Public Health Guidance

Physical activity - exercise referral schemes to promote physical activity (partial update of PH2) - Consultation on Draft Scope Stakeholder Comments and Responses Table

13th February – 13th March 2013

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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
Association of Chartered Physiotherapists in Cystic Fibrosis	General		There are some important infection control procedures that are needed to be implemented for individuals with Cystic Fibrosis which may restrict entry into exercise referral schemes and which should be taken into consideration ie individuals with CF should not exercise together and therefore a limit on the number of individuals with CF in each exercise group/scheme/leisure centres at any one time would need to be enforced to ensure equality of opportunity	Thank you for your comment. While people with CF are not excluded from the scope of this guidance, it excludes programmes for the management of specific conditions or rehabilitation from specific conditions.
Association of Chartered Physiotherapists in Cystic Fibrosis	General		How is activity being measured by AHP's/ GP's/ PCT's in general? The guidance perhaps needs to recommend a best practice for measuring and monitoring e.g. the GPPAQ only measures the last week of activity. Do we need to standardise a measure for a longer timeframe? Does the use of exercise diaries/ questionnaires help with participation and monitoring?	Thank you for your comment. This NICE guidance update focuses on exercise referral schemes. Where the measurement of physical activity appears in the literature this will be considered during the guidance development.
Association of Chartered Physiotherapists in Cystic Fibrosis	General		From our experience as physiotherapists who refer individuals to exercise referral schemes is that there is a wide geographical discrepancy in availability of schemes and cost etc	Thank you for your comment. NICE public health guidance is not mandatory, so it is up to local agencies to determine what to fund according to local needs and priorities, However, in issuing its guidance, NICE hopes to reduce unnecessary variability in provision.
Association of Chartered Physiotherapists in Cystic Fibrosis	General		From experience it is noted that criteria for referral to certain schemes can change annually which forces patients and health professionals to find a new activity/facility which in some cases leads to individuals becoming inactive once	Thank you for your comment

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			again	
Association of Chartered Physiotherapists in Cystic Fibrosis	General		Individual with more severe CF may require the use of long term oxygen therapy (LTOT) or non-invasive ventilation (NIV) during exercise. From experience this can cause issues for participation in exercise schemes.	Thank you for your comment. This guidance is about exercise referral schemes. It excludes programmes for the management of specific conditions or rehabilitation from specific conditions.
Association of Chartered Physiotherapists in Cystic Fibrosis	3a)	4	There is evidence to support the use of physical activity and exercise in the management of individuals with Cystic Fibrosis and in this section, individuals with CF should be mentioned.	Thank you for your comment. Section 3 is not intended to be a comprehensive review of the literature. It is intended to give the reader a brief overview of some of the key issues. This guidance focuses on exercise referral schemes. While people with CF are not excluded from the scope of this guidance, it excludes programmes for the management of specific conditions or rehabilitation from specific conditions
Association of Chartered Physiotherapists in Cystic Fibrosis	Section 3d)	5	A reference to the fact that individuals with established disease may have many more healthcare consultations that the 'healthy' normal population should be included here.	Thank you for your comment. Please see our response above.
Association of Chartered	Section	6	Measurement of inactivity in clinical populations is usually measured using	Thank you for your comment. NICE is

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Physiotherapists in Cystic Fibrosis	4.1.1		subjective reports (eg verbal reports, exercise diaries) rather than objective measures (eg pedometry, accelerometry). Is this satisfactory for health professionals to define an individual as 'inactive' and therefore not meeting the guidelines?	aware of the different methods (and subsequent associated limitations) of the assessment of physical activity levels. NICE will not exclude studies on the basis of whether they have assessed people via subjective or objective measures, however this may be a consideration for the committee in developing its recommendations.
Association of Chartered Physiotherapists in Cystic Fibrosis	Section 4.3 Question 4	8	Could this be one point for examination rather than two?	Thank you for your comment. This is an example and not intended to be an exhaustive list.
ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE		2	To include specialist nurses not just practice nurses	Thank you for your comment. Section 2 is not an exhaustive list of the intended audience for the guidance.
ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE		4	First paragraph – to include charities	Thank you for your comment – voluntary and community sectors are referred to in paragraph 2 d of the final scope.

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ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE		8	expected outcome – diminished side effects of treatment such as fatigue. Change in health status/	Thank you for your comment. Change in physical and mental health and wellbeing are expected outcomes in the final scope.
ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE	3 a	4	also need to highlight that exercise not only prevents cancer but also in some cancers reduces recurrence and also progression	Thank you for your comment. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review.
ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE	3 e	5	also need to highlight that exercise not only prevents cancer but also in some cancers reduces recurrence and also progression	Thank you for your comment. Please see our previous response.
ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE	4.2.2	7	excluding cardiac / pulmonary rehab programme may also mean that they exclude some cancer rehab which maybe linked with cardiac programme. Also – what is the rationale around not covering cardiac programmes?	Thank you for your comment. The exclusion of cardiac and pulmonary rehabilitation programmes is because these types of programme require specialist physical activity specifically

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				set up to address the issues associated with recovery from coronary and pulmonary incidence.
ASSOCIATION OF CHARTERED PHYSIOTHERAPISTS IN ONCOLOGY AND PALLIATIVE CARE	Q4	8	factors affecting – also would be worth considering level of appropriate expertise / guidance. Plus any additional resources that may also contribute such as healthy eating	Thank you for your comment. The sub bullets preceding the main overarching questions are an example of some of the sub questions and are not meant to be a comprehensive list. NICE envisage level of appropriate expertise and guidance to be considered in the guidance development process.
British Heart Foundation National Centre	2d Background	2/3	We fully endorse the audience for this guidance, however where appropriate we would also like this audience to include exercise referral training providers.	Thank you for your comment. NICE anticipate that the guidance will be relevant to training providers.
British Heart Foundation National Centre	3 The need for guidance	4/5	ERS are one of the most popular physical activity interventions in the UK and it has been estimated that approximately 80% of PCTs are involved in commissioning these services. Given this widespread delivery of, and substantial investment in ERS, the BHFNC would like to see this context included in the justification for the guidance.	Thank you for your comment. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review. The guidance will be relevant to commissioners of health and public health services.

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British Heart Foundation National Centre	4.2.1. What will be covered	6	Given that the inclusion criteria for many ERS is based on physical inactivity and medical conditions, we are questioning whether the scope for the guidance needs to include ERS for people with long term medical conditions	Thank you for your comment. Pulmonary or cardiac rehabilitation programmes are excluded from this guidance (please see section 4.2.2 of the final scope). This guidance does not exclude those with long term conditions (such as people with cardiovascular disease) but rehabilitation or specialist disease specific advice (such as offered in some aspects of secondary and tertiary care) will not be considered.
British Heart Foundation National Centre	4.3. Expected Outcomes – a change in physical health	8	We appreciate that under the new NHS commissioning arrangements that many commissioners will want to see the impact of ERS on health outcomes, however we have concerns about the effectiveness of ERS being assessed upon health indicators which are influenced by many other lifestyle or confounding factors. The BHFNC believes that the effectiveness of ERS should ONLY be based upon physical activity.	Thank you for your comments. The list of expected outcomes provides an example of some of the outcomes that could be found in the addressing the key questions. It is not meant to be a comprehensive list. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness, and careful deliberation by the Public Health Advisory Committee.
British Heart Foundation	4.3.	6	This question is talking about referral numbers, not referral rates. In order for it	Thank you for your comment.

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National Centre	Question 2		to be a rate a denominator is required.	
British Heart Foundation National Centre	4.3. Question 2	7	Within this question we would like to see some consideration of whether the referrer's knowledge and understanding of scheme protocols, lines of accountability and governance arrangements has any influence on referral numbers.	Thank you for your comment. The list of expected outcomes provides an example of some of the outcomes that could be found in the addressing the key questions. It is not meant to be a comprehensive list. We envisage issues pertaining to referrer's knowledge and understanding of scheme protocols as well as other elements to be considered in this guidance. We also envisage lines of accountability and governance arrangements to be considered.
British Heart Foundation National Centre	4.3. Question 3	7	We would like to see a definition of attendance at, and successful completion of the scheme included in the scope. For example, if a person attends 50% of the ERS sessions and attends an exit interview does this represent successful completion?	Thank you for your comments. NICE recommendations are based on the best available evidence of effectiveness and cost effectiveness and committee deliberation. 'Successful completion' will be defined by the study outcomes that are identified by the systematic review process (where this information is

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				available). We envisage that the variation in what constitutes "successful completion" will be considered in the systematic review(s) and by the Public Health Advisory Committee (PHAC).
British Heart Foundation National Centre	Appendix A: Potential Considerations	11	We agree with the list of other potential considerations as many of these factors are likely to impact upon the effectiveness of schemes. We would also like to see participants' knowledge and understanding of what an ERS is considered under this section.	Thank you for your comment. Participant factors could include knowledge, attitudes and beliefs relating to exercise referral schemes, health and physical activity.
British Heart Foundation National Centre	General		The British Heart Foundation National Centre for Physical Activity and Health (BHFNC) welcomes the opportunity to comment on the draft scope for the partial update of PH2 on exercise referral schemes. Furthermore, we are pleased to see the inclusion of the BHFNC exercise referral toolkit in the reference list.	Thank you for your comment.
Cambridgeshire Community Services (NHS)	General		No mention of evidence base for exercise. Local Authority Exercise referral schemes across the country are relying more on	Thank you for your comment.

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			using private companies to run their schemes. Many of these are using under qualified staff who are proscribing 'general' exercise programmes. There needs to be advice on specific exercise programme design for specific conditions.	
Cambridgeshire Community Services (NHS)	3 – the need for guidance	4	3a – no mention of Falls or increased independence in older people	Thank you for your comments. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review. Furthermore, the scope of the guidance neither excludes nor will focus on older people.
Cambridgeshire Community Services (NHS)	3 – the need for guidance	4	3b – CV focused, need to expand on Strength and Balance guidelines in order to embed in exercise programming	Thank you. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review. NICE is aware that current Chief Medical Officer recommendations on physical activity include strength and balance.
Chartered Society of Physiotherapy	General		We recognise and support this work. We acknowledge that any strategy resulting in an improvement in patients' physical activity participation will be hugely beneficial for that individual – not only for their musculo-skeletal health but also	Thank you for your comments.

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			their general health. Strategies that improve physical fitness should be an important part of modern healthcare, and are likely to facilitate the way the NHS in the 21st century delivers efficient and effective healthcare to the aging population of the UK. We feel this scope is wide-ranging and inclusive with recognition of the potential role of AHP's.	
Chartered Society of Physiotherapy	General		Variable time of wait for initial assessment for scheme is off putting for patients as this can be months.	Thank you for your comment. Barriers and facilitators will be considered in the development of the guidance.
Chartered Society of Physiotherapy	General		The cost of the exercise scheme can be off putting for some patients.	Thank you for your comment
Chartered Society of Physiotherapy	General		One intervention to consider is how to maintain attendance; some patients are put off by the lack of regular quality supervision at the exercise scheme.	Thank you for your comment
Chartered Society of Physiotherapy	Section 4.3	7	When discussing factors influencing the uptake of exercise, participant's physical limitations (and therefore ability to exercise or attend schemes) is not mentioned but obviously can have a significant impact.	Thank you for your comment. Although not specifically mentioned issues regarding physical ability are not excluded from this piece of guidance. It is anticipated that (consistent with patient centred approaches and support of a good patient experience) all contacts throughout an exercise referral scheme would invite, consider and respect each person's abilities

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				and preferences. Where exercise referral is delivered as part of the management of a disease condition or rehabilitation (for example cardiac rehabilitation) and requires specialist physical activity referral this will not be included in this guidance.
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University			**<u>Cost effectiveness</u>** Key influences on cost effectiveness are uptake and adherence. Our evaluation of a national ERS found it likely to be cost-effective at conventional thresholds, a finding consistent with recent cost-effectiveness reviews. However, subgroup analysis based on those who had adhered fully to the 16-week programme indicated a saving of –£367 per QALY gained (Murphy SM et al. An evaluation of the effectiveness and cost effectiveness of the National Exercise Referral Scheme in Wales, UK: a randomised controlled trial of a public health policy initiative. *J Epidemiol Community Health* 2012;66:745-753). Further work is required to identify the influence of scheme content on levels of uptake and adherence. Research could also usefully focus on reasons for sub group variability in cost effectiveness, with recent findings identifying greater cost effectiveness for participants with CHD and/or mental health risk factors compared with participants with a risk of CHD only; female rather than male participants and younger (<44 years) rather than older individuals (Murphy SM et	Thank you for your comments, references and summary. As defined in section 4 of the final scope, uptake of referral and continuation with exercise activity will be considered in developing the guidance.

