NICE National Institute for Health and Care Excellence

Appendix B: Stakeholder consultation comments table

2018 surveillance of Physical activity: exercise referral schemes (2014)

Consultation dates: 14 to 25 May 2018

Do you agree with the proposal to not to update the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
ukactive Research Institute	No	At present the guidelines do not contain any specific recommendations regarding the required length of exercise referral schemes in order to produce improvements in physical activity levels or health outcomes. The typical length of scheme followed in the UK is 10-12 weeks (Pavey et al., 2011), yet schemes are typically 16 weeks in Wales specifically and this length of scheme has been shown to be more cost effective (Edwards et al., 2013). In a systematic review we have recently conducted (Rowley et al. under review) it is reported that schemes of longer length (~20+ weeks) also produce greater outcomes than shorter schemes, likely due to greater attendance.	Thank you for your comments, please find a separate response to each point below: • Regarding the length of exercise referral schemes: – The paper by Pavey et al. (2012) was considered during the original development of the guideline and its findings have already been taken into account. Therefore the guideline will not be impacted. – The paper by Edwards et al. (2013), this has been added to 'Appendix A: summary of evidence from surveillance'. The trial reported in this study has already been considered during the original guideline development. This paper is an additional subgroup analysis focusing on

Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

		References: • Pavey, T., Taylor, A., Hillsdon, M., Fox, K., Campbell, J., Foster, C., Moxham, T., Mutrie, N., Searle, J., Taylor, R., 2012. Levels and predictors of exercise referral scheme uptake and adherence: a systematic review. *J Epidemiol Community Health*, 66(1), pp. 737-744. • Edwards, R., Linck, P., Hounsome, N., Raisanen, L., Williams, N., Moore, L., Murphy, S., 2013. Cost-effectiveness of a national exercise referral programme for primary care patients in Wales: Results of a randomised controlled trial. *BMC*, Volume 13, p. 1021. • Rowley, N., Mann, S., Steele, J., Horton, E., and Jimenez, A., 2018. The effects of exercise referral schemes in the united kingdom in those with cardiovascular, mental health, and musculoskeletal disorders: An updated systematic review. Under review BMC Public Health Recommendation 2 suggests that exercise referral schemes should only be funded if they include capture of data permitting analysis, monitoring, and research to inform future practice. Further, recommendation 3 argues that Public Health England should develop and manage a system to collate local data on exercise referral schemes. In 2014 Public Health England Commissioned the National Centre for Sport and Exercise Medicine in Sheffield and the ukactive Research Institute to undertake a survey of physical activity interventions across England in which none of the included interventions achieved higher than a	the effects of medical diagnosis, gender, age, inequalities, referral route and adherence on effectiveness and cost-effectiveness of a 16-week national exercise referral programme. The results of the study indicate that the national exercise referral programme was cost-effective in fully adherent patients with mental health and/or CHD risk factors. – The systematic review in development by Rowley et al. has been added to our event tracker and we will assess the impact on recommendations when it is published. Overall, there is mixed evidence on the optimum length of time an exercise referral scheme should be, with positive findings found for both 12-week and 16-week schemes. Due to this uncertainty, the guideline does not currently make any recommendations on what the length of an exercise referral scheme should be. However, research recommendation 5.1 states that more research is needed on the comparison of exercise referral schemes that vary by "intensity and duration – for example, a 12-week scheme involving 1 session a week, or a 6-week scheme involving 4 1-hour sessions per week". Until there is further evidence in this area, the recommendations will not be affected. • Thank you for your comment regarding recommendations 2 and 3 and the capture of data on exercise referral schemes. Also, thank you for highlighting the survey undertaken by National Centre for Sport and Exercise Medicine in Sheffield and the ukactive Research Institute. This provides useful background information on the types

