheme and afterwards and data on scheme reach, reasons for referral, drop out etc. However, we would recommend PHAC are cautious about recommending data is collected on clinical indicators such as blood pressure, respiratory functioning, BMI, blood lipid profiles as many of these indicators are influenced by other lifestyle behaviours or confounding factors, such as diet, smoking, alcohol consumption.	Thank you for your comment. PHAC have made changes to the guideline that reflects the points you raise. Reference is made to Public Health England's 'Standard Evaluation Framework for Physical Activity'
British Heart Foundation	Recomme	6	We would like further clarification regarding how cost is expressed – fiscal or time?	Thank you for your comment.

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	ndation 1- bullet point relating to costs			Costs could include time or fiscal cost of the programme (which may include time). The guideline has provided examples to illustrate this. The final guideline refers to Public Health England's 'standard evaluation framework for physical activity interventions (SEF)' which aims to describe and explain information that should be collected in any evaluation of an intervention that seeks to increase physical activity participation. The SEF includes a number of items relating to the collection of cost data including cost per participant as well as cost to the participant. It is accompanied by a set of explanatory notes to help with the collection and recording of the required information. The final guideline is also published with an accompanying costing tool which will assist developers and commissioners

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				in implementation of the guidelines.
British Heart Foundation	Recommendation 1- bullet point relating to physical activity data collection	6	We agree it is important to measure the impact of exercise referral schemes, but this needs to be assessed in real time benefit rather than an automatic jump to a sustained achievement of Chief Medical Officer (CMO) recommendations.	Thank you for your comment. The final guideline refers to the collection of data using SEF which includes the collection of measures of physical activity behaviour at baseline and follow up. The SEF document provides details regarding how this can be done. PHAC noted in their discussions the positive health benefits from any increase in physical activity. This is outlined in the considerations section.
British Heart Foundation	Recommendation 1- bullet point relating to reasons why people drop out	6	We think it would be beneficial to include a recommendation that this learning should be shared with other exercise referral schemes as this might help improve service delivery and increase effectiveness.	Thank you for your comment. PHAC have added an additional action that suggests that all data collected should be made available for analysis, monitoring and research to inform future practice.
British Heart Foundation	Recommendation 2	6	We would also like this recommendation to make reference to NICE's public health guideline 41 recommendation 10 – primary and secondary healthcare professionals should incorporate information on walking and cycling into all physical activity advice.	Thank you for your comment. Reference to the NICE public health guideline on walking and cycling has been outlined in the

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				final document.
British Heart Foundation	2 Context	7	We would recommend PHAC cites the CMO report as the key evidence source with regards to the relationship between physical activity and health.	Thank you for your comment. This change has been made.
British Heart Foundation	Context paragraph 2	7	Whilst we accept that most adults and children do not meet the physical activity recommendations, we wonder whether the reference to children is relevant here given that this guideline only relates to adults.	Thank you for your comment. This has now been changed.
British Heart Foundation	Lack of physical activity: the costs	8	The reference relating to the average cost of physical inactivity for every PCT no longer seems relevant AS PCTs no longer exist.	Thank you for your comment. This has now been changed.
British Heart Foundation	National guidelines, resources and indicators	8	We welcome the inclusion of the BHFNC toolkit in the guideline. However, we would like to see the description of the toolkit to be amended as the toolkit is not designed as a 'blueprint' for how exercise referral schemes must be designed, implemented and evaluated. The toolkit offers some best practice principles for all those involved in the delivery, management and commissioning of exercise referral schemes.	Thank you for your comment. This has now been amended to reflect your comment.
British Heart Foundation	Reference to 'Let's get moving'	9	We find this section is a little ambiguous and it perhaps needs further clarification regarding Let's Get Moving and how exercise referral fits within this pathway, especially in light of this draft guideline. NICE public health guideline 44 states that there is a lack of evidence on the impact of the current infrastructure, processes and systems on both the delivery and uptake of brief advice; this includes the national physical activity care pathway 'let's get moving'.	Thank you for your comment.
British Heart Foundation	Backgroun d	9	This section seems a little confusing and we would welcome some clarification regarding the findings from the evidence reviews.	Thank you for your comment. The evidence suggested

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	3.1 - 3.2		Is the evidence saying that exercise referral schemes are not effective or is the evidence saying that exercise referral schemes are not cost-effective or both? We would encourage PHAC to separate these two points.	exercise referral was marginally more effective than brief advice but at greater cost, so the economic evaluation suggests that this added benefit was not likely to be a cost effective use of resources. Additional information has been added to clarify this throughout the guideline.
British Heart Foundation	Evidence of effectiveness 3.6	10/11	Did PHAC ask the reviewers to consider the magnitude of change in terms of physical activity behaviour from baseline to follow-up? We would be interested to know whether there is any evidence regarding the effectiveness of exercise referral schemes in supporting people who are totally inactive shifting along the activity continuum, i.e., moving from 0 to 30 minutes of activity.	Thank you for your comment. The systematic review was an update of the Pavey et al health technology appraisal. A number of outputs were requested as outlined in the scope document for this guideline. The evidence identified any changes in physical activity from baseline to follow up above and did not restrict by achievement of CMO recommendations. The economic modelling did attempt to consider the achievement of below CMO levels of physical activity but

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				there was a lack of data regarding the associations of sub maximal achievement and impact on disease conditions.
British Heart Foundation	3.7	11	We would welcome some clarification regarding the scope of the evidence reviews; did the search strategy focus on secondary health outcomes?	Thank you for your comment. The search strategy was guided by the scope for this guideline which considered secondary health outcomes. In the studies identified there was very little evidence regarding the impact of exercise referral on secondary outcomes. There was also no evidence on other secondary outcomes such as community engagement and social isolation. This has been outlined more clearly in the guideline document
British Heart Foundation	3.8	11	Did any of the studies include any objective measures of physical activity? If so, we would like to ask PHAC to consider including a commentary on the findings of these studies.	Thank you for your comment. The studies identified in the systematic review did not collect any data via objective measures. PHAC noted the issues regarding the data collection via self-report and objective methods. This is

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				outlined in the considerations section.
British Heart Foundation	Economic modelling 3.11	11/12	We wonder whether this point could be moved nearer to recommendation 1 as it justifies the recommendation for minimum data collection.	Thank you for your comment. Reference to the economic modelling now features more prominently in the Introduction and a hyperlink to the considerations has been added.
British Heart Foundation	3.14	12	This is hugely important when considering access to services for those in low socio-economic groups. Especially given the importance of achieving high effectiveness in those schemes that do run. Tailoring to local audiences is vital.	Thank you for your comment.
British Heart Foundation	3.15	12	Greater clarification is sought to whether NICE are measuring in terms of absolute gain or relative gain to participants on exercise referral schemes.	Thank you for your comment. The systematic review considered all outcomes from the identified studies and these included total moderate intensity physical activity from baseline up until last data collection point and achievement of Chief Medical Officers' recommendations.
British Heart Foundation	3.18	13	We think this is a key problem and needs to be considered in further research.	Thank you for your comment.
British Heart Foundation	Scenarios of	13	Given that there is limited evidence on the effectiveness and cost-effectiveness of exercise referral schemes with different facets we wonder whether it would be better to	Thank you for your comment. The research

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	effectiveness		integrate these considerations within the research recommendations section.	recommendations have been changed to reflect the points raised in your comment.
British Heart Foundation	3.19	13	We support the comment that the effectiveness is greater if a high percentage of participants regularly attend the programme. We wonder whether PHAC would be in a position to recommend that commissioners ensure that any future schemes include robust protocols that address drop out and adherence; and ensure data is collected on intervention fidelity as this is not currently part of programme planning, monitoring and evaluation.	Thank you for your comment. The guideline document has been amended based on the findings of the stakeholder consultation and fieldwork findings. The changes reflect some of the points you raise.
British Heart Foundation	3.22	14	We believe it is vital to equip people with the skills that will form a lifelong habit from childhood and throughout their life and for people not to see exercise referral as the only environment in which they can be physically active as this will lead to problems when the programme comes to an end. Is there any scope for PHAC to make reference to the model that is suggested in NICE weight management services, regarding teaming up success stories from the same programme to help sustain levels of activity?	Thank you for your comment. This guideline is based on the best available evidence of effectiveness and cost effectiveness. This guideline is focused on exercise referral schemes (as defined by the scope). The guideline makes reference to related guidelines, which includes NICE public health guideline 53: overweight and obese adults: lifestyle weight management.
British Heart Foundation	3.25	15	Since the publication of both of these documents the training and qualifications framework for those professionals involved in the delivery of exercise referral schemes has changed considerably, we would recommend that PHAC consult with the sector skills council to ensure this section is up to date and relevant.	Thank you for your comment.

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British Heart Foundation	3.26	15	We strongly welcome this statement and think it is crucial that programmes offer a range of affordable and accessible opportunities which meet the needs and preferences of people from different age, socio-economic and ethnic groups.	Thank you for your comment.
British Heart Foundation	Recommendations for research 4.1	16	We would also recommend this considers the cost to the individual.	Thank you for your comment. The guideline has changed and reference is made to the collection of data utilising the essential criteria within Public Health England's standard evaluation framework for physical activity interventions (SEF)'. The SEF outlines the collections of cost to the participant as one of its essential criteria.
British Heart Foundation	4.2	16	About giving skills and confidence to primary care professional to discuss physical activity with their patients.	Thank you for your comment. The final guideline reflects your point regarding training and its potential impact on the effectiveness of exercise referral in the considerations section. The guideline makes reference to public health guidance 44 'physical activity: brief advice for adults in primary care and this includes a specific recommendation

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				regarding the skills and confidence of primary care professionals to discuss physical activity with their patients.
British Medical Association	Recommendation 1	5	It is self evident and supported by good quality evidence that increasing levels of activity in the inactive helps improve health outcomes in a variety of disease areas. There are also demonstrable gains in those with or without current co-morbidities. However, the ways in which activity levels can be improved by healthcare professionals is not always clear cut. The evidence base for the use of exercise referral schemes is poor, and implementation variable. The cost is high and beyond the upper threshold normally applied by NICE and commissioners need to be very aware of this when allocating funds. Brief interventions to increase activity levels by GPs or other members of the primary healthcare team, for unselected patients, is more cost effective. This intervention would require adequate funding to achieve in general practice, and a structured approach which acknowledges the existing pressures on consultations and practices.	Thank you for your comments and we welcome the BMA's contribution. Please note that brief advice on physical activity is covered by other NICE guidance.
British Medical Association	Recommendation 2	6	Referral of specific groups by GPs requires a similar structured approach which acknowledges the existing pressures on consultations and practices. Clear, evidence-based referral criteria applied equitably by practitioners with appropriate training to triage at the consultation in needed. Although this guideline refers to the need for appropriate resource at the GP consultation for case identification, triage and referral, it should apply to staff training.	Thank you for your comment. PHAC considered training specifically. The considerations section makes reference to role of training.
British Medical Association	General		Schemes should be evidence based and cost effective, and apply the same inclusion criteria on entry as at referral. Data collection to improve the evidence base	Thank you for your comment. The final guideline includes a

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			should be routinely collected. Feedback to GPs must be mandatory at initiation and discharge from the service, and in the event of significant events. Outcome data for the individual should be fed back, as well as a clear follow up plan to continue the changes in activity, and thus health benefits. Data should be relevant and appropriate for the patient and primary care, and presented in a suitable way (ideally electronically) for inclusion in the GP record. Commissioners will need to consider and apply these guidelines and the referenced evidence to existing exercise referral schemes, as well as newly commissioned services. Though popular and with ample anecdotal evidence of benefit, other interventions may be more cost effective and with better health outcomes.	recommendation about data collection.
Camden and Islington Public Health		1	EOR schemes in Camden & Islington are available 18+. Any reason why 19 and older?	Thank you for your comment and we welcome Camden and Islington Public Health's response. The age cut of 19 and older was to bring the guideline in line with the current Chief Medical Officers physical activity recommendations for adults (19-64).
Camden and Islington Public Health		2	Agree that EoR should not be solely be about increasing PA levels	Thank you for your comment.