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			al. An evaluation of the effectiveness and cost effectiveness of the National Exercise Referral Scheme in Wales, UK: a randomised controlled trial of a public health policy initiative. *J Epidemiol Community Health* 2012;66:745-753).	
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	2	5	Changing society one individual at a time, through relatively resource-intensive behaviour change interventions, is perhaps unlikely to be an efficient means of achieving substantial population level health improvement. Statements such as the one at the top of Page 5 imply a desire to achieve population health improvement through primary care based physical activity (PA) promotion, with exercise referral schemes (ERS) representing one tool for achieving this. There is often a disjuncture between the openness of referral criteria (reflecting a desire to benefit the population) and the number of people an ERS can realistically serve. If all patients not currently meeting PA recommendations are eligible for an ERS, then this is most people a GP will see on any given day. Offering a resource intensive intervention such as ERS to *even a sizeable minority* of these patients would soon become unmanageable. To what extent should guidance expect GPs to be solely responsible for activity to promote ERS, or as gatekeepers responsible for rationing access to a limited resource, in often non-systematic ways? *Some of the most critical questions* for which more evidence is needed surround how targeting decisions are made and justified and the process by which health professionals choose to refer or not to refer patients.	Thank you for your comment. NICE understands that exercise referral schemes are just one of a number of potential interventions to promote physical activity. In determining cost effectiveness, the committee will consider the costs and benefits of ERS for different population groups.

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DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	4.1.1	6	It is *unclear why the guidance only cover adults aged 19 or over*. While the vast majority of patients within ERS tend to be older, we recommend age 18 or over would be more reflective of the populations schemes are likely to serve.	Thank you for your comment. The age cut off of 19 years and over was selected to bring the guidance in line with the current CMO recommendation categories for physical activity and NICE has already published guidance on the promotion of physical activity in children and young people which includes those 18 years old and younger (Public health guidance 17).
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	4.2	6	These inclusion criteria mostly seem sensible, although largely ignore the agency of the patient. The referral process within ERS is often somewhat naively presented in terms which present patients as passive recipients of health professional assessment and advice. Quite often patients will enter ERS having become of aware of the scheme and themselves identified it as something they would benefit from, before approaching their GP to request referral. Our research found '(h)igh levels of drop out in some areas were attributed to failures to identify patients who were sufficiently motivated to benefit from the scheme. Hence, professionals sometimes described a need to focus attentions on patients for whom change was already internally motivated, rather than directing efforts towards motivating patients less ready to change.' (Moore GF et al. Facilitating adherence to physical activity: exercise professionals' experiences of the National Exercise Referral Scheme in Wales. A qualitative study. *BMC Public Health* 2011, 11:935). This has implications for targeting appropriate referrals, patient screening at scheme entry and scheme approaches to motivation.	Thank you for your comments. If as you have outlined evidence suggests that consideration of the agency of patients is key this will be picked up in the evidence and subsequently considered on its merits by the PHAC

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DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University			Secondly, the inclusion of 'a formal assessment by the physical activity specialist' as a defining feature of an ERS highlights a real current tension in ERS. In line with DoH recommendations, ERS are increasingly attempting (albeit not always successfully) to incorporate patient centred motivational counselling approaches into one-to-one consultations. This attempt to move towards patient centred approaches is hampered by a continuing focus on somewhat incongruent 'practitioner as expert, assess and advise' models of consultation delivery. ERS which have genuinely moved towards a model where the patient is seen as the expert on their own lives, where internal motivations are elicited and harnessed, and where a suitable exercise programme is agreed in partnership with the patient would be excluded from a definition which assumes that the professional must serve a traditional didactic role of assessing the patient before telling them what is good for them. (Moore GF et al. Facilitating adherence to physical activity: exercise professionals' experiences of the National Exercise Referral Scheme in Wales. a qualitative study. *BMC Public Health* 2011, 11:935).	Thank you for your comment. The committee will seek to understand what may influence numbers of referrals, attendance and completion of a programme of activity, and long term adherence to physical activity. The committee will carefully consider available evidence on context, barriers and facilitators relating to exercise referral schemes.
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	4.3	7	**<u>Effectiveness</u>** Questions related to differential effectiveness by scheme type and participant are important to ask – the fact that most evaluations of ERS provide only minimal descriptions of what the intervention is meant to be, and little or no data on what was actually implemented in practice, means that it will almost certainly be	Thank you for your comment. NICE guidance is based on best available evidence. NICE recognise that evidence may be limited, but is experienced in supporting its advisory

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			impossible to draw firm conclusions, however highlighting this evidence gap *is important.* ERS increasingly draw on approaches such as self-determination theory or motivational interviewing. It may also be of value to examine variations in effectiveness by the stated theory of the intervention (if any is stated). While subgroup analysis of trial outcomes is relatively rare, and usually underpowered, there are a number of studies which examine patterning in adherence and uptake by patient characteristics (Pavey, T et al. Levels and predictors of exercise referral scheme uptake and adherence: a systematic review. *Journal of Epidemiology and Community Health* 2012, 66:737-744). It should however be noted that the factors which predict completion of an ERS *are not necessarily the same as the factors which will predict long term behavioural change*.	bodies to identify and consider what evidence it available. Comments noted, thank you.
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	4.3	7	The inclusion of participant factors is welcome. The guidance could more explicitly discuss that patients can/will actively seek referral *rather than being passive recipients* of assessment and advice. This has implications for the roles and functioning of the programme which are often ignored in the literature. For example, is the scheme simply providing highly motivated patients with advice and guidance so they can achieve a self-determined goal of becoming more active without exacerbating existing illnesses and injuries? Or is it helping people to resolve their ambivalence about physical activity and make changes they wouldn't previously have contemplated? (see for example; Moore GF et al. Facilitating adherence to physical activity: exercise professionals' experiences of the National Exercise Referral Scheme in Wales. a qualitative study. *BMC Public Health* 2011, 11:935)	Thank you for your comment. It is implicit that the person's preferences should involved at all stages of an exercise referral schemes (consistent with support good 'patient' experience and 'patient' centred care approaches as promoted in and by NICE guidance). This document is the scope document. Its role is to outline the boundaries that this guidance will consider in its

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			Research finds that older age increases adherence (e.g. Gidlow C et al. Attendance of exercise referral schemes in the UK: A systematic review. *Heal Educ J* 2005, 64:168-186). Longer schemes may have more of an impact, suggesting that it is not effective to implement very short ERS (Tobi P et al. Who stays, who drops out? Biosocial predictors of longer-term adherence in participants attending an exercise referral scheme in the UK. *BMC Public Health* 2012, 12:347).	development. NICE guidance is based on the best available evidence of effectiveness, cost effectiveness and careful committee deliberation
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	4.3	7	There is perhaps a need for greater attention to contextual / structural factors here. For example, the way in which an activity leader delivers an ERS may be linked not only to the individual characteristics indicated, but also to factors such as the training and support provided within the programme, whether ERS delivery is a small part of their role or the entire job they are paid to do, etc (Moore GF et al. Facilitating adherence to physical activity: exercise professionals' experiences of the National Exercise Referral Scheme in Wales. a qualitative study. *BMC Public Health* 2011, 11:935). In addition, the *social context* provided by ERS is also often given little attention, and varies hugely from scheme to scheme, with implications for their functioning. For example, a scheme in which patients are provided with opportunities to exercise in a group with other patients struggling to overcome the same illnesses, who may become sources of empathy and realistic role models for social comparison, may work in very different ways to a scheme in which a patient is prescribed a programme of activity by a professional and expected to	Thank you for your comments. Key questions in section 4 of the final scope consider contextual and structural factors and issues pertaining to social context.

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			undertake this in a mainstream environment, surrounded by fitter individuals (e.g. Sharma H et al. Experiences of an exercise referral scheme from the perspective of people with chronic stroke: a qualitative study. *Physiotherapy* 2012, 98(4): 336-343). Leijon et al. outline the variety of reasons for non-compliance (Leijon ME et al. Who is not adhering to physical activity referrals, and why? *Scandinavian Journal of Primary Health Care* 2011, 29(4): 234-240). In particular they highlight that those who are least active at baseline were most likely not to adhere, thus the groups with the greatest need may require more attention or tailored interventions.	
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	General		In applying any health intervention, it is important to acknowledge the potential impact of the intervention to reduce or exacerbate health inequalities. Currently however, there is little evidence on how ERS interact with disability, gender identity, ethnicity, religion and belief, or sexual orientation. Our evaluation of the Welsh ERS found 'significant interactions with gender for both mental health outcomes, with the beneficial effect of the intervention only apparent among females'. This research also found 'a possible need for more intensive longer term support for the older age group to maintain activity levels' (Murphy S et al. *The evaluation of the National Exercise Referral Scheme in Wales*. Welsh Assembly Government Social Research, 2010). The scope should therefore emphasise the importance of evaluation studies that assess sub group variation and impacts on inequalities. Whilst schemes should monitor strategies for promoting reach and addressing inequalities in referral uptake, adherence and outcomes.	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness, and committee deliberation. The key questions (section 4.3) and the potential considerations (appendix a) highlight some of the issues you have raised and as such we envisage that they will be considered in the guidance development process. NICE also conducts equality impact assessment throughout the guidance development process.

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			Research in the area of ERS and inequalities is growing. Evidence from Holland examining exercise on prescription found recruitment and retention of women from diverse ethnic background was high, however impact on PA, health and mental well-being was limited (Gademan MGJ et al. The effect of exercise on prescription on physical activity and wellbeing in a multi-ethnic female population: A controlled trial. *BMC Public Health* 2012, 12:758). This suggests targeting of these populations can work, but more effective interventions are needed. Our own research found 'effectiveness was highly dependent on adherence' and it is this area that requires more attention in the scope (Murphy SM et al. An evaluation of the effectiveness and cost effectiveness of the National Exercise Referral Scheme in Wales, UK: a randomised controlled trial of a public health policy initiative. *J Epidemiol Community Health* 2012;66:745-753).	
DECIPHer, Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement, Cardiff University	General		In terms of the equality of opportunity that affects the scope of this guidance, it is key to note the inequalities that may occur in general practice, as GPs are primarily responsible for referring people to ERS. Socio-economic status, gender and age have been shown to influence the doctor-patient relationship. Research has shown doctors communicate different information according to patients' income, gender, age and ethnicity (e.g. Kelly-Irving M et al. Do general practitioners overestimate the health of their patients with lower education? *Social Science and Medicine* 2011, 73(9): 1416-1421). This confirms research into discussions between GPs and patients on cardiovascular-risk management which found the most salient disagreements related to advice on physical activity and nutrition and that as a patient's level of education decreased, there was also	Thank you for your comment. Please see our response above.

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			more likely to disagree on the information given during the GP consultation (Schieber AC et al. Do doctors and patients agree on cardiovascular-risk management recommendations post-consultation? The INTERMEDE study *British Journal of General Practice* 2011, 1; 61(584): e105–e111). As such, any guidance should specifically address the potential for inequalities to be exacerbated, particularly in terms of socio-economic status. The scope should also consider which professional groups may be best placed to provide referral routes for those most in need.	
Department of Health	General		Will the scope be addressing the standards of ERS providers? Does having an accreditation scheme help to drive up standards and offer confidence to health professionals who make referrals?	Thank you for your comment. Standards of ERS providers are not excluded from this piece or work.
Department of Health	General		Will the scope examine the role of Sport and Exercise Medicine consultants?	Thank you for your comment. Sport and exercise medicine consultants are not excluded from this piece of guidance. Where evidence of the roles of this particular set of professionals and other professionals appear in the evidence regarding the effectiveness of exercise referral or factors impacting exercise referral (as outlined in section 4.3) this will be considered.
Department of Health	4.3 Key	7	Would you factor insurance costs for the people/ organisations that runs the	Thank you for your comment. It is

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	questions and outcomes Q1		scheme? Ultimately, the safety of a scheme and its ability to operate within their budget will influence cost effectiveness.	possible that the committee may take 'insurance costs' into consideration.
Department of Health	4.3 Key questions and outcomes Q2	7	Confidence of medical professionals (e.g. GPs) of ERS providers will affect referral decisions and rates.	Thank you for your comment. We envisage that in addressing the key question elements regarding the confidence of practitioners will be considered where the evidence allows.
Department of Health	4.3 Key questions and outcomes Q4	8	Participant's perception of improvement to their health/ condition might influence their longer term participation.	Thank you for your comment. Such features of a person's experience may be considered through the review of context, barriers and facilitators to be conducted for the guidance.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	4.3 Question 1	7	We would like to see effectiveness and cost effectiveness explored in both the short and long term.	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness, cost effectiveness and committee deliberation. Where the evidence allows the committee will consider both short and long term impacts. If economic modelling is required for this piece of work it will consider both short

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				term and long term impacts.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	4.3 Question 1	7	We would like to added factors related to the nature of the scheme eg length, intensity	Thank you for your comment, question 2, 3 and 4 will consider aspects relating to the 'nature' of exercise referral schemes which may include length and intensity of exercise referral schemes
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	4.3 Question 2	7	Factors about the person making the referral may also include their ethnicity & previous experience	Thank you for your comment. Features of professional and service user experience, knowledge and attitudes will be considered as evidence allows.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	4.3 Question 2	7	Factors about the participant may also include age, gender, ethnicity, previous experience, physical and mental health.	Thank you for your comment. Features of professional and service user experience, knowledge and attitudes will be considered as evidence allows.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	4.3 Question 3	7-8	Could 'successful completion' be defined please.	Thank you for your comment.. 'Successful completion' will be defined by the study outcomes that are identified by the systematic review process (where this information is available).

