

Development

Maintaining quality in exercise referral schemes: a case study of professional practice

Diane Crone, Lynne Johnston Leisure and Sport Research Unit, University of Gloucestershire, Gloucester and **Trudi Grant** Somerset and Dorset Health Authority, Yeovil, Somerset, UK

The epidemiological evidence regarding physical activity and health has triggered, within health care, an interest in the development of physical activity promotion, in an attempt to address concerns regarding levels of physical inactivity within the population. These initiatives have varied during the past decade, from public health campaigns, to the development of nationally recognized training qualifications. By far the most prolific physical activity programme that has developed however, has been the 'exercise referral scheme'. These schemes now exist in most towns and cities, providing a formal link between local primary care and leisure provision. However, professional bodies in both medicine and exercise, responsible for the care of their members, have expressed concerns over the duty and quality of care that exists within such schemes. Research too, has provided conflicting evidence regarding their efficacy for health improvement. As such, national recommendations have been produced and published by the Department of Health to set and maintain standards in this growing area of service delivery.

This case study of professional practice provides one innovative approach to ensuring that a countywide exercise referral scheme is a successful conduit for raising physical activity levels, and thus, health. By employing professionals from exercise science to deliver the Proactive Management Service, Somerset Physical Activity Group have devised a unique approach to ensuring and maintaining the quality of service delivery to the patients referred onto the exercise referral scheme within Somerset.

The case study concludes with lessons learnt from these developments and proposals for the future, including, establishing a national register of exercise referral schemes and the importance of addressing the competencies of both health professionals and leisure professionals, who are involved in such schemes.

Key words: exercise referral schemes; exercise scientists; health professionals; interdisciplinary; multidisciplinary; quality assurance

Part 1: Emergence of the use of physical activity for public health

Physical activity has long been recognized as being influential to both physical and mental health

Address for correspondence: Diane Crone, Leisure and Sport Research Unit, University of Gloucestershire, Oxstalls Campus, Oxstalls Lane, Gloucester, GL2 9HW, UK. Email: dcrone@glos.ac.uk

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(Biddle *et al.*, 2000; Blair and Connolly, 1996; Morris *et al.*, 1953; Paffenberger *et al.*, 1978; Paffenberger *et al.*, 1986; Paluska and Schwenk, 2000; Powell and Blair, 1994). With this acknowledgement has come the recognition that physical activity can play a role in improving public health. Morris (1994: 807) summarized 40 years of research in this area and concluded by calling for the strategic inclusion of physical activity within the social policy agenda and public health policy.

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Using the phrase 'physical activity is the best buy in public health', he extolled the value of physical activity for public health and highlighted its importance for policy development.

The need for a strategic approach regarding the use of physical activity as a means to health maintenance and enhancement was also supported following the findings from the Allied Dunbar National Fitness Survey (ADNFS, 1992). The findings, from a public health perspective, were alarming because of the number of people who were found to be inactive. The study concluded that only a small proportion of the population were active enough to benefit their health, with only 14% of men, and 4% of women, indicating that they took part in vigorous activity more than three times a week, for at least 20 minutes. In addition, the survey concluded that a large proportion of the population was mildly overweight or obese (49% of men and 56% of women), and that there were numerous types of activity undertaken, indicating a variety of preferences.

The findings from the ADNFS (1992) and epidemiological research have resulted in the government promoting the need for a more active population. As a consequence, physical activity was included in the government white paper (Department of Health, 1993) and in 1996, the first national physical activity campaign (Active for Life) was launched by the Health Education Authority. This campaign was a direct response from government highlighting its concern regarding physical inactivity and its implications for public health. These concerns and initiatives were not exclusive to Great Britain, other countries, such as Australia, also launched similar public health campaigns, for example 'Exercise – take another step' during the 1990's (Sallis and Owen, 1999). Furthermore, at a strategic level, lobbying groups such as the International Federation of Sports Medicine and the World Health Organisation, also became involved in the international concern for health and physical activity levels. These two bodies forged an alliance and called for governments in the west to promote and enhance physical activity programmes as part of the public health and social policy agenda (World Health Organization/International Federation of Sports Medicine, 1995). To date, in Great Britain, the result of this political interest has begun to filter through into public health and social policy. Although this recog-