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Camden and Islington Public Health		6	We understand the rationale behind collecting minimum data sets but those data sets have little meaning when used to assess improvements in some conditions. Suggest that, where possible, data requirements are linked to specific conditions.	Thank you for your comment.
Camden and Islington Public Health		13	3.20 Multiple disease risk factors – obesity is mentioned in this section but there is uncertainty around the inclusion of obesity within EOR – as EOR schemes do not tend to offer intervention that is NICE compliant. Suggest that the relationship between EOR and obesity is made clearer within guideline.	Thank you for your comment.
Camden and Islington Public Health		14	3.22. Developing skills – could these be explored further in terms of how this might be best demonstrated/monitored.	Thank you for your comment. The reference to 'developing skills they (participants) need to be physically active on their own' is an example of how to increase adherence throughout the duration of an exercise referral scheme. This was something PHAC considered in the development of this guideline. These do not constitute the

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				recommendations.
Camden and Islington Public Health		15&16	3.23 & 4.2 We suspect that the challenge in making appropriate referrals to 1) wider physical activity initiatives (NICE 44) or 2) into EOR in part comes down to limited capacity and knowledge of wider physical activity 'offer' within primary care. We are currently exploring use of a model where referrals for physical activity would be dealt with through a single point of referral rather than individuals within primary care having to be fully cognisant of the wider physical activity offer to make appropriate referrals. EOR would for a part of this and support in treatment of specific conditions. Also see 4.2	Thank you for your comment and information regarding your ongoing work.
Camden and Islington Public Health		16	In Islington we are commissioning a small insight study (concludes June 14) to further understand the decline in PA levels post 55 by including those aged 40+. Perception among respondents that they are active and do other forms of exercise which aren't captured by assessment tools e.g. cleaning & vacuuming (housework), shopping (walking and carrying) and dancing	Thank you for your comment and information regarding your ongoing work.
Camden and Islington Public Health		GENERAL	General need to change public perception of EoR that is gives free or heavily subsidised access to gym membership. Previous Islington model combined group delivery of community-based activity with gym based and aqua exercise. Proved popular with participants that would be deterred by a solely gym based programme. Social benefits were also reported from this model. Evaluation underway expected October 14	Thank you for your comment and information regarding your ongoing work.
Chartered Society of Physiotherapy	General		The Chartered Society of Physiotherapy welcomes this guideline. We recognise that this is part of an important suite of publications on increasing physical activity in at risk populations	Thank you for your comments and we welcome the Chartered Society of Physiotherapy's contribution.
Chartered Society of Physiotherapy	General		The CSP will support its 52,000 members to implement this and the other NICE physical activity publications	Thank you.

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Chartered Society of Physiotherapy	Introduction	1	The list of indicative NICE recommendations on exercise schemes to support people with specific conditions is curious. We would suggest other NICE publications are more intuitive, e.g. hip fracture, osteoarthritis, stroke rehab, falls.	Thank you for your comment. PHAC have amended this aspect of the guideline based on stakeholder comments and the findings of the fieldwork report.
Chartered Society of Physiotherapy	Recommendation 1	5	We understand the reasons for NICE in making this recommendation. 3rd bullet point: the "do not do" is a very strong point; the subsequent sentence – the "do do" (i.e. commission services that are collecting the minimum data set) is lost here, presented as a second sentence. We suggest it is strengthened by either making it a 4th bullet point or by putting the **Do** into bold.	Thank you for your comment. PHAC have made changes to the structure of the guideline and its recommendations.
Chartered Society of Physiotherapy	Recommendation 1	5	3rd bullet point : would be stronger if the recommendation is that commissioners DO commission exercise referral schemes that collect a minimum data set: this is a more constructive recommendation	Thank you for your comment. The changes to the guideline now reflect the point raised in your comment.
Chartered Society of Physiotherapy	Recommendation 2	6	2nd bullet point: this is inconsistent with bullet point 3 of recommendation 1. If commissioners do commission an exercise referral scheme then presumably we do want primary care providers to refer to them. We suggest this bullet point is rewritten to say that refer people to exercise referral schemes that collect the NICE defined minimum data set. Do not refer to exercise referral schemes that do not. It might be helpful to add in a sentence explaining why this is so (because of lack of information about the detail of the schemes).	Thank you for your comment. The changes to the guideline now reflect the point raised in your comment.
Chartered Society of	General		The presentation and layout of this document is complicated by the constant cross	Thank you for your comment.

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Physiotherapy			referencing to other NICE publications. It may now be more helpful for users to implement the physical activity recommendations if NICE constructs a new document with all its recommendations in one place, laid out in a more user-friendly fashion. This confusion is liable to lead to poor implementation. For example, 1. PH2 Four commonly used methods to increase physical activity (PH2) (partially updated by PH41 and PH44); 2. PH6 Behaviour change: the principles for effective interventions (PH6); 3. PH8 Physical activity and the environment (PH8); 4. PH41 Walking and cycling (PH41); 5. PH44 Physical activity: brief advice for adults in primary care (PH44); 6. PH49 Behaviour change: individual approaches (PH49)	The changes to the guideline now reflect the points raised in your comment.
Chartered Society of Physiotherapy	General		Equality issues We are concerned that people with long term conditions who are or could have been referred to an exercise referral scheme as an ongoing part of their rehabilitation will lose out on valuable exercise provision.	Thank you for your comment. Changes to the guideline have been made that clarify specifically what is included and what is excluded in this guideline. It has been made clear that structured exercise programmes for rehabilitation are not covered by this guideline.
Chartered Society of Physiotherapy	General		The scope identified a question that the guideline would address the barriers to exercise referral schemes. It is unfortunate if there is insufficient evidence to inform a recommendation. We hope NICE strategy will support a greater evidenced understanding of such barriers so that potential beneficiaries of exercise do not miss out because of the “do not commission” recommendation. A lack of evidence is not evidence of ineffectiveness.	Thank you for your comment. Changes have been made to clarify the recommendations made. The considerations sections highlight aspects related to ‘what factors’ would

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				increase effectiveness and cost effectiveness of exercise referral schemes, which include reference to barriers and facilitators to exercise referral schemes. Research recommendations have also been refined and capture the points you raise. The gaps in the evidence section also specifically highlight the issues regarding the evidence base.
DECIPHer	'What is this guideline about?'	1	Guideline is stated as for people aged 19 or over, why not 18? Selection criteria for studies in the review included adults aged 18 or over (pg22), although selection criteria on pg 24 says 19 or over again.	Thank you for your comment. The guideline is aimed at adults aged 19 or older to bring it in line with the current chief medical officers' physical activity recommendations for adults (19-64). There is also existing NICE guideline on the promotion of physical activity in children and young people (up to the 18 year of age). The inclusion criteria for the effectiveness review was set at 18 year and older as the systematic review

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				commissioned for this piece of guideline was an update of National Institute for Health Research Health Technology Appraisal on exercise referral (Pavey et al 2009) which has stated cut off points at 18 years and over.
DECIPHer		1	Including 'an assessment involving a physical activity specialist or service to determine what programme of physical activity to recommend' as a key feature of an ERS appears to reflect an understanding of ERS with practitioner as expert and patient as passive recipient. There have been (not always wholly successful) attempts to move away from this toward a more patient-centred model.	Thank you for your comment. The definition was established as part of the scope.
DECIPHer		2	'Therefore, NICE does not recommend exercise referral schemes for the sole purpose of increasing people's physical activity'. Although this seems to be quite a central statement, it is very unclear what this actually means, and it appears to critique a model of ERS which doesn't really exist. If referring professionals referred all inactive patients as a means of improving population activity levels, the schemes would struggle to cope with the volume of referrals. Hence, referring professionals offer access to ERS on the basis of perceived benefits to the patient, likely linked to the management or prevention of specific conditions.	Thank you for your comment. PHAC have considered stakeholder comments and the findings of the fieldwork report and made changes to the guideline.
DECIPHer	General	n/a	Overemphasis on economic model? Especially bearing in mind the 'considerable uncertainties about the correct parameters to use' (pg3 & 11).	Thank you for your comment.
DECIPHer	3.3	10	Evidence on factors that influence effectiveness was very limited – this should therefore be addressed in recommendations for research.	Thank you for your comment. The final guideline includes a number of research

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				recommendations to address these issues.
DECIPHer	General	n/a	Disconnect between recognition that overall aim of ERS is to improve health and that increase in PA is not always primary outcome (pg10) and recommendation that they are not commissioned solely for purpose of getting people to be more active (pg5).	Thank you for your comment. Changes have been made to the guideline. The PHAC considered that the primary aim of ERS is to increase physical activity, on the basis that physical activity has a range of positive health benefits. Exercise referral schemes may offer other benefits, such as helping people to socialise. However, no evidence was identified in the reviews.
DECIPHer		10	'The PHAC noted that , compared with brief advice, the 'relative risk' of exercise referral schemes is 1.08.' As the guideline acknowledges, the variability in types of ERS, and likely variability in their effectiveness, means that a crude estimate of overall effectiveness such as this one is not particularly illustrative. Would it be useful to give an indication of the extent of variability in effects between studies?	Thank you for your comment.
DECIPHer	3.6 and 3.15	10-11 and 12	Meeting 'recommended level of activity' should not be the only measure of evidence of effectiveness. Schemes may increase physical activity from a very low starting point to just below the threshold of recommendations, and as such appear to have failed to achieve any change at all where assessed in terms of proportion meeting public health recommendations. Movement from doing nothing to doing a little brings the greatest health gain.	Thank you for your comment. The effectiveness evidence identified through the systematic review process did not provide evidence that allowed the impact of exercise

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				referral schemes on below recommend level physical activity, and its subsequent impact on health to be elucidated. Subsequent attempts were made in the economic modelling exercise to clarify the impact of the achievement of sub CMO level physical activity on health conditions. There was no evidence found that allowed this scenario to be modelled individually or across other disease conditions.
DECIPHer		13	'Effectiveness is greater if … participants continue to be physically active afterwards' seems a bit tautological?	Thank you for your comment. This has now been changed.
DECIPHer		14	'There was a feeling that more 'simplistic' models could be effective and more cost effective for certain subgroups. Such models consist of more self-directed and less resource - intensive activities (such as walking and cycling), rather than gym-based activities.' Do feelings and conjecture about what may or may not work belong in NICE guideline in the absence of evidence to support it?	Thank you for your comment. The section to which you refer is the considerations section. This section outlines the key issues that the Public Health Advisory Committee discussed in the development of this guideline. They do not constitute recommendations.
DECIPHer	4	16	There seem to be some disjunctures between the evidence gaps and the	Thank you for your comment.