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Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	4.3 Question 4	8	Additional factors which may influence longer term participation include local environment and infrastructure and perceptions of these (e.g footpaths, lighting, cycle lanes, safety). Factors such as these which are outside the control of the individual may have a differential effect on those in more deprived areas, increasing the potential for inequality of opportunity in those individuals.	Thank you for your comment. NICE has recently published guidance on walking and cycling (Public health guidance 41) and physical activity and the environment (public health guidance 8) which address the issues pertaining to the impact of infrastructure and environment on physical activity. NICE guidance is based on the best available evidence of effectiveness, cost effectiveness and committee deliberation. Where the evidence allows issues pertaining to the environment and infrastructure will be discussed.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	Expected outcomes	8	Could weight (eg weight changes) be included as a physical health outcome please.	Thank you for your comments. Weight or changes in weight may be considered where the evidence allows.
Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	General		We welcome this timely update.	Thank you, noted

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Dietitians in Obesity Management UK (domUK); a specialist group of the British Dietetic Association	The need for guidance (d)	5	We welcome the recognition of every consultation as a potential opportunity to promote physical activity.	Thank you.
Faculty of Health and Life Sciences	3 a	4	In addition to 'physical and mental wellbeing' it may also be worth stating that physical activity improves life-quality. Perhaps specifically because wellbeing is a broad term and may cause confusion in terms of evaluation and outcome measurement. Whilst defining quality of life has similar challenges, it is generally accepted that it may be easier to measure than wellbeing. The Exercise referral Quality of Life Scale (ER-QLS) shows good reliability and validity, was specifically designed to measure quality of life (QoL) for individuals referred into an exercise scheme and is being integrated into a number of evaluation protocols for schemes across the UK. If we are going to state that physical activity improves mental wellbeing/QoL we need to ensure that we have to tools to measure the outcomes effectively. Mental health is not referred to yet there is sufficient evidence to suggest that physical activity may at a minimum help individuals diagnosed with a mental health condition manage the symptoms better, if not improve mental health in more general terms.	Thank you for your comment and we welcome the Faculty of Health and Life Sciences contribution. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review. Section 4.3 specifies that physical health, mental health and wellbeing will be considered (where evidence allows). Quality of life is used as an example of 'wellbeing'. No particular tool or metric is specified in the scope, though PHAC will carefully consider relevance, applicability and comparability of different measure of wellbeing and/or quality of life.

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Faculty of Health and Life Sciences	3 d	5	Only the promotion of physical activity and the opportunity to refer into a physical activity programme are mentioned. Whilst I understand that there is other guidance regarding brief interventions available, there may be a critical opportunity here to offer clarity for practitioners; how this promotion of physical activity should be done. Simply advising individuals on what they should or could be doing to be more physically active has shown to be consistently ineffective. The Lets get Moving (LGM) initiative utilised motivational interviewing (MI) as an evidence-based method of helping people change physical activity behaviour. Perhaps there is scope to refer to the recommendation of the method here for continuity. The confusion regarding the most appropriate/effective methods is evident across the behaviour change/brief intervention literature and in practice (such as Make Every Contact Count; MECC). Again, consistent reference to and recommendation of an evidence based method such as MI would help with clarity, consistency and large-scale evaluation.	Thank you for your comment. This document is the scope document. Its role is to outline the boundaries that this guidance will consider in its development. NICE guidance is based on the best available evidence of effectiveness, cost effectiveness and committee deliberation. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review. Where appropriate NICE will cross reference recommendations from this guidance with those in other published NICE guidance.
Faculty of Health and Life Sciences	3e	5	It is suggested that poor mental health can be exacerbated through lack of physical activity. Perhaps improvements in mental health specifically, or improved management of mental ill-health conditions should be referred to in 3a page 4 (see comments above re: 3a page 4) or in this section.	Thank you for your comment. The guidance will consider physical health, mental health and wellbeing. People who experience problems with their mental health are not excluded from the scope of the guidance. PHAC will consider evidence on specific groups of people offered exercise referral

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				schemes, if it is available.
Faculty of Health and Life Sciences	4.2.1	6	This guidance will also consider other factors that support the delivery of effective exercise referral schemes." It would be beneficial to have examples of what such other factors may be, particularly when referring to effectiveness because the term effectiveness is fraught with difficulty in terms of establishing what is actually meant. For example, would an exercise referral scheme be deemed as ineffective if it was demonstrated to improve QoL but not reduce weight or increase physical activity to a level sufficient to meet the current guidelines?	Thank you for your comment. This document is the scope document. Its role is to outline the boundaries that this guidance will consider in its development. NICE guidance is based on the best available evidence of effectiveness, cost effectiveness and careful committee deliberation. Key questions and outcomes are specified in section 4.3 of the final scope.
Faculty of Health and Life Sciences	4.3	7	Again, the term effective and effectiveness needs clarification. What factors will be considered in an assessment of effectiveness? For example, changes in physical activity, physiological outcomes such as reduction in blood pressure and weight loss and improved life-quality.	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee deliberation. Effect and effectiveness will be considered as outlined in each study and is an output of the systematic review process. The committee will consider these outcomes and, based on the NICE process (which includes stakeholder interaction and comments on draft

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				recommendations and evidence reviews), will develop recommendations. Examples of key questions and outcomes are presented in section 4.3 of the final scope.
Faculty of Health and Life Sciences	4.3	7	"What factors about the person making the referral (such as age, gender and/or attitude to physical activity) have an impact?" Again, would include method of making the referral (e.g., person-centred, empathic, direct signposting and knowledge regarding physical activity). This is reflected in Question 3 with respect to activity leaders and is equally important for those who make the referral.	Thank you for your comment
Faculty of Health and Life Sciences	4.3	7	"What 'participant' factors (such as knowledge of physical activity, travel and/or cost) have an impact?" I have a paper in preparation that reports on such things.	Thank you for your comment. Relevance of participant factors will be explored in the evidence review process.
Faculty of Health and Life Sciences	Expected Outcomes	8	Again, it is important to refer to an assessment of perceived importance and confidence to continue to be physically active in addition to levels of intrinsic motivation here.	Thank you for your comment
Faculty of Health and Life Sciences	Expected Outcomes	8	"A change in people's physical health (for example, cardiovascular capacity or blood pressure) or their mental health and wellbeing (for example quality of life)." The ER-QLS is the only scale that has been developed for the assessment of QoL within exercise referral settings. I would recommend the use of this scale to	Thank you for your comment.

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			assess changes in exercise-related QoL for those referred.	
Faculty of Health and Life Sciences	General		Perhaps include guidance regarding how practitioners/researchers should demonstrate these outcomes. For example, a combination of routine audit (e.g., numbers referred) quantitative (e.g., psychometrics and physiological outcome measures) and qualitative (e.g., individual interviews and focus groups with medical and leisure professionals and those referred). Partnerships between health/leisure practitioners and academics should be encouraged in order to demonstrate the suggested expected outcomes adequately.	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee deliberation. The guidance is born out of the evidence, committee discussion and consideration of stakeholder comments. Monitoring and evaluation processes are outlined in appendix A as a potential committee consideration.
Faculty of Health and Life Sciences	Question 4	8	It is important to refer to other factors that contribute to longer-term participation such as perceived importance and confidence to continue to be physically active in addition to levels of intrinsic motivation.	Thank you for your comment The key questions highlighted in section 4.3 will consider issues such as factors that influence referral to exercise referral, adherence on exercise referral and long term physical activity post referral.
Lincolnshire Sports			Barriers include access, and distance to venue. Our Evaluation has shown a significant increase of incompletion if participants have to travel more than 6 miles to the venue. Other barriers can include poor quality referrals and poor	Thank you for your comments and we welcome Lincolnshire Sports contribution. Barriers and facilitators

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			customer service or communication with participants.	will be considered in the guidance.
Lincolnshire Sports			Anecdotally, coordinators tell us that patients prefer a wider range of options, such as pool and classes, but our evaluation does not reflect this.	Thank you for your comment. The scope is not limited to a particular exercise activity, providing these are part of an exercise referral scheme – as define din section 4 of the final scope.
Lincolnshire Sports			Facilitators are usually local champions, such as co-ordinators, practice nurses and buddy volunteers.	Thank you for your comment, noted.
Lincolnshire Sports			The person making the referral must share detailed information and make clear the expectations that the programme has of the patient to achieve success. (Some people turn up without the realisation the programme will involve change and effort)	Thank you for your comment. If evidence allows, components and conduct of referral processes will be considered by PHAC.
Lincolnshire Sports			The initial consultation is a key part of the process and can influence success rates, as part of establishing readiness for change and potentially signposting to more appropriate programmes.	Thank you for your comment. Please see our previous response.
Lincolnshire Sports			Participant factors - Patient experience is key, as is the relationship that is formed with the instructor. Buddy systems work well, where the patient feels they will let someone down if they do not attend.	Thank you for your comment. The PHAC will consider available evidence on context, barriers and facilitators.
Lincolnshire Sports			Cost has a positive effect, locally evaluation has shown that whether or not patients pay, patient postcode does not influence completion rates. So no relationship between cost and deprivation.	Thank you for your comment
Lincolnshire Sports	4.3	7	Cost per participant varies from £49 to £250 in Lincolnshire	Thank you for this information.

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	Question 1			
Lincolnshire Sports	4.3 Question 1	7	Larger organisations/facilities offer better value for money, if they have infrastructure, a wide range of options (pool, classes) or can contribute in kind staff time and campaigns. Larger organisations can also support administration and operate on a larger scale. Sometimes quality can be compromised, and our smaller providers mostly achieve better outcomes, but at a higher cost.	Thank you for your comment. Implementation is carefully considered with PHAC, along with other factors , in developing recommendations
Lincolnshire Sports	4.3 Question 1	7	Cost effectiveness varies according to the condition. Since 2010, 5000 clients have been evaluated and 481 mental health participants achieved a 53.8% completion rate, whereas 3,000 physical conditions achieve around 68%. This affects cost effectiveness where there is drop off	Thank you for your comment, noted.
Lincolnshire Sports	4.3 Question 1	7	Cost effectiveness has been improved locally by thorough screening of patients before they start the programme, to clarify expectations, improve attrition rates and save resources	Thank you for your comments. This aspect of 'pre-screening' people before offering exercise referral schemes may offer some insight into how referrals may be 'optimised' (such as questions for professionals to ask people when considering an exercise referral scheme), but the scope of the guidance will still consider the general, unselected 'inactive' population.
Lincolnshire Sports	4.3 Question 2	7	Influencing factors - Health Professional awareness and the quality of referrals that are received are significant factors. A campaign in Lincolnshire increased rates from 3000 – 4000 patients annually. Local relationships determine the	Thank you for your comment. Review of evidence of barriers and facilitators will be undertaken as part

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			quality of referrals.	of the guidance development process.
Lincolnshire Sports	4.3 Question 2	7	Influencing factors - Availability of alternative services such as Health Trainers, weight management programmes and community exercise classes. Perceptions of Health Professionals of what exercise referral is designed to do. (most perceive it as weight management only)	Thank you for your comment Features of professional and service user experience, knowledge and attitudes will be considered as evidence allows. Please note, this guidance is focused on exercise referral schemes as defined in section 4 of the final scope.
Lincolnshire Sports	4.3 Question 3	7	Activity factors - Cost has a positive effect, locally evaluation has shown us that £15 for the 12 week referral increases likelihood of completion by 2.5 times.	Thank you for your comments
Lincolnshire Sports	4.3 Question 3	7	Patient support is key. Regular contact with the instructor is a vital component for maintaining motivation. Variety in the programme is also crucial. Patients need to feel they are making progress and that their efforts are paying off.	Thank you for your comment.
Lincolnshire Sports	4.3 Question 3	7	Instructor knowledge is also an important factor. Empathy is needed and is usually developed with experience and suitable knowledge through qualifications. High quality customer service and specific, appropriate exercises must be given to meet the outcomes agreed with the patient.	Thank you for your comment.
Lincolnshire Sports	4.3 Question 3	8	Participant factors include personal circumstances. Of those patients asked why they did not complete, most said their circumstances had changed (such as work, caring duties, childcare) and another significant reason was poor health. As mentioned before, cost has not been a deterrent.	Thank you for your comment. The sub bullets that follow the outlined key question are only examples of exploratory sub questions and are not

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			The forming of friendships and a social circle are also strong influences for completion.	intended to be a comprehensive list. We envisage that other participant factors such as personal circumstances will be considered (where the evidence allows) in the development of this guidance.
Lincolnshire Sports	General		There is an understanding, that exercise referral is of benefit, but the health professional should be advised through NICE to discuss the consequences of not becoming more active with the patient, as well as the holistic benefits of being more active more often.	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee deliberation. The key questions (section 4.3) and potential consideration (appendix a) outline the consideration of content of exercise referral schemes and also factors that impact referral to schemes, attendance on schemes and longer term adherence to physical activity. NICE has also produced guidance on brief physical activity advice in primary care which considers aspects pertaining to discussion of the impact of physical activity advice (see www.nice.org.uk/ph44).

