



Mapping physical activity referral schemes in Northern Ireland

Final report prepared for the Health Promotion Agency

June 2008

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17 June 2008

Dear Nicola

We have pleasure in presenting our findings from the study to map physical activity referral schemes in NI.

We have enjoyed working with you on this project. If you require any further information please do not hesitate to give me a call.

Warm regards



Maureen Treacy
Managing Director

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1. Introduction

The Health Promotion Agency commissioned Perceptive Insight Market Research to undertake an audit to map physical activity referral schemes operating across Northern Ireland and the mechanisms for training, delivery and evaluation of these schemes.

The “National Institute for Health and Clinical Excellence” provides the following definition of exercise referral;

‘An exercise referral scheme directs someone to a service offering an assessment, development of a tailored physical activity programme, monitoring of progress and follow-up. They involve participation by a number of professionals and may require the individual to go to an exercise facility such as a leisure centre.’

Within recent years a number of physical activity referral schemes have been established across Northern Ireland involving partnerships between primary care and leisure services. These schemes are coordinated by the local physical activity coordinators and leisure services within local councils.

The aim of this project is to assist with the development of these schemes. While there has been some evaluation of physical activity referral schemes in Northern Ireland these have not allowed the HPA to establish a comprehensive picture of what schemes exist. Therefore it is important to get an overview of what is happening within NI at present and to identify possible gaps in provision.

Terms of reference

The aim of this project is to carry out a mapping exercise to assess the number of exercise referral schemes operating across NI and the mechanisms in place for training, delivery, and evaluation of these schemes. In addition the project assesses the use of exercise referral schemes by primary health care professionals. To meet these aims research was conducted with three key groups:

- Primary care health professionals;
- Leisure centre managers; and
- Physical activity coordinators/ Physical activity referral scheme coordinators.

The following bullet points detail the specific objectives of the research with each of these groups:

Primary care health professionals

- To assess the number and type of health professionals referring into exercise referral schemes ;
- Assess adherence to NICE guidelines on the promotion of physical activity.
 - Establish professionals’ assessment of patients in terms of physical activity levels and need and follow-up of referred patients;
- To identify the main reasons why people are referred to a physical activity scheme; and
- To assess the barriers preventing professionals from referring patients to a scheme.

Leisure centre managers

- To assess current mechanisms of delivering exercise referral schemes;
- To assess opinions of the current running of the schemes in terms of the benefits and difficulties; and

- To identify the level of training provided for fitness instructors involved in the delivery of these schemes.

Physical activity coordinators/ Physical activity referral scheme coordinators

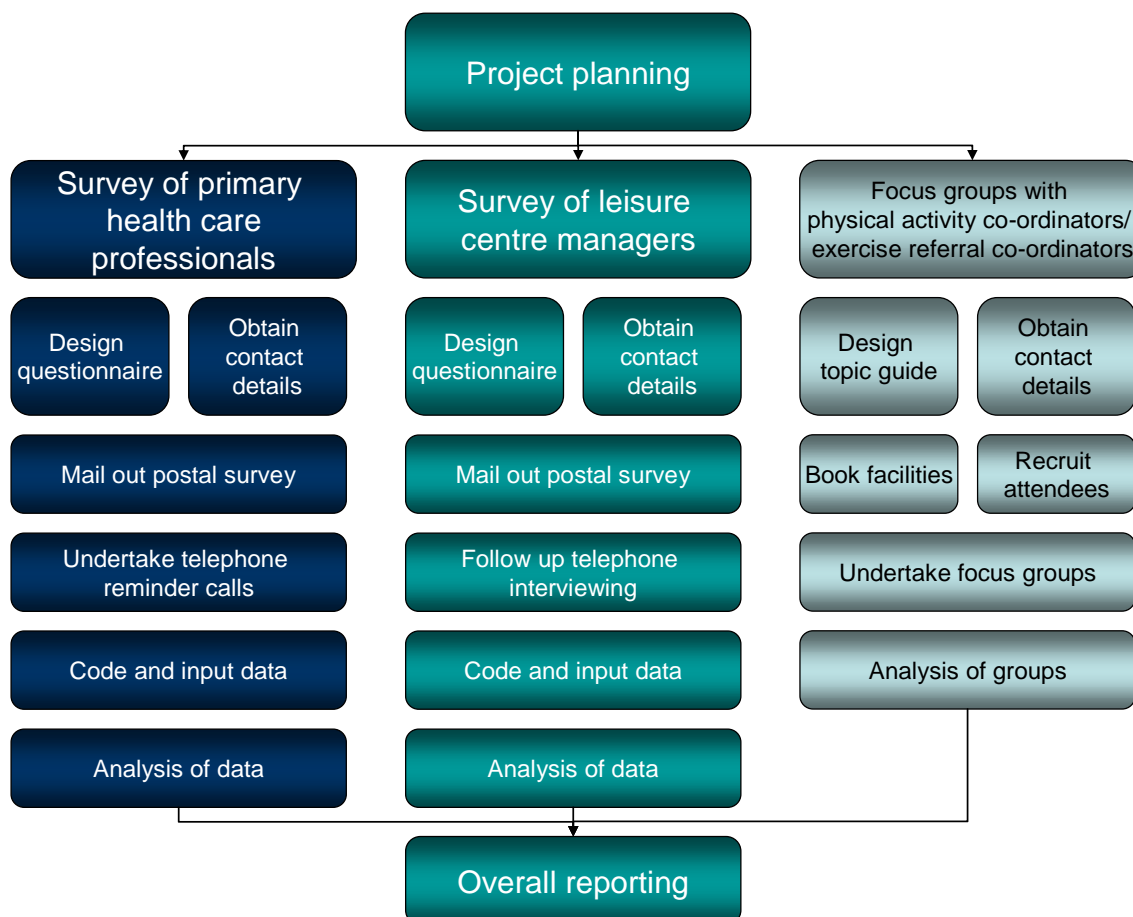
- To establish the number of physical activity referral schemes operating across NI and where these schemes are located (PA coordinators only);
- To assess coordinators experiences of being involved in the schemes; and
- To establish their perception of benefits of the physical activity schemes and barriers to implementation of these schemes.

Further objectives applying to all target groups

- To assess specific training needs of professionals in relation to exercise referral; and
- To make recommendations for the development of physical activity referral schemes within NI.