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			recommendations for research. For example, the first evidence gap is a shortage of good quality. But filling this gap is not identified as a priority for research.	The research recommendations are written to be discrete research questions that were identified as key research areas by the PHAC. The identified gaps are broader areas identified as lacking in evidence. The two items are not mutually exclusive and are seen to be complimentary.
DECIPHer	4.1	16	Should 'reason for referral' be included as a 'factor to consider'?	Thank you for your comment. Changes to the guideline have been made to reflect your comment.
DECIPHer	4.1	16	Does the delivery and effectiveness of evidence informed motivational communication strategies also belong here?	Thank your for your comment. The list provided in research recommendation 4.1 (now research recommendation 5.1) was not intended to be exhaustive. If the delivery and effectiveness of evidence informed motivational communication strategies is something that is a model or a specific component within a model of exercise referral that

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				may influence its effectiveness and cost effectiveness then it could be consider within this research recommendation.
DECIPHer	4.2	16	Missing from this recommendation is a consideration of how primary care professionals make referral decisions (see 'Gap in the evidence' number 6 on page 30), and the issue of self-referral by patients. It also assumes a practitioner as expert, patient as passive recipient model as discussed earlier. To what extent do patients actively seek referral to ERS?	Thank you for your comment. The guideline only considered exercise referral schemes that include a referral from primary care.
DECIPHer	4.4	16	As well as a focus on factors that encourage under-represented groups to take part in exercise referral schemes, a consideration of how participation by these groups may impact on health inequalities would be welcome/useful.	Thank you for your comment
DECIPHer	10	29	Number 2 (effect for people with multiple health conditions) appears to have been neglected in the research recommendations section.	Thank you for your comment. The research recommendations are written to be discrete research questions that were identified as key research areas by the PHAC. The identified gaps are broader areas identified as lacking in evidence. The two items are not mutually exclusive and are seen to be complimentary.
Department of Health	General		**I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you and we welcome the Department of Health's

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				contribution.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	General		We welcome this important and timely update.	Thank you and we welcome domUK's contribution.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	What is this guideline about?	2	Although it appears counterintuitive not to recommend exercise referral schemes solely to increase physical activity levels we accept that renewed evaluation of the available evidence suggests this. However we agree with the Committee's observation that existing models do not necessarily capture all of the potential benefits of increased activity. As part of a holistic approach to health which includes mental and physical wellbeing, we agree that further research is needed and that current evidence may underestimate the benefits of these schemes to individuals.	Thank you for your comments.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Recommendation 1 Commissioning interventions to increase physical activity	5	We agree that a minimum data set should be collected by service providers to allow further evaluation in the future. In addition to the parameters suggested we would like to see 'signposting to additional suitable local activity opportunities' or similar added, in order to encourage providers to build long term support into their schemes.	Thank you for your comments.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Context: introduction	7	We are pleased that sedentary behaviour as an independent risk factor is highlighted and would like this fact emphasised in any brief interventions given to patients, since even if they do not increase their activity levels or take part in exercise referral schemes they may still reduce their sedentary behaviours. We would like this to be included as a	Thank you for your comment. This guideline and thus this stakeholder consultation is focused on exercise referral.

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			recommendation.	NICE has published a guideline on Brief physical activity advice in primary care (PH44) and make reference to this in this guideline. NICE has considered the development of a guideline on sedentary behaviours. Please see the NICE website (www.nice.org.uk) for further information regarding this
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Considerations: background. Section 3.2	10	Although we accept that there is currently insufficient evidence to assess relative effectiveness of different schemes, we would note that this is not the same as evidence of no effect.	Thank you for your comment. NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. The research recommendations and gaps section further highlight the need for evidence in this area. The considerations section further highlights some of the issues regarding the evidence base in this area and the point you raise.
Dietitians in Obesity Management UK (domUK), a specialist group of the British	Considerations: backgroun	10	As becoming more active is a change to behaviour, we would like the communication skills of providers added to factors that influence effectiveness.	Thank you for your comment. The considerations section highlights the comment you

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Dietetic Association	d. Section 3.3			raise.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Evidence of effectiveness. Section 3.7	11	With regard to the limited evidence on medium and long term health benefits of these schemes, we note from 3.5 that very few studies were identified for this update.	Thank you for your comment. NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. The lack of evidence was discussed by PHAC at length and is outlined in the considerations section. . The research recommendations and gaps sections both emphasis the need for research on the effectiveness of exercise referral schemes to be increased.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Economic modelling. Section 3.9	11	We agree with the important point raised by the PHAC that not all potential benefits are captured by the model, particularly in relation to 3.4 (primary outcome of many exercise referral schemes being an improvement to health rather than necessarily an increase in physical activity).	Thank you for your comment.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Economic modelling. Section 3.11	11	We agree that more detailed data needs to be collected by providers in order to allow commissioners to make informed decisions.	Thank you for your comment.

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Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Economic modelling. Section 3.15	12	We agree that the true gains of exercise referral schemes are likely to be underestimated by the model, both with relation to numbers achieving the CMO recommendations on physical activity and in relation to point 3.16, and the difficulties in assessing magnitude of the 'feel good factor'.	Thank you for your comment.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Economic modelling. Section 3.18	13	We feel this is a crucially important point. It is not unusual to have several conditions and co-morbidities co-existing, and increasing activity is likely to benefit all of those. This multiple effect is not captured by the model.	Thank you for your comment.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Economic modelling. Section 3.20	13	We agree that being active is likely to be cost effective for some groups such as those with multiple co-morbidities (see point above).	Thank you for your comment.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Economic modelling. Section 3.24	15	We agree that sustainability is critical both in terms of physical health but also on the mental health benefits of adopting a new and positive health behaviour and keeping it up. We wonder if those who complete an exercise referral scheme but do not sustain their activity may have feelings of failure, which potentially impact negatively on their willingness to engage with other behaviour changes. We would like signposting to local activity support groups and opportunities to be included as part of exercise referral schemes.	Thank you for your comment. PHAC considered the point you raised regarding impacts of not sustaining a referral but no information regarding this was identified in the evidence reviewed.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	Recommendations for research.	16	Since there is a dearth of evidence on medium and long term benefits, we would like to see this added here, so that the outcome measures required to assess effectiveness of exercise referral schemes in the short, medium and long term are considered.	Thank you for your comment. The research recommendations section has changed in line with your

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	Section 4.5.			comments.
Fitness 4 health working under contract to South Cambridgeshire District Council	General		In South Cambridgeshire we have run an Exercise Referral Scheme for over 15 years . Our Experience supports the guidelines finding that Exercise Referral should not have the sole aim of increasing Physical Activity. Clients are accepted onto the scheme only if they have a specified medical condition including CHD risk, Diabetes, Musculoskeletal Conditions and Mental Health problems. Baseline data collected includes data relevant to the referred condition and changes in these should be used as a measure of effectiveness in addition to monitoring increased physical activity .These changes eg Blood Pressure BMI or improved strength or mobility are motivational to the client and encourage continued activity.	Thank you for your comments and we welcome Fitness 4 health's contribution.
Fitness 4 health working under contract to South Cambridgeshire District Council	General		FUNDING Many schemes are jointly funded by former PCTs –now Public Health within County Councils and District Councils. Recently Cambs County Council has taken a view that Exercise referral Schemes should be ' Free at the pont of delivery' This will make schemes difficult to fund and our experience is that clients are prepared to pay a subsidised rate and this can also prepare them to plan to continue with activities within the local community.	Thank you for your comment and additional information.
Fitness 4 health working under contract to South	General		DATA COLLECTION AND ANALYSIS Exercise referral schemes collect demographic and reason for referral data in addition to	Thank you for your comment.

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Cambridgeshire District Council			changes in fitness and health parameters and adherence. Funding will need to be made available for collation and interpretation of these. Motivational interviewing and an Exit plan are essential.	
Greenwich Leisure Limited	General	1	Exercise referral typically see's those that have long term conditions, this document doesn't cover programmes for those with long term conditions. Therefore the title and reference to exercise referral is misleading and should be changed to a more general reference to general population physical activity opportunities. If this is not the case then it needs to be clearer on what they define as specific diseases and what long term conditions have been considered.	Thank you for your comments and we welcome Greenwich Leisure Limited contribution. PHAC have considered the findings of the stakeholder comments and fieldwork report and have made changes to the guideline to aid clarity.
Greenwich Leisure Limited	Section 2 - National guidelines, resources and indicators. (Paragraphs 1 & 2)	8	References here are to NQAF and BHFNC Exercise Referral Tool Kit. These are for exercise referral schemes for those living with specific diseases (LTC'c) so therefore add to the confusion of what this document is guiding on. Why include this if the guideline isn't for those with specific diseases.	Thank you for your comment.
Greenwich Leisure Limited	Section 3 – Economic modelling 3.9	11	Can recommendations be asserted either way if "there were considerable uncertainties about the correct parameters to use for the economic modelling" and that the model "does not capture all potential benefits". What are the potential benefits?	Thank you for your comments. NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. The considerations section outlines key points discussed by PHAC

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				in the development of the guideline. The point regarding uncertainties reflects the lack of evidence identified in the area. However, even in the best case scenario, the estimated incremental cost effectiveness ratio was £31,009 per QALY gained. NICE normally considers that any interventions over a threshold of £20,000–£30,000 per QALY are not cost effective.
Greenwich Leisure Limited	3.17	13	The start of the guideline states that "This guideline does not consider exercise referral schemes designed for, or that include, management of, or rehabilitation for, specific diseases. This includes cardiac or pulmonary rehabilitation programmes." yet this sections states "The PHAC was aware that the economic modelling to determine the long-term health benefits of exercise referral schemes was based on cohort studies limited to coronary heart disease, stroke and type 2 diabetes." These individual exercise referral programmes are significantly more expensive than general exercise referral programmes by a significant amount.	Thank you for your comment. The economic modelling seeks to understand the impact of increases in physical activity from exercise referral on various outcomes including disease conditions. The cohort studies referred to look at the impact of physical activity on disease conditions, not the impact of exercise referral schemes on the management of disease conditions.