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Lincolnshire Sports	Question 4	8	Cost can become a factor for patients for whom the referral period was free. If cost is not staggered, patients can perceive the sudden cost of £20 per month as a barrier to continuing. Around 50% of referrals who start our programme are reported to continue attending for 6 months as either a member or a pay and play user at the same facility. Recording those who do not continue using the centre has proved difficult.	Thank you for your comment Such features of exercise referral schemes will be explored in the systematic review of effectiveness studies (as evidence allows) and may also be considered through the review of context, barriers and facilitators to be conducted for the guidance.
Luton Borough Council	Question 3: What factors influence attendance at, and successful completion of, the scheme? […] impact? What		Times of session, location, facilitator Knowledge, empathy	Thank you for your comments and we welcome Luton Borough Council's contribution.

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	'activity leader' factors (such as attitude, empathy and/or knowledge) have an impact? What 'participant' factors (such as resource, time and/or availability of activities) have an impact?		Support from the facilitator, availability, childcare and affordability. Very important but once they see they benefits that can justify to cost element	

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	Question 4: What factors influence longer-term participation in physical activity following attendance at an exercise referral? For example: How does the availability, cost and/or location of			

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	activities influence participation?			
Luton Borough Council	Section 4.3 Question 1: Question 2: What factors influence the rate of referral to an exercise referral scheme? […] What facets of		Deliver free to patients or at a subsided cost Negative attitude to exercise and readiness to undertake programme Cost and location	Thank you for your comments. Context, barriers and facilitators; adherence and predictors of uptake will be considered in the development of the guidance. These could include some and potentially all of those suggested in your comments.

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	an exercise referral scheme (such as the type, location or cost) have an impact? What factors about the person making the referral (such as age, gender and/or attitude to physical		Positive role model, influential Facts, benefits of exercise	

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	activity) have an impact? What 'participant' factors (such as knowledge of physical activity, travel and/or cost) have an impact?			
Luton Borough Council	What 'participant' factors (such as time, travel		Seeing benefits, health gain, enjoyment and consistency of support	Thank you for your comments. Context, barriers and facilitators; adherence and predictors of uptake will be considered in the development of the guidance.

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	and/or availability of activities) influence participation? 4.2.1		Important referral is made by a specialist but that doesn't necessarily have to be a GP or health professional	Noted, the definition of exercise referral scheme used in section 4 of the final scope, specifies that the referral should be made by a primary care or allied professional. The referral need not be by a GP, but would have to be an allied health professional.
Mind	4.3.2		When considering the barriers to referring people to exercise programmes it is important to include the comparative lack of awareness of these programmes as a beneficial intervention to promote good mental health, as compared to physical health. This may be compounded by the debate in the media contesting the mental health benefits of exercise, which often distorts research findings.[1] The mental health knowledge and understanding of the person making the referral will have a significant impact on their likelihood of making a referral, so it is critical this issue is included in the scope of the guidance.	Thank you for your comment. We envisage that issues pertaining to practitioner and participant understanding of the impact of physical activity to physical and mental health to be considered in this guidance where the evidence allows.
Mind	4.3.2		Under the 'participant factors' that may pose a barrier to referral, the person's mental health, wellbeing and confidence should be included. In a Mind survey of	Thank you for your comment. The sub bullets preceding the main overarching

[1] http://www.mind.org.uk/blog/6948_getting_your_headline_straight-exercise_and_depression

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			nearly 1,500 women, 9 out of 10 aged over 30 said that they battle body confidence and low self-esteem when considering outdoor exercise.[2]	questions are an example of some of the sub questions and are not meant to be a comprehensive list. NICE envisage level of appropriate expertise and guidance to be considered in the guidance development process.
Mind	4.3.3		Similarly, the nature of the group and perceived level of activity should be considered alongside things like location and cost; 2/3 of women surveyed by Mind felt that if they joined an exercise group the women were likely to be unwelcoming and 65% said they thought it was unlikely that they would be able to keep up.	Thank you for your comment. See the response above.
Mind	4.3.3		When considering the knowledge of activity leaders and its impact on people's attendance at, and successful completion of, exercise schemes it is important that their mental health knowledge is included. Some of our Local Minds have run Mental Health awareness training for local gyms, and have found this to be an effective way to increase participation in physical exercise among their service users, as staff are more aware of their needs.	Thank you for your comment. NICE envisage that issues regarding the knowledge of practitioners and participants including those related to mental health in the context of exercise referral will be considered as part of this guidance
Mind	4.3.3/4.3.4		As with referrals, it is important that the participant's mental health, wellbeing and confidence are included as 'participant factors' that may influence successful completion of, or longer-term participation in, the scheme. Connected to this, flexibility is an important 'activity factor' for many people with mental health	Thank you for your comment. Please see our previous response.

[2] http://www.mind.org.uk/news/6732_new_findings_show_women_run_scared_from_outdoor_exercise

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			problems, who have told us that they appreciate being able to continue with a course if they have to miss a session or arrive late because of their mental health (ie due to being unwell, to medical appointments, to the effects of medication etc).	
Mind	General		Generally we welcome that this scope focuses on the potential impact of exercise referral schemes on both physical and mental health. Mind's own research has found that participating in green exercise activities provides substantial benefits for mental health and wellbeing.[3]	Thank you for your comment.
Mind	General		We believe that the key areas covered by the scope are helpful. However, these could be improved by including more explicit reference to people's mental health as a potential barrier to their participation in exercise referral schemes, as well as an area positively affected by their participation in such schemes.	Thank you for your comment. This document is the scope document which outlines the boundaries of coverage for this guidance. Barriers and facilitators will be considered as outlined in the key questions (section 4.3) and in the potential considerations (appendix a). Mental health although not explicitly outlined would be considered throughout the review of the evidence regarding barriers and facilitators
Mind	General		We also welcome that the expected outcomes cover an improvement in people's mental health, as well as other social outcomes such as work productivity and	Thank you for your comment

[3] http://www.mind.org.uk/assets/0000/2138/ecotherapy_report.pdf

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			social interaction. We know that the social interaction associated with physical exercise can sometimes be as important for people with mental health problems as the exercise itself.	
National Obesity Observatory	2d	2	We note this says the guidance will 'provide recommendations for good practice, based on best available evidence of effectiveness' etc. We are concerned that this might indicate a positive bias in favour of exercise referral schemes. It may imply an intention to draft guidance that sets out the best possible practice in ERS, even if this results in clinically ineffective and non cost-effective schemes. We would like to see the scope make it explicit that one option open to the committee is to recommend that ERS are not funded by local authorities in the future if the review finds negative or conflicting findings on their effectiveness and cost effectiveness.	Thank you for your comments and we welcome the National Obesity Observatory's contribution. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness. The original PH2 guidance did not recommend exercise referral schemes as there was insufficient evidence. The purpose of this update is to consider additional, relevant evidence to determine whether ERS are effective and cost effective.
National Obesity Observatory	4.2.1	6	We agree with the wording here but draw the committee's attention to the need to avoid conflict with the existing guidance on physical activity promotion in primary care. Specifically, that bullet 3 'a formal assessment…' could be confused with counselling programmes.	Thank you for your comment. The wording in the final scope has been updated and does not use the term 'formal' (please see section 4.2.1 in the final scope).
National Obesity Observatory	4.3	8	Note that the HTA review provides a number of different outcome metrics for physical activity participation and these should be taken into account.	Thank you for your comment. NICE is aware of the HTA review (Pavey et al 2011) and the various metrics included

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				the report.
NHS North Essex	3 d	5	Much is made of the made of the fact that 95% of people see a primary care professional, but we know opportunities for PA promotion in primary care are often not optimised. I think the scope should include question: why is this? (this question is relevant to understanding patterns of referral from primary care)	Thank you for your comment and we welcome NHS North Essex's contribution. This section of the scope aims to provide the reader with a brief overview of some of the key issues in the area. It is not intended to be a comprehensive literature review. This guidance focuses on exercise referral interventions and question 2 (section 4.3 p.7) seeks to explore issues regarding referral to exercise interventions.
NHS North Essex	4.2.1		More explicit recognition of problems associated with determining whether or not someone is inactive needs mention. Systems in primary care are not sufficiently sensitive to determine this. Generally people are recruited to schemes on the basis of their clinical criteria (which could be ameliorated through physical activity), so including in the scope review of how best to identify people using other methodology than "inactive" may be beneficial.	Thank you for your comment. The guidance will seek to explore aspects such as factors affecting referral into exercise referral) as part of its 'key questions' (see section 4.3).
NHS North Essex	4.2.2		Excluding brief PA advice on its own may be excluding useful and relevant schemes and data. If a GP surgery has a practitioner with dedicated time to delivery brief PA advice, using a client centred approach which may not result in referral to a leisure facility/specific structured exercise programme, these schemes should be included, not least because they are more supported by the	Thank you for your comment. This proposed guidance is a partial update of NICE public health guidance 2. It focuses on exercise referral schemes only. NICE has already updated the

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			evidence base for physical activity than the traditional exercise referral scheme format.	other aspects of public health guidance 2 and published new guidance on 'Brief physical activity advice in primary care' (PH44) in May 2013.
NHS North Essex	4.3 Expected outcomes	8	Should there be a hierarchy of outcomes or treat all outcomes with the same importance? I would argue that a change in knowledge would be less important than change in no. increasing activity/completing exercise plan. The move towards outcomes based commissioning in public sector organisations means this outcome hierarchy is likely to be needed	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee deliberation. Evidence of effectiveness from a systematic review of the literature will be considered on both its strength and applicability to the key scope questions.
NHS North Essex	4.3 question 1		Need to define what you mean by effectiveness and cost effectiveness. Given today's cash strapped public sector QALYs do not have sufficient currency/immediacy. Whole system impact (ie. if investment is made in referral for exercise, what other benefits may accrue beyond being active *per se* could/should be measured. These could include reduced medication as a result of weight loss or increased insulin sensitivity for example. Whilst not mandatory outcomes , if these are not included as potential outcomes we miss out on a method of engaging other key stakeholders such as CCGs who are likely to need greater immediacy and relevance of outcomes than increased activity *per se*	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness, and committee deliberation. NICE expresses cost effectiveness in terms of cost per QALY to allow comparison across interventions and settings. In the calculation of QALYs, the impact of exercise referral schemes on disease

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				conditions *per se* is to be considered. It is expected that the committee will consider a variety of issues in the guidance development process this may include issues pertaining to whole systems impact, current context for recommendation implementation (including the current public sector context). Our stakeholder process will request input from all registered stakeholders which includes CCGs.
NHS North Essex	4.3 question 2		Add to this: the type of professional making the referral eg any distinction between GP & practice nurse/other health professional	Thank you for your comment. The sub bullets preceding the main overarching questions are an example of some of the sub questions and are not meant to be a comprehensive list. NICE envisage the type of professional making the referral to be considered in the guidance development process.
NHS North Essex	4.3 Question 3		I think you need to define scheme duration over time and what completion means. If there is variability in scheme duration this would need to be taken into account in drawing conclusions, and, if sufficient data analysis of factors associated with any differences in attendance over time	Thank you for comment. Thank you for your comment. NICE envisage scheme duration will be considered in the guidance development process.
NHS North Essex	Question	8	Please can you ask what data exists for longer term outcomes to build a picture	Thank you for your comment. This

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	4		of what this is (where data exists). Important to know what the benchmark is on this (probably very low?) so we can aim for improvements, based on furthering our understanding of factors which determine adherence	guidance focuses on exercise referral interventions. It will aim to address questions (see section 4.3) on effectiveness of exercise referral intervention as well as elucidating factors that impact effectiveness regarding referral to exercise referral, delivery of activity in interventions and long term activity post exercise referral.
Poole Hospital NHS Trust	General		I am a specialist physiotherapist with post graduate qualification in Ante Natal, Post Natal and Pelvic floor conditions. I would recommend that a Chartered Physiotherapist is considered to be ideally placed as a primary assessor for onward referral to exercise prescription. As a profession we are trained in assessment skills and used to red flags specific to case types. Of concern would be that this scheme were rolled out without due regard for red flags, I especially emphasize this where pregnancy is concerned. Health screening will be imperative. Additionally Physiotherapists are motivational and are very used to working their patients to achieve goals inspite of physical limitations.	Thank you for your comments and we welcome Poole Hospital NHS Trust's contribution. Physiotherapists are specifically outlined as an example of allied health professionals whom this guidance would be aimed at (see section 2 d). Health screening is beyond the remit of this particular piece of guidance but NICE envisage that issues pertaining to risk assessment, individual need and appropriateness of exercise referral to certain populations will be considered in the guidance development process (see section 4.3 key questions and

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				appendix a potential considerations)
Results Weight Loss Group	general		Have you thought about linking some form of health care/private medical insurance whereby the cost of the medical insurance lowers albeit the patient/persons health improves? The healthier the person gets the lower the premium becomes. Obviously, this needs to be closely monitored and reported. Don't see no reason why a multifaceted approach, GP to personal trainer/gym to Health insurance provider sharing information	Thank you for your comment. The guidance is concerned with the effectiveness and cost effectiveness of exercise referral schemes funded by the NHS.
Results Weight Loss Group	general		Referring to a gym that covers a large spectrum of services i.e. gym facility, customised programs, individual nutrition guidance, physiotherapy, personal trainers available at all times, lifestyle support, life coaching qualifications, functional medicine, psychological help – obviously all experienced in every area but also trust would need to be established	Thank you for your comment. This document is the scope document and sets out the boundaries of the proposed guidance. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee deliberation. The key questions (section 4.3) will consider aspects pertaining to factors that impact referral into schemes, attendance at schemes and physical activity post scheme.
Results Weight Loss Group	general		BMI and other indicators could be the key indictors to whom you refer the patient to. A gym that is reluctant to share information back and forth with the GP. This way milestones or certain levels of achievement/health improvement can be the deciding factor whether further help is need or not – can also help decide certain exit strategies i.e. once preferred health indictor reached then the patient is more	Thank you for your comment.

