Final report

Field testing NICE guideline on Exercise Referral Schemes to Promote Physical Activity

Report to: National Institute for Health and Care Excellence

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1 Executive summary

The Centre for Public Health at the National Institute for Health and Care Excellence (NICE) commissioned fieldwork to test the draft recommendations on 'Exercise referral schemes to promote physical activity'.

The fieldwork was conducted among people who have responsibility for commissioning exercise referral schemes (ERS), people in primary care who refer people to exercise referral, people who develop, manage and deliver exercise referral schemes and physical activity 'exit strategies'.

The overall aim of this work was to capture the views of participants on the updated guidance in general and on the two recommendations in particular, in terms of how clear, relevant and implementable they thought they were.

The fieldwork involved six group discussions of between 9-12 participants in London, Birmingham and Leeds, together with a number of individual interviews. Fieldwork was conducted in March and April 2014.

Key messages from the fieldwork

Key message 1

The guidance was considered unclear and unhelpful by the majority of participants. Participants felt that the central purpose of NICE guidance is to provide clarity about what to do and what not to do. This guidance did not fulfil that basic requirement. Most participants were confused about the definition of ERS, the scope of the guidance and the in/exclusion criteria for schemes and groups.

Key message 2

The key recommendation (recommendation 1) was unclear. Even allowing for the lack of clarity over the definition of ERS and the scope of the schemes and groups that should be in/excluded, many participants were unclear about what NICE intended to communicate in recommendation 1. This was because the two key sentences were understood to be in contradiction with each other.

Key message 3

The guidance is likely to be used to justify existing practice – whether that be to not commission or to continue commissioning ERS. The lack of clarity and the ambiguity of both the preamble and the recommendations led participants to interpret the guidance in any way that suited their existing preference and practice.

Key message 4

The guidance was felt to be undermining of physical activity promotion as a public health intervention. The wording of the guidance was understood by many participants to imply that all ERS are ineffective and that physical activity is not valued by NICE. There was a strong call for a re-orientation of the guidance document to ensure that physical activity promotion is seen positively and ERS is set in the context of other NICE guidance recommendations on physical activity.

Key message 5

The guidance may have an unintended consequence of increasing social inequalities in health. Many ERS do not have increasing physical activity levels as their sole purpose – and instead use them as part of a broader social inclusivity/engagement programme that benefits the most socially disadvantaged groups. Participants felt that some decision makers would not be alert to the nuances of different schemes, and would simply use the guidance to call for decommissioning of all ERS, which would impact most on the socially disadvantaged groups.

Key message 6

The recommendation to use brief advice and brief interventions to increase physical activity as recommended in PH44 was derided as impractical. Participants felt that this recommendation would not be implemented by primary care professionals (mainly GP's and Practice nurses) as many do not have the time or capacity, capability, incentive or the belief in the value of physical activity.

Key message 7

The evidence base used to inform the recommendations was questioned. The considerations section led some participants to question whether the recommendations were justified by what they regarded as a lack of an evidence base. Participants assumed that NICE would have applied strict quality criteria in its assessment of the evidence of effectiveness of ERS, and that it would not have considered evidence from the types of schemes they commissioned and operated.

Key message 8

The guidance did not reflect the current ways in which ERS is commissioned and delivered. Refer to page 30 and also to the different delivery models highlighted in pages 19-22

ERS is only one part of a physical activity pathway – it may be seen as an exit route from a rehabilitation programme such as cardiac rehab, COPD rehab or a route into physical activity following a brief intervention in primary care. Partcipants felt that, presently guidance

positions ERS as a standalone intervention which does not reflect the reality of existing practice.

2 Introduction

2.1 Background and scope

The Centre for Public Health at the National Institute for Health and Care Excellence (NICE) commissioned fieldwork to test the draft recommendations on 'Exercise referral schemes to promote physical activity'.

The purpose of this fieldwork was to test the relevance, use, acceptability and ease of implementation of the draft recommendations on 'exercise referral schemes (ERS) to promote physical activity', among those who have responsibility for commissioning physical activity programmes including ERS, those who refer people to exercise referral, those who develop, manage and deliver exercise referral schemes and physical activity 'exit strategies'.

2.2 Background

The guidance is a partial update of previously published NICE public health guidance 'Four commonly used methods to increase physical activity (NICE public health guidance 2 [2006].) An update of the recommendations on 'brief advice in primary care (PH44)' has already been published. When the guidance was first reviewed in 2009, NICE deferred a decision about the recommendation on exercise referral schemes, pending the findings from a health technology assessment (HTA) review. The HTA review was published in December 2011 (Pavey et al) and subsequently, it was decided to update the recommendation about exercise referral schemes. In addition, the recommendations on pedometers and community-based programmes for walking and cycling have been superseded by NICE guidance on walking and cycling (PH41).

The guidance focuses on adults aged 19 years and over who are inactive and the effectiveness and efficacy of exercise referral in the promotion of physical activity in these populations. The guidance assesses how effective and cost effective exercise referral schemes are and what are the most important factors that influence effectiveness and cost effectiveness. The guidance also assesses what factors effect referral to an exercise referral scheme, what factors influence attendance at, and successful completion of, exercise referral schemes and what factors influence longer-term participation in physical activity following attendance at an exercise referral scheme.

Exercise referral schemes included in this guidance consist of:

- An assessment involving a primary care or allied health professional to determine that someone is 'inactive', that is, they are not meeting the current UK physical activity guidelines;
- A referral by a primary care or allied health professional to a physical activity specialist or service;
- An assessment involving a physical activity specialist or service to determine what programme of physical activity to recommend;
- Participation in a physical activity programme.

This guidance also considers other factors that support the delivery of effective exercise referral schemes. Excluded from this guidance are interventions that deliver brief physical activity on its own, walking and cycling schemes that are not part of an exercise referral scheme and rehabilitation programmes used to aid recovery from specific conditions.

The guidance is primarily aimed at those who have responsibility for referring people to exercise referral, those who commission, develop, manage and deliver exercise referral schemes and physical activity 'exit strategies',

2.3 Overview and purpose of field testing

Word of Mouth Research was commissioned by the Centre for Public Health at NICE to field test draft guidance on exercise referral schemes to promote physical activity.

This report presents the findings of a series of consultations undertaken with commissioners, referrers and service providers working in the field of physical activity promotion in general, and exercise referral in particular.

The aim of NICE fieldwork is to gather views on implementation of the draft guidance (including interpretation and clarity, challenges to application or omissions of key actors) and how the recommendations might work in practice from those outlined in the guidance 'Who should take action' section. .

In this study, feedback was gathered from 70 commissioners and practitioners in England. Participants were asked questions about the clarity, relevance, utility and feasibility of implementation of the recommendations on exercise referral schemes to promote physical activity (see topic guide Appendix 1).

The views contained in this report and the conclusions derived from them are entirely based on the evidence given by the participants to whom we spoke. Word of Mouth Research would like to thank all the participants who committed their valuable time in order to give their feedback during this study.

2.4 Structure of the report

The full report continues in the following sections:

- **Methodology** (section 3), describing the selection and achievement of the sample, recruitment, and the analysis of data.
- **Responses to the recommendations as a whole** (section 4), analysing the evidence given by practitioners that is pertinent to the content and form of all the recommendations and their associated measures, structures and processes.
- **Responses to recommendations and considerations** (section 5), analysing responses to each individual recommendation and considerations

3 Methodology

This section describes the aims and methodology used to carry out the fieldwork and analysis, including the fieldwork aims and objectives, recruitment strategies employed, and a description of the resulting sample. The data analysis techniques employed are also described in this section.

3.1 Aims and objectives of the fieldwork

The overall aim of the fieldwork was to capture stakeholders' views on the recommendations in terms of how relevant, usable, acceptable, and implementable they thought they were.

Six specific questions were set by NICE:

a. What are the views of those who have responsibility for referring people to exercise referral, those who commission, develop, manage and deliver exercise referral schemes and physical activity 'exit strategies' on the relevance and usefulness of the recommendations to their current and future practice?

b. What factors could either help or hinder the effective implementation and delivery of the recommendations, as part of current or future practice?

c. What are the potential consequences of the recommendations for improving health and tackling health inequalities?

d. What is the potential impact of the recommendations on current policy, service provision or practice?

e. Which of the recommendations are both feasible and likely to make a difference to practice?

f. What would be the relative priority of each of the recommendations?