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Greenwich Leisure Limited	General		If there were economic modelling uncertainties how can one form of intervention be favoured over another just because it's cheaper and not necessarily better value for money. There is confusion over what exercise referral is and the types of people who access them. Also how can guideline on general exercise referral be made on a more expensive specific disease related provisions that are more expensive. It needs to be clear what the guideline is referring to i.e. is it a group based specialist programme (Cardiac Rehab etc) or general exercise referral.	Thank you for your comment. NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. This guideline excludes structured exercise programmes set up for the management and/or rehabilitation from specific diseases. The estimated cost of exercise referral schemes was taken from the identified evidence. The economic modelling did run sensitivity analysis that sought to assess the impact on cost effectiveness of changing inputs such as cost of scheme.
Liverpool John Moores University	Recommendations 1 & 2	5&6	We are concerned the recommendations for commissioners *not to commission exercise referral schemes*, and primary care practitioners *not to refer people to exercise referral schemes* are too strongly worded, and **could have a detrimental effect on national attempts to promote PA to those who are most at risk.** There is insufficient evidence to draw conclusions of this strength. The real issue is the	Thank you for your comments and we welcome Liverpool John Moores contribution. NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. PHAC have

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			poor quality of evidence that is available and the varied consideration that goes into supporting long-term behaviour change through the schemes. Little, if any, research has measured changes in physical activity using objective measures (such as accelerometry or direct observation) and few schemes are underpinned by behaviour change theory. Rather than de-commissioning schemes that it has taken years and cost millions to implement (many of which are providing a vast array of benefits to individuals), the emphasis needs to be on **learning how we can adapt the existing schemes to make them more effective.** This may for example entail a move away from the standard "12-week gym programme" and focus more on integrating PA into daily lives, or allow a combination of leisure centre and other activities with a more flexible programme that spreads the support over a longer timescale. We are currently undertaking some mixed-method research evaluating a local exercise referral scheme. This will add to our understanding of the draft recommendations for research 4.1,, 4.3 and 4.5 (a protocol of this research is available on request from p.m.watson@ljmu.ac.uk). Unfortunately NIHR public health research programmes will not fund intervention costs, therefore the only way we can undertake such research is **if the services continue to be commissioned.** Essentially, our plea is that **we do not throw away a good thing before we have really tried to make it work, and until we have something better to replace it.** What needs to happen instead: a) Invest some money and time into building the evidence base b) Encourage commissioners to draw on this evidence base as it builds, which will allow them to consider alternative models of delivery to enhance the effectiveness of their local scheme c) Review the guideline in 5 or 10 years, once we have a stronger evidence base from which to form recommendations	considered stakeholder comments and the findings of the fieldwork report and have made changes to the guideline document that addresses the points you and others have raised.

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London Borough of Barking and Dagenham	**General**	1	The definition of Exercise on Referral in this document is inaccurate • Barking and Dagenham does not accept individuals that are just 'inactive' on to the programme. • Barking and Dagenham's Exercise on Referral programme is designed to specifically improve participants long term health conditions. Therefore this document does not relate or have any bearing on our programme.	Thank you for your comment and we welcome the London Borough of Barking and Dagenham's contribution. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline to clarify what's covered.
London Borough of Barking and Dagenham	**Recommendation**	5 Point 3	The language used in this document could be damaging and misleading for Exercise on Referral programmes. This section should be re worded to explain that Exercise on Referral programmes should only be commissioned if they focus on specific medical conditions and collect the relevant data.	Thank you for your comment. Please see our response above.
London Borough of Barking and Dagenham	**General**		The title of this document should focus on physical activity interventions for inactive adults rather than exercise referral.	Thank you for your comment.
London Borough of Barking and Dagenham	**Scenarios of Effectiveness**	13 3.20	Agree with this statement that Exercise on Referral programmes need to focus on specific groups and conditions.	Thank you for your comment.
London Borough of Barking and Dagenham	**Barriers to Success**	14 3.32	Barking and Dagenham would like to introduce a triage approach where Exercise on Referral will feature.	Thank you for your comment. No evidence was identified regarding a triage approach

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				and exercise referral or its impact on the effectiveness of exercise referral schemes. PHAC did consider 'poor referral practice' as a barrier to success. PHAC discussed the use of triage or a 'stepped' approach as a possible way of overcoming this issue. This is outlined in the considerations section. It should be noted that considerations are not recommendations and outline some of the key discussions point in the development of the guideline.
London Borough of Barking and Dagenham	**Reviewing Evidence Selection Criteria**	22	Concerns were raised about where the evidence from this research has come from. Research only included adults without a medical diagnosis, therefore effectiveness of Exercise on Referral cannot be measured.	Thank you for your comment. The studies identified as part of the evidence review process that underpins this guideline included people who are sedentary or inactive; who have an existing health condition (for example coronary heart disease); who have other risk factors for disease (for example being

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				overweight). This is all made clearer in the introductory sections of the final guideline.
Macmillan Cancer Support	Recommendation 1	6	We support the recommendation to use the EQ-5Dquestionnaire to measure health-related quality of life changes. At Macmillan Cancer Support we have developed the Cancer and Physical Activity Standard Evaluation Framework and all projects use the framework to evaluate their outcomes (the framework utilises the EQ-5D). It essential for all physical activity interventions to be properly evaluated to understand their effectiveness and improve outcomes in the future.	Thank you for your comment and we welcome Macmillan Cancer Support's contributions.
Macmillan Cancer Support	2	7	Being inactive is also an independent risk factor for some types of cancer	Thank you for your comment.
Macmillan Cancer Support	2	9	The Let's Get Moving physical activity care pathway ensures individuals receive initial and ongoing support to become and stay active. Exercise on referral may be one of the activity options available but should be embedded within a wider framework. Macmillan Cancer Support suggests this point should be made more explicitly.	Thank you for your comment.
NHS England	General		I wish to confirm that NHS England has no substantive comments to make regarding this consultation	Thank you and we welcome NHS England's contribution.
Nottinghamshire Healthcare NHS Trust	4 (4.3)	16	Supporting the recommendation of factors effecting uptake and adherence to exercise referral schemes, in our experience working with a dedicated consistent team of highly trained staff that aim to create a safe and controlled environment promotes self empowerment for patients to feel safe and confident to engage in exercise, this supports their integration into mainstream activity and ongoing recovery.	Thank you for your comment and we welcome Nottinghamshire Healthcare NHS Trust's contribution.
Nottinghamshire Healthcare NHS Trust	4. (4.4)	16	We provide exercise observer training for nursing staff from the patients own ward environment to help break down existing barriers and create new opportunities for engagement in an environment that the patients feel safe in.	Thank you for your comment.

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Nottinghamshire Healthcare NHS Trust	4.2	16	We recognise the importance of MDT working and links to identify patients that need the interventions, we have defined patient pathways and a clear referral process.	Thank you for your comment.
Nottinghamshire Healthcare NHS Trust	4.1	16	Our model of exercise referral currently consists of 2 consecutive 16 week programs, that offers structured physical intervention in the following activities per week: 1 x 45 minute swim session 1x45 minute personal training plan in the gym/sports hall 1x walking program this is incorporated with a weekly 60 minute weight management education session including cooking lessons. This model is further supported by the nursing staff through accessing the exercise observer course. Patients are continually assessed with exercise and nutrition care plans amended accordingly.	Thank you for the information on your schemes content.
Nottinghamshire Healthcare NHS Trust	4.5	16	We measure the following outcomes, BMI , body fat percentage, lung capacity, aerobic capacity, resting heart rate and blood pressure, O2 sats, and waist and weight measurements. In addition we also measure behaviour change in relation to diet, self esteem, motivation and general engagement in physical activity. This data is captured in an end evaluation report and feeds back into program reviews.	Thank you for your comment.
Nottinghamshire Healthcare NHS Trust	General		The programme we offer follows a patient care pathway that includes all patients who are assessed in regards to their Health and Fitness status and level of engagement in exercise. Patients are then signposted into different interventions according to their individual need.	Thank you for your comment
Nottinghamshire Healthcare NHS Trust	General		One of the interventions offered is the Healthy Lifestyle programme and referral criteria includes BMI status, whether the patient has co morbidities, and motivation to engage. A minimum data set is completed which includes information regarding the patients current lifestyle habits and identifies any barriers to change and what the patients interests are. The programme is then delivered according to this individual patient need but does include group work to promote the social benefit of participating in such programmes to help improve mental wellbeing.	Thank you for your comment.

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Nottinghamshire Healthcare NHS Trust	General		Exit plans – patients are offered an initial intensive programme followed by continuum where they are still supported but more emphasis is placed on the patient to take responsibility for adopting their own healthy lifestyle behaviours. Patients can access the continuum programme as long as they need to, but are signposted to other exercise opportunities such as room based exercise, exercise on ward gym equipment, walking during fresh air opportunities and hospital general fitness sessions.	Thank you for your comment.
Nottinghamshire Healthcare NHS Trust	3.17	Page 13	Need to take into consideration research into the effects of exercise on mental health symptoms such as depression and anxiety.	Thank you for your comment. Outcomes such as anxiety and depression were not excluded from the systematic review that underpins this guideline.
Nottinghamshire Healthcare NHS Trust	3.20	Page 13/14	Need to look at the evidence for exercise on alleviation of poor mental health conditions. In terms of the cost-effectiveness of exercise referral schemes, patients suffering from depression symptoms may not benefit from advice only due to motivation issues to take part in scheme.	Thank you for your comment. Outcomes such as anxiety and depression were not excluded from the systematic review that underpins this guideline.
Nottinghamshire Healthcare NHS Trust	3.26	Page 15	General note on the availability and range of physical activities in the community which are appropriate for patients with Mental Health issues and general exercise classes are often inappropriate for these patients. It is also important that patients can 'Pay as they go' for these schemes if a cost is involved rather than paying for a block of sessions (as they have to for many privately run classes).	Thank you for your comment.
Nottinghamshire Healthcare NHS Trust	Continued 3.26	Page 15	Also for the people we see transport is an important factor. Many of them cannot use public transport alone even if it is available for reasons of confidence, cognitive ability and also physical ability.	Thank you for your comment.
Public Health England	General		PHE supports this guideline. In particular the decisive, evidence-based rationale for disinvesting from exercise referral schemes for the sole purpose of getting people more	Thank you for your comment and we welcome Public Health