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			or less given the all clea	
Results Weight Loss Group	general		Initiative for the medical profession to be educated on obesity management by personal trainers would give a good indicator whether or not they are the right fit to be referred out to	Thank you for your comment
Results Weight Loss Group	general		Create pathways for GPs etc, to use the services of whom they are going to refer their patients to.	Thank you for your comment
Results Weight Loss Group	general		Some form of pilot scheme for patient to trial an exercise referral service before committing	Thank you for your comment
Results Weight Loss Group	general		Small private gyms/personal trainers may be the better choice. small amount of members, can open up times just for gp referrals, better services, more attention, better monitored and assessed, full assessments and can report on the following conditions from blood pressure, cholesterol levels, blood sugar, weight, bmi, body fat, hormonal profiling, biomechanical assessment, lung function, fracture risk., heart disease, aerobic fitness, etc.	Thank you for your comment.
Results Weight Loss Group	general		Patients suffering from back issues, anything to do with occupational health a qualified physiotherapist is a must	Thank you for your comment. The guidance will be relevant to allied health professionals including physiotherapists.
Results Weight Loss Group	general		When considering referral scheme, experience is a must, success stories, and qualifications, credentials like awards or already affiliated partners. Possible experience with bariatric patients pre and post surgery	Thank you for your comment. This guidance focuses on exercise referral intervention. It will not cover exercise referral intervention where the reason for referral is to manage specific

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				conditions that require specialist physical activity intervention or rehabilitation for example post surgery.
Rethink Mental Illness			*Public Mental Health.* (http://www.rcpsych.ac.uk/PDF/Position%20Statement%204%20website.pdf) Targeted exercise referral schemes for people with mental illness could therefore have a significant impact on outcomes for this group. Reducing the premature mortality of people affected by mental illness is a key priority under Domain 1 of the NHS Outcomes Framework and Domain 4 of the Public Health Outcomes Framework. We would therefore recommend that people affected by severe mental illness are treated as a discrete at-risk group and explicit reference is made to this group in the guidance.	Thank you for your comments and we welcome the contribution of Rethink. People affected by mental health issues are not excluded from this guidance.
Rethink Mental Illness	4.2.1	6	The document covers a number of interventions that will predominantly be delivered in primary care. People affected by severe mental illness often find it difficult to engage with primary care services and might need support to do so. Although everyone on a practice's severe mental illness register should be invited to an annual health check as part of the Quality Outcomes Framework, mental health indicators have one of the highest reported exception rates. (Ref: NHS Information Centre (2012) *Quality and Outcomes Framework Achievement, prevalence and exceptions data 2011/12*). These high figures suggest that health professionals might not be getting the opportunities to assess physical activity with this group, which is concerning given the increased health risks for people affected by mental illness described above.	Thank you for your comments. This guidance will focus on exercise referral interventions that meet the parameters outlined in section 4.2.1. The key question highlighted in section 4.3 will consider issues such as factors that influence referral to exercise referral, adherence on exercise referral and long term physical activity post referral.

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			People might need proactive support to engage with primary care services and there might also be a lack of reasonable adjustments for people in these settings. Rethink Mental Illness has produced a resource on reasonable adjustments in GP practices in collaboration with the RCGP called *What's Reasonable?* (available from www.rethink.org/phc). Rethink Mental Illness has also developed a pathway outlining the responsibilities of both primary and secondary care services in addressing the physical health needs of people affected by mental illness. The *Integrated Physical Health Pathway*, which was recommended in the National Audit of Schizophrenia and endorsed by the Royal Colleges of GPs, Nursing and Psychiatrists, can also be accessed at www.rethink.org/phc.	
Rethink Mental Illness	4.3	7	The side effects of antipsychotic medication can include fatigue and sedation, which impact on a person's ability and motivation for physical activity. (See, for example WW, F., U, M., V, G. and M, K. (1994) *Compliance with antipsychotic drug treatment: influence of side effects.* Acta Psychiatrica Scandinavica 89: 11–15) This could therefore be considered under 'participant' factors in these questions so that referrals can be tailored appropriately.	Thank you for your comment. The guidance will consider exercise referral schemes for the general 'inactive' population. People with mental health conditions are not excluded from the guidance and a person's needs, abilities and preferences should be considered throughout the exercise referral schemes process.
Rethink Mental Illness	General		People affected by severe mental illness face significant health inequalities and die, on average, 15-20 years younger than the general population, often from	Thank you for your comment and references. NICE envisage that the

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			preventable physical health conditions. A significant factor in this reduced life expectancy is the weight gain associated with the initiation of antipsychotic medication. (Ref: Casey, Daniel E et al., *Antipsychotic-Induced Weight Gain and Metabolic Abnormalities: Implications for Increased Mortality in Patients With Schizophrenia* Journal of Clinical Psychiatry, Vol 65(Suppl7), 2004, 4-18) This group is also at high risk of conditions such as diabetes, stroke and cardiovascular disease, all of which are listed in the draft guidance as conditions where inactivity is also a risk factor. (See, for example, Expert Group. '*Schizophrenia and diabetes 2003*'. Expert Consensus Meeting, Dublin 3–4 October 2003: consensus summary. Br J Psychiatry 2004; 184 (suppl 47): s112–4.) Physical activity can also have a positive impact on people's mental health and wellbeing. This is mentioned in the proposed guidance and is also referenced in the Royal College of Psychiatrists briefing *No Health Without*	outlined key questions (section 4.3) and potential considerations (appendix a) would include the issues you have raised and so would be considered in the guidance development process
Royal College of General Practitioners	4.2.2	7 of 14	Seems sensible to include the first two current exclusions (cardiac/pulmonary rehab is included elsewhere)	Thank you for your comment. Cardiac and pulmonary rehabilitation programmes are excluded. These types of programme require specialist physical activity specifically set up to address the issues associated with recovery from coronary and pulmonary incidence. This guidance will focus on the

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				promotion of physical activity in the general 'inactive' population.
Royal College of Nursing	General		The feedbacks I have received from nurses working in this area of health suggest that there are no comments to submit on behalf of the Royal College of Nursing to inform on the consultation of the draft scope of the Exercise Referral Schemes public health guidance	Thank you for your comment and we welcome RCN's contribution
Royal College of Physicians (RCP)			The comments below were submitted as the RCP response to the recent consultation on Physical activity – brief advice for adults in primary care (partial update of PH2). We believe that they are equally pertinent in this context. Our experts in sport and exercise medicine believe that there is very clear evidence that regular exercise has a beneficial effect on health and can be used in the management of several chronic diseases. However, they acknowledge that the most difficult aspect of regular exercise for some patients to achieve is the 'regular'. To achieve regular exercise, especially in someone not doing any exercise (which is the group we most want to target) requires a behavioural shift. To that end many experts are not convinced that brief advice in primary care will lead to such a major shift in behaviour that the patient takes up regular exercise for a prolonged period of time. Overall, many believe that a more structured approach in Primary care is required to not only get the message across (that exercise is good for you) but to have effective ways of implementing this advice. This would apply especially to	Thank you for your comment and we welcome the RCP's contribution. The guidance will consider structures, components of the context of exercise referral schemes as well as barriers and facilitators to referral, uptake and completion of exercise referral schemes. This includes factors related to the professional and the consultation with the service user which may lead to offering an exercise referral scheme. The guidance focusses on exercise referral schemes as defined in section 4 of the final scope. Other NICE guidance has updated the

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			the groups that would gain the greatest benefit ie those with chronic conditions who do not exercise. Our experts agree that further evidence needs to be collected to establish the best way of offering good advice to the patient so that the behavioural shift takes place and is embedded in the patients psyche so that they maintain this lifestyle change.	recommendations on brief advice (see www.nice.org.uk/ph44).
Royal College of Physicians (RCP)	General		The RCP is grateful for the opportunity to respond to this draft scope consultation. Our experts in sport and exercise medicine would like to make the following points.	Thank you and we welcome the RCP's comments
Royal College of Physicians (RCP)	General		Exercise referral schemes require the primary care team to assess the subject and then, if necessary, refer them to the physical activity specialist who will work with the subject to increase their level of physical activity. This requires the following:- 1. Finding time in Primary care for someone to spend the time identifying the relevant patients 2. Training that member of the primary care team to be able to identify the relevant patients 3. The primary care team need to have confidence in the physical activity specialist they are referring their patient to. 4. The physical activity specialist works with patient to improve fitness. Our experts believe that point 3 presents the biggest barrier to success. Physical activity specialists (PAS) are currently unregulated and a very heterogeneous	Thank you for your comment.

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			group with varied levels of training and of experience. A GP or primary care team may be reluctant to refer to a PAS if they are unclear of the level of expertise. If the patient suffers an adverse event from the exercise given who will be responsible? We believe that the regulation of the profession of Physical activity specialists is required. As a key part of this pathway and the scheme we believe it is unlikely to succeed unless they are highly skilled and well regulated.	
Royal College of Physicians (RCP)	General		Key questions include:- 1. Who should be delivering the advice/education? 2. What advice should be given and how should it be delivered? 3. How often should the advice be given and how should the patient be followed up? 4. How do we train the advisers? We agree that advice is less lightly to be given if the therapist is not enthusiastic about exercise and has not received the appropriate training. 5. Should each CCG appoint a therapist to act as the exercise advisor/prescriber for that group of Practices? Their remit would be to oversee the prescription of exercise, help to provide the behavioural change and monitor response to the exercise.	Thank you for your comment. This guidance focuses on exercise referral intervention. Interventions that consider the delivery of brief advice or advice as a standalone intervention is excluded from this piece of guidance. The sub bullets preceding the main overarching questions are an example of some of the sub questions and are not meant to be a comprehensive list. NICE envisage that the questions you have raised would be considered in the development of this guidance.
Royal College of Physicians (RCP)	General		Other important themes that could be incorporated into the advice include: 1. The advice gives examples such as the value of walking before and after work by getting off public transport one stop earlier etc. Another concept is to have walking meetings. These can be done successfully	Thank you for your comment. This guidance focuses on exercise referral intervention. Interventions that consider the delivery of brief advice or advice as a standalone intervention is

Public Health Guidance

Physical activity - exercise referral schemes to promote physical activity (partial update of PH2) - Consultation on Draft Scope Stakeholder Comments and Responses Table

13th February – 13th March 2013

Comments forms with attachments such as research articles, letters or leaflets cannot be accepted. If comments forms do have attachments they will be returned without being read. If the stakeholder resubmits the form without attachments, it must be by the consultation deadline

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			when only two people are involved in the meeting. Important points from the meeting can be recorded on a dictation machine and transferred onto paper at the end of the meeting. This can be preferable to sit-down meetings 2. Another point is that, although there are many ways of doing effective exercise, the patient is more likely to do exercise that they enjoy – 'the exercise that is right for you is the exercise that is right for you'. 3. A rough guide to assess the intensity of exercise is the 'sing-talk' test, ie if you can sing during your exercise it is low-to-moderate intensity exercise; if you can talk but not sing during exercise it is moderate-to-high intensity exercise; if you can do neither it is high intensity exercise	excluded from this piece of guidance and are covered in recent NICE public health guidance (PH44). The sub bullets preceding the main overarching questions are an example of some of the sub questions and are not meant to be a comprehensive list. NICE envisages that the questions you have raised would be considered in the development of this guidance.
Sandwell and West Birmingham NHS Trust			Some research suggests that the onset of obesity stems from when children are weaned and how the weaning process is undertaken. By tackling the issue of obesity and lifestyle management as early may make a bigger impact.	Thank you for your comment and we welcome Sandwell and West Birmingham NHS trust's contribution. The guidance focuses on exercise referral schemes as defined in section 4 of the final scope.
Sandwell and West Birmingham NHS Trust	4.1.2	6	By excluding the under 18 age group does not provide equality of service provision. Although there is guidance under development for children, I believe both these guidance need to be linked closely. To ensure continuity of care and prevent support networks from changing as children go beyond the age of 18 and then are offered support from a different group of professionals.	Thank you for your comment and we welcome Sandwell and West Birmingham NHS trust's comments. The age cut off of 19 years and over was selected to bring the guidance in line with the current CMO

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				recommendation categories for physical activity and NICE has already published guidance on the promotion of physical activity in children and young people which includes those 18 years old and younger (Public health guidance 17).
Sussex Community NHS Trust	general		As a Physiotherapist working in the NHS, the use of exercise referral scheme has become more common. This is both GP's directly referring into the schemes and physiotherapists and other health professionals. The benefits to patients have been to reduce the time needed in physiotherapy and encourage a non medical model in ongoing management of physical health. However, my concern, held by myself and other physiotherapists is that the relationship with non medically trained staff [sports and exercise professionals] has not been established well enough. Patients with more complex medical conditions are being seen and may have needs outside the scope of an exercise professional. There should be established pathways for advice guidance or re-referral into appropriate medical staff for advice or professional guidance. We need to all work together with an understanding of each others scope of practice and all working with the patient at the centre of the pathway.	Thank you for your comment. This guidance focuses on exercise referral intervention. It will not consider exercise referral for the management of or rehabilitation post specific condition that requires specialist physical activity intervention for example cardiac or pulmonary rehabilitation.
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	Thank you and we look forward to the publication of the Professional and operational standards for exercise referral.