2. Our approach

In this section we have identified the key steps that were undertaken in the implementation of the project. The following diagram provides an overview of our approach to meeting the terms of reference for this study.



Project planning

On commissioning a planning meeting was held with the HPA project team. The aim of this meeting was to discuss, refine and agree the approach to the research. At this meeting we also agreed the timetable and reporting procedures.

Survey of primary health care professionals

Our approach to researching the primary health care professionals was a postal survey of GP practice managers with telephone follow up to boost response rates.

HPA provided a draft copy of the questionnaire. Working with the HPA team we refined the questionnaire to ensure that it met the objectives of the research. The questionnaire was kept concise so as to encourage response.

The questionnaire was piloted to ensure that the questions flowed, were relevant and easy to understand. A copy is enclosed in Appendix A.

HPA provided a list of 370 GP Practices in Northern Ireland. This formed the basis of our survey with this group. The postal questionnaire was sent to each practice manager, who we asked to liaise with their primary health care colleagues to complete the questionnaire.

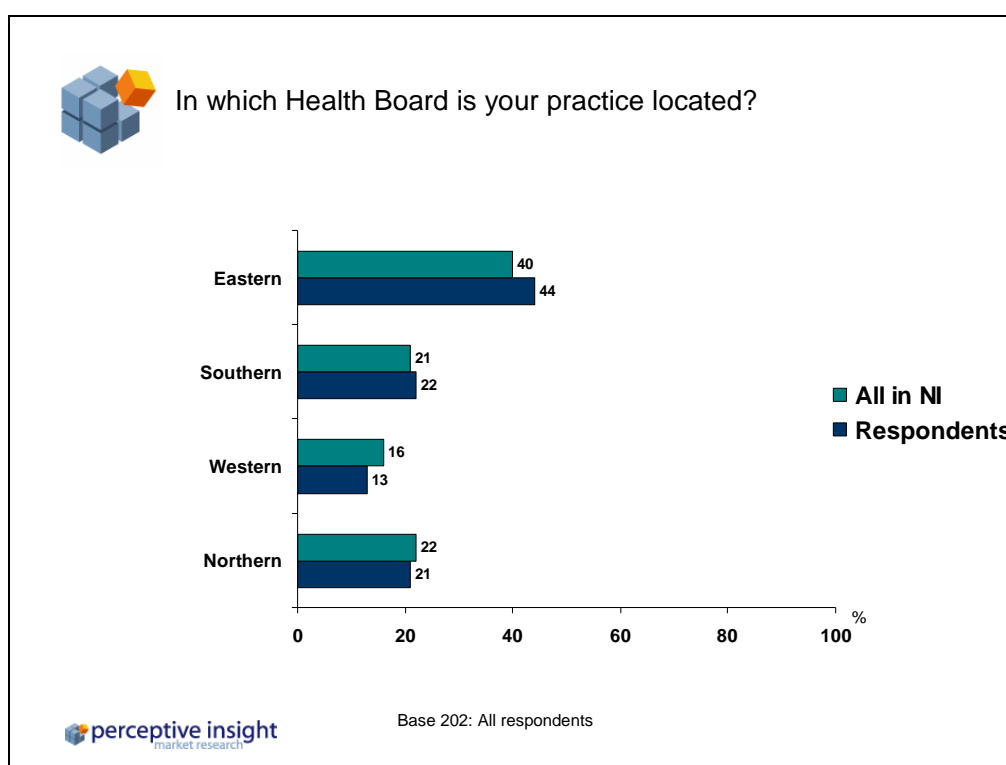
The completed questionnaires were returned directly to Perceptive Insight’s offices using freepost envelopes. The response to the postal survey was monitored and any practice not responding within the agreed timeframe was contacted by telephone. The Practice Manager was offered the facility of completing the questionnaire by telephone so as to ensure response.

A total of 202 completed questions were achieved representing a response rate of 55%.

The completed questionnaires were coded and entered into our survey software for analysis purposes. We produced a set of data tables detailing the response to each question. Using this information we compiled a set of charts depicting the key findings from this element of the research.

Assessing response to the survey by Health and Social Services Board area shows that those who responded are broadly representative of GP practices by location. As Figure 2.1 shows there is a slight over representation of GP practices located in the Eastern Board area and a slight under-representation from the Western Board area.

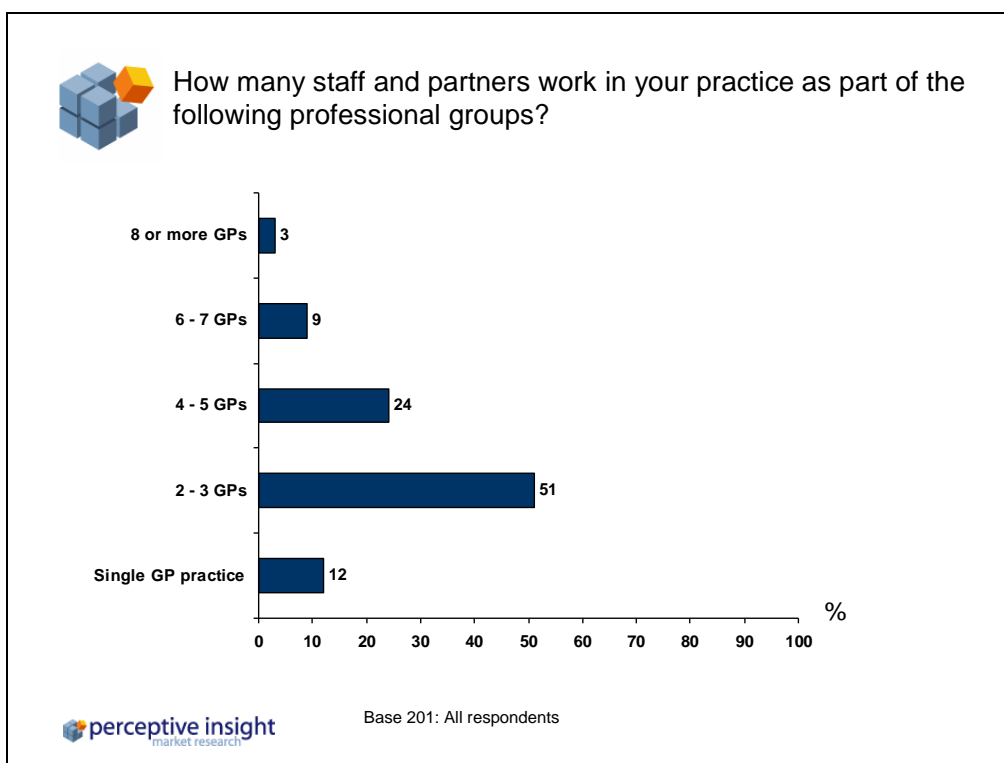
Figure 2.1: Location of GP practices



Analysis of respondents showed that 28% regarded themselves as an urban practice, 23% as a rural practise with just less than half (49%) saying that they served both urban and rural based patients.