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			active and the use of cost effective structured brief interventions.	England's contribution. PHAC have considered stakeholder comments and the findings of the fieldwork report and have made changes to guideline. The considerations section specifically outlines that the PHAC did not feel they had enough evidence to recommend disinvestment in exercise referral schemes. However, they do recommend exercise referral should not be commissioned for those identified as sedentary or inactive but who are otherwise apparently healthy. For those with an existing condition or risk factor, they recommend exercise referral should only be commissioned if based on core behaviour change principles, and if they collect data in line with the 'Standard evaluation framework for physical activity'.
Public Health England	1, *Draft recommen*	6	Recommendation 2 should state *"Encourage adults to do enough physical activity for good health."*	Thank you for your comment. PHAC agrees that any

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	dations		'Inactivity' is defined as doing less than 30 minutes of physical activity per week, which equates to 27% of the population. However there is a significant group of the population who are not inactive by this definition, but are not active at health-enhancing levels (i.e. levels outlined in the National Guideline) and so need to be encouraged to be more physically active.	increase in physical activity is associated with positive health benefit (See considerations). However, due to a lack of data associating the health benefits gained from the achievement of sub CMO physical activity levels this relationship could not be considered in the economic modelling.
Public Health England	3, *Scenarios of effectiveness*	13, 14	This section should recognise the greater potential benefit in targeting those who are significantly inactive (i.e. engaging in less than 30 minutes of activity per week). This was explicated recommended in the UK CMOs' guidelines: *"..targeting those adults who are significantly inactive (i.e. engaging in less than 30 minutes of activity per week) will produce the greatest reduction in chronic disease."* [Ref: DH (2011) *Start Active, Stay Active: A report on physical activity from the four home countries' Chief Medical Officers*.]	Thank you for your comment. Please see our response above.
Public Health Wales NHS Trust	General; and *What this guideline is about*; and 3.4		**This draft guideline specifically refers to 'generic' exercise on referral (ER) targeting 'inactive' population groups, not meeting the current UK guidelines and, for the sole purpose of increasing physical activity.** The guideline *is* explicit that it *does not* include the more 'specialist' level 4 type interventions for management and rehabilitation of long term conditions, such as those in Wales for example. The guideline should be more explicit that it is <u>not</u> saying that all designs of ER aimed at people	Thank you for your comment and we welcome Public Health Wales NHS trust's contributions. PHAC have considered the stakeholder comments and the findings of

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			with different degrees of inactivity or with other specific characteristics such as identified health conditions to improve their PA are ineffective or cannot prove their effectiveness.	the fieldwork report and have made changes to the guideline that considers the point you raise.
Public Health Wales NHS Trust	General, and *What this guideline is about* and 3.3, 3.13, 3.15, 3.24 3.25 and 3.26		**The guideline states that the additional benefits of ER were only small compared with giving people brief advice about physical activity.** The size of the difference in effectiveness between BI and ER is important and is provided as a large part of the rationale for the recommendations. However, the effect size of ER will depend on the outcome(s) under study, whether we are considering population measures, which population (how inactive they are, physical limitations to exercise and readiness to change) and the intervention protocol (clinical heterogeneity under review). As such a large group of our population do not meet the recommendations for exercise for health (even more if we consider the additional strengthening activities), many of them will be 'active', and benefitting from that, just not optimally active. As a whole, people referred to ER will be more likely to be different to those receiving BI/A – e.g. those more active (in the inactive category) will be likely to be more compliant but have less health gain from reaching 150 mins – making comparison difficult. The fact that populations, intervention protocols and settings for ER are heterogeneous and given the suggested components of effectiveness, is it right to combine them giving a summary of their effectiveness? Especially when comparing effectiveness and cost effectiveness against another, very different, intervention. BI/A and ER shouldn't be *either or* but rather considered as valid parts of a physical activity pathway as described in "Lets Get Moving". In that scenario the population referred to ER would be those who did not benefit from BI/A – different from the whole 'inactive' population.	Thank you for your comment. NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. PHAC considered the stakeholder comments and the findings of the fieldwork and have made changes to clarify what is covered. Structured exercise programmes designed to manage or rehabilitate people with specific conditions are excluded. The final guideline acknowledges that physical activity programmes offered as part of an exercise referral scheme – and the reasons why people are referred to them – vary considerably. NICE is unable to differentiate between the effectiveness or cost effectiveness of different types

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				of scheme because there is little evidence of effectiveness for specific schemes or subgroups.
Public Health Wales NHS Trust	General; and *What this guideline is about;* and 3.1, 3.9, 3.10 and 3.19 and 3.20 and 3.21, 3.22,		**The guideline states that exercise referral schemes are relatively expensive compared with other primary care interventions aimed at encouraging physical activity and considerably higher cost than other physical activity (PA) interventions which increase PA.** The guideline should provide the list of interventions that ER is relatively or considerably more expensive than. The guideline acknowledges significant limitations in considering the diversity of important outcomes and importantly multiple-morbidity to inform the economic evaluations, resulting in the guideline NOT recommending disinvestment. Yet, this analysis seems to form the main part of the recommendations which endorse an 'alternative'. In addition to the limited outcomes in the economic analysis, considering the other issues of heterogeneity within ER and likely differences in the population between ER and BI/A this comparison of cost effectiveness and resulting conclusion might not be entirely valid.	Thank you for your comment. Due to a lack of evidence PHAC could not recommend disinvestment. It acknowledges that some schemes may be cost effective, or may only be cost effective for some subgroups. The identified study comparators were mostly brief advice. The guideline now makes reference to the other guidelines that seek to promote physical activity and where 'referral to structured exercise programmes tailored to individual need' for the management of, and rehabilitation from health conditions are outlined.
Public Health Wales NHS Trust	General; and *what this*		**ER, when done well, can be effective**; by facilitating access to a range of support, from motivational interviewing and coaching, through to mentoring and ongoing support to participate in a variety of activity in a range of settings. Working as the 'central hub' of an	Thanks for your comment. Please see our response above.

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	guideline is about; and 3.3 and 3.13, 3.23, 3.24 3.25 and 3.26		integrated pathway with different entry and exit routes to promote sustainability they can be very effective indeed. The guideline recognises that participants and people connected with the delivery of ER feel that it is effective. Combining the available studies in ER for a summary conclusion might not be appropriate as discussed. There is also the problem of the paucity of research considered, which the guideline acknowledges. With over 600 exercise referral projects and programmes in operation, the evidence on which to base real world recommendations must take more account of the grey literature. We recommend there needs to be a more thorough review of before this guideline is published. This again suggests that there may actually be a place for ER in increasing physical activity, in a pathway, for the right group (those who cannot benefit from BI/A) and with an effective protocol. The recommendations should reflect that.	
Public Health Wales NHS Trust	Recommendations 1	5	It is welcome that the guideline is clear about which interventions to increase physical activity amongst the wider population not meeting the UK recommendations for exercise for health should be prioritised by policy makers and commissioners. It is positive that this guideline focus on the environment, walking and cycling, and, BI/A. Notwithstanding the lack of evidence considered for ER, the variability of population, setting and protocol within ER and the differences in comparison with BI/A. ER *is* in practice often tailored to address specific health needs amongst a defined group of sedentary patients through physical activity interventions, particularly in Wales, whereas brief	Thank you for your comments. Please see our previous response.

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			interventions are designed to initiate (in this context) increases in physical activity behaviour usually requiring additional follow-up and other support to maintain the change which may well be ER. It is difficult to see the relevance of this guideline in that context. Whilst ER may be a useful adjunct to brief interventions it is not designed to be a replacement for them, nor vice versa. Based on the comments above, this recommendation could just as easily include that ER with the right protocol, for the right patients, as part of a pathway to improve physical activity, should be considered for commissioning and policy. E.g. *Lets Get Moving.* Whilst this guideline acknowledges that there is insufficient evidence for this the lack of evidence also applies to the proposed recommendation not to.	
Public Health Wales NHS Trust	Recommendation 1	5 and 6	Evaluation is important to add to the evidence-base so we broadly agree with that aspect of recommendation 1. However guideline may be required for the support enabling schemes to comply with rigorous evaluation as proscribed; there are cost implications (health related QoD, eg.) and the perception that a big evaluation protocol adversely affects recruitment and retention. Recommendations could include a governance and reporting structure with targets against this suite of evaluation measures. This recommendation could incorporate Recommendations for Research because of the paucity of research on this topic and provide guideline for researchers and funders of research.	Thank you for your comments. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline.

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Public Health Wales NHS Trust	Recommendation 2	6	As with recommendation one there are specific recommendations needed around delivery and follow up which could be from policy to practice. It is understood that the evidence is not sufficient to recommend referring to certain exercise referral schemes, for certain populations as part of a pathway. However, given the limitations of this guideline this could just as easily be valid.	Thank you for your comments. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline.
Public Health Wales NHS Trust	General		This guideline seems to be saying don't commission or refer a person to ER for the sole purpose of increasing their physical activity, because there's not much evidence to support that; start with the environment, develop walking and cycling and consider using brief intervention or brief advice (BI/A) 'instead' as it is more cost effective. However, as discussed, considering acknowledgement of: • Paucity of evidence considered despite the number of ER schemes • Heterogeneity of intervention protocol and setting of ER • Likely differences in the populations of BI/A compared to ER • Limitations of economic analyses in considering all outcomes and only considering • Ability of certain schemes, their components or specific populations to benefit It seems that the guideline could just as easily be saying that ER, which must contain: certain known components, with specific populations, following BI/A, addressing known barriers and with rigorous and relevant evaluation in partnership with academia could be a useful part of a physical activity pathway EVEN IF it is just for the sole purpose of becoming more physically active. The most relevant recommendation are 4 Recommendations for Research which should be strengthened and promoted.	Thank you for your comments. Exercise referral interventions were identified as being marginally effective over brief advice at greater cost. The review considered a range of types of exercise referral with participant samples covering a range of risk factors and disease conditions. Brief advice was in most case the comparator intervention in the identified studies. The consideration section outlines all the points you raised and the discussion had by PHAC.