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			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 drafted and is due to publish a new set of Professional and Operational Standards for Exercise Referral in April 2013. These set out the minimum standards for exercise referral services delivered by exercise professionals. The publication defines the process, delivery and evaluation of exercise referral services, using current evidence, so that auditable and comparable outcomes of services can be produced. Many of these recommendations are included in this consultation response.**	
ukactive	General		ukactive welcomes the opportunity to respond to the consultation on the public health guidance on exercise referral schemes and supports the NICE draft scope to promote physical activity. **ukactive is the not-for-profit body which provides services and facilitates partnerships for a range of organisations, all of which support the vision of more people, more active, more often to improve the health of the nation.**	Thank you for the information and we welcome ukactive's contribution.
ukactive	General		ukactive's membership, which stands at over 3,000 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 include leisure operators such as DC Leisure and SLM that provide community exercise referral programmes and established physical	Thank you for this information.

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			activity interventions. **ukactive supports organisations that 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		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 responsibilities and increase local levels of activity.**	Thank you for your comment.
ukactive	General		For 21 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.
ukactive	General		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**	Thank you for your comment and the findings of your research. It would be useful if you could send the full reference (not the publication) for NICE to consider further.

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			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.	
ukactive	General		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 is being 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.**	Thank you for your comment and information regarding ongoing research.
ukactive	General		ukactive has also traditionally supported the delivery of physical activity interventions and programmes aimed at changing behaviour. For example, ukactive completed a physical activity behavioural intervention programme based on motivational interviewing called Let's Get Moving. This was commissioned by the Department of Health and rolled out to 5 Essex PCTs and 10 local GP surgeries. The programme incorporated a Physical Activity Care Pathway based on recommendations of the NICE Public Health Guidance 2 and 6 and was piloted and evaluated by the British Heart Foundation National Centre for Physical Activity and Health at Loughborough University. Let's Get Moving	Thank you for your comment and information regarding research.

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			was a behaviour change programme that was designed to assist practitioners in guiding inactive adults aged 16-74 towards gradually become more active through motivational counselling and tailored exit routes and activity pathways. Results from Let's Get Moving showed that physical activity motivational programmes with tailored activity pathways are an effective way to change behaviour, produce positive health outcomes and increase local physical activity levels. **This programme should be rolled out nationally so that it is delivered into every local community through qualified community exercise professionals as means to tackle inactivity, sedentary behaviour and rising chronic disease.**	
ukactive	Question 1: How effective and cost effective are exercise referral schemes ?	7	Evaluations by NICE have shown that short term primary care exercise interventions have been used to some effect by GPs and have proven to offer value for money. However exercise referral schemes continue to vary in cost and effectiveness. ukactive contends that service level evaluation should be carried out regularly to support service improvement, on-going commissioning decisions and national evidence collection. The service level evaluation should be both internal and external; conducted on pooled, anonymous patient data; published in an annual report submitted to the referring healthcare professional and commissioner. Furthermore, ukactive believes a follow up report should be drafted that includes: patient satisfaction surveys; patient adherence rates; sources of referral; chosen validated physical activity and quality of life questionnaires recorded at each stage of the programme and at six and 12 months after the programme; percentage of potential referrers who have made referrals, e.g. the percentage of general practices in a given locality; overall cost	Thank you comment and further information.

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			of the service and cost per patient; data broken down by each individual service, where this report includes several services in a locality. **The quality of the 1,300 exercise referral schemes that are currently being delivered vary because no professional and operational standards exist. The new standards due to be published by the Joint Consultative Forum will improve the quality and provide a national set of collective standards for exercise referral.**	
ukactive	Question 1: How effective and cost effective are exercise referral schemes ?	7	There are some GPs who question the competence of exercise professionals. We recommend that all exercise professionals involved in the delivery of exercise referral should hold recognised and approved qualifications for their profession and the specific client group with which they are working. Those delivering exercise referral within the fitness sector should be registered with The Register of Exercise Professionals (REPs) either as a Level 3 exercise referral fitness instructor or a Level 4 specialist instructor, depending on the nature and severity of the condition meeting the National Occupational Standards (NOS) for the knowledge, competence, and skills of good practice. Those working with children should hold a qualification in teaching health related activities for children (such as the Level 2 Physical activity for Children qualification). They should further be committed to an appropriate programme of continuing professional development (CPD) to maintain and develop their knowledge and skills; hold a suitable basic life support qualification and have recognised first aid skills, if working in an environment where there are no other staff with these skills; and have been checked through an enhanced disclosure via the Criminal Records Bureau, if their practice involves contact with children or vulnerable adults. **This ensures that exercise referral schemes are delivered by**	Thank you for your comment. This guidance will consider those aged 19 years and over. Key questions (section 4.3) will consider factors that impact the effectiveness of exercise referral pertaining to referral to exercise referral, delivery of activities on exercise referral as well as long term physical activity post exercise referral intervention. NICE will consider training and qualifications of those referring and those delivering activities on exercise referral interventions in the development of this guidance

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			qualified exercise professionals who have had the suitable training and experience.	
ukactive	Question 2: What factors influence the rate of referral to an exercise referral scheme?	7	At present, around 95% of the population see a primary care practitioner within a 3-year period but only 1 on 4 patients are likely to be sufficiently physically active. NICE guidelines currently encourage doctors to promote physical activity in clinical settings. However, the evidence suggests that there is a lack of awareness and understanding, and inadequate training and guidance within the healthcare profession. For example, in a survey of 48 London GP practices, no GP was aware of the latest physical activity guidelines. A recent questionnaire also showed that only 15 out of 27 medical schools taught the current CMO guidance for physical activity. **Every GP should be obligated and specifically incentivised to clinically recommend physical activity in every consultation, offer specific advice on suitable exit routes to local physical activity opportunities and/or refer inactive patients to particular physical activity programmes.**	Thank you for your comment. Some of the points you have raised are discussed and covered in the soon to be published NICE public health guidance on brief physical activity advice in primary care. This guidance focuses on exercise referral interventions. Where aspects relating to training, knowledge and awareness in physical activity (including current CMO guidelines) and/or methods to increase referral/delivery of exercise referral intervention (where appropriate) these will be considered (see key questions section 4.3)
ukactive	Question 2: What factors influence the rate of referral	7	There is a need to redress the balance between GPs simply prescribing drugs and actually offering broader healthy lifestyle advice. This is very challenging given the time constraints of a 10-minute consultation faced by GPs which make bringing up the topic of increased physical activity very difficult. At present, QOF indicator primary prevention 2 awards five points to GPs for offering lifestyle advice including increasing physical activity to patients with hypertension.	Thank you for your comment. This guidance focuses on exercise referral intervention. Some of the points you have raised are discussed and covered in the soon to be published NICE public health guidance on brief

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	to an exercise referral scheme?		However, there has been no indication that GPs will be specifically incentivised to prescribe physical activity to other groups of patients despite the fact that the majority of adults do not meet the minimum recommendations of daily physical activity. **GPs should be specifically incentivised to prescribe physical activity through QOF points to increase activity and support local authorities deliver their public health outcomes.**	physical activity advice in primary care. Where aspects relating to methods to increase referral/delivery of exercise referral intervention (where appropriate) these will be considered (see key questions section 4.3)
ukactive	Question 3: What factors influence attendance at, and successful completion of, the scheme?	7	It is important that the appropriate patients are be referred by healthcare professionals and risk stratified by the exercise referral service. Referrals to exercise referral services should be made for patients who would benefit from exercise as part of the overall management of their conditions, having stable or significant limitations related to a chronic disease or disability and/or one or more significant cardiovascular disease risk factors. Prior to referring to an exercise referral service, the referrer should consider whether a healthcare sector service (for example physiotherapy, occupational therapy, or sports and exercise medicine) would be more appropriate. A comprehensive referral document completed by a healthcare professional should accompany any patient referred to a service, clearly stating the following: date of the referral and patient's personal details including date of birth, gender, ethnicity and preferred method of contact; reason for the referral, nature and severity of the primary illness and any underlying condition(s) / other relevant past and present medical history; drug history and other treatment(s) being undertaken; blood pressure and body mass index; any known functional impairment that may affect a patient's response to / ability to undertake activities of daily living and / or to participate in exercise (if known); any specific considerations (e.g. communication or cultural	Thank you for your comment. Exercise referral schemes are defined in section 4 of the final scope all inactive adults are considered. The guidance will explore components of exercise referrals schemes and participant characteristics in order to determine (where evidence allows) what is effective and for whom.

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			considerations). **Patients should continually be monitored and risk stratified by the exercise professionals delivering the exercise referral service. This risk stratification should be applied rigorously throughout the patients care pathway.**	
ukactive	Question 3: What factors influence attendance at, and successful completion of, the scheme?	7	Furthermore, the referral document should be passed to the exercise referral service in line with the Caldicott principles. When discussing referral with the patient, the healthcare professional should: explain the reasons for transferring their care and gain consent for the referral; advice the patient who will be responsible for their overall care during the exercise programme and whether the transfer is temporary or permanent; ensure the patient knows who they should contact if they have questions or concerns about their care; advice the patient on what information about them will be passed on to the service and gain consent for the transfer of information. **This will lead to a greater number of exercise referral schemes being commissioned and delivered.**	Thank you for your comment. NICE guidance should be implemented in line with good professional practice.
ukactive	Question 3: What factors influence attendance at,	7	he exercise referral service should risk stratify the patient on entry into the service using an appropriate risk stratification tool, to ensure the patient is assigned to the most appropriate programme. Patients identified as low risk should remain within the exercise referral service and may undertake a wide range of activities, programmed and monitored, but not necessarily supervised by, the exercise professional. Patients identified as medium risk should be	Thank you for your comments. The definition of exercise referral schemes for this guidance includes assessment involving the service user and relevant professional.

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	and successful completion of, the scheme?		entered into an individualised supervised exercise programme, relevant to their condition and managed by an appropriately qualified professional. Cardiac patients identified as high risk should be referred back to the referring healthcare professional for onward referral to an early cardiac rehabilitation service. Non-cardiac patients identified as high risk should be referred back to the patient's GP for referral to an appropriate healthcare team for further assessment, and management of their exercise programme. **Patient risk stratification based on individual needs on entry ensures that they receive appropriate programme relevant to their condition.**	
ukactive	Question 3: What factors influence attendance at, and successful completion of, the scheme?	7	The exercise referral professional should ensure the patient's experience is positive and deliver exercise referral safely, effectively and in line with principles of good practice. Exercise professionals involved in the delivery of exercise referral should be adequately covered by professional and public liability insurance; subscribe to an appropriate code of ethical conduct, which includes only working within the boundaries of their qualification; understand the issue of consent and be able to obtain and document the service user's informed consent; be able to communicate effectively with service users and colleagues; maintain appropriate patient confidentiality, abiding by the Data Protection Act 1998, Human Rights Act 1998, Caldicott Principles and Common Law Duty of Confidentiality: only using patient information for the purposes for which it has been provided and not knowingly releasing any personal or confidential information to anyone who is not entitled to it. **These factors are key to ensuring the successful completion of a scheme.**	Thank you for your comments It is implicit that the person's preferences should be invited, discussed and respected at all stages of an exercise referral schemes (consistent with supporting good 'patient' experience and 'patient' centred care approaches as promoted in and by NICE guidance). Other aspects of the selected programme should conform to the definition of exercise referral scheme as in section 4 of the final scope. In addition, the guidance will review

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				available evidence on context, barrier and facilitators.
ukactive	Question 3: What factors influence attendance at, and successful completion of, the scheme?	7	Initial consultation should include a discussion on the purpose and process of exercise referral, thorough assessment, risk stratification and goal setting. On receipt of the patient referral by the service, the referral details should be checked for completeness. The exercise professional should ensure the patient understands the purpose of the referral and the process, along with what is expected of them. A method of regular communication during the treatment and follow-up phases of the scheme should be agreed at the initial consultation. The patient must give consent to taking part in the programme, having been given all the relevant information required to allow informed consent. The patient should be risk stratified by the exercise referral instructor. The basic assessment/measurement set should include: pre-exercise heart rate and blood pressure; height, weight and body mass index and waist circumference; physical activity using a validated outcome measure; quality of life using a validated outcome measure; other measurements requested by the referring healthcare professional. If additional measurements including aerobic fitness or muscular strength and endurance testing are to be conducted they should take place after these resting measurements and include a warm up specific to the activity to be tested. Short medium and long-term goals should be set at initial consultation and reviewed regularly. Short-term goals should be set on a week to week basis and may be outcome and / or process based (including actually attending the sessions). Medium-term outcome goals may be either: (a) condition specific or	Thank you for your comments. The definition of exercise referral scheme for this guidance includes information giving during contacts between service user and professionals (interventions only offering written information are not the focus of this guidance) and some form of monitoring of those taking-up the exercise referral.