nition is still marginal, in contrast to other health issues, it has resulted in a more congenial political climate, and as such there has never been a greater political emphasis placed on the role of physical activity for health (Crone-Grant, 2001). This climate is clearly evident through the number of references to physical activity and leisure within national public health policy; for example, *Saving lives: our healthier nation* (Department of Health, 1999a), and the national service framework documents on coronary heart disease (Department of Health, 2000), mental health (Department of Health, 1999) and older people (Department of Health, 2001a). In terms of specific physical activity programmes, the publication in 2001, of the National Quality Assurance Framework for Exercise Referral Schemes (NQAF ERS), (Department of Health, 2001b) has also been a significant step forward for exercise referral schemes, and the health and exercise partners that are involved in their development. This document has publicly acknowledged and recognized the important role that physical activity, exercise scientists and health professionals have in multiagency projects to promote physical activity to medically symptomatic individuals in health care. The Secretary of State for Health, in the introduction to the document, provides an example of the political awareness of the implications of such schemes for health and highlights the shared responsibility and need for partnership working, between health services, leisure providers and the individual:

The health service has a key role to play in giving people not only advice, but also the support they need in making changes to improve their health. Referral schemes can form an important option. By working in partnership with appropriately qualified fitness and leisure providers, primary care teams can offer people real opportunities to take part in safe and effective exercise.

(Department of Health, 2001b: iii)

The NQAF ERS (Department of Health, 2001b) provides guidelines for exercise referral schemes. By detailing these, it aims to improve the standards of schemes already in existence, and provides guidelines for those in a development stage. It promotes a client centred approach and includes sections on relevant aspects of referral schemes,

ranging from the medico-legal considerations, professional competencies, and scheme development and monitoring. This document is significant because it has placed exercise referral schemes firmly onto the public health policy agenda. In providing recommendations for the delivery of these schemes, it provides a defined structure for the development of good practice, and parity across the country. The document details a range of recommendations including, professional competencies, exercise prescription, motivational strategies to promote a behaviour change, and monitoring and evaluation. The significance of detailing the requisite competencies of the professionals involved in schemes, by laying down clear competencies, qualifications, and the need for national registration, through SPRITO (National Training Organisation for Sport, Recreation and Allied Occupations), for people working with patients, has highlighted nationally the requirement for appropriate and safe scheme delivery.

These national policy developments have begun to proliferate into practice at a regional and local level. The development of interventions targeting a range of people is apparent, with physical activity being included in health improvement programmes and specific strategies such as falls prevention. Central government has assisted with this local implementation by including a requirement in the national framework documents, for regional health authorities to provide evidence verifying their implementation of policy, and its effectiveness, including, where applicable, the development of physical activity and leisure opportunities for older people (Department of Health, 2001a), people with mental health problems (Department of Health, 1999) and people with coronary heart disease (Department of Health, 2000). The increase in evidence, political awareness, and policy developments of physical activity promotion, has led to the development of interventions within the community.

Part 2: The emergence of physical activity programmes in primary care

Over the past decade, there has been an increasing rise in the number of community based physical activity programmes (Fox *et al.*, 1997; Riddoch

et al., 1998). These initiatives, although geographically disparate in their emergence, now exist in many towns and cities in the UK. Arguably, the most common schemes and those with a history dating back to the early 1990s are exercise referral schemes. These schemes involve a health professional, usually a general practitioner (GP), referring a patient to a leisure professional for a programme of supervised exercise. In essence, the GP recognizes that physical activity could significantly assist health and refers their patient to a local leisure provider for a programme of physical activity, usually at a reduced price. Patients commonly referred include those at risk from coronary heart disease or people already displaying risk factors such as hypertension, diabetes and obesity.