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Public Health Wales NHS Trust	4 and 3.11		Agree with recommendations for research with the addition that researchers should work with existing schemes improving rigour of evaluation towards publishable research quality to contribute to the evidence-base. These should be strengthened and promoted to the Recommendations. The partnership with academia should also be linked in to recommendation one on evaluation and there should be an additional recommendation for research funding streams to prioritise this community/service-based research of effectiveness.	Thank you for your comments.
Royal College of General Practitioners	General		Whilst obviously physical exercise extremely important for maintaining physical and psychological health, personally I think this is one area where the boundary between personal responsibility for maintaining health and medicalisation of an individual can be blurred. It cannot be right for someone to say that they cannot get fit because they have not been referred for an exercise programme. In the end it is our own personal responsibility, although I agree some people who have certain medical problems would definitely benefit from a structured exercise programme	Thank you for your comments and we welcome the Royal College of General Practitioners contributions.
Royal College of General Practitioners			Physical exercise is one area where people are able to freely participate: a brisk walk in the park, simple keep fit exercises, swimming etc and I personally thing these simple activities are preferable to needing a “referral for exercise”	Thank you for your comment.
Royal College of General Practitioners			There also needs to be care in individuals doing too much vigorous exercise – there is a vogue for doing short bursts of vigorous exercise for 15 – 20 minutes. I believe this can be harmful, especially for those that have a poor pre-existing level of fitness.	Thank you for your comment.
Royal College of General Practitioners			There is no mention in the document of dancing as enjoyment and exercise. Women, in particular, will dance much more readily than they will play games. In the 1950’s-70’s “going to a dance” was an important way to socialise, to meet a partner and meant a good deal of pleasant exercise. It may be useful to teach dancing in school and encourage dancing to music in clubs,	Thank you for your comment. This guideline is about exercise referral schemes. The evidence identified provided some detail regarding the

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			pubs and even in the street!	specific of the activities delivered. There was no specific reference to dancing but this guideline does not specifically exclude on the basis of the types of activities on exercise referral schemes.
Royal College of Paediatrics and Child Health	General		We have not received any responses for this consultation	Thank you and we welcome the Royal College of Paediatrics and Child Health's involvement.
Royal College of Physicians (RCP)	General		The RCP is grateful for the opportunity to comment on the draft guideline. Our experts on the RCP Sport and Exercise Committee have reviewed the "Four commonly used methods to increase physical activity" and are satisfied with the content.	Thank you for your comment and the RCP's contribution.
Royal College of Physicians and Surgeons of Glasgow	general		The Royal College of Physicians and Surgeons of Glasgow support the aims of this guideline to increase participation in physical activity by the means of exercise referral schemes. We are currently involved in a Commonwealth Games legacy project which involves taking around 50 people with type 2 diabetes and putting them through a local exercise referral scheme. We hope that this will add to the evidence available about the potential benefits of this type of intervention. At the same time we have obtained considerable publicity and are using these participants as exemplars to try and interest a wider group of people with diabetes to take up physical activity.	Thank you and we welcome the Royal College of Physicians and Surgeons of Glasgow's contributions.
Royal Pharmaceutical Society (RPS)	General		The Royal Pharmaceutical Society welcomes the guideline on exercise referral schemes to promote physical activity. Pharmacists are regularly involved in the promotion of better public health and are suitable health care professionals to identify, support and encourage patients who need	Thank you and we welcome RPS's contribution.

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			to review their exercise regime.	
Royal Pharmaceutical Society (RPS)	Recommendation 2 : Encourage inactive adults to be more physically active	6	Pharmacists as public faces of healthcare, are well placed to implement this recommendation first by appropriately identifying patients who are inactive or display key signs that warrant lifestyle modification that may include increasing the physical activity. Pharmacists through their direct interaction with patients, can play a significant role in emphasising the benefits of being physically activity, not only from the point of view of managing existing ailments and preventing other conditions but the potential of improving mental health (eg anxiety/ stress levels, mood). Pharmacists can play an active part in the proposed referral scheme with patients, as and when opportunities arise and in more controlled settings (eg when undertaking a patient's medicines management review). As part of the referral process , pharmacists can confidently suggest motivational tools and provide information on local activities depending on patient needs and requirements. With a firm commitment to the delivery of public health, pharmacists and pharmacy teams should be considered in any further recommendations regarding the promotion of physical activity	Thank you for your comments. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline.
Royal Pharmaceutical Society (RPS)			provide information on local activities depending on patients' requirements, where appropriate. With a commitment to the delivery of public health services, pharmacists and pharmacy	Thank you for your comments. PHAC have considered the stakeholder comments and the findings of the fieldwork report

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			teams should be considered in any further recommendations regarding the promotion of physical activity.	and have made changes to the guideline.
SkillsActive/Register of Exercise Professionals	General	1	The House of Lords Select Committee on Science and Technology Report of Session 2012-13 "Sport and exercise science and medicine: building on the Olympic legacy to improve the nation's health", presented in October 2012 made the following recommendation: *"We recommend that the NHS and NICE evaluate the most effective mechanism for assuring the quality of service delivered by exercise professionals in exercise referral schemes" (paragraph 44) (Recommendation 6).* The Government Response to this recommends that participating exercise professionals hold appropriate qualifications and belong to the Register of Exercise Professionals (REPs); and the comment made on bullet point 2 that a referral should be made to a physical activity specialist should be viewed in the context of this recommendation. It should also be noted in the context of this recommendation, that REPs is owned and operated by SkillsActive, not the Fitness Industry Association as implied in the Government Response. SkillsActive is the Sector Skills Council for the active leisure sector.	Thank you for your comments and we welcome SkillsActive/REPs contribution.
SkillsActive/Register of Exercise Professionals	3.3	10	SkillsActive have created a set of National Occupational Standards in order to standardise the operation of Exercise Referral Schemes and create minimum criteria for the successful delivery of these schemes. These NOS state clearly that Exercise Professionals working in the fitness sector delivering exercise referral must be REPs 'Registered' Exercise Professionals.	Thank you for your comment and further information.
SkillsActive/Register of Exercise Professionals	3.22	14	An appropriately qualified REPs member is able to facilitate interventions which can increase long-term adherence by developing such strategies as group exercise classes,	Thank you for your comment and further information.

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			buddy systems and the like.	
SkillsActive/Register of Exercise Professionals	3.25	15	The British Heart Foundation exercise referral toolkit specifically details utilising REPs members as they have been assessed against the occupational competencies and National Occupational Standards.	Thank you for your comment and further information
SkillsActive/Register of Exercise Professionals	10.7	30	SkillsActive would be happy to help the PHAC with information on participation and dropout rates.	Thank you for your comment and the offer.
SkillsActive/Register of Exercise Professionals	General		Whilst SkillsActive understand that it is not current government policy to pursue mandatory registration, SkillsActive would welcome legislation which enforces this as it would allay fears about the skills and knowledge of exercise professionals from the medical community.	Thank you for your comment.
Public Health Directorate Stoke on Trent City Council	General		There is no mention of the use of a behaviour change measure prior to actioning a referral for exercise. It is clear that an oft missed opportunity to assess readiness to change would benefit a referral mechanism. Many clients are simply 'referred' without a proper assessment being made by clinicians of the behaviour change status of the client. Clinicians often refer clients who are not as informed about the process as they should be and this could be enhanced by conducting a readiness to change assessment at the 'pre referral' stage. Without a suitable assessment of readiness to change being undertaken a high proportion of clients will simply be lost to the system adding cost to the process.	Thank you for your comment and we welcome the Public Health Directorate Stoke on Trent City Council's contributions. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline. Recommendation 3 now makes specific reference to 'core behaviour change techniques' as outlined in 'Behaviour change: individual approaches' NICE public

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				health guideline 49 recommendations 7 to 10.
Public Health Directorate Stoke on Trent City Council	General		There is no mention of a cooling off period and the use of this time to enable a client / patient to demonstrate motivation. From experience gained over 25 years in leisure management/delivery and public health commissioning, I have introduced various opportunities that enable a client to clearly demonstrate their readiness to change. The latest iteration of this which is aligned to the local Health Trainer Service I commission applies a 4 week cooling off period which uses brief intervention techniques to help determine readiness to change. A client develops a personal health improvement plan and if a personal priority is identified that includes becoming more active then the client is asked to demonstrate their readiness by making measurable steps to becoming more active during a 4 week cooling off period. If the client can demonstrate they are slowly increasing their activity they can move into a more formalised physical activity offer. However, some clients become so active that they are motivated enough to remain active without access to a formal exercise referral process.	Thank you for your comment. The scope and subsequent review did not restrict by exercise referral scheme type. The absence of any particular type or facet of exercise referral scheme is due to its absence in the published literature reviewed.
Public Health Directorate Stoke on Trent City Council	General		There is a need to clarify the responsibilities of all those involved in the 'referral' process. Referral and Recommendation require clarification as do the responsibilities of individuals during each step of the process. In the new world of PH and CCG's the responsibility for increasing PA clearly sits with PH. However, for any ER programme to succeed there is a requirement for total sign up to roles and responsibilities from all those engaged. It is also important for the Clinical Director at the CCG and the LA Risk Manager to be engaged in the development of a referral framework. Responsibilities for the management of clients has shifted with the changes in NHS structures and this document does not recognise this at present.	Thank you for your comment The NICE guidelines are based on the best available evidence of effectiveness and cost effectiveness. The scope of this guideline sought to identify factors that influence effectiveness and cost effectiveness of exercise referral schemes, referral to and attendance at schemes.

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				The evidence identified and reviewed did not highlight any items relating to the organisation of schemes (which would include the allocation of responsibilities) and the effectiveness of schemes.
Public Health Directorate Stoke on Trent City Council			ER cannot operate in isolation and there must be appropriate 'exit routes' available for all those encouraged to become more active. These must be explained to clients prior to starting a programme of activity and reviewed in light of progress and suitability as a programme progresses.	Thank you for your comment.
Public Health Directorate Stoke on Trent City Council	General		The inclusion of adherence rewards should be considered. These can be offered to both the provider of the service and the client. Enhanced payments for vulnerable groups should also be considered.	Thank you for your comment.
Public Health Directorate Stoke on Trent City Council	General		The use of clearly defined inclusion and exclusion criteria must be adopted and this must not be diluted.	Thank you for your comment.
Public Health Directorate Stoke on Trent City Council	General		Electronic means of referral must be considered to aid the efficiency of the referral process. The use of EMIS and System One as a common platform for client records should be enhanced so that a national template is developed to aid the referral process. This will then ensure all crucial data is harvested and can be evaluated.	Thank you for your comments.
Public Health Directorate Stoke on Trent City Council	General		How does the removal of GPPAQ impact on this whole process? At least GPPAQ could have provided a reward system for General Practices and encourage their engagement in a ER process.	Thank you for your comment.
Tri-borough Public Health Team,	General		We agree with the recommendations in the draft guidelines	Thank you for your comment

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Westminster City Council				and we welcome the Tri-borough Public Health Team, Westminster City Council's contribution. PHAC have considered the stakeholder comments and findings of the fieldwork report and have made changes to the guideline.
Tri-borough Public Health Team, Westminster City Council	General		We recommend that Exercise Referral schemes should be one of a number of options (as part of the Physical Activity Care Pathway) to promote and support people to be physically active,	Thank you for your comment.
Tri-borough Public Health Team, Westminster City Council	3.7 (Economic modelling)	11	Further research into the medium and long term benefits is required and appropriate funding for such research needs to be available.	Thank you for your comment.
Tri-borough Public Health Team, Westminster City Council	3.10 (Economic modelling)	11	There is an ongoing debate about cost effectiveness but we agree with point in 3.10 that says there is not enough evidence to suggest disinvestment.	Thank you for your comment.
ukactive	General	n/a	ukactive welcomes the opportunity to respond to the consultation on the public health guideline on exercise referral schemes and supports the NICE draft scope to promote physical activity. ukactive is a not-for-profit health body that works to get more people, more active, more often. We are committed to improving the health of the nation through promoting active lifestyles and do this by designing, developing and conducting research; facilitating partnerships; promoting innovation; providing high quality services to our members; and sharing evidence and insights.	Thank you for your comments and we welcome ukactive's contribution to the stakeholder process
				Thank you for the information.