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			clinical outcomes where there is a measurable change (b) personal or patient specific which may or may not relate to the condition. Long-term outcome goals should include meeting a minimum threshold of physical activity after a 12-month period from the start of the programme. **Again these factors are critical to ensuring the successful completion of an exercise referral scheme.**	
ukactive	Question 3: What factors influence attendance at, and successful completion of, the scheme?	7	The programme should be progressive, personalised and consistent with the current evidence base, as well as supporting sustainable physical activity appropriate to the patient's needs. The programme should be: consistent with current condition specific guidelines (for example those set down by the American College of Sports medicine (ACSM), the Swedish National Institute of Public Health Physical Activity in the Prevention and Treatment of Disease or in "ABC of Physical Activity for Health: a consensus statement by the British Association of Sports and Exercise Sciences); progressive and adapted to the individual patient's fitness, while remaining within the recognised guidelines for their condition; tailored to the patient's individual needs and goals; and a minimum of 12 weeks in duration. Longer periods may be more beneficial in achieving an independent, sustainable increase in physical activity. **The programme must be appropriately tailored to the needs of the patient.**	Thank you for your comment. This guidance focuses on exercise referral intervention. Where exercise intervention is for the management of specific health condition or rehabilitation that requires specialist physical activity referral these will not be considered.
ukactive	Question 3: What factors	7	All services should have a named exercise referral co-ordinator or service manager. The exercise referral co-ordinator or service manager should: ensure that the service complies with relevant legislation and, if delivered within a	Thank you for your comments. Some features of exercise referral schemes and user experience could

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	influence attendance at, and successful completion of, the scheme?		leisure centres, should ensure that the centre can demonstrate compliance with the additional requirements of the ukactive Code of Practice; ensure that all the appropriate operational requirements and clear policies (including a complaints procedure) are in place to deliver a safe and effective exercise referral service and ensure that these are reviewed regularly; verify the competencies of exercise professionals working in the service and ensure that, in addition to statutory training, they are provided with opportunities to undertake required professional development, without detriment to their income; ensure all employees whose duties include contact with children or vulnerable adults have been checked through an enhanced disclosure via the Criminal Records Bureau; regularly monitor and quality assure the programmes written and delivered by exercise professionals to evaluate prescription against guidelines; ensure that staff with basic life support and appropriate first aid training are on site when patients are exercising within the service; monitor and nurture working relationships with referrers, commissioners and site operators; inform patients of the organisation's approach to documenting personal health information and the information governance policy in place (e.g. through displaying information in the waiting room or through patient leaflet). **Every patient referred to a service should have an appropriate record and their referrer should receive and appropriate report, both managed in accordance with professional and legal requirements.**	be considered through the review of context, barriers and facilitators to be conducted for the guidance. Established legal and professional requirements would not normally be with the remit of NICE guidance.
ukactive	Question 4: What factors	8	An appropriate exit strategy from the programme should be developed for each patient, once the programme is complete or goals have been met, ensuring they have an agreed sustainable physical activity plan. The exercise professional	Thank you for your comments. The key questions highlighted in

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	influence longer-term participation in physical activity following attendance at an exercise referral?		should: establish what physical activity the patient enjoys doing and promote this; be conversant with physical activity opportunities outside the programme into which the patient can move, signposting the patient towards them; reassure the patient that opportunities for continued support will be provided; establish contact within 6 weeks of completing the programme, then at 12, 24 and 52 weeks and encourage a formal follow up session at these times. **This will ensure that participants remain physically active beyond their exercise referral programme.**	section 4.3 will consider issues such as factors that influence referral to exercise referral, adherence on exercise referral and long term physical activity post referral.
ukactive	Question 4: What factors influence longer-term participation in physical activity following attendan	8	Patients should be monitored throughout the period of exercise and during engagement with the service, using appropriate information, recorded in a standard local format which can be subjected to analysis. Patients should be monitored appropriately by the exercise referral instructor, throughout the period of exercise. Progress should be evaluated against the agreed short, medium and long-term goals. The baseline assessment / measurement should be repeated halfway through the programme and again at the end of the programme. The chosen validated physical activity and quality of life questionnaires should be repeated six and 12 months after completion of the programme. **A report should be sent to the referring healthcare professional (and GP if different) at the end of the supervised exercise phase, including a summary of: the exercise programme(s) undertaken; the patient's adherence to the service;**	Thank you for your comment. Noted, however, this level of detail would be normally be included in the scope and may pre-empt the committee's careful consideration of the evidence.

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	ce at an exercise referral?		**the progress against agreed goals; the agreed exit strategy; the follow up plan; any issues of concern or relevance to the referring healthcare professional.**	
ukactive	The Need for Guidance	4	The Chief Medical Officers of England, Scotland, Wales and Northern Ireland issued joint UK physical activity guidelines for people of all ages. There are additional recommendations on strength and balance, and for older people and children. However, the latest figures show that 7 out of 10 men and 8 out of 10 women fall below their age appropriate recommended activity levels. **The physical activity sector is a significant resource and is playing a leading role in supporting communities to become more physically active. The sector will play a critical role in supporting and enabling local authorities to deliver their public health responsibilities.**	Thank you for this information
ukactive	The Need for Guidance	4	Exercise professionals work with a range of community groups but also increasingly with patients with particular medical conditions. The sector has over 2,300 level 3 and 4 qualified exercise professionals able to deliver exercise referral programmes. Level 3 exercise referral qualifications allow a professional to work with low risk patients with asthma or COPD; hypertension or hypercholesterolemia; OA; RA; joint replacement; simple mechanical back pain or osteoporosis; depression; stress or anxiety; type 1 and type 2 diabetes or obesity. Level 4 specialist exercise qualifications additionally include cardiac rehabilitation; falls prevention; low back pain; stroke; cancer; accelerated rehabilitation. **ukactive work with our members to raise standards and**	Thank you for this information

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			ensure the highest quality services; professionals involved in the delivery of exercise referral should have the necessary qualifications, competencies, knowledge, skills and background checks required to work with the specific patient group.	
University of Edinburgh	Appendix A	11	Payment to primary health care practices for referral/asking screening questions may be important. This may either be as an incentive or by reducing barriers of staffing/administration. The Qof also requires specific targets to be met for payments.	Thank you for your comment.
University of Edinburgh	General		We feel there is a terminology mismatch in the scope. Traditional term of exercise referral is used throughout the document, whereas all approaches that are covered relate to physical activity programmes and physical activity approaches (pg 6) rather than exercise explicitly. We feel that the term physical activity referral would be more appropriate.	Thank you for your comment. We use the term exercise referral in its broadest sense. We have used the term “exercise referral” as this piece of guidance seeks to update the “exercise referral” aspects of NICE public health guidance 2 and also Exercise referral is a term that is currently in use. Exercise referral is not restricted to “exercise” and does include the broader umbrella term of physical activity.
University of Edinburgh	General / 2		What level of evidence will the review be considering? If the review is only seeking quantitative results from peer reviewed journal articles, we feel it is unlikely that it will uncover any more than the Pavey et al review. We suggest	Thank you for your comments. NICE guidance is based on best available evidence. CPH methods

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			that NICE consider including local evaluations of service provisions/grey literature to complement the peer reviewed evidence. We also suggest that NICE could include expert opinion should evidence in any particular area be lacking (e.g. for sedentary behaviour change). Both of these approaches have been successfully used in previous NICE guidance (e.g. in PH17 Active Play, review 8 and in recent PH41 walking & cycling)	allow for a broad range of evidence to be considered. This will be supported by a review available evidence on context, barrier and facilitators
University of Edinburgh	3 (b)	4	Should sedentary behaviour be included in this scope as well as MVPA, strength and balance activities? There is possibly a lack of evidence, but it would be useful to have this highlighted for practice and future research.	Thank you for your comment. Section 3 provides only a brief overview of the literature. It is not meant to be a comprehensive review of the literature.
University of Edinburgh	3	4	There is no understanding of capacity for Exercise referral at present in the scope. Is it possible to map the frequency of exercise referral schemes available at present to understand the impact the guidance may have?	Thank you for your comment. Section 3 is not intended to be a comprehensive review of the literature.
University of Edinburgh	Section 4.2	6	The definition of exercise referral needs clarification. We think that it should include both an assessment of PA (1st bullet point) **plus** at least one of the additional bullet points – referral, assessment, PA programme.	Thank you for your comment. For the purposes of this **guidance** exercise referral would have to include all of the aforementioned points in section 4.2 to be categorised as an exercise referral intervention.
University of Edinburgh	Section 4.2.2	7	It needs to be specified that the brief advice on its own (that is not covered by the guidance) is that which is delivered by the G.P.	Thank you for your comment. Brief advice delivered as an intervention without referral to physical activity specialist and referral to physical

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				activity as part of an exercise referral intervention is not covered by this guidance. NICE has recently published guidance on 'Brief physical activity advice in primary care' (www.nice.org.uk/ph44)
University of Edinburgh	Section 4.3	Pg 7	Q1 is 2 different questions that should be addressed separately (effectiveness and cost effectiveness). Also within Q1 there appears to be a question relating to outcome (effectiveness) and another about process (factors relating). Again these should be considered separately with a list of sub-questions as per Q2 and Q3	Thank you for your comment. These questions have been grouped together as they focus on the effectiveness of exercise referral intervention. The second part of question refers directly to the first part and thus it was felt appropriate to keep together. The sub bullets preceding the main overarching questions are an example of some of the sub questions and are not meant to be a comprehensive list.
University of Edinburgh	Section 4.3	Pg 7	It is not clear by what is criteria effectiveness will be determined. We presume that it will be an increase in PA rather any change in medical conditions. Also the level of change in PA to be considered effective is not clear i.e. change in number of people meeting the PA guidelines or just any significant increase in PA?	Thank you for your comment. This document is the scope of the guidance and its aim is to provide an outline of the boundaries of the guidance. Section 4.3 expected outcomes provides some examples of what the outcomes to questions 1-4 may

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				consist of. At this stage of the guidance development process it is not appropriate (nor does NICE attempt to) categorically define study outcomes without reviewing the evidence. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee deliberation
University of Edinburgh	Section 4.3	Pg 7	Q2 seems to be missing the question about what is the mean reason people do get referred to an exercise referral scheme. And what leads to getting an exercise referral, i.e. what was their initial appointment for, how did PA get introduced into the consultation?	Thank you for your comment. The sub bullets/questions are only examples of potential questions and are not meant to be an exhaustive list.
University of Edinburgh	Section 4.3	Pg 7	We are not sure how participant factors eg knowledge of PA should impact on PA referral (should perhaps be factors for Q 3) . Unclear at present.	Thank you for your comment. Participant factors in the context of question 2 refers to the consideration of individual participant factors such as their knowledge of physical activity and the person responsible for referring that participants likelihood of referring that person.
University of Edinburgh	Section 4.3	Pg 7	Participant factors are not clear in this question	Thank you for your comment If interpreting your comment correctly – and you are referring to question 2 in

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				the draft scope: Participant factors in the context of question 2 refers to the consideration of individual participant factors such as their knowledge of physical activity and the person responsible for referring that participant's likelihood of referring that person. If referring to question 3 participant factors outlined here refer to factors that would impact on their potential to attend a referral. The sub bullets/questions are only examples of potential questions and are not intended to be a comprehensive list.
University of Edinburgh	Section 4.3	Pg 8	Q4 - A fuller explanation of 'longer term' is required – 12 weeks, 6 months, 1 year, 5 years…?	Thank you for your comment. This document is the scope of the guidance and outlines the boundaries of guidance coverage. Section 4.3 (key questions) outline the question that this guidance will address. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and committee