3.2 Sampling approach and achieved sample

Selection of regions and cities

The guidance applies to a wide range of commissioners and practitioners across England. A sampling framework was developed in order to give a robust picture of how diverse professionals, working in different settings responded to the draft guidance and recommendations developed by NICE. The framework was developed to include local authority areas that reflected:

- A geographical spread across the country
- Different sizes and types of areas
- Good balance between urban and rural areas
- A range of disadvantage (using the Index of Multiple Deprivation (IMD), 2010 as a measure of disadvantage)

The group discussions were held in March and early April 2014 in three locations:

- London (2 groups), Birmingham (2 groups) and Leeds (2 groups)

3.3 Recruitment methods

The following methods were used to contact and secure the involvement of the professionals in each of the three areas:

- An announcement was placed in the BHF NC newsletter, and this was sent by electronic mail to the BHF NC membership, requesting participation from relevant individuals
- An email was sent to physical activity and exercise referral specialists, commissioners, coordinators and providers known to BHF NC, requesting participation
- Following a reply from interested parties, email and/or telephone contact was made with the relevant individuals, with details of job role and area recorded, to place respondents into the appropriate groups
- Individuals who registered interest in participating were then sent a formal invitation and asked to reply to confirm attendance
- A reminder email with information about the time, date and venue along with a hyperlink to the draft recommendations was sent to professionals ahead of the event.
- Paper copies of the draft recommendations were also provided at each of the discussion groups.
- Consent to note-taking was gained from professionals at the beginning of each discussion group as part of the sign-up process.

Overall we achieved a total sample of 70 participants, which was made up of 60 focus group participants, and 10 one to one telephone or face-to-face interviews.

AREA		**Participants**
London 25 March	2 Groups - 23 people	24
Birmingham 28 March	2 Groups - 15 People	16
Leeds 1 April	2 Groups - 21 people	20
In depth interviews across all three areas	10	10
TOTALS	6 groups and 10 in depth interviews = 70 people	70

These participants came from the following groups and settings.

PROFESSIONAL GROUP OR SETTING	**No.**
Commissioners	30
Referrers	11
Providers	29
TOTAL	**70**

NICE guidance on undertaking fieldwork was followed throughout the data collection stage.

- We undertook two discussion groups in each of the three areas, with commissioners, referrers and providers from statutory and non-statutory organisations.
- We gave participants information in advance of the discussion groups about the draft recommendations and the structure of the consultations.
- We ensured that each discussion group was led by an experienced facilitator.
- We audio-recorded all group discussion and transcribed the recordings following the groups.

Discussion groups (timed to take 2 ½ hours) were structured in line with NICE guidance. The discussion group template can be seen at Appendix 1.

3.4 Data gathering and analysis

Each focus group discussion was moderated by the authors (AC and DM). KB attended one group (Birmingham) as an observer. Both group discussions and telephone interviews were audio-recorded and written up soon after completion. Write ups for focus groups and interviews were structured by the individual recommendations, supported by stakeholder quotes, and themed according to the fieldwork aim and objectives, (see Section 2.1).

Once all the focus groups and interviews were completed, analysis took place using a content analysis approach[1]. Using the fieldwork's key aim and objectives, the researchers identified core themes emerging from the data, defining concepts, providing explanations and finding associations and key differences between the views of different groups of participants. Regular briefing and debriefing sessions took place throughout the fieldwork process to agree themes and ensure that analysis was carried out in a robust manner.

[1] The analysis process is based on the Framework analysis method developed by the National Centre for Social Research (Natcen). It involves a series of key steps and a constant critical and reflexive approach to identify relevant themes and explanations for observations. The steps include:

- Familiarisation with the data: from each recording a description and summary of salient themes is produced and descriptive quotes are identified for potential inclusion in the report.
- Listing of themes: once all interviews have been summarised, a list of emerging themes is compiled
- Construction of the analytical grid: a matrix is constructed from the themes identified, to enable cross referencing (or mapping) of substantive points with explanatory variables
- The grid is populated with data
- Analysis of the grid: the connections between substantive themes and explanatory variables become apparent, and issues are sifted and prioritised by importance/salience from the large volume of data on the grid

4 Feedback on the guidance overall

4.1 Participants look to NICE guidance for clarity and direction. This guidance was felt to be confusing and unhelpful

Participants reported that they and their peers use NICE guidance as the starting point for determining both what to commission and and how to deliver. They have an expectation that NICE guidance will provide the 'building blocks' of a programme, telling them what to do, what not to do, and provide the evidence for the recommendations.

This guidance was found to be confusing and unhelpful because it was unclear what was being recommended. There were a number of features that participants found unhelpful, which are described in full below. In summary, these included a lack of clarity over the definition of ERS, and which schemes and groups would be in/excluded by this guidance. Participants also felt that recommendation one appeared internally inconsistent: in one sentence giving a clear directive, 'do not commission..' followed in the subsequent sentence by an apparent contradiction or 'get out' clause - 'the only exception is..'

> 'NICE guidance serves as an "idiot's guide" to what I should have in my programme. I looked at this and thought, "that's not really going to help". I know it's contentious and a difficult area, but give me some minimums and maximums – it tells me what I should not commission – but be a bit clearer about what I should be commissioning.' *Commissioner, North England*

Commissioners were hoping to find in this guidance recommendations about what to commission, and in particular what to commission for people who are not motivated - or able - to use gym based facilities. Instead, they were disappointed to find that the guidance appeared to say nothing substantially different from NICE guidance PH2 in relation to ERS, and – if it was decided to withdraw from ERS - that there was nothing recommended to commission in its place.

A small number of participants in all group discussions were so confused by the wording of the guidance that they failed to understand the key recommendations and goals of the guidance.

> 'I am just confused. In the first instance it says that commissioners should be doing things to get people more active but then it says they shouldn't be commissioning ERS. It doesn't make sense to me.' *Provider, London*

> 'So what then? Are we saying that this guidance is not for us then?' *Commissioner, North England*

4.2 There were strongly expressed responses to the key recommendations (not to commission exercise referral schemes and not to refer people to exercise referral schemes)

Participants expressed strong views to the key recommendations. Some commissioners supported the recommendation not to commission exercise referral schemes, and instead to focus resources on brief advice in primary care.

> 'Exactly.. It confirms the evidence – it confirms the direction of travel of previous guidance. For me it is supportive of the approach I have been taking – we don't commission but we do support them. So I will use this to ensure that they are provided for specific conditions.' *Physical activity lead, Midlands*

Other commissioners were very concerned at the recommendation to not commission ERS, and for reasons that are discussed below it was felt that this recommendation would have negative impacts on physical activity promotion in general, would harm socially vulnerable groups and increase social inequalities in health. They also felt that the recommendation was based on flawed or incomplete evidence and that it failed to appreciate the range of ERS currently in operation.

> 'I can understand why they want to do the fieldwork before it goes out. It's very controversial what they're recommending.' *GP referrer and commissioner, London*

> 'Exercise referral schemes are the best thing since sliced bread.... the best thing for getting people with long term conditions more active and more connected. This guidance is very misleading and confused and could lead to ERS being dumped full stop.' *GP referrer and commissioner, Midlands*

Participants' responses (positive or negative) to the recommendations tended to reflect their existing practice in relation to ERS. Participants from areas (mainly rural) that did not have a history of publicly funded ERS, or where they were already considering not re-commissioning, tended to support the tenor of the recommendations.

Conversely, among participants from areas (mainly highly urban areas) where ERS was described as 'part of the mix' of physical activity promotion, and where ERS was seen to be part of a broader social programme, and where there was significant public investment in promoting physical activity, the recommendation was criticised as unhelpful. Overall among this group, there was disappointment and concern at the recommendation.

> 'I think the first thing people say is 'have you seen it – it's saying not commission'..i'm not saying take it out – it's making it so up front – word it a bit diffently. Say, 'ok it's probably not good for this – even there that may be because we don't have the evidence, not that it doesn't work – but if you do this and this then potentially it could work.' *Provider, North England*

> 'It doesn't make a clear enough distinction about which schemes work for whom. It's too black and white. What this says to me is, 'brief intervention works and ERS doesn't'. Now that's not the case. If you take away the pathway, it doesn't work.' *Provider, North England*

4.3 What impact will the guidance have on practice? Some felt it was unlikely to lead to significant changes in practice. Others were concerned that it may undermine physical activity promotion more generally. Most thought it would have no impact and be ignored

This updated guidance was described by commissioners in one of the groups as so 'wooly' and lacking in clarity that it could – and would - be used to justify any of three identified courses of action (all of which were represented by the various participants). These included:

a) Supporting a decision in areas where there was no history of ERS not to commission these services, on the grounds that they appear to be ineffective and costly, by comparison with brief interventions and other forms of physical activity promotion.

b) Supporting a decision to withdraw funding from existing ERS in a locality where the commissioner had found existing schemes to be ineffective in increasing physical activity levels.

c) Supporting the continuation of ERS in areas where such schemes were well established (and where there was significant local political commitment and financial investment in physical activity promotion and increasing access to leisure services). Participants felt that the guidance did not appear to apply to schemes that did not have increasing physical activity levels as their *sole* purpose, and that it appeared to exclude schemes designed for the management of people with specific medical conditions (see below).

While all commissioners reported that they look to NICE guidance as a 'first port of call', and several reported that it was a key factor in decision making, many commissioners reported that this guidance would be unlikely to influence their commissioning practice.