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ukactive	General	n/a	ukactive's membership, which stands at over 3,500 members, includes operators of fitness facilities of all sizes, as well as local authority leisure centres, leisure trusts, outdoor fitness providers, trainers, sports providers, education and training providers, lifestyle companies, equipment suppliers and charities. ukactive members develop, manage and deliver develop, manage and deliver exercise referral schemes and provide the subsequent physical activity exit strategies from those schemes. This includes exercise professionals and public health specialists.	
ukactive	General	n/a	ukactive works to establish physical activity as a routine part of the prevention and management of chronic disease and in turn support members to deliver these services. Over the last few years, ukactive has sought to improve the links between the physical activity sector and medical profession in order to improve the take up of these services at the highest standard. As such, ukactive established an independent forum, the Joint Consultative Forum, with the Medical Royal Colleges and Faculties, the Chartered Society of Physiotherapy and the College of Occupational Therapy. The Joint Consultative Forum has begun the drafting of Professional and Operational Standards for Exercise Referral. The drafting has currently been postponed so as to incorporate this review by NICE of exercise referral whilst also supporting a means of generating further evidence. The JCF remains committed to working with NICE in the development of these standards.	Thank you for the information.
ukactive	General	n/a	ukactive additionally works with an even larger range of stakeholders to promote the role of physical activity in both the prevention and management of chronic diseases. **ukactive and our members work closely with commissioners, managers and professionals with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. This includes GPs and other members of primary health care teams. One of the key ukactive strategic objectives will be to support local authorities to deliver their public health**	Thank you for the information.

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			responsibilities and increase local levels of activity.	
ukactive	General	n/a	ukactive has recently conducted research into the scale and impacts of physical inactivity in England in its 'Turning the tide of inactivity' report. We found that • One in four people in England fail to achieve more than 30 minutes of moderate intensity physical activity per week over a 28-day period. • There is a broad relationship between levels of physical inactivity and socio-economic status; highest deprivation areas are almost 10 per cent more physically inactive than lowest deprivation areas in England. • There is a broad relationship between levels of physical inactivity and premature death; areas with the highest levels of physical inactivity have the lowest levels of premature mortality and vice versa in England. • There is a disproportionately low spend on programmes to tackle physical inactivity by local authorities in England compared to other top tier public health concerns such as sexual health, smoking cessation programmes and alcohol and drug services. • The most inactive local authorities have on average a third fewer indoor and outdoor facilities than the least inactive areas in England. • There is no significant relationship between the volume of green space in a local authority in England and its level of physical inactivity; the utilisation of green space, rather than its volume, is the determining factor in reducing levels of physical inactivity.	Thank you for the information and the reference to your report.
ukactive	General	n/a	For 23 years, ukactive has existed to serve any organisation with a role to play in, or benefit to be gained from getting more people, more active, more often. **We provide supportive, professional and innovative platforms for our partners to succeed in getting local communities more physically active.**	Thank you for the information

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ukactive	General	n/a	In 2011, the ukactive Research Institute was founded in partnership with the University of Greenwich. The Research Institute launched an initial pilot study which specifically assessed the impact of exercise referral programmes by evaluating the effectiveness of structured exercise, unstructured exercise and physical activity counselling all carried out in local leisure centre facilities. It was a 12 week study that involved 105 participants with both physiological and psychological health improvement as the key markers. **The study proved the benefits of fitness centre based exercise and physical activity upon cardiovascular health and psychological wellbeing, and particularly highlighted the benefits of physical activity counselling delivered by trained exercise professionals. (**Mann et al. *Effect of structured exercise, free exercise and physical activity counselling on cardiovascular risk factors: A pilot study http://researchinstitute.ukactive.com/downloads/managed/Mann_Physical_Actvity_and_Cardiovascular_Risk.pdf* *http://researchinstitute.ukactive.com/downloads/managed/Mann_Physical_Actvity_and_Cardiovascular_Risk.pdf)*	Thank you for highlighting the Mann et al 2011 evaluation. This study did not meet our definition of an exercise referral scheme.
ukactive	General	n/a	The ukactive Research Institute has since expanded the pilot and launched the largest evaluation study of its kind on the delivery of exercise referral programmes through physical activity motivational counselling in local leisure centre facilities. This has been carried out in partnership with the University of Greenwich and Aberystwyth and includes 1,200 participants nationwide. **The Research Institute sees the programme expanding, in particular through the provision of physical activity counselling in primary care in partnership with local leisure providers. We see this is an important part of a broader care pathway that must be established to use physical activity to prevent and manage patients with differing needs and conditions. (ukactive Research Institute – preliminary findings from Project Get ukactive -**	Thank you for the information on your planned evaluation

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			http://researchinstitute.ukactive.com/downloads/managed/Steven_Mann.pdf)	
ukactive	Section 1	Page 5	ukactive welcomes *Recommendation 1 Commissioning interventions to increase physical activity*. In particular its recommendation to policy makers and commissioners with a remit for increasing physical activity levels to continue to support people to be physically active as part of their daily life. ukactive's mission is to get more people, more active, more often. In January 2014, ukactive published its report 'Turning the tide of inactivity' which provided the first borough by borough breakdown of physical inactivity in England.	Thank you for your comment.
ukactive	Section 1	Page 5	Recommendation 1 in the NICE draft Guideline asserts that a method of supporting people to be physically active is to make modifications to the physical environment (according to Physical activity and the environment, NICE public health guideline 8). We strongly support this recommendation and would go further to say that Local authority departments should work together to ensure consistency and compatibility between their open spaces strategy, the local transport strategy and their development plans. Evidence exists (ukactive, 'Turning the tide of inactivity' 2014) that there is no significant relationship between the volume of green space in a local authority in England and its level of physical inactivity; the utilisation of green space, rather than its volume, is the determining factor in reducing levels of physical inactivity. Therefore we would recommend that local authorities should specifically incorporate walking, cycling and other outdoor activities into their environmental planning strategies to ensure that patients are able to gain the health benefits of being active in a safe and supportive environment.	Thank you for your comment.
ukactive	Section 1	Page 5	We welcome the recommendation that policy makers and commissioners with a remit for increasing physical activity levels should implement NICE's recommendations on 'physical activity: brief advice for adults in primary care'. ukactive delivers the Let's Get Moving physical activity intervention in partnership with a	Thank you for your comments.

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			number of local authorities across the country. Let's Get Moving is based around the provision of a trained exercise professional located within GP surgeries providing brief advice and motivational interviewing. Its aim is to ensure that support is available to help inactive people to get moving, with clear onward pathways to physical activity opportunities. It does this by placing an exercise professional directly into a GP surgery. The role of the exercise professional is to support inactive people to understand what stops them from living a more active lifestyle and why it might be beneficial to change their habits; furthermore provides support to the patient whilst exploring the ways they might become more active.	
ukactive	Section 1	Page 5	While ukactive agrees that there is currently a lack of evaluated exercise referral schemes which has led to a lack of evidence, evidence demonstrating the health and wellbeing benefits of physical activity are irrevocable. As such, we believe that the lack of evidence of the effectiveness of exercise referral schemes is largely due to the wide range of services that exist, a lack of standardisation and a lack of capacity and expertise with regards to evaluation of services. For this reason we strongly believe that the language used "***Not*** *commission exercise referral schemes for the sole purpose of getting people to be more active. The only exception is for schemes that collect a minimum data set and make it available for analysis, monitoring and research to inform future practice"* may in fact be misleading or unhelpful for policy makers and commissioners and is unduly negative. It doesn't take into account the wide range of schemes and services available. For example, further work should be done to explain that schemes can and should be commissioned as part of the recognised care pathway for the treatment and management of specific conditions. Such a caveat was placed in the Department of Health Statement of 2007 which we strongly believe remains a fair and accurate position of the evidence base. http://www.bhfactive.org.uk/sites/Exercise-Referral-Toolkit/downloads/resources/dh-	Thank you for your comment. NICE fully endorse physical activity, its promotion and the benefits it accrues (the final guideline emphasises this). PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline to address issues raised regarding clarity. The recommendations now suggest that exercise referral schemes should not be commissioned for those identified as sedentary or inactive but with no other health issues. The

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			statement-exercise-referral-march2007.pdf In particular, ***"Not** commission exercise referral schemes for the sole purpose of getting people to be more active"* is an ambiguous statement and may lead to confusion over what amounts to getting people more active, and what the wider benefits are e.g. improving mood and mental wellbeing. We agree that **all exercise referral schemes should be robustly evaluated** throughout the intervention in order to build the evidence-base of what is effective. As such, we believe that the recommendation would be more constructively worded as follows: "**Only** commission exercise schemes that collect a minimum data set and make available for analysis, monitoring and research to inform future practice." Matters We feel that this would be more helpful in successfully turning the tide of physical inactivity and promoting the enormous health benefits that being active brings. It would promote the development of critically needed evidence in this area.	final guideline recommends that schemes are only commissioned for those identified as sedentary or inactive with an identified health condition or risk factor and if a minimum data set is collected. Finally, it makes clear that it excludes structured exercise programmes designed to manage specific conditions.
ukactive	Section 1	Page 6	We welcome Recommendation 2 of the Guideline, focusing on encouraging inactive adults to become more active. In particular, the assertion that primary care practitioners should implement Recommendation 1 and 2 from NICE public health guideline 44. Our recent analysis of inactivity in England shows that 1 in 4 adults in England is physically inactive (achieving fewer than 30 minutes of moderate intensity exercise per week) so urgent action is needed. However, ukactive believes that primary care practitioners and commissioners should not rely on referral alone. Instead practitioners should proactively identify and contact those who are most at risk of being inactive. ukactive's Let's Get Moving intervention proactively identifies an 'ideal target group' by running data extraction from GP surgeries to generate target lists, allowing for highly targeted interventions and thorough screening processes. They are then contacted and invited to meet with an exercise professional.	Thank you for your comment.