Size of practice also varied with 12% saying that they we a single GP practice, just over half (51%) had two or three GPs, 24% had four or five GPs and 12% had six or more GPs (Figure 2.2).

Figure 2.2: Number of GP in the practice



The vast majority of practices (93%) employed at least one practice nurse. Most employed one or two practice nurses, with only three practices employing five or more.

Just over one in five practices (22%) employed nurse specialists/practitioners. Of this group the majority employed only one. Five practices employed more than one nurse specialist/practitioner.

Survey of leisure centre managers

A similar approach was undertaken to survey the leisure centre managers i.e. a postal survey with telephone reminders.

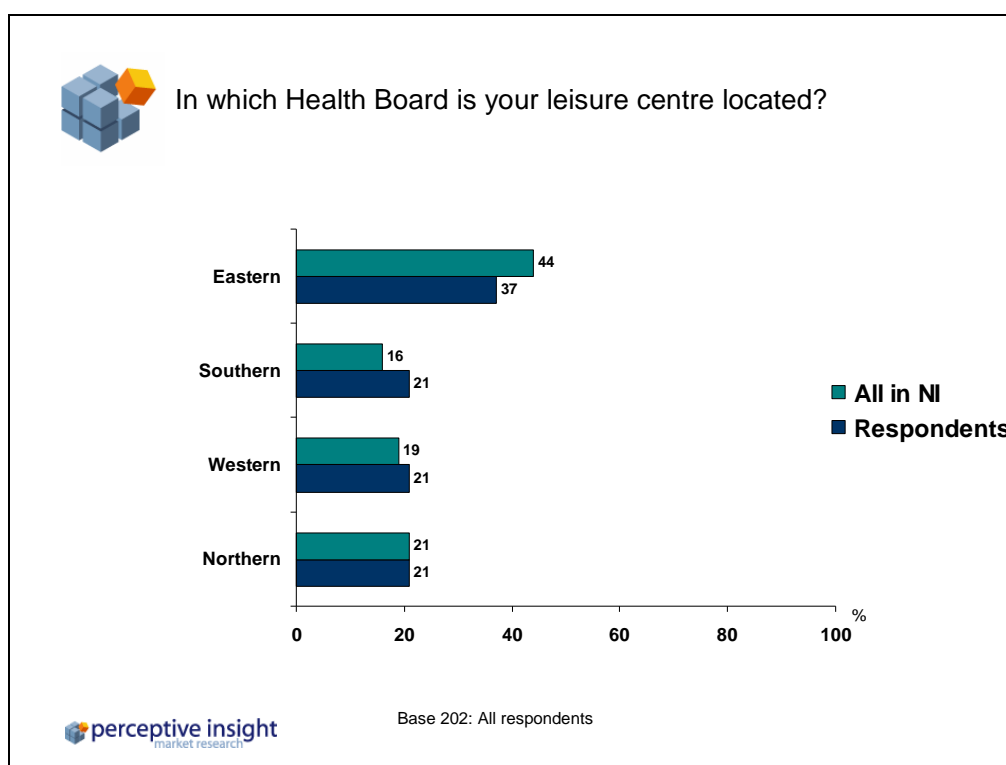
The HPA team provided details of contacts for 63 council-run leisure centres. They also provided a draft questionnaire. We worked with the team to refine it further to ensure that it fully met the objectives of the research. Again, the questionnaire was kept concise so as to encourage response.

A total of 43 completed questionnaires were achieved representing a response of 68%.

The data from the completed questionnaires was coded and entered into our survey software for analysis. We produced a set of data tables detailing the response to each question along with a PowerPoint presentation charting the key findings.

As can be seen from Figure 2.3, the response from leisure centres was broadly representative by location of those who are participating in the scheme. However, there is a slight over-representation of those located in the Eastern Board area and a slight under-representation of those in the Southern Board area.

Figure 2.3: Location of leisure centres



Focus groups with physical activity coordinators and exercise referral scheme coordinators

Three group discussions were held, one with physical activity co-ordinators and two with exercise referral co-ordinators.

The HPA team provided a list of potential participants for the group discussions. PIMR contacted each of them and offered a number of alternative dates upon which to attend one of the three discussions being held. Written confirmation of the date and venue and a reminder email the day prior to the focus group date was sent to each participant who agreed to take part.

The group discussions were held at three locations; in Belfast, Antrim and Armagh. A total of 14 professionals participated in the discussions. A topic guide was drafted around which each discussion was based. Each discussion lasted up to 1.5 hours.

Each discussion was audio-taped and reviewed to identify key themes emerging from the research. We then identified the range of views that exist around each of these themes and quotations to illustrate any points made.

Reporting

This report draws together the key findings from each of the elements of the research.

3. Views and experiences of GP practices

In this section we detail the findings from the survey of GP practices. The findings are presented under the following headings:

- Promoting physical activity;
- Physical activity referral;
- The operation of Physical Activity Referral Schemes; and
- Training and information.