> 'I think this guidance won't be disseminated. I think it will be ignored. I think even if other commissioners thought this is not a cost effective scheme – in comparison to what I would spend on A+E, the costs of this are not high, so it's not a high enough cost for me to decommission knowing what aggravation in the community it will cause. ' *GP referrer and commissioner, London*

> 'There is quite a disjoint between the national guidance and what's happening on the ground. The national guidance [PH02] was really weak and said exercise referral doesn't work unless you throw lots of money and resource at it – which no one has – but everyone carried on doing it. Everyone has decided they want to commission it – it has lots of benefits but the guidance doesn't support that position. I think that still continues. This guidance is quite weak in terms of its support for it. Primary health care and CCGs will take one look at this and say, 'right we'll pull out of that. We'll have nothing to do with it – there's no evidence'. It's those of us at the grass roots who appreciate its value, who see the broader stuff that isn't easy to evaluate and again they recognise that.' *Commissioner, Midlands*

However, some participants were concerned that this guidance would be acted upon by commisisioners and primary care professionals who may fail to appreciate the range of benefits that ERS provides to patients - beyond increasing their physical activity levels.

> 'If I was a commissioner and I read this, I would interpret it as saying, 'ok I should be pushing more money and effort, which is not a lot of money, through promoting physical activity

brief interventions through GPs. Then, three years later they do some survey and find that physical activity levels are the same or worse and then it's, 'ok how are we going to fix this?' and they'll go back to GP referral schemes because there was other evidence that wasn't referenced - that showed they had a benefit that was included – in terms of social aspects, community engagement.' *Provider, London*

Most participants were familiar with previous NICE guidance PH2 and with the knowledge that NICE had concerns about the evidence of effectiveness of ERS to increase physical activity dating from that guidance. While there was appreciation of the slight shift in emphasis from PH2 to the current Recommendation 1 (**not** commission..) and Recommendation 2 'not refer to ERS', most felt that the updated guidance was not saying anything fundamentally different from the PH2.

PH2 had prompted the non-recomissioning/decommissioning of ERS in some areas, and had led to a change in focus (in terms of what was provided and to whom) in others. However, some participants reported that the DH advice on ERS that followed the NICE guidance had appeared to contradict the NICE PH2 guidance – and had encouraged some to continue to commission ERS.

'What happened was, NICE produced its guidance and then the Department of Health came out with their guidance some time after, saying basically 'carry on'.' *Commissioner, North England*

Participants in one group described PH02 as a 'stay of execution on ERS' overall, and say this guidance is an extention of that stay of execution.

4.4 In order to minimize the potential for the guidance to be misinterpreted as undermining physical activity promotion, particiapants called for a clearer, more positive affirmation of physical activity in the preamble and recommendations

The majority of participants (although not all) felt strongly that an unintended consequence of the guidance in its current form is that it gives a message that physical activity promotion is not valued by NICE, and that it should not be a priority for prevention in primary care or public health. This was felt to be particularly worrying, given the current context of cuts to public expenditure, the threat to public health budgets, and what was described as a prevalent attitude among many primary health care professionals that phsycial activity lacks a firm evidence base.

'By publishing guidance that says ERS isn't a good route to get people into physical activity, you're saying, 'don't bother recommending physical activity'. The way this is worded is very negative.' *Provider, London*

'I think it totally undermines it [physical activity promotion]. This is one of the few methods that we have to encourage physical activity. I think this totally undermines it.' *GP referrer and commissioner, London*

'Just thinking about the primary care side of things and the buy in from GPs point of view.. The majority of GPs do not think that physical activity will improve someone's health – they'd sooner prescribe medications for diabetes or hypertension. So I wonder if there needs to be some hearts and minds stuff at the beginning to highlight the evidence base around PA and what it should be targeting.' *Commissioner, Midlands*

> ‘I think if you gave this to a GP, they would just say, ‘oh well I won’t refer them any more’ and the implications of that are quite severe because that encourages them to not promote physical activity to their patients – which just doesn’t make any sense.’ *Provider, London*

> ‘It could be seen as undermining the physical activity message we give out. If they are suggesting it doesn’t affect us – it really does. Somehow you need to help to get people to be physically active. You need that encouragement to be physically active, and it does undermine that message.’ *Provider, London*

Participants called for a much stronger statement at the beginning of the guidance than exists in the current version, that makes clear the value of physical activity for prevention of a range of conditions, that re-affirms the ‘business case’ at a general level for investment in physical activity promotion and that identifies a clear pathway for physical activity promotion.

> ‘I think there is a real need to promote the benefits of physical activity to primary care.’ *Commissioner*, *North England*

4.5 The guidance was considered confusing – with all participants unsure about the scope of the guidance and the definition of ERS

For all participants there was confusion about the guidance. There were several points of confusion.

Defintion of ERS

The definition of ERS provided in the preamble was felt to be inadequate, and not reflective of the diverse forms of ERS that operate in different parts of the country currently. The four bullet points used to define ERS in the preamble (primary care assessment, referral, assessment by a physical activity specialist, opportunity to participate) were described as being so lacking in specificity that they were interpreted by some participants to include all forms physical activity promotion that involve these elements - including behaviour change interventions such as ‘Let’s Get Moving’, and even walking and cycling schemes that are recommended in recommendation one.

A major area of confusion was over the way the term is used to cover a range of schemes – most of which were described as having ‘management and treatment of long term conditions’ as their focus, as well as what one participant said would better be described as ‘physical activity referral schemes’ where people may be referred to increase physical activity levels.

> ‘I have interpreted it in the way I have because I have been working in ER for 12 years. But what you’ve brought up is – looking at it with fresh eyes – if you start looking at an opportunity to participate in a physical activity programme, that’s where – if it was someone else reading it they would go, “actually, it’s all physical activity it’s talking about here” – there’s always got to be referral, assessment and signposting to some physical activity programme.’ *Commissioner, Midlands*

> ‘Those four bullet points -[that define an ERS in the preamble]- could be interpreted as appropriate for a programme that is recommending physical activity but is not defined as ER.’ *Commissioner, Midlands*

'I suppose what it is, is that these bullet points are a bit general - "anyone could be referred so long as they are inactive" - is what those bullet points are saying. But obviously NICE is saying that it's not for that purpose, it's for more specific groups..' *Commissioner, Midlands*

'Does it need to go back to look at what evidence was actually reviewed to more closely define what ER is? If you say ERS you are talking about people with comorbidities – people who have been referred from a GP or a Practice Nurse to primarily a gym based environment, where they're given a programme over a set number of weeks. That is what most people define ER as. But with this (guidance) you could be talking about 'Let's Get Moving' which they go on to recommend. It means basically anyone that is signposted to any type of physical activity programme isn't going to work – but we don't know what specific evidence they have reviewed. And I suspect its more likely that what they have reviewed relates more to the traditional gym based ERS. So you need more defining of what ER is.' *Commissioner, Midlands*

'I think most ERS is for the purpose of management and treatment of specific conditions. Perhaps it would be clearer if NICE talked about 'Physical Activity Referral Schemes' rather than ERS, because what you're talking about in those 4 bullet points doesn't have to be an ERS, it's about helping people to be more physically active. So why are you calling it ER? There needs to be some clarity about the two different types of scheme.' *Commissioner, Midlands*

Outdated assumptions implicit in the definition of ERS

Many participants described the guidance as having been written with an assumption about what ERS may entail, but that this vision was several years out of date. Most participants felt that NICE's guidance assumed what was described as a, 'traditional, gym based environment, with a 12 week programme', and that the kind of people referred to such schemes would be people whose only risk factor/referral criterion would be that they were inactive. In reality, in almost all cases, this model had been superceded long ago by a wide variety of scheme types and the referral in/exclusion criteria *always* required more than inactive.

'I think the point is that everyone has set up ER slightly differently- so everyone will have a different interpretation of what an ERS is – I agree that it should go back to look at what they originally defined as an ERS and then allow for the fact that it's developed over the years. Perhaps being more specific because otherwise you would include quite a range of physical activity opportunities within that and I think people would then get confused.' *Commissioner, Midlands*

'It just feels that the guidance doesn't understand what it is that we deliver. We've changed with the times in what we're delivering and accepting to support our communities – so as more people are diagnosed with diabetes, high blood pressure - we are just another avenue for them to improve their health. This assumes that ERS is just about physical activity and nothing else. Physical activity is a part of the management of so many conditions – but this has completely separated the two and you can't have that.' *Provider, London*

The 'sole purpose' element of the definition was understood by participants to exempt most ERS

The '*sole purpose'* element of the definition was interpreted by almost all participants to mean that their own ERS would not be covered by the guidance. None of the participants reported that the ERS they commission/refer into/operate has the increase of physical activity levels as the sole purpose of the scheme, and as a result, considered the guidance to be irrelevant to them.