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				deliberation. At this stage of the guidance development process it would be inappropriate to comment on what 'longer term' regarding physical activity post exercise referral constitutes before considering the evidence fully.
University of Edinburgh	Section 4.3	Pg 8	It is important to consider that baseline levels of PA may have an impact on recruitment/retention. This has implications for the effectiveness/reach of referral	Thank you for your comment. The key question s (section 4.3) will consider the issue you raise and depending on the evidence found may be discussed further as the guidance is developed.
University of Edinburgh	Section 4.3	Pg 8	We would like to see the expected outcomes linked to the aforementioned specific research questions	Thank you for your comment. This document is the scope. It sets the boundaries for what the may guidance consider. The expected outcomes (section 4.3) are examples of what we may find as it not meant to constitute an exhaustive list of outcomes for each question. In the absence of the evidence that will underpin this guidance it would be inappropriate to speculate further than NICE has in the scope document regarding what

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				specific outcomes we could expect.
University of Edinburgh	Section 4.3	Pg 8	The term 'change' is not clear in the expected outcomes. Could it be altered to sound more positive – e.g. increase/improve	Thank you for your comment. This document is the scope and sets the boundaries regarding what this guidance will cover. As the impact of exercise referral could be an increase or decrease we aim to stay as 'neutral' as possible in the absence of the evidence, when providing examples to what we expect outcomes to be.
University of Exeter	Also in the above doc.		A further journal article was published: Anokye NK, Trueman P, Green C, Pavey TG, Hillsdon M, Taylor RS. The cost-effectiveness of exercise referral schemes. BMC Public Health. 2011 Dec 26;11:954. doi: 10.1186/1471-2458-11-954.	Thank you for the reference
University of Exeter	General		We welcome the decision to update the guidance on ERS.	Thank you and we welcome the University of Exeter's contribution
University of Exeter	General		We welcome new consideration of how an ERS should be defined, and the nature of the core components. Only with a tighter definition can comparison of intervention effectiveness be made across studies.	Thank you for your comment.
University of Exeter	General		We welcome the broader scope of the guidance to also focus on the determinants of engagement in ERS and longer term change in PA, following our review: Pavey, T.G., Taylor, A.H., Hillsdon, M., Fox, K.R., Campbell, J.L., Foster, C., Moxham, T., Mutrie, N., Searle J., & Taylor, R.S. (2012). Levels and	Thank you for your comment. The guidance will review available evidence on context, barrier and facilitators.

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			predictors of exercise referral scheme uptake and adherence: a systematic review. J of Epidemiology and Community Health, 66(8):737-44.	
University of Exeter	In Section 3 (c)	4	The generally stated fact that physical activity is lower among lower socio-economic groups is only true in relation to leisure-time physical activity. Daily physical activity (without car ownership) and engagement in manual occupations undermine the general assumption about this relationship.	Thank you for your comment, this is noted.
University of Exeter	In the 'Decision to Update NICE guidance on ERS doc', footnote 3, on p. 5.		Makes reference to the wrong reference. It refers to Pavey et al 2011b, (which should 2012 as: Pavey, T.G., Taylor, A.H., Hillsdon, M., Fox, K.R., Campbell, J.L., Foster, C., Moxham, T., Mutrie, N., Searle J., & Taylor, R.S. (2012). Levels and predictors of exercise referral scheme uptake and adherence: a systematic review. J of Epidemiology & Community Health, 66(8):737-44). However, the correct reference, which did include the Murphy et al (2010) study in the meta-analysis, is: Pavey, T.G., Taylor, A.H., Fox, K.R., Hillsdon, M., Anokye, N., Campbell, J.L., Foster, C., Green, C., Moxham, T., Mutrie, N., Searle, J., Trueman, P. & Taylor, R.S. (2011). Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: systematic review and meta-analysis. British Medical Journal. Nov 4;343:d6462.	Thank you for your comment.
University of Exeter	In the section 6 on 'related NICE guidance'	9	Reference could also be made to: NICE (2009) Guidelines for treating depression (CG90) (7.4.1.4) which states: 'Physical activity programmes for people with persistent sub-threshold depressive symptoms or mild to moderate depression should: be delivered in groups with support from a competent practitioner; and consist typically of 3 sessions per week of 45-60 mins over 10-14 weeks (average 12 weeks).'	Thank you for your comment.

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University of Exeter	Section 4.2.1 Bullet 3.	6	In defining an ERS, the reference to 'A formal assessment by the physical activity specialist or service to determine what programme of physical activity to recommend.' implies a directive approach to behavior change. Other approaches attempt to engage individuals in taking a more active role in behavior change. An ERS could also involve motivational counseling in which individuals receive support to increase PA after assessing an individual's level of PA, past experiences and associated beliefs. This would involve more than brief advice. Further, it is not clear what kind of assessment method is being referred to here and how the outcomes of an assessment might be used. Given that any self report instrument will lead to considerable misclassification it is unclear what value further assessment might bring.	Thank you for your comments. This document is the scope of the guidance and its aim is to establish the boundaries of what will be considered by the guidance. Although section 4.2.1 highlights "formal assessment..." as part of its definition of what constitutes exercise referral its does not exclude other forms of assessment such as those that are patient directed. This definition of exercise referral does not exclude motivational interviewing. Interventions which only include brief advice are not covered in this guidance (see recently published guidance www.nice.org.uk)/ph44). Formal assessment in bullet 3 refers to an assessment post referral by a physical activity specialist regarding the appropriateness of any physical activity intervention as part of the exercise referral scheme. This assessment could include patient centred approaches aswell as other approaches.

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University of Exeter	Section 4.2.1 Bullet 4	6	In defining an ERS, the reference to 'A physical activity programme' is vague and could be misconstrued as a structured exercise programme. If the ERS can only include 'a programme' then it is likely to be short-term and any change in physical activity may dissipate quickly. Could the words 'A physical activity programme or period of motivational support for physical activity' be better?	Thank you for your comment. The definition of an exercise referral intervention for the purposes of this guidance would include a physical activity programme or physical activity element. The provision of motivational support is part of the process which could occur at any point in the exercise referral intervention. The provision of motivational support without referral to physical activity self initiated or as part of a formal programme would be excluded from this guidance.
University of Exeter	Section 4.3 'Expected outcomes' Bullet 2.	7	'A change in the number of people attending and completing the supervised or directed exercise activity.' This could be reworded to refer to changes in daily physical activity resulting from support from a specialist, to be relevant to less prescriptive approaches.	Thank you for your comment The outcomes in the final scope include physical activity and do not exclude any frequency, duration or intensity. The evidence based may be limited to particular types or records of physical activity, but relative differences between interventions and groups of people may be useful. PHAC will carefully consider applicability, relevance and

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				completeness of the evidence in developing recommendations.
University of Exeter	Section 4.3 'Expected outcomes' Bullet 5.	7	The questions are appropriate. There could be further reference to the expected outcomes for specific special populations. From our review, we found that there was little or no evidence for ERS with tightly defined referral categories, but instead patients referred into ERS tended to have a wide range of conditions and/or risk factors, which reduced any likelihood of showing change for specific conditions. We have identified 23 different NICE guidelines (more than in the related NICE guidance section) in which physical activity was mentioned as an appropriate treatment, and no studies were identified in our review which enabled us to assess the effects of ERS on specific expected health outcomes.	Thank you for your comment. The expected outcomes (section 4.3) are not intended to be a comprehensive list of all the outcomes but examples of possible outcomes.
Yoga for Healthy Lower Backs	3 c and General	4	Yoga is an activity (with physical and mental health benefits) that appeals to women. Very often people are unsure how to raise their fitness levels from below-average to average and therefore do not have confidence to begin movement. Appropriate yoga can be an ideal starting-point and gradually and progressively strengthens and mobilizes the body. This can, as shown in our research, lead on to regular home practice (Annals of Internal Medicine Nov 1st 2011 Yoga for Low Back Pain: A Randomized Trial, H Tilbrook et al). Yoga gives people the confidence to regain a more active lifestyle, e.g. begin gardening, take up tennis again. Entry-point yoga, such as the yoga programme designed and developed for the research mentioned is appropriate for all ages as the yoga is adapted and modified for individuals.	Thank you for your comment and we welcome Yoga for Healthy Lower Back's contribution. The guidance focuses on exercise referral schemes as defined in section 4 of the final scope. Yoga could be included as part of the exercise referral. Evidence on such a referral could be considered providing all aspects of an exercise referral scheme were included.
Yoga for Healthy Lower Backs	3 d and General	4	When a person is physically unfit, it may not be easy for a GP or health professional to feel confident referring this patient on to exercise unless they	Thank you for your comments. The guidance will explore (as evidence

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			know exactly what is involved. They will want to know that there will be professional and adequate supervision and preferably an education element. The yoga profession is aiming to follow the evidence-base of the University of York research mentioned above by putting in place professionals who will offer the very same 'Yoga for Healthy Lower Backs' yoga programme with teachers trained in the same way as the 20 trained trial teachers. Yoga always addresses the whole body and mind of the person (not just the lower back) and so will actively address Yellow Flags and the appropriate and gentle yoga programme mentioned above acts as an ideal entry-point yoga programme. It has been shown to help those who are a. Afraid to move b. Not strong enough to launch into other more vigorous exercises c. Do not have the confidence to do much activity of any kind, let alone 'exercise' as they may understand it. It educates patients about their bodies, minds and health to encourage more health and well-being for the long-term	allows) professionals experience of the referral component of exercise referral schemes.
Yoga for Healthy Lower Backs	3e	4	Yoga has been shown to help prevent osteoporosis due its weight-bearing, gentle muscle and tissue challenging, and stress-reduction (cortisol level) benefits. It has also been shown in many research studies to help significantly with regards to depression and therefore can encourage a healthier more active lifestyle.	Thank you for your comment. The guidance focuses on exercise referral schemes as defined in section 4 of the final scope
Yoga for Healthy Lower Backs	4.2.1	6	We would strongly recommend that 'Yoga for Healthy Lower Backs' teachers should be considered to be part of any recommended programmes aiming to encourage more active lifestyles. Particularly those who are overweight, depressed, stressed, have high blood pressure, have musculo-skeletal pain, lower back conditions, hormonal problems and more could benefit from such an	Thank you for your comment. NICE guidance is based on the best available evidence of effectiveness and cost effectiveness and the deliberations of Public Health Advisory

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			appropriate entry-point yoga programme. Teachers qualified in this particular yoga programme (200 and more training) are trained to recognize Red Flags, to refer back when appropriate.	Committee (PHAC). The guidance is for exercise referral schemes for people who are 'inactive'. Section 4.2.2 for the final scope defines interventions that will not be considered.
Yoga for Healthy Lower Backs	4.2.2	7	'Yoga for Healthy Lower Backs' 12-week programme is unique in that it has educational resources to empower the patients to continue to self-manage their health and to continue to remain active. A book, relaxations CD and home practice handouts are a part of the programme and Arthritis Research UK (as funders of the RCT) support the use of these resources.	Thank you for your comment.
Yoga for Healthy Lower Backs	4.3	7	Question 1 'Spine' journal published cost-effectiveness data on this 'Yoga for Healthy Lower Backs' programme showing it would be cost-effective compared to other usual NHS treatments for non-specific chronic low back pain. It found that participants in the yoga group had 3.83 days off work over the 12 months studied compared to 12.29 in the usual care control group. Having learnt to practice yoga at home safely and effectively, they had become more active in daily life. Question 2 The referring Health Professional does need to know that the exercise professional will be knowledgeable enough to supervise these people. They often do not know exactly what they are referring to, i.e. will the actual exercise be appropriate for the individual. (The Yoga for Healthy Lower Backs yoga programme is taught by experienced and skilled yoga teachers who understand how to carefully encourage participation in movement and activity	Thank you for your comments. Thank you for your comment. This guidance will consider issues pertaining to interactions in the exercise referral process as well as levels of training and knowledge.

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			and know how to modify exercise for individual needs.) Knowing that participants will be in a warm, clean, safe environment supported by the same teacher/exercise health professional and that they will be exercising with the same group of people acts as encouragement for participation. Expected Outcomes. At a time when physical and mental health are known to be so interlinked, an ideal solution would be to begin to recommend more mind/body disciplines, such as yoga, for potential multiple, life-changing benefits. The population of the UK seems to be willing and ready to accept this and it would help to have more encouragement from NICE and the NHS. In the USA yoga is a main-stream treatment option for many conditions.	
Yoga for Healthy Lower Backs	Appendix and General	11	Certainly, patients 'obey' their GP and this may be key to giving them the impetus to understand the importance of keeping active. Offering 12 group classes helps to get people into the habit of continuation of exercise. Exercising with the same group of people offers support aiding increased class attendance. The NHS currently gives a small mention of yoga being helpful for the more elderly population. We would like it noted that there are often younger members of the public who lead sedentary lives and are unable to begin exercising safely until they have regained some understanding of posture and some initial strength and mobility – yoga would be ideal for them and might be a popular patient choice. It should be noted that not all yoga would be appropriate for everyone. Appropriate, beginners, entry-point yoga taught by experienced and suitably qualified yoga teachers would be most appropriate to recommend to those unused to exercising.	Thank you for your comments.

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			We would be pleased to give further information about yoga standards, regulation, as we feel this is important to differentiate between yoga taught by someone having done a weekend course and teaching at a fitness centre and someone with a long professional training.	

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