Promoting physical activity

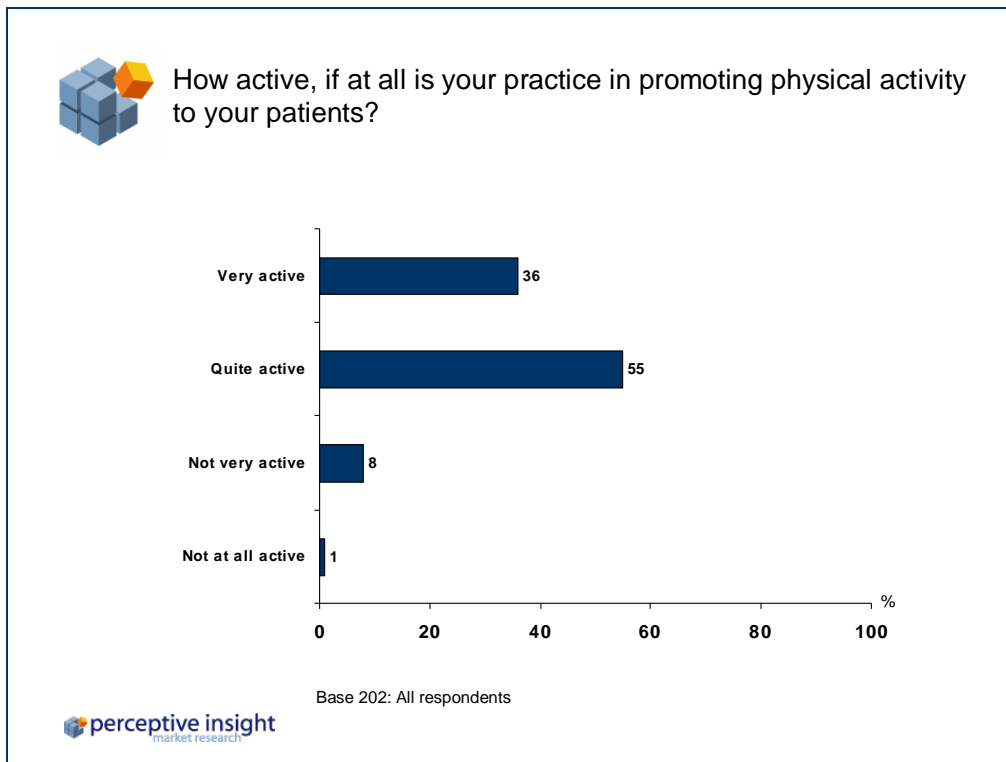
NICE¹ guidelines recommend that primary care practitioners should take the opportunity, wherever possible, to:

- identify inactive adults;
- advise them to aim for 30 minutes of moderate activity, five days per week;
- agree goals with the individual;
- provide written information about the benefits of activity;
- inform them of the local opportunities to be active; and
- follow them up at appropriate intervals over a 3 to 6 month period.

The majority of GP practices (91%) report that they promote physical activity to their patients (*Figure 3.1*). 36% say that they are very active in this regard and 55% state that they are quite active. However 8% consider that they are not very active and 1% not at all active.

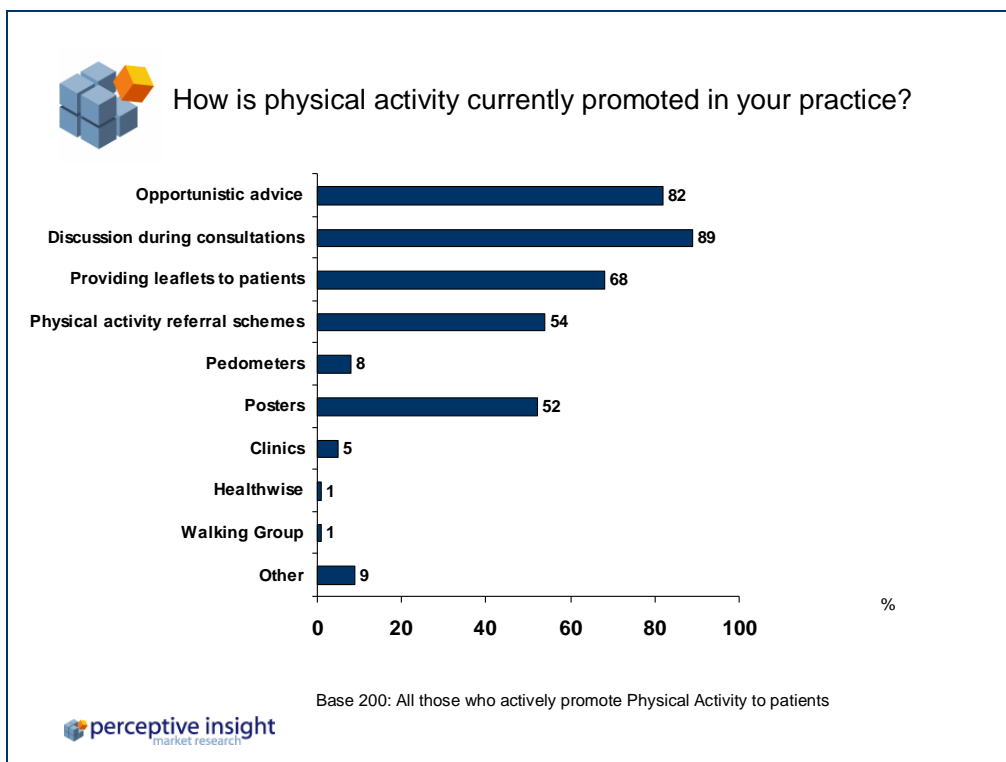
¹ National Institute for Clinical Excellence. Physical activity: Quick reference guide 2006. http://www.nice.org.uk/nicemedia/pdf/PHYSICAL-ALS2_FINAL.pdf

Figure 3.1: The activity of GP practices in promoting physical activity



The majority promote physical activity during consultations (89%) and opportunistically (82%) (Figure 3.2). Written information in the form of leaflets is provided by 68% of practices and 52% display posters. This means that approximately one third of practices are not following NICE guidelines about the provision of written information on physical activity.