> 'A lot of people will think it's not relevant to what they do. You need to feed back to them [NICE] that it is unclear. It is irrelevant to what a referrer will think their aim of referral was. It will not be just for increased physical activity. There will be other reasons why they were referred. People we refer would have additional factors – it wasn't clear in the preamble. I know that it doesn't include cardiac rehab, but I'm doing the referral because they're obese, at CV risk, because they're anxious, stressed. It wasn't clear that NICE's impact modelling had taken these things into account.' *GP referrer and commissioner, London*

> 'We're not just looking at physical activity levels – we're looking at health and wellbeing and health outcomes. So this is very much saying, 'if the sole purpose of is to get people more active then ERS is not appropriate', but that's not how ER sits for us as a business. We don't deliver it just for that purpose.' *Provider, London*

> 'I think they are saying that people have to be referred for things other than exercise – but personally I don't just refer people for exercise. I refer them for the support they get there: the health trainers, the dieticians – it's a whole package. So it's not just them on their own. It's them treating the whole person.' *Referrer, London*

> 'As everyone here has said the measures are not just based on physical activity. Our commissioners are looking in terms of reducing people's risk for developing cardiac disease – the health measures like BMI and blood pressure – that's what we're commissioned to do – not just to see whether people adhere to the scheme. It's not just being inactive – being inactive is a criterion, but it is not sufficient. They have to have a chronic long term condition (not an injury) – that's why this guidance is so confusing.' *Provider, London*

The groups/conditions that are identified as in/out of scope was unclear

The statement, 'this guideline does not consider ERS designed for, or that include management of, or rehabilitation for, specific diseases' was understood to mean that schemes designed for people with what were described as 'chronic' and/or 'long term conditions' (including obesity, weight management, hypertension, back pain, anxiety/depression, diabetes, pre-diabetes, coronary heart disease) would be exempt, and that this guidance would not apply to such schemes.

> 'It says, "this guideline does not consider ERS designed for, or that include, management of, or rehabilitation for, specific diseases". In my experience, a lot of GP referral schemes are there for that reason – so I'm wondering what is the point of this guidance?

The inclusion of examples 'cardiac and pulmonary rehabilitiation programmes' was taken as further evidence that most ERS would fall outside the scope of this guidance, because most schemes

currently in operation are aimed at these groups (alongside people with a broader range of conditions, identified above).

Again, the guidance was felt not to reflect the experience of most providers and commissioners. When describing the different forms of ERS on offer to people with varying levels of need, they tended to speak in terms of 'level 3 and below' as a more general service offering, and 'level 4' as a specialist rehabilitation service provision.

> 'It doesn't take into account the conditions that people are being referred for – it just assumes that they're being referred for being inactive – and that pretty much misses the point of most ERS – so I'm concerned that this would be ignored because people will say "this guidance is not relevant for our scheme because we have people with hypertension, mental health – so we can ignore it".' *Provider, North England*

> 'It says it excludes people in cardiac rehab. But it doesn't say where the cut off point is. Presumably it's between Level 3 and Level 4. That needs to be made clear in the guidance. It needs to be more specific.' *Provider, Midlands*

References to three NICE guidance documents was considered unhelpful

The three NICE guidance documents (for spinal cord stimulation, hip replacement and Chrone's disease) referenced in the preamble were felt to be out of place ('that's just bizzare' and 'that's random'). Participants expected to see guidance related to cardiac and pulmonary conditions, as these are identified as specific conditions that fall outside the scope of the guidance.

> 'When they specifically list them and say this is not for cardiac or pulmonary - and then they don't reference a specific guidance, people will go "where do I go for that?".' *Commissioner, Midlands*

Examples of schemes identified in fieldwork

The schemes varied considerably in the length of the intervention period, the range of conditions that were referred to the schemes and the type and range of the interventions provided.

Most of the schemes focused on long term conditions or rehabilitation, and several offered what participants described as more of an holistic approach beyond physical activity alone. Some schemes addressed mental health concerns by providing opportunities for social interaction. These schemes were described as offering some clients the only opportunity in their everyday lives to socialise. One scheme even provided advice about debt management.

Most schemes had only a small proportion of people (if any) who are referred because they are sedentary or inactive. Most agreed it was less than 5 per cent of their clientele. There were two exceptions to this - the schemes described in Wigan and Wakefield.

Wigan

'Our service now has broad inclusion criteria - including anyone who is sedentary who needs activity to improve health. We also have specialist rehabilitation programmes. Half of our clients would be included in this NICE guidance.

There are 2000 people on our programme. We were originally designed as a ‘find and treat" scheme - people aged 50 plus with CHD risk factors. Half of our clients (about 1000 people) are on this scheme. The other half are people on the exercise referral scheme because of existing medical conditions. We used to run the schemes separately, but GPs said it was too confusing. They just wanted one scheme for exercise so we merged the two. However, our contract is coming up for renewal and we can see services changing to more specialised schemes.’

Wakefield

‘Our client group is divided approximately:

- 25% - open category - anyone - sedentary /inactive
- 50% - referred by GP for Long Term Condition (LTC)[2]
- 25% - from LTC via physiotherapist

We do the standard 12 week programme initially- with follow up at 6, 12 months and 2 years

If the activity is popular we mainstream that activity and then staff can move on with new referrals.

The schemes make the most of the social aspects - "it's all about a natter"- very important and we use volunteer staff to maintain some of the social aspects.’

Shropshire Council

‘We run a level 4 scheme. All staff are level 4 trained so we can look at cardiac rehab. GPs can refer to any programmes up to level 4.

We don't accept inactive people but we are working on a hub to make sure people are on the right care pathway even if they don't have a long term condition - yet. We are more in line with these NICE guidelines.

We are working to make the schemes more consistent across providers - and tidy everything up.’

‘Fit for Life’ - Telford

‘We have 6 aspiration sites and 24 supervised sessions - gym only and some swimming.

We do cardiac rehab and we have trained specialists in level 4 obesity, cancer rehabilitation session, and level 4 mental health specialists.

When someone comes into the centre, they will see a physical activity consultant on site who will make a make a judgement about whether that person needs to go to the GP to be referred into the scheme.

The other way in is that GPs are constantly referring to us and we make a judgement about what is appropriate for the client.’

Kirklees

[2] Particpants outlined that long term conditions (LTC) ranged from obesity and high blood pressure to diabetes, CVD, COPD , and musculo-skeletal conditions

‘Our long term condition, exercise referral scheme only includes people with long term conditions. It is one mechanism to support people with LTCs to be active - part of the jigsaw. We are very patient centred but are led by the commissioner priorities. At the moment they want us to look at each condition and what the effectiveness and outcomes are for each condition. With the current climate we may not be able to function as we currently do, so we have to direct resources where there is the biggest potential impact.

We have 3000 a year going through the programme. When the scheme started 20 years ago we started with a 20 week programme - we later decided to increase it to one year.

The scheme is run in a socially friendly way. One of the key motivators for people to come to the scheme is the social aspect. People living with long term conditions can become socially isolated and this is one way of addressing that.

We do have walking groups for people who are couch potatoes, but these are not part of exercise referral schemes. Whatever we do for them, we will never get them to achieve the physical activity guideline level - we just need them to make a small change, as a start, which is an achievement.

We also have an exercise scheme for people with enduring mental health problems and a scheme for people with dementia.

The length of time on the scheme depends which route they come in from. If they have come via cardiac rehabilitation they will have an education programme to which we contribute, then they exit onto a particular programme. It is generally a year's programme. They build up personal resilience and then move on after 12 months, after achieving a state where they can maintain long term participation. We have a lot of partners who provide exit routes from us. Some exit at 10 weeks, some exit at 52 weeks - whatever is appropriate to them - we are very patient centred.’

Oldham

‘We have a three stage programme:

- Stage 1- 12 weeks - supervised
- Stage 2 - 12 weeks - supervised and encouraged to go to other activity
- Stage 3 - Maintenance stage - they can still access some classes but mainly do other activity. Some people have been with us for 6 years.’

Liverpool

‘We do patient consultation/education first, then give the option for exercise. We have pharmacists, mental health workers, dieticians involved.

We take an holistic view. We are looking at the issues that are important to that person and the capacity of the person to do something about them. If their priority is to sort out their children’s needs or have a debt issue - and that is going to prevent you from accessing health in general - we will get them some debt management advice.

People can attend the scheme for a year. We were funded by the council after competitive tender and the commissioner liked the case we made for the holistic approach.’

Durham

'The first 10 weeks are free, then 16 weeks subsidised in a leisure or community centre and depending on whether they complete the evaluation at 6 months they can then use leisure and community facilities for up to 2 years at a reduced rate.

> Exit strategies don't always work because the social aspects can be so important it is difficult to move people on. Commissioners only have a limited amount of money and that is shrinking. Most of the classes are up to capacity now.
>
> Keeping it focused on the exercise aspect makes the exit strategy cleaner but it is the social contact that keeps them coming in the first place.'