		NESTA level 3 rating (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/374560/Whatworksv1_2.pdf). When considering exercise referral schemes none achieved higher than a NESTA level 2 rating and many where no higher than NESTA level 1. Following this in 2017, the ukactive Research Institute conducted a follow up survey considering the quality of evaluations being undertaken (http://research.ukactive.com/001-moving-scale/Moving-at-scale---Pr.pdf). A total of 127 exercise referral schemes submitted responses to this survey. Though in this round there were at least some submissions attaining NESTA level 3-5 (n=6), many were still not capturing any data relevant to the scheme and thus still received NESTA level 1 ratings (n=20). Though there has seemingly been an improvement in capture of data since 2014, many are still not following this suggestion. Further, although they were involved in the process of the evaluations noted, Public Health England have not yet established a system to collate and manage data on these schemes. Thus it has been left to not-for-profit organisations and commercial partners. The ukactive Research Institute has now partnered with ReferAll (http://www.refer-all.net/) to try to gain an understanding of the effectiveness and cost effectiveness of exercise referral schemes through their database. As a result, NICE should perhaps consider the benefits of similar partnerships and recommend that providers of exercise referral schemes consider joining with such services in order to contribute to	of schemes being run in the UK and highlights issues with data collection. As stated in 'Appendix A: summary of evidence from surveillance', NICE public health guidelines no longer make recommendations directed at Public Health England so recommendation 3 will be withdrawn. However, we acknowledge the importance of collecting data in this area to inform future practice. Recommendation 2 states that "Policy makers and commissioners should only fund exercise referral schemes for people who are sedentary or inactive and have existing health conditions or other factors that put them at increased risk of ill health if the scheme: - Collects data in line with the 'essential criteria' outlined in the Standard Evaluation Framework for physical activity interventions. Specifically: programme details, evaluation details, demographics of individual participants, baseline data, follow-up data (impact evaluation) and process evaluation. - Makes the data collected available for analysis, monitoring and research to inform future practice." We have passed on the concern around adherence to this part of the recommendation to the implementation team at NICE, and will review this area at the next surveillance point.

		the evidence base, as well as suggesting policy makers and commissioners consider these options for ensuring data capture occurs.	
Physical Activity Special Interest Group, Wolfson Research Institute of Health and Wellbeing, Durham University.	No	NICE's proposal is 'not to update' the 2014 guidelines (PH54). Broadly speaking, we endorse this perspective. Overall, the evidence base has not shifted substantially or significantly since the 2014 guidelines were published. Therefore, it is appropriate to retain the recommendations of PH54. However, there have been some important developments in the literature that could be reflected in minor amendments to the existing guidelines. Our proposed amendments are likely to additionally help improve the quality and utility of data accrued from future scheme evaluations. This is an important consideration given the lack of improvement in data concerning some key questions identified in 2014. Specifically, we propose that NICE may consider the following: 1. While we recognise that recommendations are no longer directed towards PHE, removing recommendation 3 entirely means other important information is lost. We would argue it is important to retain the recommendation that appropriately anonymised programme data should be	Thank you for your comments. Please find a separate response to each point below: • Thank you for your comment regarding the proposal to withdraw recommendation 3 from the guideline. We acknowledge the importance of collecting data in this area and would like to highlight the final 2 bullet points of recommendation 2 which states the following requirements of an exercise referral scheme: "- Collects data in line with the 'essential criteria' outlined in the Standard Evaluation Framework for physical activity interventions. Specifically: programme details, evaluation details, demographics of individual participants, baseline data, follow-up data (impact evaluation) and process evaluation. - Makes the data collected available for analysis, monitoring and research to inform future practice". The second bullet overlaps with that in recommendation 3, so we are content that no important information is lost. • Thank you for your comment regarding the barriers to exercise referral scheme uptake. As you have noted, we did identify new evidence on barriers to the uptake of exercise referral schemes, however we suggested these barriers are likely to be addressed by following recommendation 8 in NICE guideline PH49 (Behaviour change: individual

		made publicly available for analysis. NICE may recommend routine submission of scheme data for evaluation to a specific database, for example, an appropriate alternative platform, or routine publication/contacts for obtaining data identified via provider sites/within trial registrations. This is likely to increase the quality of available data for analysis of key questions identified in the 2014 guidelines. 2. As the consultation document recognises, there have been advances in understanding concerning the range of barriers to exercise referral scheme uptake, and also adherence. The cross reference to PH49 is helpful; however, we feel that the exercise referral scheme guidelines could usefully be more specific about the barriers that have particular relevance to this type of scheme. Requiring providers to consider "assessing then addressing" participants' needs such as their physical and psychological capability to make change, and the context in which they live and work, is relatively vague and non-directive. It is not clear how exercise referral scheme practitioners or services might reasonably be expected to 'address' some of these complex circumstances. In reality, it means that entry to an exercise referral scheme may be inappropriate for some individuals (for example, those with multi-morbidities and/or multiple barriers to activity engagement) at a given point in time. We argue this should be clearly highlighted in PH54 itself, raising awareness of this in those referring patients, those	approaches) which is already cross-referred to in the guideline. As exercise referral schemes will be different across providers and for each patient, it was decided during guideline development that broad recommendations on the core principles of behaviour change were the most appropriate for this section of the guideline. However, please see the considerations section for more specific comments from the guideline committee on 'scenarios of effectiveness' and 'barriers to success'. Whilst the considerations section does not contain recommendations, it provides useful discussion points on barriers to exercise referral uptake as well as links to other resources which may be of use. It is acknowledged that exercise referral schemes may not be an appropriate option for some people with multi-morbidities and/or multiple barriers to activity engagement. However, this may not be the case for all patients in these groups and we identified no evidence to suggest any indications of harm being caused. It is expected that by taking into account individual needs and monitoring progress (as set out in recommendation 2) clinicians and professionals would recognise any issues and consider alternative options accordingly. It is not in the remit of the surveillance process at NICE to amend or add new research recommendations, however it is acknowledged that there is a gap in evidence for studies looking at the effect of exercise referral schemes on people with multiple health conditions (as highlighted in Section 11 'Gaps in evidence').