Figure 3.2: Methods used to promote physical activity in GP practices



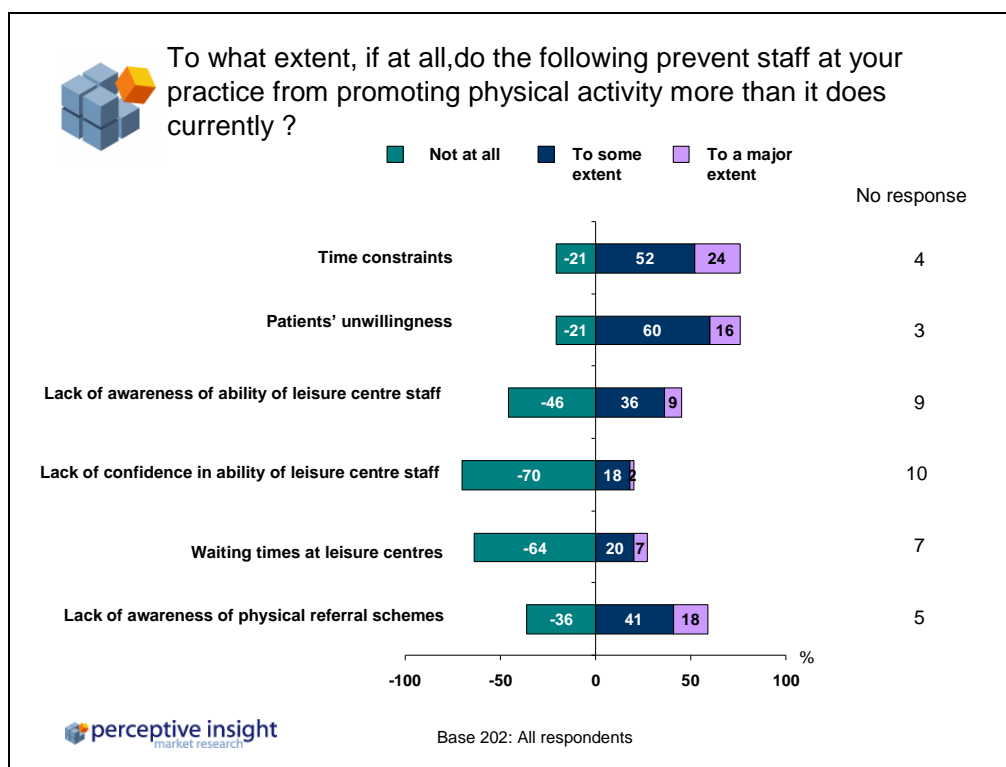
Analysing promotional activities by location of GP practice shows that there is some variation by Board area. Those located in the Eastern Board area are more likely to say that they use the Physical Activity Referral Scheme for promotion (73%) and to rely on discussions during consultations (93%). They are less likely to display posters (41%). Those based in the Southern Board area are most likely to rely on opportunistic advice (98%) and are least likely to use the Physical Activity Referral Scheme (26%). The results for both the Western and Northern Board areas are broadly similar to the overall results, although those in the Western Board area are more likely to display posters (73%) and those in the Northern Board area are most likely to provide pedometers (19%).

GP practices were asked the extent to which they encountered barriers to promoting physical activity (Figure 3.3). Time constraints and patient’s unwillingness were most likely to be identified as barriers with over three quarters (76% for both) saying that they impacted on their ability to promote physical activity.

Lack of awareness, both in relation to the physical activity referral schemes and the ability of leisure centre staff, was considered to have an impact by 59% and 45% respectively. Over one quarter (27%) considered waiting times to be an issue and one in five (20%) reported a lack of awareness in relation to the ability of leisure centre staff.

Among the spontaneous responses GP practices also identified a lack of referral forms (1 response), leisure centres not participating in the scheme (4 responses) and accessibility of leisure centres (3 responses) as issues which prevent them from promoting physical activity.

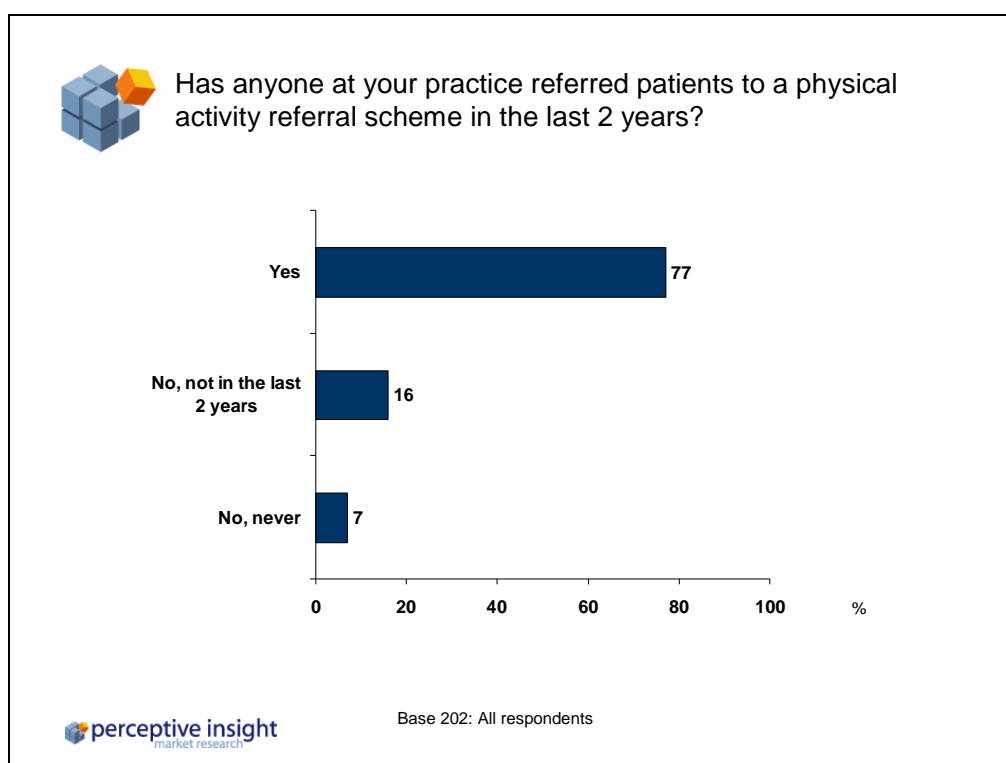
Figure 3.3: Barriers to promoting physical activity



Physical activity referral

Over three quarters (76%) of practices reported that they refer patients to the physical activity referral scheme (Figure 3.4). A further 17% said that they had not referred to the scheme in the last 2 years and another 7% had never used the scheme.

Figure 3.4: Percentage referring to the physical activity referral scheme



There are some differences in the percentages referring to the schemes based on the HSSB area. Those in the EHSSB area are more likely to use the scheme compared to those located in other board areas (91% compared to an average of 77%). There appears to be a drop in usage by those in NHSSB with 38% saying they have not referred to the scheme in the previous two years and those in SHSSB are least likely to have used the scheme at all (15% compared to 7% on average). Given the level of usage of the scheme by those in the EHSSB area, it is not surprising that those in urban areas are more likely to refer than those based in rural areas.