4.6 Most participants felt that the guidance in its current form may harm the most socially disadvantanged and increase social inequalities in health

Most providers and most commissioners expressed a concern that a recommendation not to commissioner ERS would have negative impacts on the most socially disadvantaged groups. They reported that in many instances ERS have broader goals than increasing physical activity levels – or even other health benefits. The schemes are viewed as an integral part of broader social programmes that aim to improve access to public services, including leisure services, particularly for socially disadvantaged groups.

Many such schemes are viewed positively by decision makers (including local elected representatives), in many cases regardless of the evidence of effectiveness or cost effectiveness about whether they increase physical activity levels – because they offer a discounted membership to leisure services and are popular among users and the local community.

> 'This is one of many ways of getting people active and this is one tool. And people who do use this like it a lot – so even if it wasn't cost effective, decommissioning it would be very controversial and politically difficult. Because people like it – because there's something you can go to the GP and get a gym for a cheaper rate and get a personal trainer and people rarely turn it down, and people who do participate in it, love it. I work in a very deprived area, so whether you spend £11 a month or £25 a month on gym membership is a huge difference in people's budgets… It's not worth de-commissioning something the user likes. The backlash is a political thing for a council to say it is no longer available – I don't think they can pull that off.' *GP referrer and commissioner, London*
>
> 'Councillors override things – they are the ultimate decision makers. So even if it was something that was non evidence based, if they felt like this was a good thing, it would be implemented. It's very different from how a CCG works.' *GP referrer and commissioner, London*

4.7 Questioning the evidence used to inform the recommendations

Most participants felt that the recommendations were the consequence of a flawed evidence review process. While all participants were familiar with NICE and its standing as an independent and research based organisation, most felt that the recommendations reflected what they saw as inherent limitations in NICE's review methodology.

Participants discussed spontaneously and without prompting, what they felt was the probablity that NICE would only have considered RCT type evidence, and that the evidence that most providers collected and some commissioners requested, would not have met the NICE review inclusion threshold, because such schemes were not part of a RCT.

> 'They're said that their recommendations are based on research evidence, but their criteria for evidence is very strict and based on RCTs. And we don't do RCTs – it's too costly to do in a real world setting. So it should be looking at the evidence that ERS can provide in a real world setting, And we are able to evidence the impact that ERS has on physical activity on a longer term. But they're not asking for that because it's not part of an RCT.' *Provider, London*

Similarly, several participants (both commissioners and providers) questioned the methods used to assess cost effectiveness. There was a widespread concern that such an analysis would have been unlikely to have investigated the differential impacts on people with different long term/chronic conditions.

> 'I don't know whether they looked at the different groups. I think they just compared ERS versus lifestyle advice. I don't think they broke it down into, 'would that work for depressed patients, would that work for LT patients?' I don't think they have done that level of analysis.' *GP referrer and commissioner, London*

5 Feedback on the recommendations

5.1 Recommendation 1 Commissioning interventions to increase physical activity

Policy makers and commissioners with a remit for increasing physical activity levels should:

- Continue to support people to be physically active as part of their daily life using:
  - modifications to the physical environment (see Physical activity and the environment, NICE public health guidance 8)
  - interventions to encourage walking and cycling (see Walking and cycling, NICE public health guidance 41).

- Implement NICE's recommendations on 'Physical activity: brief advice for adults in primary care' (NICE public health guidance 44). Specifically:
  - Recommendation 3 Incorporating brief advice in commissioning.
  - Recommendation 4 Systems to support brief advice.
  - Recommendation 5 Providing information and training.

- **Not** commission exercise referral schemes for the sole purpose of getting people to be more active. The only exception is for schemes that collect a minimum data set and make it available for analysis, monitoring and research to inform future practice. As a minimum, schemes should collect details on:
  - inclusion and exclusion criteria for participation, physical activity options and plans for remaining physically active beyond the end of the scheme
  - participant characteristics, including disease risk factors and reason for referral
  - costs, including the primary care practitioner's time spent making referrals, the cost of the physical activity programme and costs for participants
  - the intensity, duration and frequency of physical activity at baseline, during the scheme and afterwards (up to 1 year after the programme ends)
  - reasons why people drop out, and action taken by providers and commissioners to get them involved in physical activity again
  - changes to health-related quality of life associated with being physically active, for example, as measured by the EQ-5D questionnaire or another validated questionnaire
  - mental and physical health benefits associated with participating in the exercise referral scheme, such as changes in blood pressure, respiratory functioning, mobility, sedentary behaviour, body mass index (BMI) and anxiety levels.

Summary

This recommendation was considered both controversial and very unclear. Based on an interpretation that the intention of the recommendation was to not commission ERS, a minority of respondents welcomed it, while the majority felt it would have a negative impact on physical activity promotion. It was considered to be internally inconsistent. There were suggestions that the intention could be made clearer by adjusting the emphasis to, 'Only commission ERS that collect a minimum data set…' but it was also unclear whether that shift in emphasis was what NICE intended.

Clarity

In terms of the wording of the recommendation, participants were not clear about the meaning of the first two bullet points.

The main element of confusion within this recommendation hinged on the two sentences, '**Not** commission exercise referral schemes for the sole purpose of getting people to be more active. The only exception is for schemes that collect a minimum data set…'

These two sentences were considerd by most participants to be in contradiction with each other and left participants confused about NICE's intentions.

Understanding and relevance

However, for reasons discussed in the previous section, there was widespread confusion about the applicability of this recommendation (for reasons of concerns over the definition of ERS, which schemes or groups would be in/excluded, whether the 'sole purpose' would exempt most schemes).

Again, as stated earlier, some participants felt that the guidance would be taken as a call to disinvest from all forms of ERS – and in some cases from physical activity promotion altogther.

While not all participants agreed, around half voiced the concern that the message that key decision makers (commissioners and political leaders) would take from this guidance was that ERS are a) ineffective and b) too costly and that this would be sufficient reason for 'pulling the plug'.

They also felt that these key decision makers often lacked the sophistication to realise that the guidance related to specific circumstances, and only to certain forms of ERS, nor that the intention of NICE was to encourage physical activity. Many participants reported that they would probably not have the time or interest in reading beyond the recommendations in any case.

No one felt that any decision maker would read beyond the first few pages and would certainly not read the 'considerations' section or take the time or trouble to consider the complexities that PHAC had considered in developing the guidance.

> 'It will undermine physical activity promotion.' *Commissioner, Midlands*

> 'It's throwing out the baby with the bathwater.' *Provider, London*

Minimum data set collection

Most providers felt that the collection and reporting of the type of data identified in the recommendation was either standard practice and would not represent a significant challenge. Some providers reported that they routinely collected these types of data as part of standard practice, but questioned what use commissioners or others would make of these data.

> 'I think most people collect these data. So where they say "the only exception should be these schemes", I would say these are the schemes we all run.' *Provider, London*

They reported that in the past, commissioners had not been interested in reviewing this level of detailed information and that requirements about schemes varied year to year – often without reference to this type of data.

> 'If commissioners ask for it is another matter. In the 43 sites we deliver ER – some ask for it, some don't. Where we do ER we're able to provide it.' *Provider, London*

However, there was interest and some enthusiasm among both providers and some commissioners in collecting such data, if it were made clear in the NICE guidance that such information would be collated by a national body, that would be charged with analysing the data and using it to contribute to the evidence base on ERS.

> 'I agree with the idea of requiring the collection of minimum data, but the question is what use is made of it. We do collect most of this already.' *Provider, North England*

A minority of providers and commissioners felt that the requirement to collect the data identified in the recommendation was both impractical and costly.

> 'I think it's ridiculous to put in all those requirements. It's completely impractical. Because it's tortuous and demanding. It will drive up the cost of the service, just to put those things in place.' *GP referrer and commissioner, London*

As identified in section 4.7, participants debated the fact that the NICE guidance appeared to have been based on what they felt was inadequate evidence of effectiveness and cost effectiveness. Participants were unclear what evidence had been used to develop the guidance, but assumed that NICE had used 'gold standard' RCT type evidence.

Several felt that these forms of evidence did not capture the evidence that they knew/believed about the effectiveness of their own schemes. There was a call for NICE to include in this guidance a requirement to collect a minimum data set that would help to establish a more reliable evidence base for future guidance.

> 'Do you know what would be really helpful? To define a minimum data set – it's all very well for them to say there's not RCT but the reality is that it's very difficult to do RCTs when there are so many schemes established. So we need to be clever about how we collect the data. And it's very hard to compare schemes when everybody is collecting different data.' *Provider, North England*

Views on other referenced NICE guidance in the recommendation

Within the context of the fieldwork for this guidance participants were encouraged to focus on the new recommendation and to not deliberate the existing NICE guidance referenced in the recommendation. However, some participants commented that in their opinion, such guidance had made little impact on physical activity levels.

> Provider 1: 'If I was a commissioner I would think this is all about giving information which doesn't cost a lot of money. So if I produce a few leaflets and install a few bike racks, then theoretically I've ticked these boxes. It depends what's in these documents and how that's measured – because these statements are very vague. It's very easy for a commissioner to

say ‘yes, I’ve applied NICE principles to the environment and provided information’ without it having any meaningful impact.