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			The exercise professional is then able to advise on methods and opportunities for becoming more active and importantly, then uses motivational interviewing to improve the chances of people maintaining their engagement in physical activity. The screening of individuals, capturing of baseline activity levels and regular periodised follow up should be standardised across interventions with best practice guideline issued. ukactive would welcome an opportunity to discuss such an approach. It has also been a major area of focus for the Joint Consultative Forum.	
ukactive	Section 3.5	Page 10	ukactive welcomes NICE's drafting of guidelines on exercise referral schemes and can understand their disappointment at the relatively small number of studies identified for this update. Of 1,300 exercise referral schemes that are currently being delivered, only 12 have been thoroughly evaluated and the findings shared. We believe that there is an urgent need to address this gap in research as recommendations are currently being made on an incomplete picture of exercise referral schemes. The ukactive Research Institute is developing evidence into the use of physical activity in public health. Despite a substantial body of evidence demonstrating the amelioration and even prevention of chronic health conditions through increased levels of physical activity many public health initiatives aimed at increasing levels of physical activity have failed to demonstrate clinically relevant effects. It has been hypothesised that the highly controlled environments in which much physical activity and health research is conducted limits its replicabilty in real-world public health or community settings (Beedie et al, Community fitness centre-based physical activity interventions: a brief review - http://researchinstitute.ukactive.com/downloads/managed/Mann_Fitness_centre_based_research_Review.pdf) For this reason, the studies that it conducts take place in 'real world' environments such as gyms and leisure facilities to ensure the results have more relevance to, and application in, public health. The Institute is also currently evaluating services and	Thank you for your comment. The final guideline provides greater clarity regarding the issues you highlight and the considerations sections outlines the discussion had by PHAC regarding these items. The guideline also makes a series of 'research recommendations' which outline key research required in this area as identified by PHAC during the development of this guideline.

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			validating programmes to ensure they are robust, effective and scalable. In response to the findings from this NICE review, ukactive would like to work with NICE to develop the evidence base of exercise referral schemes that the physical activity and leisure sector runs. This would also address the urgent need to develop the research as outlined in section 4 (pages15-16) and the research gap as identified in section 10 (pages 29-30) ukactive has formed a strategic partnership with Public Health England, the Local Government Association and County Sports Partnership Network to establish regional physical activity fora in England. This would provide a prime opportunity to further develop the evidence-base and consult with key stakeholders from health, physical activity, sport and local government.	
ukactive	Section 3.26	Page 15	We fully support the need for a range of activities that encourage inactive people to be more active as shown through our continued work on programmes such as Asda Active, our management of Spogo (an innovative online tool that brings together over 121,000 sports venues, facilities and clubs, leisure centres, personal trainers and events, in the same place for the first time) and with a membership base that ranges from StreetGames to Arthritis Research UK. We appreciate this need for a range of activities and understand that this conclusion is based on currently available evidence. We believe that as this only includes around 12 fully evaluated exercise referral schemes being run in leisure facilities, it may not be representative of the full picture. This shows the urgent need to address the evidence gap and develop a single framework of reporting and standards of exercise referral. We would also like to emphasise that fitness centres house the equipment and expertise to facilitate exercise and provide specialist supervision and guideline to those who require it. Further, group exercise classes are available that provide a social yet supervised environment for activity. However, we recognise and promote the concept of more people, more active, more often – irrespective of mode or means of achieving that	Thank you for your comment.

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			goal.	
Weight Watchers	General		Weight Watchers welcomes this timely and informative update, particularly that the guideline highlights the disparity between commissioners' beliefs about the effectiveness of ERS and the evidence that emerged from the reviews conducted for this guideline.	Thank you for your comments and we welcome Weight Watchers contribution
Weight Watchers	General		Weight Watchers has frequently encountered providers at a local level offering ERS to individuals as an alternative intervention for weight management. In such cases individuals are often asked to choose between ERS and an evidence based behaviour change intervention tier 2 service. Therefore Weight Watchers proposes the guideline makes explicit that ERS is not a clinically or cost effective option for weight management and suggests the following wording: • Current evidence does not support ERS as being clinically effective or cost effective for weight loss. For guideline on weight loss, providers should refer to NICE Guideline CG43 on the prevention, identification, assessment and management of overweight and obesity in adults and children.	Thank you for your comment. This guideline is focused on exercise referral schemes. The scope did not exclude schemes on the basis of scheme outputs for example impact on weight management. The evidence identified did not provide evidence to make a statement regarding the effectiveness of exercise referral in relation to weight management. NICE Guideline CG43 is referenced in related guideline as is its partial update (PH53 Overweight and obese adults – lifestyle weight management). The guideline also makes reference to the currently in development NICE guideline on Maintaining a healthy weight and preventing excess weight gain among children

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				and adults.
Weight Watchers	1	5	Weight Watchers welcomes the recommendation that clearly emphasises that the commissioning of ERS should only be undertaken with the aim of increasing the research base, and that clear data collection strategies are in place. In addition to the items included as necessary for data collection, we also suggest that commissioners commit to sharing raw data and analysis of results via a robust dissemination strategy to improve future practice.	Thank you for you for your comment. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline that further emphasis the points you raise.
Weight Watchers	1	6	Weight Watchers also welcomes the recommendation that primary care practitioners should not refer to ERS for sole purpose of increasing the PA of adults. However, for the purposes of clarity, we would suggest that this section should therefore also explicitly include when primary care practitioners *should* refer to ERS.	Thank you for you for your comment. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline to address issues regarding clarity.
Weight Watchers	3.24	15	In addition to the important point made about relapse prevention, we would also like the PHAC to consider including the risk of relapse and attrition from an ERS on an individual level in relation to adherence to other lifestyle modifications that maybe being made concurrently, for example dietary change or participation in a weight management intervention. Due to the unfounded anecdotal beliefs of the effectiveness of ERS, individuals are perhaps more likely to internalise their lapse as a personal failure, which maybe detrimental to motivation for behaviour change in other domains.	Thank you for your comment. The focus of this guideline is the effectiveness of exercise referral. The scope of this guideline did not restrict or exclude on the basis of exercise referral outcomes. There was no identified evidence that allowed any comment on the issues

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				regarding the relapse and attrition from exercise referral schemes and subsequent impact on participant adherence to other lifestyle modifications.
Weight Watchers	General		Based on the evidence provided in this guideline, Weight Watchers supports the comment made previously by the National Obesity Observatory in response to the original ERS scoping document: that if exercise on referral schemes were shown to be ineffective clinically and with regards to cost effectiveness that they should no longer be funded by Local Authorities.	Thank you for your comment. Thank you for your comment. PHAC have considered the stakeholder comments and the findings of the fieldwork report and have made changes to the guideline which clarifies the decisions arrived at. The consideration section outlines PHAC discussions regarding evidence of effectiveness and cost effectiveness. On the basis of the evidence PHAC could not recommend disinvestment in exercise referral schemes.
Weight Watchers	4	15	Service providers are able to offer multiple lifestyle interventions for a range of conditions concurrently (e.g. a Stop Smoking service, alongside ERS and/or weight management). What advice should be given to service commissioners and providers on the efficacy of offering individuals simultaneous or sequential behaviour change intervention? Research on this would offer a very valuable steer on how to use a range of different NICE	Thank you for your comment. The focus of this guideline is the effectiveness of exercise referral. The scope of this guideline did not restrict or

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			guideline in combination.	exclude on the basis of exercise referral outcomes. There was no identified evidence that allowed any comment on issues regarding what advice should be given to service commissioners and providers on the efficacy of offering individuals simultaneous or sequential behaviour change intervention.
Welsh Local Government Association	3.5 & 4.1	10& 16	The Welsh National Exercise Referral Scheme was evaluated with a RCT. This is the link to evaluation report www.wales.gov.uk/about/aboutresearch/social/latestresearch/exercise/?lang=en	Thank you for the reference and we welcome the Welsh Local Government Associations contribution.
Welsh Local Government Association	3 General recommendations based on experience	9	Since the publication of the favourable results NERS has continued to receive funding and has developed in line of the evaluations recommendations. Earlier signposting to alternative activities where appropriate, additional data collection on a central database for evaluation purposes, introduce more varied activities inclusive of outdoor activities and specialist instructors have been extensively trained to deliver prescribed exercise to more complex conditions it is especially important to undertake Motivational Interviewing and or Brief Intervention training . At the time of evaluation mean retention at the end of programme was 44% currently it stands at 62% which is an improvement due in the main to the impact of MI training, more varied activities and suitable exit route opportunities to signpost to encourages long term participation..	Thank you for your comment and the additional information about NERS.
Welsh Local Government Association	3 General		I am currently advising a number of areas in England and Northern Ireland on how we set up scheme in Wales and the lessons learnt to achieve continued success. I firmly	Thank you for your comment.

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	recommendations based on experience		believe the appointment of a National Coordinator to support local coordinators, access and commission training to meet the local needs, develop standards and protocols of delivery that meet current National Standards and gain the approval of Allied Health Professionals in Wales, and also to monitor performance is crucial for continued success.	
Welsh Local Government Association	General	1	The Welsh NERS programme has just reduced entry age to 16 it was previously 17. Reasoning was Nationally to access mainstream adult activities clients need to be 16 and as a direct request from GP's with concerns over growing stress and binge eating/drinking amongst this younger age group we have reduced age as of April 1st 2014.	Thank you for your comment and the further information regarding the development of NERS.

Document processed	Stakeholder organisation	Number of comments extracted	Comments
British Heart Foundation.doc	British Heart Foundation	37	
British Medical Association.doc	British Medical Association	3	
Camden and Islington Public Health.doc	Camden and Islington Public Health	8	
Chartered Society of Physiotherapy.doc	Chartered Society of Physiotherapy	9	
DECIPHer.doc	DECIPHer	16	

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Department of Health.doc	Department of Health	1	
Dietitians in Obesity Management UK.doc	Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association	14	
Fitness 4 health working under contract to South Cambridgeshire District Council.doc	Fitness 4 health working under contract to South Cambridgeshire District Council	3	
Greenwich Leisure Limited.doc	Greenwich Leisure Limited	5	
Liverpool John Moores University.doc	Liverpool John Moores University	1	
London Borough of Barking and Dagenham.doc	London Borough of Barking and Dagenham	6	
Macmillan Cancer Support.doc	Macmillan Cancer Support	3	
NHS England.doc	NHS England	1	
Nottinghamshire Healthcare NHS Trust.doc	Nottinghamshire Healthcare NHS Trust	12	
Public Health England.doc	Public Health England	3	
Public Health Wales NHS Trust.doc	Public Health Wales NHS Trust	9	
Royal College of General Practitioners.doc	Royal College of General Practitioners	4	
Royal College of Paediatrics and Child Health.doc	Royal College of Paediatrics and Child Health	1	
Royal College of Physicians (RCP).doc	Royal College of Physicians (RCP)	1	
Royal College of Physicians and Surgeons of Glasgow.doc	Royal College of Physicians and Surgeons of Glasgow	1	
Royal Pharmaceutical Society (RPS).docx	Royal Pharmaceutical Society (RPS)	3	
SkillsActive.doc	SkillsActive/Register of Exercise Professionals	6	

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Stoke on Trent City Council.doc	Public Health Directorate Stoke on Trent City Council	8	
Tri-borough Public Health Team, Westminster City Council.doc	Tri-borough Public Health Team, Westminster City Council	4	
ukactive.doc	ukactive	15	
Weight Watchers.doc	Weight Watchers	7	
Welsh Local Government Association.doc	Welsh Local Government Association	4	