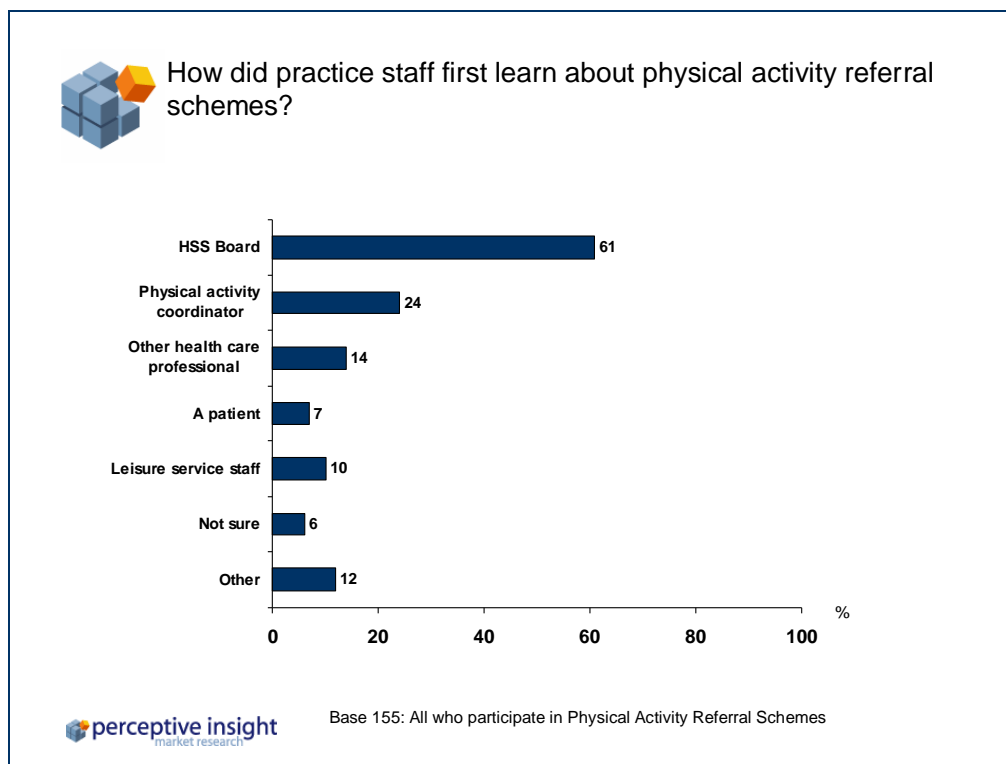
Table 3.1: Percentage referring to the physical activity referral scheme

Base	EHSSB % (88)	SHSSB % (46)	WHSSB % (26)	NHSSB % (42)	Urban % (56)	Rural % (46)	Mixed % (99)	Total % (201)
Yes	91	45	73	60	86	67	77	77
No, not in the last 2 years	3	18	23	38	5	22	19	16
No, never	6	16	4	2	9	11	4	7
<i>Total</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>

The following map shows the geographical distribution of the schemes that GP practices currently refer patients (*Figure 3.5*).

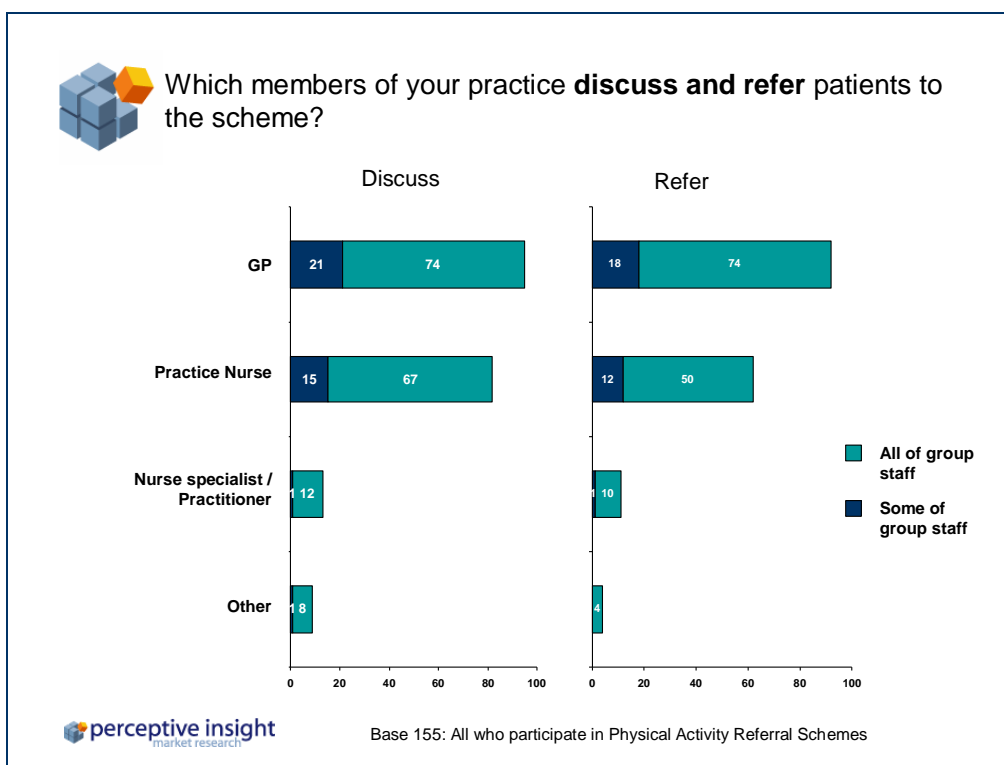
GP Practices were most likely to report that they had first learned of the physical activity referral scheme through their Health and Social Services Board (61%) (Figure 3.6). Surprisingly less than one quarter (24%) reported learning of the scheme through their Board’s physical activity co-ordinator and only one in ten had heard through leisure services staff (10%). 14% stated that they had learned of the scheme through another health care professional and 7% had been informed by a patient. Among the ‘other’ responses were receiving information by post (5 responses), through leaflets (3 responses), contact from the local area council (4 responses), the HPA (3 responses) and through practice staff (1 response).

Figure 3.6: How staff became aware of the physical activity referral scheme



Within the GP practices it is the GPs themselves who are most likely to discuss the scheme with patients (95%) and to refer them (92%) (Figure 3.7). Practice nurses are also quite likely to be involved in discussing the scheme (82%) but slightly less likely to refer to the scheme (72%). Although the chart shows low levels of nurse specialists or practitioners referring to the scheme this is more to do with the availability of this type of nurse within practices – only 22% employed Nurse Specialists/Practitioners. Of those practices that are involved in a scheme and who employ Nurse Specialists/Practitioners (n=39) 38% are active in referring to the scheme.