Provider 2: That’s exactly it – we’re supposed to encourage green travel – so we have cycle racks outside. Its not like it actually encourages people to cycle – it’s just that there’s somewhere to park your non-existent bike. You’re right. What is the meaning of ‘encourage people to do these things?’ *Providers, London*

5.2 Recommendation 2 Encourage inactive adults to be more physically active

Primary care practitioners should:

- Implement NICE's recommendations on giving adults brief advice on physical activity (NICE public health guidance 44). Specifically:
  - Recommendation 1 Identifying adults who are inactive.
  - Recommendation 2 Delivering and following up on brief advice.
- Not refer people to exercise referral schemes for the sole purpose of getting them to be more active.

Summary

This recommendation was clear and understood by all participants. It was felt by the majority that brief advice and brief interventions would not be a sufficient alternative to ERS. Most participants felt that these forms of intervention were less effective than ERS and that the guidance had failed to appreciate that ERS was linked to brief advice in many areas.

Brief advice and brief interventions are not thought to be an adequate alternative to referring people to ERS

Almost without exception, the notion that brief advice and brief interventions may be an effective means of engaging inactive people with risk factors for chronic conditions to become physically active – was derided.

The vast majority of participants (although not all) did not feel that the recommendation to implement PH44 was an adequate or acceptable alternative to referring people to ERS.

Key reasons for this view included:

i. Primary care staff lack the capacity (including time, motivation and skills) to do this.

Participants spoke of their experience that many GPs and other primary care staff do not have the time, skills, interest or incentive to undertake such additional activities. They also described their experiences that in order for GPs to do any form of additional activity (such as refer a patient to a walking or cycling scheme for instance) they would require payment.

'The front line primary care staff are so busy – you do not have capacity [to do brief advice]. Primary care does not have the capacity to take on this extra role. That's why we have created these other avenues to take on this. You will be burdening primary care for something that could be done elsewhere. This won't go down well with CCGS. We have Long Term Conditions – this doesn't have to be done by a doctor – it won't be done by a doctor. Naïve is a strong word but that's what it is.' *GP referrer and commissioner, London*

'The clear message nationally is that physical activity is not important to primary care because they haven't incentivised referrals at all. They've incentivised many other things but physical activity is not one of them. So for GPs there are many other things they'll do before they do a referral for physical activity.' *Commissioner, Midlands*

'With brief interventions, there's only so much I can do. I don't have the time (nor do GPs) nor the training or qualification to work out an exercise programme for people. Not everyone goes on ER. There are lots of other schemes. There is no way I could do brief interventions and get success rates..' *Primary care referrer, London*

'If you've never had it (ERS) – you wouldn't see the benefit. Unless you fund it and you have the capability. We're flat on our backs with the workload. It's a change of mindset – GPs don't see this as their job. It's very naïve to think primary care will pick this up. They've got targets around cancer to detect, diabetes, you name it. They will see this as the job of health promotors and public health. It's a reality check – you can recommend it but there has to be something pragmatic that takes account of the reality of the situation in primary care.' *GP, London*

ii. Concern that most GPs dimiss physical activity as an effective form of intervention: this guidance was felt to reinforce that view

Another reason why participants considered recommendations to undertake brief interventions and brief advice in primary care was unrealistic, lay in the belief that most GPs dismiss physical activity as ineffective compared with alternatives (mainly pharmacotheraphies), and that this guidance would re-inforce this view.

'At the minute they (GPs) see physical activity as – I was going to say 'Mickey Mouse' but let's say a very poor evidence base - which isn't going to have an impact. And this guidance is just going to reinforce that view.' *Commissioner, Midlands*

Q: Are brief advice and brief interventions adequate?

A: Not for me. We've had *Let's Get Moving* for years and nothing has happened. *Commissioner, Midlands*

iii. Environmental factors: a lack of safe spaces in which to cycle or walk

Other reasons included the concern that recommending walking or cycling in many areas of urban England was unrealistic, because of the concerns about lack of adequate safe spaces.

'Rec 2 – I think we are doing the brief intervention but having no resources – people don't have money to buy a bike or feel safe to go jogging.' *GP referrer and commissioner, London*

'*Participant 1*: What do they define as brief intervention? Do you know?
Primary care referrer: The main thing we're told is to increase people's physical activity – it's signposting. In the area I am – I personally wouldn't go for a walk in that area – so there's no way my patients are going to.' *Provider and referrer, London*

iv. A view that ERS as currently structured in many localities, is integrally linked to brief advice

Some participants viewed the ERS they operated as part of the pathway for referrers in primary care. ERS was described as one of a range of possible options that should be available to individuals, depending on the assessment.

'Given that we get huge numbers of referrals into our scheme - about 800 referrals a quarter – mainly from GPs and allied healthcare staff in hospitals – they are using that brief advice and using us as an option to follow up that brief advice. So I think its quite difficult because if you look at our area – the GPs provide the brief advice to do physical activity and use us as places to do physical activity. You cant separate the two.' *Provider, London*

v. A view that provision of information is not sufficient to change behaviour

'Brief interventions is just saying 'oh go and do some more' – which we know, just exhorting and giving people information doesn't work.' *Provider, London*

Concerns about the evidence for the effectiveness of brief advice and brief interventions

Many participants commented (again unprompted) about what they felt was likely to be poor quality evidence that NICE had used to develop recommendations on brief advice and brief interventions. Most expressed a concern that – in their opinion - the only evidence on the effectiveness of brief advice would come from self reports of physical activity which were unvalidated and non-verifiable. By contrast, they felt that many ERS were able to provide validated measures of change in physical activity levels over the course of the programme.

'Also the brief advice is likely to be never monitored or followed up. So it doesn't ring true. If a GP says 'right – you need to do 30 mins of waking 5 times a week, they say 'yeah I did it' but how do you know? At least with a ERS they come on and are monitored for a minimum of 12 weeks – or even 6 or 12 months.' *Provider, London*

'And people who come to me say they wouldn't do it on their own, and they won't do it unless they are monitored.' *Primary care referrer, London*

'And the evidence around brief advice is very much based on self reported physical activity levels, whereas we're able to provide real, objective measures of people's physical activity levels.' *Provider, London*

5.3 Considerations: 'Scenarios of effectiveness' and 'Barriers to success'

Participants felt that it was very unlikely that anyone other than committed physical activity /public health specialists would read this section of the guidance. Most felt that key decision makers would stop reading at the the recommendations section.

Accepting this, the fieldwork research probed for responses to these sections, at the request of NICE.

The general view was that it was of some (limited) interest to some participants to see the kind of discussions, and the limitations of the evidence base, that had been used to inform the recommendations. At the same time, the section was felt to reveal what was felt to be a relative paucity of evidence – and indicated an uncertainty in the PHAC decision making – that some participants questioned how such an unequivocal recommendation (do not commission) could be justified.

> 'I think it's helpful to have it there – it shows how they arrived at their decisions, doesn't it?' *Public health specialist, Midlands*

> 'I think we understand it – they are really honest with the poor quality of the evidence – but then the question I have is, "what gives them the right to make the recommendations they have?" *Commissioner, London*

> 'I think given how poor the evidence is – to come up with such poor evidence and then say the whole lot doesn't work is… ambitious.' *GP referrer and commissioner, London*

> 'It's not really helpful – you are giving me a rationale for the things that might be more cost effective but the outcome is still the same. I think people's reaction is likely to be, "well you haven't seen what's happening in Bolton – or Lambeth".' *Commissioner, London*

Paragraphs 3.19 to 3.22

> 'These paragraphs are trying to balance the negative recommendations a bit. It doesn't give you the detail but manages to read as a bit long winded. These things need stating somewhere in the guidance more clearly". *Public Health Specialist, London*

> 'It is clear there is little good evidence on effectiveness of ER.' *Commissioner, London*

> 'Motherhood and apple pie - it feels true but there nothing to back it up.' *Physiotherapist, London*

> 'It is stating the obvious.' *Public Health Specialist, London*

> 'They haven't got any evidence - so they are saying 'please go and do some trials for us'.' *Public Health Specialist, London*

> 'Why is there a lack of evidence? Because there is not a framework for ER to work within.' *ER Provider, Walsall*

Paragraph 3.20

> 'This seems to be saying that brief advice will do it so don't bother with ER - because we haven't got the evidence for this .' *ER Provider, Leeds*

> 'They need to say what they are looking for people to research. Intervening at different stages of long term conditions – some will be more cost-effective - so look at that?' *Public Health Specialist, Enfield*

Barriers to success

Paragraph 3.23

There was evidence of 'poor referral' practice but some people thought that this is expected as there is no agreed standard for many referrers to work to.

> 'I don't agree with the "poor referral" statement. I read that as inappropriate referral from a GP but if there are no set standards for referral practice - no set referral process - it is going to be judged as poor. You need a standard to measure that against.' *ER Provider, Walsall*

> 'People have to want to engage with doing exercise otherwise you are wasting your time.' *Practice Nurse, Greenwich*

> 'The key is to ensure a good triage system is working' *ER Provider, Leeds*

Several participants reported the experience of clients not being clear about why they were referred to a scheme in the first place.