During the 1990s, exercise referral schemes grew at a grass roots level based on local initiative and enthusiasm. However, despite their obvious potential in terms of addressing health issues, the lack of strategic vision or planning from both health and leisure services, either regionally or nationally, resulted in an ad-hoc development. As a consequence, schemes were commonly being established without a standard format, lacking in criteria for the referral of patients or other quality control measures and considerations (Hillsdon, 1998). Some regions addressed this lack of strategic planning and quality control by introducing a type of 'certification' or kite marking which leisure centres, fitness clubs, or individual's had to achieve, prior to receiving patients. Two counties (Somerset in 1993 and Shropshire in 1996) developed such systems, and as a result have sustained countywide schemes where exercise and health professionals formally liaise with each other. The government in 1993 acknowledged this co-ordinated, multiagency approach to holistic health care and provision. They commended a number of multiagency alliances which had been successful in this approach, through a series of national awards, titled Healthy Alliance Awards. Somerset Physical Activity Group, the multi-professional group that devised the Somerset referral scheme, was one such recipient. The continued commitment to a co-ordinated approach also appears to be a priority for the current government (Department of Health, 1999a) who have actively promoted and adopted partnership working as a mechanism to provide a seamless service in health and social services (Department of Health, 1998)

and for the new NHS development (Department of Health, 1997). This approach helps to reduce the concerns of professionals working on multiagency groups and provides health professionals with confidence to get involved with leisure professionals and refer patients onto such schemes (Johnston *et al.*, 2001).

Part 3: Case study

The Proactive scheme provides a case study of professional practice which involves partnership approaches aimed at addressing the issues of quality assurance and parity in the service delivery of exercise referral schemes in Somerset. The case study details how a co-ordinated multiagency group provides the macro structure for the Proactive Management Service, a multidisciplinary team of exercise scientists, which monitors and aims to maintain and improve the service received by referred patients from leisure providers. Taylor (2002) states that if physical activity interventions are to be beneficial for public health, they need to be guided by a strategic infrastructure. The eclectic approach taken in Somerset provides this infrastructure, and as such, provides a valuable case study on which to base recommendations for the implementation of the NQAF ERS (Department of Health, 2001b) for health and exercise professionals/alliances.

The background

Somerset Physical Activity Group (SPAG), established in 1993, is a multiagency alliance. It is strategically linked to Somerset Specialist Health Promotion Service, who oversee the service for the counties primary care trusts. SPAG includes representatives from Somerset Specialist Health Promotion Service, five local district councils (usually the leisure officer or physical activity development officer), the local medical committee (a GP), Somerset County Council, Sustainable Somerset, Sport England, private leisure providers, and Age Concern. Its agreed objective is to promote and increase physical activity levels in the county, with the aim of improving health. The range of partners, exhibits the diverse agendas that must be met, for the group to be sustainable and effective. The physical activity referral scheme, initially launched in 1994, is one initiative that SPAG has developed

that effectively addresses activity levels within the county (Grant *et al.*, 1999).

The scheme was evaluated between 1995 and 1997 and the findings (Grant *et al.*, 1999: 1) report the following:

- three quarters of the people who were referred on to the scheme completed their programme of physical activity (where scheme duration was typically between eight and 12 weeks),
- people who completed the programme significantly increased their physical activity levels from base line to six months follow-up,
- intention to treat analysis also showed a significant overall improvement in physical activity levels from baseline to six months,
- significant improvements in some aspects of perceived health (physical functioning, role physical and vitality) were found for people who completed the physical activity referral.

As a consequence of these findings, Somerset Health Authority continued with their financial support for the scheme, by contracting an exercise science support service, Proactive Management Service (PMS). This service, currently provided by the University of Gloucestershire, is a unique aspect to the referral scheme and brings an additional dimension to the multiagency alliance, SPAG. As a co-opted member of SPAG and as a direct link between patient and leisure provider, PMS aims to bridge the divide between health professionals, patients and leisure providers by recognizing and addressing the differing needs of each partner involved.

Proactive Management Service (PMS)

PMS provides consultancy and support to leisure and health professionals involved in the physical activity referral scheme. The British Association of Sport and Exercise Sciences (BASES) accredited sport and exercise scientists deliver the service. This accreditation is a postgraduate qualification that involves a peer review process demonstrating the practical application of theory and the development of evidenced based practice. Accreditation is typically gained over a period of three years and is renewable every five years.