		delivering schemes, and patients themselves. As an outcome, exercise referral schemes might be better targeted towards patients able to engage, reducing drop-out and improving cost effectiveness, and ensuring patients with complex circumstances are better supported with alternative services. Given the profile of patients being referred to schemes, improving our knowledge of how best to tailor exercise referral services to patients with multimorbidities could be raised as an area for further research in RR 01 para 5 on page 10. 3. We suggest the following on-going study be listed as having potential to change recommendations, being of comparable scope and rigor to the multi-centred RCT of web based support already listed: Hawkins, J., Edwards, M., Charles, J., Russell, J., Kelson, M., Morgan, K., Murphy, S., Oliver, E., Simpson, S., Tudor Edwards, R. & Moore, G. (2017). Protocol for a feasibility randomised controlled trial of the use of Physical ACtivity monitors in an Exercise Referral Setting: The PACERS study, *Pilot and feasibility studies, 3 (1).* p. 51. https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-017-0194-z	• Thank you for highlighting the ongoing trial by Hawkins et al. We have added this trial to our event tracker and will assess the impact of the results on the guideline when they are published.

DECIPHer, Cardiff University	Yes	No comments provided	Thank you.
Royal College of Physicians (RCP)	No answer	No comments provided	Thank you.
Public Health England (PHE)	Yes	As noted by the Surveillance, evidence has not moved on significantly to justify an update to the Recommendations. PHE supports the withdrawal of Recommendation 3 for PHE to "develop and manage a system to collate local data on exercise referral". We are aware that the ukactive Research Institute has established a database for providers to undertake research that can provide evidence to inform a future review.	Thank you for your comments and for highlighting the database established by ukactive Research Institute. We will monitor the progress of this database and reconsider this area at the next surveillance point.
Royal College of Nursing	Yes	This is just to let you know that the feedback I have received from nurses working in this topic area suggests	Thank you.

		that there is no additional comments to submit to inform on the consultation of the above draft guidelines.	
Do you have any comments on areas excluded from the scope of the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
ukactive Research Institute	Yes	As noted, the ukactive Research Institute are at present working with ReferAll on the analysis of their exercise referral database. A number of areas, though not excluded from mention in the existing guidelines, at present have little evidence to support them. These include but are not limited to: the effects of exercise referrals for specific health conditions, the effects of different scheme components (i.e. modality, length, frequency, intensity), and what factors might predict success with exercise referrals schemes. Due to the ongoing nature of this work, we would be eager to continue to input into the consultation process as findings emerge.	Thank you for your comment and for highlighting the ongoing research in relation to your work with ReferAll. We will consider any research findings that come out of this work and assess the impact on the recommendations when the results are available.
Physical Activity Special Interest Group, Wolfson Research Institute of Health and Wellbeing, Durham University.	No	No comments provided	Thank you.

DECIPHer, Cardiff University	Yes	'Ongoing Research': A 3-year study assessing the long-term implementation and effectiveness of a national exercise referral scheme in all 22 local authorities in Wales is ongoing. Funded by Health and Care Research Wales in October 2016, the findings from this study have the potential to change the recommendations. The findings will provide invaluable evidence on post-trial implementation across a 10-year period and produce the first evidence examining the longer-term effects of exercise referral participation (i.e. examining 3- and 5-year health outcomes and health service use). We are currently half way through the study and due to publish our implementation findings later this year. http://decipher.uk.net/research-page/long-term-implentation-effects-national-exercise-referral-scheme-ners-wales/ As lead investigator, please do let me know if you require any further detail at this stage.	Thank you for highlighting this ongoing research. We have added this study to our event tracker and will assess the impact on recommendations when the results are published.
Royal College of Physicians (RCP)	No answer	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Sport and Exercise Medicine Committee and we like to make the following comments. We commented on the original document from 2014 and noted that there was no input from an SEM specialist on the Public Health Advisory Committee and the NICE	Thank you for your comment regarding input from a specialist in sport and exercise medicine. We will ensure that efforts are made to recruit a specialist in this area to advise at the next surveillance review. Regarding your comment on clinical pathways for chronic diseases, these can be found in the respective NICE guidelines for separate conditions, where structured exercise programmes are delivered by a specialist physical activity and exercise instructor (trained to level 4). As detailed in Box 1, exercise programmes for patients with chronic conditions are not in scope for PH54.