> 'These things ring true - the whole referral system needs to be tightened up. Sometimes people who are referred to us don't know why they are referred - we ask them when they arrive and the GP hasn't told them why he has referred them. It also needs to be tightened up in terms of delivery- with people being referred to gyms which are over 4 miles away when they could have been referred to somewhere nearer their home.' *Public Health Manager and Commissioner, London*

> 'I think that is really important that people know why they are being referred and what they are being referred to. We have the same experience were people don't know when they come to use" People (e.g. GPs) need to know what the ER scheme is they are referring people on to.' *ER provider, London*

> 'Some people turn up confused because they haven't been told by the GP what they were being sent on.' *ER provider, Leeds*

There were suggestions that the issues described in this 'barriers to success' section should be presented more positively or moved into the 'scenarios of effectiveness' section and described as success criteria.

'The statement, *"may not be able to complete it because of their current fitness levels"* this reflects quite negatively on ER schemes. This hardly ever happens as they will have an initial assessments. This could be more positively framed.' *ER provider, Blackburn*

'Talk about what works well - pull out the positive - do we need barriers? How about what works well. "Scenarios of effectiveness" are supposed to cover that but it focuses more on cost effectiveness rather than the factors that make things more effective.' *ER provider, Leicester*

'Put some bolds text in here to highlight the key points' *Commissioner, London*

Paragraph 3.25

In this paragraph the *National Quality Assurance Framework* for exercise referral and the British Heart Foundation National Centre for Physical Activity and Health *Exercise Referral Toolkit* were cited as good examples and both documents were endorsed by those who were aware of them.

On page 8 of the guidance it states that the National Quality Assurance Framework (2001) is being updated and many thought this was well overdue.

'When you train to do a GP referral course they don't even reference National Quality Assurance Frameworks because it's so out of date (2001) . That was good but needs updating. It gave you everything you needed to do operationally - there is nothing else except the previous NICE guidance which was poorly received. So if you are keen on ER you don't refer to NICE guidance. ' *ER provider, Walsall*

There was also a desire to see NICE reference guides that are commonly used by people working in this area.

'the toolkit is great but unless the toolkit is approved by NICE we can't endorse it.' *Provider, Bimimgham*

Section 4 : Recommendations for research

Many thought this section was clear and should act as a guide for future research.

'these questions should be asked in future research.' *ER Provider, Walsall*

Paragraph 4.2

Some respondents thought that some referrers too easily recommend sports based referrals which are inappropriate for a lot of people.

'This section is important- in my area there tends to be more of a sports based referral - post Olympics and all that - which may not be the best thing. ' *ER provider, Dudley*

Paragraph 4.3

'it's teaching us to suck eggs.' *ER Provider, Leicester*

Many people said they already knew the factors that encourage uptake and adherence to physical activity in the long term.participants Participants generally agreed these things should always be asked but they already knew the answer to them.

> 'We need to do something with the data we already have.' *ER provider, Wigan*

Paragraph 4.4

People generally thought they had a good understanding of why people doesn't participate .

> 'It is not a burgeoning question*.' ER Provider, Dudley*

> 'We only take people with a readiness to change.' *ER Provider, Telford*

The factors that prevent certain groups from participating can be nothing to do with the individuals themselves but about the availability of the service.

> 'People with disabilities - I have just lost funding for my young people with disability schemes- they were really well attended - it wasn't about people not wanting to participate.' *ER provider, Leeds*

Most participants believed there needed to be more emphasis on those on low incomes who are struggling , people who are cash and time poor and people who have to give up work to look after children. Children were also mentioned when discussing this section.

> 'I have had refrrals from GP for people under 16.'*. ER Provider, Leicester*

> 'We have a young person's exercise referral schemes in Walsall.' *ER Provider, Walsall*

> 'When does it switch from adult to children's recommendations? This guidance is for 19s and over, the 17 and 18 years olds are in limbo.' *ER Commissioner, Shropshire*

Paragraph 4.5

Most participants would welcome a common evaluation framework against which to measure effectiveness.

> 'It is great - we need baseline.' *ER Provider, Dudley*

> 'in order to evaluate success - need a baseline and a framework -more willing to accept bad news with good evidence.' *ER Provider, Walsall*

> 'We can't update the guidance evidence without a framework in place and a standardised database .' *ER provider,Wigan*

Most participants supported the measurement of other health indicators such as mental health and social well being.

Appendix 1 Topic guide

TIME (all groups 10.00-12.30)	**ERS fieldwork topic guide**
10.00	**WELCOME** **Introduce NICE colleague (if present), and facilitators** **Introduce the purpose of the discussion group. Hold up/have available copies of guidance** **'the purpose of fieldwork is to test out draft guidance on people who are expected to use it.. and broadly to discover views and opinions on its value, what difference – if any – it will make to practice and what can be done to improve the wording.'** • Outline the design of the fieldwork, i.e. that it includes consultation with a wide range of commissioners, referrers and providers of ERS across 3 areas, together with individual interviews and– in addition to a *separate online consultation organised by NICE itself, and which any registered stakeholders, including those at the workshop today, are allowed to also submit to.* • The objectives of the fieldwork are to elicit the views of professionals working in exercise referral and related areas on the draft guidance. The key questions to be addressed are: a. What are professionals' views on the relevance and usefulness of the draft recommendations to their current work or practice? b. What impact might the draft recommendations have on current policy, commissioning, service provision or practice? c. What factors could help or hinder the implementation of the guidance? d. Do those working in these services know of any evidence, either from their own experience and practice ~~*or from what NICE calls 'robust evidence'*~~ elsewhere, not currently taken into account by the draft recommendations? • Explain how important it is for NICE to get the views of professionals who work in the field of exercise referral schemes: "this is your opportunity to influence national guidance". • Explain that views will feed into the development of the final guidance. • REMIND PARTICIPANTS OF SPEAKING IN TURN AND NOT OVER ONE ANOTHER **Consent and confidentiality** • *We don't anticipate that there will be any disclosure of sensitive personal information. However, please could we ask everyone to ensure that all information of a personal nature is respected as private. We will not be attributing personal information in our report to NICE.* • Recordings will be taken during the discussion group – to avoid us having to take notes. • All views will be treated in confidence and anonymised, neither individuals or their organisations will be named in any written report - but we will attribute quotes to a

	role and a region. • Please respect the opinions of other participants. Please also do not discuss the name or organisations of other group participants outside of the meeting. • Explain that the group is time-limited, please do not be upset if we have to try and move the discussion on – this is not because we're not interested in your views but that we have a lot of ground to cover. Also remember that additional comments can be made as part of the NICE online consultation. • Remind respondents to complete the sign-in sheet and to give consent that they wish to take part (if they have not already done so) I want to begin by being very clear about what the guidance covers and what it doesn't cover. And to ask whether everyone is clear about this.
10.15	**Participants to introduce self, role and responsibilities** one sentence intro. Ask each person to introduce self, role and responsibilities, length of time in the area of physical activity/ERS.
10.25 Views on ALL of the preamble READ OUT	**FOR US.. avoid temptation to get drawn into overall views until we've dealt with this question.** **Before we start even on general impressions – and don't worry - we will ask about what you think about the document overall and section by section in a moment – but before everything else, can we start with whether scope for whom the guidance is intended and the definition of ERS are clear, understandable and written in a way that makes sense to you..** **WHAT NICE IN/EXCLUDES IN THE GUIDANCE** ➢ **Is it clear what is in/out of scope of the guidance?** ➢ **Does the wording of the groups for whom it is intended – and the definition of what ERS is - make sense/resonate with participants' experiences of ERS** NICE sets out in the introduction the following: 'This is an update of existing NICE guidance on exercise referral schemes (which were part of PH02 2006) and the guidance is aimed at people aged 19 and over to promote physical activity.' The introduction to the guidance says 'this guidance does not relate to exercise referral schemes that are designed for - or that include management of or rehabilitation for specific diseases – for example cardiac or pulmonary rehabilitation programmes..' NICE also defines Exercise Referral Schemes in the following way: Consisting of • an assessment involving a primary care or allied health professional to determine that someone is 'inactive', that is, they are not meeting the current UK physical activity guidelines (Department of Health 2011) • a referral by a primary care or allied health professional to a physical activity specialist or service • an assessment involving a physical activity specialist or service to determine what programme of physical activity to recommend an opportunity to participation in a physical activity programme.