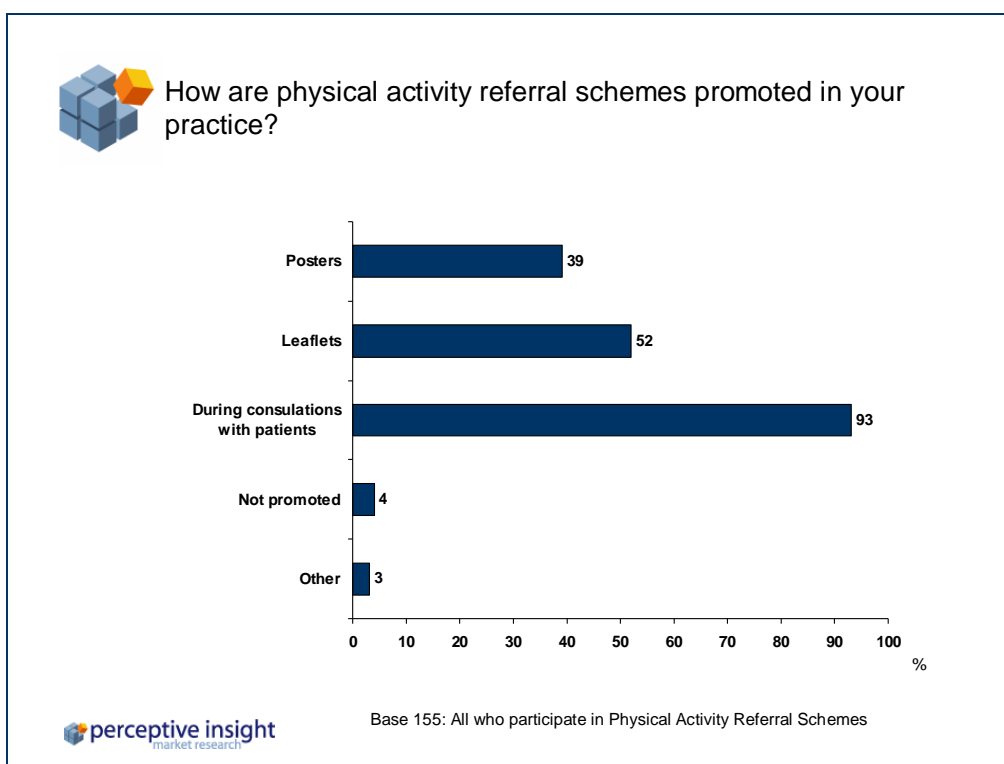
Figure 3.7: Types of health care staff that discuss and refer to the scheme



The operation of Physical Activity Referral Schemes

The vast majority of practices (93%) promote the physical activity referral scheme during consultations with their patients (*Figure 3.8*). In addition just over half (52%) provide leaflets and 39% display posters. Only 4% report that they do not promote the scheme.

Figure 3.8: Promotion of physical activity schemes within GP practices



GP practices were asked how they identify potential participants to the physical activity referral scheme. The key methods used included opportunistically through consultations (54 responses), through key indicators such as BMI (36 responses) and other health risks (26 responses) such as hypertension, diabetes and heart disease and through specific clinics. In addition 10 practices said they were prompted through patient self referral, a further 10 practices identified patients through their weight management/obesity clinics and 11 practices used their chronic disease management clinics to identify suitable candidates.

“Opportunistically through consultation”

“Patient self referral”

“BMI >25/28/30/35”

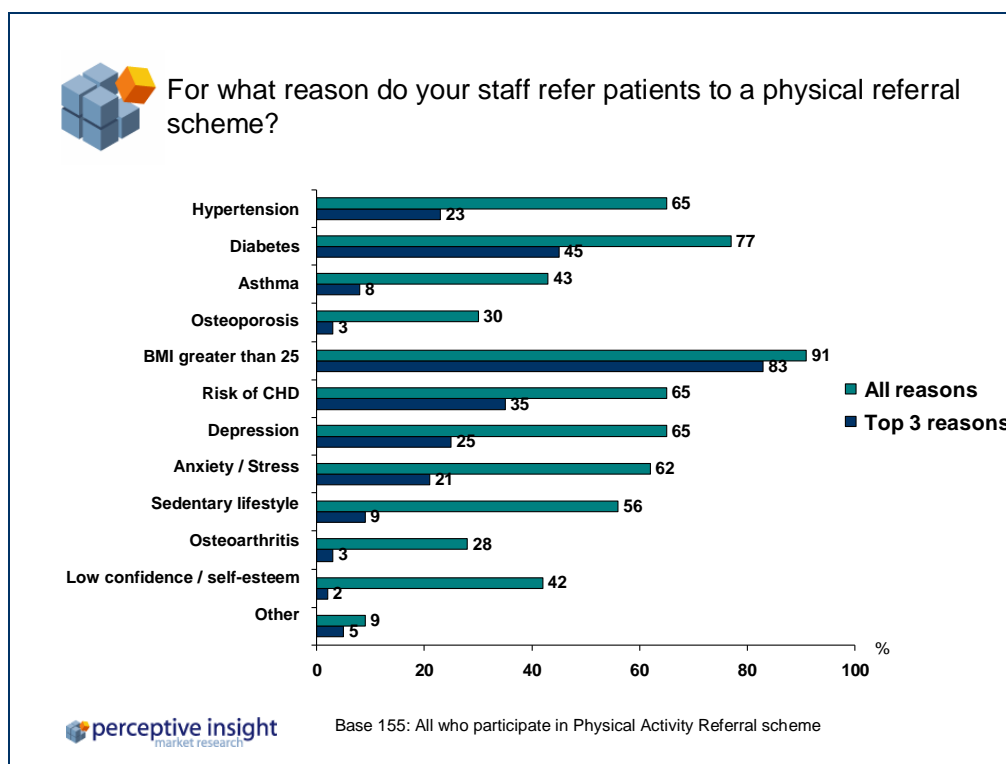
“Health risks, BMI, Diabetic, Hypertension, Heart disease”

“Weight management clinic”