This multidisciplinary team of sport and exercise scientists has specialisms in health psychology, exercise physiology, health and leisure policy, and project management. As the nature of the contract

is varied, it requires different aspects of the service to be delivered in three approaches; monodisciplinary (i.e., the application of one discipline), multidisciplinary (i.e., a team approach with a combination of different disciplines) or interdisciplinary (i.e., an individual integrating disciplines). The involvement of the multidisciplinary team of sport and exercise scientists is crucial to ensure that the quality of delivery from the leisure providers involved in the physical activity referral scheme is maintained and improved for the contractors and the referral schemes co-ordinating body, SPAG. The involvement of these professionals as an intermediary between the health professionals, patients and leisure providers, supports the governments recent proposal to adopt innovative service delivery models within health care (NHS Service Delivery and Organisation Research and Development Programme, 2000).

PMS consists of the following aspects.

Central Referral Mechanism

Somerset's referral scheme is centrally co-ordinated by means of a centralized Microsoft Access database, termed the Central Referral Mechanism (CRM). This is managed by the PMS's physical activity counsellor, who, following a patients referral from one of the 77 practices in Somerset contacts each patient by telephone to initiate their inclusion into the scheme. During this telephone consultation the physical activity counsellor ascertains that the information on the referral form is a full and accurate record of their health status and discusses with them their choice of referral scheme, available through the *SPAG Recognized Leisure Provider Scheme*.¹ The role of the project worker requires knowledge, from an exercise science perspective, of the physiological aspects of disease, the implications of medication and exercise, the psychological variants of behaviour change; and the psychosocial implications of commencing physical activity at a venue, perhaps previously alien, to the typically over 50-year-old patient. The CRM is an interdisciplinary aspect of

PMS. An understanding and appreciation of these different disciplines and an ability to identify and apply them where appropriate, is crucial to ensure a patient-centred approach and facilitate, where possible, patient empowerment (Department of Health, 2001b). It is also important, as this is the first contact with the scheme that the patient is fully informed, and that following their consultation with the physical activity counsellor, they feel they are appropriate for referral onto a SPAG recognized leisure provider. The majority of people do perceive themselves as appropriate and join a scheme. However, in some instances cost, availability, accessibility or motivation prevents this, when this occurs the physical activity counsellor suggests a one-off meeting with the local recognized leisure provider to discuss suitable alternatives such as home based activity or an increase in daily life activity, such as walking. However, because these participants do not formally join the scheme there is not, to date, a tracking mechanism in place for these people. This would be useful in determining whether they continue with this activity 'outside' of the leisure centre scheme based activity, longer term.

Workshops

PMS is contracted to provide workshops to the 20 SPAG recognized leisure providers within the county. Within these 20, there are approximately 50 'fitness instructors' involved in the referral programme who have differing qualifications and levels of experience. The aim of the workshops is to provide the fitness instructors with adequate knowledge and competencies to meet with the NQAF ERS's (Department of Health, 2001b) requirements for staff working with low to medium risk patients on exercise referral schemes. Workshop topics therefore vary depending on leisure provider need (identified by the fitness instructor's themselves), the PMS team (usually based on an awareness of current developments in evidence based practice) or from the contractor.

The delivery of each workshop also varies and depends on the nature of the content. For example, an interdisciplinary approach is promoted when addressing exercise prescription issues, so that the resulting exercise programme is client centred; whereas a monodisciplinary approach is assumed

¹ In Somerset all leisure providers are required to apply for, and be assessed via a peer review, for SPAG Recognition which they must achieve prior to receiving patients from the local medical practices.

in discipline specific workshops such as a physiology workshop, detailing the underpinning physiology of medical conditions or a psychology workshop where 'motivational interviewing' and motivational strategies are considered. There are also workshops that address professional development issues, such as reflective practice. It is important therefore to maintain a balance of both topic and delivery which is decided on need and on the most appropriate method, based on the topic and specific learning outcomes for each workshop.

Once again, the ability of the multidisciplinary team to discuss the content of the workshops, and the nature of their delivery, ensure that leisure providers' knowledge, and more importantly the ability to apply this, are maximized to ensure a high standard of service to referred patients and, hopefully, an improvement in client adherence and retention.