	➢ Views on the scope, who is in/out – what NICE defines as an ERS. How do the in/exclusion criteria relate to how ERS currently operate/commissioning decisions? ➢ Are participants familiar with existing NICE guidance (PH02)? ➢ **Views on the rest of the PREAMBLE** – outlining what NICE has done and how it has arrived at the conclusions reflected in the recommendations – but also some uncertainties relating to potential benefits not being captured by the economic model ***[IF any participants feel their ERS is exempt/not covered by the guidance because it is delivered to people with long term medical conditions and is not solely concerned with promoting physical activity – ask them to 'assume for the purposes of this exercise' that it is covered]*** **Views on the GUIDANCE overall – opportunity to 'clear the air' on what's good and limitations of the guidance..** **We want to spend the first 30 minutes getting your initial impressions of the document and what it says.** **(Important to identify GOOD as well as limitations – where they exist)** ➢ **What was your response on reading the guidance…?** **PROMPTS if necessary..** ➢ What were your initial impressions on reading the guidance? ➢ Was it a surprise? Or does it reflect what has been known in the field for some time? ➢ Does it say anything new/different to what was known already? ➢ What emotional response does the guidance produce? Eg disappointment/outrage/concern or relief/gratitude that recs are being based on evidence etc ➢ Having reflected on the guidance – what are your impressions now? ➢ What are the key concerns/issues you want NICE to take out of this fieldwork? ➢ Clarity, usefulness and value ➢ Will it be implemented - what will help/hinder this? ➢ Is there any more that can be done to aid implementation by NICE? ➢ Will it make a difference – if so how, for whom? ➢ Who will benefit most/least – why?
How do these vary by areas that do/don't commission ERS or that have higher/lower referral rates? (need to ask	**Questions to discover potential impact of guidance on practice** ➢ How does the commissioning of ERS work at present? What factors influence current decisions about commissioning of ERS? How are these decisions arrived at? ➢ Who are the key decision makers/Key people – professionals and public and organisations (which ones?) ➢ What is the role of written documents – which ones? ➢ Policy and research? – what is used? ➢ What is the role of current NICE guidance (PH02) and NICE guidance on walking and cycling (ph41) and on brief advice (ph44)?

whether respondents are from pro or anti ERS areas) How do responses vary by commissioner/referrer/provider?	➢ What has been the impact of NICE guidance PH02 on commissioning of ERS? How have things changed/stayed the same before and after publication of that guidance? ➢ What has been the experience of service providers of ERS before and after NICE PH02? Has there been an impact on service provision – if so – what? ➢ What actions have service providers taken to secure ERS? ➢ **WHAT IMPACT WILL THIS GUIDANCE HAVE ON YOUR OWN PRACTICE AND WHAT IMPACT WILL IT HAVE/HOW WILL IT BE RECEIVED BY OTHER GROUPS (COMMISSSIONERS/ PLANNERS – REFERRERS – PROVIDERS – OTHER GROUPS)**
11.15	**Recommendation 1** ***Commissioning interventions to promote physical activity*** **READ OUT RECOMMENDATION** **General views on the recommendations** **PROMPTS..** a. Are participants familiar with referenced guidance (PH 8, PH41 and PH44) and relevant recommendations? **AVOID FOCUS ON THESE** – MAKE PARTICIPANTS AWARE BUT NO DISCUSSION b. Is the recommendation clear and easily understood and worded? c. What impact might it have on current local practice, services, or policy? – WILL EXISTING ERS BE THREATENED BY THIS GUIDANCE? HOW/WHY? WHAT IMPACT WILL LOCAL COMMISSIONING RESPONSIBLIITES (ROLE OF ELECTED MEMBERS ETC) HAVE ON THE FUTURE OF ERS? d. Does it conflict with existing advice/protocols that you follow at a local level? If yes – what how why? Are you aware of any national advice/protocols it might conflict with? e. What factors might influence its implementation *positively or negatively* or effectiveness? f. Is there anyone else who should take action on this recommendation? **Recommendation 2** ***Encouraging inactive people aged 19 years and over to be more physically active*** **READ OUT RECOMMENDATION** **PROMPTS.. AS ABOVE FOR REC 1**
11.45	**Section 4 Considerations** **EXPLORE VIEWS TO CONSIDERATIONS OVERALL BUT PAY PARTICULAR ATTENTION TO SCENARIOS OF EFFECTIVENESS AND BARRIERS TO SUCCESS** **Background (explains NICE methods, lack of evidence of effectiveness etc)**

	Effectiveness (few new studies, risk ratio, medium/long term benefits) **Economic modelling (NICE's assessment based on the evidence is that ERS for PA are not cost effective, although this is NOT a call for disinvestment)** **Scenarios of effectiveness** **Barriers to success** Impressions and views on this section. Clarity, usefulness and relevance? Does it help to explain the reasons for the recommendations? Will it be read/taken notice of? <u>ONLY IF TIME AVAILABLE – this is less important section</u> **Section 5 Research recommendations (5 research recs)** Impressions and views on this section. Clarity, usefulness and relevance? Does it help to explain the reasons for the recommendations? Will it be read/taken notice of?

Spend final 15 minutes (12.10-12.25) reviewing the guidance based on the discussion.

12.25-12.30 THANK PARTICIPANTS AND CLOSE MEETING

Appendix 2 Invitation to participate sent via BHF NC newsletter

Can you help? Participants required to contribute to fieldwork on NICE updated guidance on 'exercise referral schemes to promote physical activity'

The National Institute for Health and Care Excellence (NICE) is producing an update of its guidance on exercise referral schemes to promote physical activity. For background information about the guidance click here http://guidance.nice.org.uk/PHG/76

NICE has commissioned independent 'fieldwork' to test the forthcoming draft guidance with a range of professionals who the guidance is aimed at.

This includes the following groups:

- people who plan and commission exercise referral schemes
- people who refer to exercise referral schemes
- people who provide, deliver and manage exercise referral schemes and who manage individuals' exit strategies from schemes

Fieldwork is an important part of NICE's methodology and the findings from fieldwork are considered by the Public Health Advisory Committee (PHAC) when it produces the final guidance.

BHFNC is working with Word of Mouth Research Ltd to conduct the fieldwork on behalf of NICE. The fieldwork will involve group discussions to be held during March in London, Birmingham and Leeds.

If you are a commissioner, referrer or provider of exercise referral schemes and would like to contribute to a group discussion – or if you can help identify key individuals who you feel should be involved – please get in touch with us.

Your opinions about the draft guidance are sought in your capacity as an individual, and not as a representative of any organisation you work for. Organisations are invited to provide views by registering as a stakeholder with NICE. Details of how to do this are available at the link above.

Please contact the project manager, Adam Crosier of Word of Mouth Research Ltd at adam@womresearch.org.uk - providing your name, contact details and your geographical area (local authority).

Appendix 3 Sample details (areas and roles)

Areas Covered

Barking	Leicester
Barnsley	Lewisham
Bassetlaw	London
Birmingham	Newham
Blackburn	Northumberland
Bucks	Norwich
Calderdale	Peckham
Camden	Salisbury
Darlington	Sandwell
Dudley	Shropshire
Durham	Southwark
Enfield	Staffordshire
Greenwich	Stockport
Hinckley	Sunderland
Islington	Wakefield
Kingston upon Thames	Walsall
Kirklees	Wirral
Lancashire	Yeovil
	York

Professions included (The range of job titles provided by participants)

Active Lifestyles Officer ERS	Health & Fitness Development Manager	Public Health Principal
Active Lifestyles Manager	Health and Fitness Manager	Public Health Programme Lead
Assistant Director of Public Health	Health and Recreation Manager	Public Health Specialist (Health Promotion)
Assistant exercise referral coordinator	Health checks manager	Senior Health and Physical Activity Development Officer
Commissioning Lead - Lifestyles	Health Improvement Programme Manager	Senior Health Improvement Specialist
Community Liaison Manager	Health Improvement Specialist	Senior Manager – Adult Treatment Cluster
Community Nutrition, Weight Management and Physical Activity Team Lead	Healthwise Manager	Senior Public Health Manager
Community Sport and Physical Activity Officer	Healthy Lifestyles Manager	Senior Public Health Practitioner
Corporate Health Manager	Healthy Living & Sport Project Manager	Senior Sport and Physical Activity Officer
Digital Fitness Development Manager	Physical Activity Care Pathway Coordinator	Sports Development Manager
Director of Public Health	Physical Activity Coordinator	Wellness Programme Manager
Economic Development Officer (Health and Wellbeing)	Physical Activity Development Officer (Targeted Interventions)	
ERS coordinator	Physical Activity Lead	
Exercise & Physical Activity Development Officer	Physical Activity manager	
Exercise on Referral and Cardiac Rehabilitation Programme Manager	Physical Activity Referral Hub Coordinator	
Exercise Pathways Co-ordinator	Physical Activity Specialist Consultant	
Exercise Referral Coordinator	Policy and projects officer	
GP	Primary Prevention Services Programme Manager	
Practice Nurse	Public health commissioner	
Head of Community Health Improvement Services	Public Health Development Officer: Physical Activity & Falls	
Head of Community Sport and Healthy Lifestyles	Public Health Interventions Manager	
Head of Health Development	Public Health Portfolio Lead	
Head of Sport & Physical Activity		