		project team. We found this surprising in 2014 and continue to find it surprising. The minimal cost benefit of 'brief advice' and the use of exercise referral schemes have been maintained. It would also be helpful for NICE to suggest how to create clinical pathways for patients with chronic diseases to follow once it was felt that the patient would benefit from exercise intervention. It is disappointing the work from 2014 has not been progressed. We wish to highlight the difficulty encountered in trying to guarantee standards and create some form of accreditation for level 4 professionals. This undermines confidence for referrers and if we could accredit them in some way it would likely strengthen confidence in the whole process.	Regarding your comment on accreditation for level 4 professionals, it is not within the remit of NICE to monitor accreditation standards, however we have made a note of this concern as a possible implementation issue and will consider this in future reviews.
Public Health England (PHE)	No	No comments provided	Thank you.
Royal College of Nursing	No answer	No comments provided	Thank you.

Do you have any comments on equalities issues?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
ukactive Research Institute	No answer	Similar to the above, though equalities issues are considered in the existing guidelines, there is a distinct lack of evidence as to whether schemes as they are currently being undertaken either increase or reduce these. A further avenue of work with respect to the database is to examine the impact of exercise referral schemes upon health inequalities.	Thank you for highlighting this ongoing work, we look forward to considering the results when they are available and will consider the impact on the guideline accordingly.
Physical Activity Special Interest Group, Wolfson Research Institute of Health and Wellbeing, Durham University.	Yes	In Section 5.3, expanding the examples of 'underrepresented groups' to include: 'males' and 'younger adults'. There is stronger evidence of underrepresentation for these groups in exercise referral schemes than for some of the other example groups listed. Women are more likely to be referred to and/or enter a scheme; age is a positive predictor of both uptake and adherence (e.g., see work below). Gidlow, C., Johnston, L., Crone, D., Morris, C., Smith, A. and Foster, C. (2007). Socio-demographic patterning of referral, uptake and attendance in Physical Activity Referral Schemes. Journal of Public Health, 29(2): 107–113. Hanson CL, Allin LJ, Ellis JG et al. (2013). An evaluation of the efficacy of the exercise on referral scheme in	Thank you for your comment and for highlighting additional evidence on underrepresented groups. The papers by Gidlow et al. (2007), Pavey et al. (2012) and Hanson et al (2013) were considered during the original development of the guideline and their findings have already been taken into account. The work by Hanson et al. (2017) is in the form of an unpublished PhD thesis which is not an evidence type that we can consider. The paper by Kelly et al. (2016) was not identified in the surveillance review and has since been added to Appendix A: summary of evidence from surveillance. The results indicated that significant predictors of dropout included being a smoker and being referred from Tier 3 services. Factors that decreased the likelihood of dropout were: increasing age, drinking alcohol, secondary care referrals, lack of motivation or lack of childcare. This evidence is related to research recommendation 5.2 which asks "What factors encourage uptake of, and adherence to, an exercise referral scheme?". However the new evidence is based on one retrospective

		Northumberland, UK: association with physical activity and predictors of engagement. A naturalistic observation study. BMJ Open, 3(8):1–11. Hanson, CL. (2017). Advancing understanding of effective exercise on referral: a mixed methods evaluation of the Northumberland scheme. PhD Thesis, Durham University, Durham, U.K. Kelly, M, Rae, G, Walker, D, Partington, S, Dodd-Reynolds CJ & Caplin, N (2016). Retrospective cohort study of the South Tyneside Exercise Referral Scheme 2009–14: Predictors of dropout and barriers to adherence. J Public Health, 39(4): e257–e264, https://doi.org/10.1093/pubmed/fdw122 Pavey T, Taylor A, Hillsdon M et al. (2012). Levels and predictors of exercise referral scheme uptake and adherence: a systematic review. J Epidemiol Community Health, 66(8):737–44.	cohort study and, as the authors point out, more research is needed in this area before any firm conclusions can be drawn. For this reason, the research recommendation will be kept and no impact on the guideline is expected.
DECIPHer, Cardiff University	No	No comments provided	Thank you.

Royal College of Physicians (RCP)	No answer	No comments provided	Thank you.
Public Health England (PHE)	No	No comments provided	Thank you.
Royal College of Nursing	No answer	No comments provided	Thank you.

Additional comments:

None.