Consultancy

The consultancy aspect of the service provided by PMS is largely interdisciplinary and draws upon disciplines from exercise science, i.e., physiology and psychology, but also from health promotion, leisure and project management, health policy and administration. The consultancy is provided to the leisure providers to help them to gain SPAG Recognition. SPAG Recognition involves the development of a comprehensive portfolio detailing all aspects of the scheme, its management and delivery. Once this is achieved consultancy is provided to ensure a quality service is maintained. The standards set by SPAG are aligned with the NQAF ERS's (Department of Health, 2001b) recommendations for scheme development. For example, the requirement to identify appropriate motivational strategies to encourage unstructured and structured physical activity outside of the exercise programme thereby encouraging patient autonomy in physical activity choice. Assessing leisure providers to achieve these standards requires an ability of the team to integrate the following:

- national recommendations for the operation of schemes (Department of Health, 2001b),
- SPAG's recognition criteria,
- medical condition and exercise prescription issues,

- medico-legal considerations,
- scheme design and management,
- adherence to maintenance of protocols and patient auditing systems.

In addition, the ability to 'crisis manage' is also required when schemes lose their co-ordinators (as is common in the leisure industry) when patient care and support could be potentially jeopardized. This ability to crisis manage can result in the Central Referral Mechanism ceasing the referral of patients to leisure providers, if SPAG's requirements have not been maintained. The ability to co-ordinate the referral of patients and redirect them to alternative leisure providers, when necessary, is essential in maintaining a countywide service that has parity across all leisure providers within the scheme.

Newsletters

A bimonthly newsletter is produced as a means of updating leisure providers and SPAG members on current relevant events within the county and, from an exercise science perspective, as a medium for information dissemination. Typically, this information is monodisciplinary based, as each of the workshop presenters (the BASES accredited members of the team) provide articles on topics that relate to, for example, a recent workshop or an update from research, pertinent to leisure providers working on referral schemes.

Summary

The aim of PMS is to maintain quality, and improve standards, for SPAG's Physical Activity Referral Scheme. These standards are similar to the national recommendations laid out in the NQAF ERS (Department of Health, 2001b), this case study of professional practice therefore provides insight into how one multiagency strategic group has addressed the implementation of these recommendations. To maintain the required standards successfully, Proactive requires a multidisciplinary team who are appreciative of the need to apply PMS in a variety of approaches, dependent on the aspect of the service, or the requirements of its recipients.

The leisure providers and members of SPAG have acknowledged improvements to the scheme, anecdotally. However, empirical research is needed in this area to evaluate the effect of PMS, and in particular the CRM aspect and its impact on patient adoption, adherence and maintenance, longer term, of physical activity. Funding has been secured for this work and commenced in 2003.

Part 4: Conclusion

This case study of professional practice highlights the importance of a co-ordinated approach to maintaining quality in the delivery of exercise referral schemes. It emphasizes the need for a multiagency alliance who have an agreed objective and who recognize each other for the differing strengths and competencies that they bring to the group. The case study reinforces the need for a steering group who oversee the development of referral schemes and support (Taylor, 2003) the establishment of an infrastructure in which to operate. It also supports the use of a quality assurance mechanism at a local level. The quality assurance mechanism in Somerset is partly established through the requirement for leisure providers to have their schemes recognized by the co-ordinating body SPAG. This is a model that could be replicated across the country and is something that a national co-ordinating body, similar to the National Register of Fitness Instructors managed by SPRITO, could incorporate and would complement the existing register of individuals. This would help to ensure the implementation of the NQAF ERS (Department of Health, 2001b) and improve standards of patient care within exercise referral schemes across the country.

The importance of maintaining quality in exercise referral schemes is crucial if they are to achieve their potential in improving public health. Despite referral schemes being prolific in their existence (Riddoch *et al.*, 1998) the mechanisms by which the NQAF ERS (Department of Health, 2001b) recommendations can be implemented to ensure parity in client centred services across countries, has been lacking in any literature to date. This case study, by providing one perspective of how quality can be maintained through the involvement of an exercise science support service, is one way to address the concerns health professionals and researcher's have regarding the efficacy of referral

schemes. Clearly other case studies where multi-agency groups have implemented co-ordinated partnership approaches to achieve this also need to be considered in the development of best practice in this emerging area.

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