“Through obesity management and chronic disease clinics”

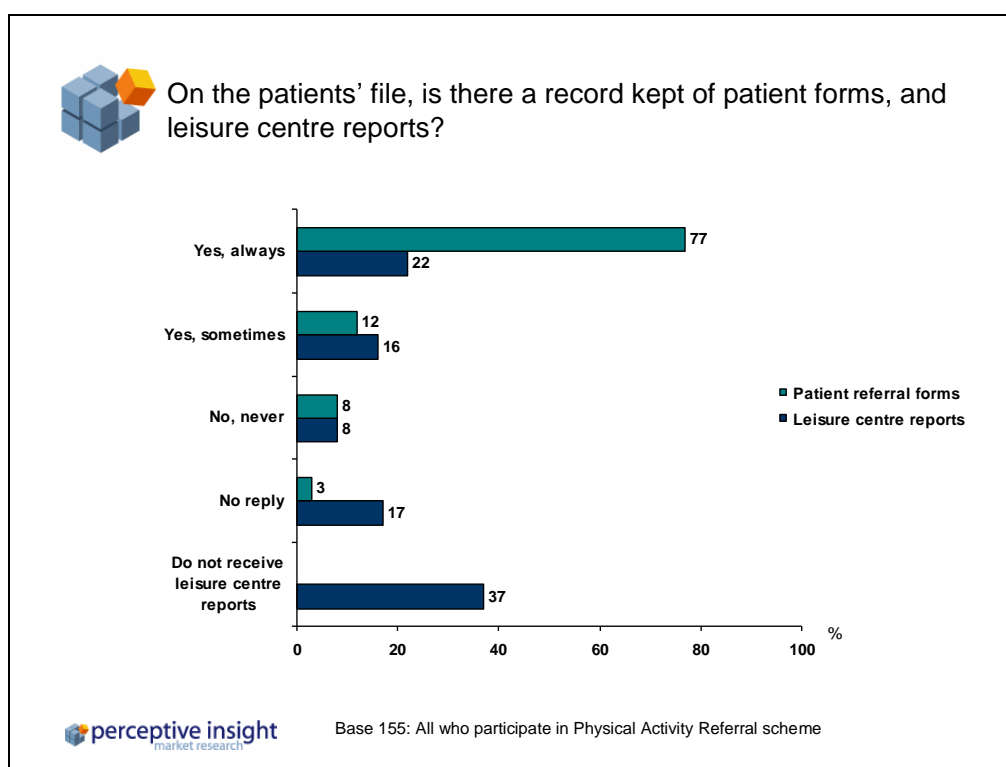
Respondents were asked the most common reasons for referring patients to the scheme and to identify which of these were their main three reasons for referral. GP practice staff appear to refer to the scheme based on a wide range of reasons as demonstrated in Figure 3.9. The top reasons include BMI greater than 25 (83%), diabetes (45%), risk of coronary heart disease (35%), depression (25%) and hypertension (23%).

Figure 3.9: Reasons for referring to the scheme



While the majority of GP practices (77%) keep a record of the patient’s referral form they are much less likely to always keep the leisure centre report on file (22%) (Figure 3.10). Indeed 37% report that they do not receive reports from the leisure centres.

Figure 3.10: Record keeping



Just over one third (35%) report that they carry out an assessment of patients physical activity levels. A variety of methods were used for assessment including questioning during consultation (21 responses), the use of a health questionnaire or template (11 responses), health checks of weight, height blood pressure etc (9 responses), and regular weight management consultations (3 responses). While some referred to a questionnaire template, their response did not detail the source of this template.

“Questioning during consultation”

“Health questionnaire”

“Health check – weight, height, blood pressure and so on”

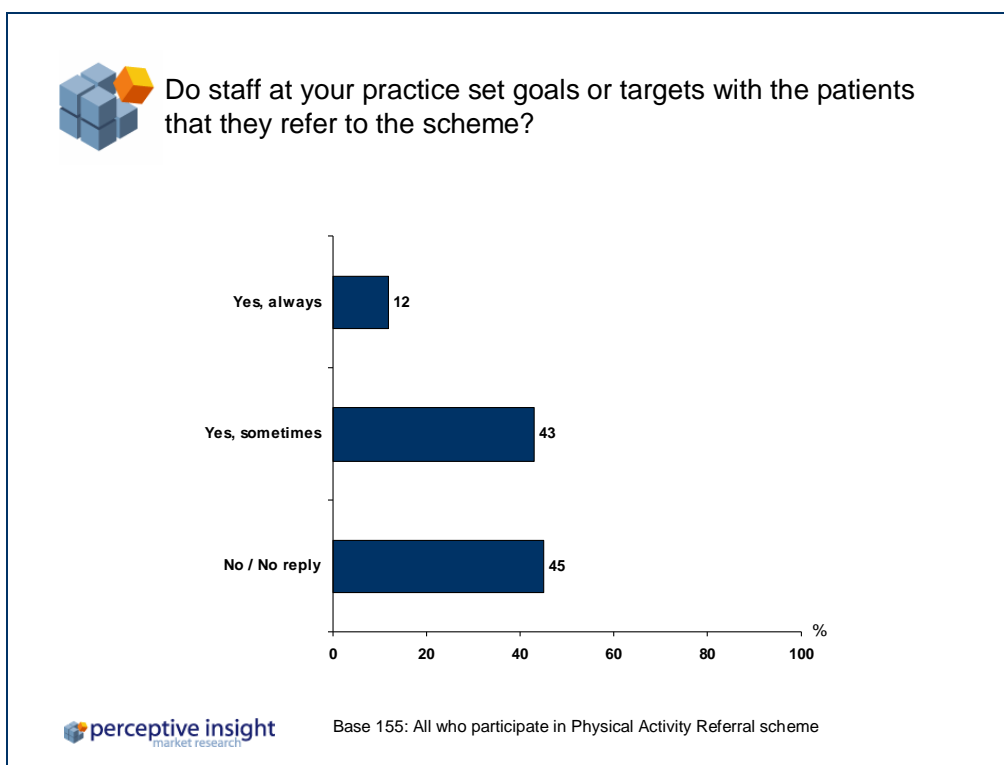
“Regular health checks”

“Weight management every 3 months”

It is apparent from the response to this question that many of the assessments are not actual assessments of physical activity levels of patients. Also it appears that there is not standardised assessment method being used.

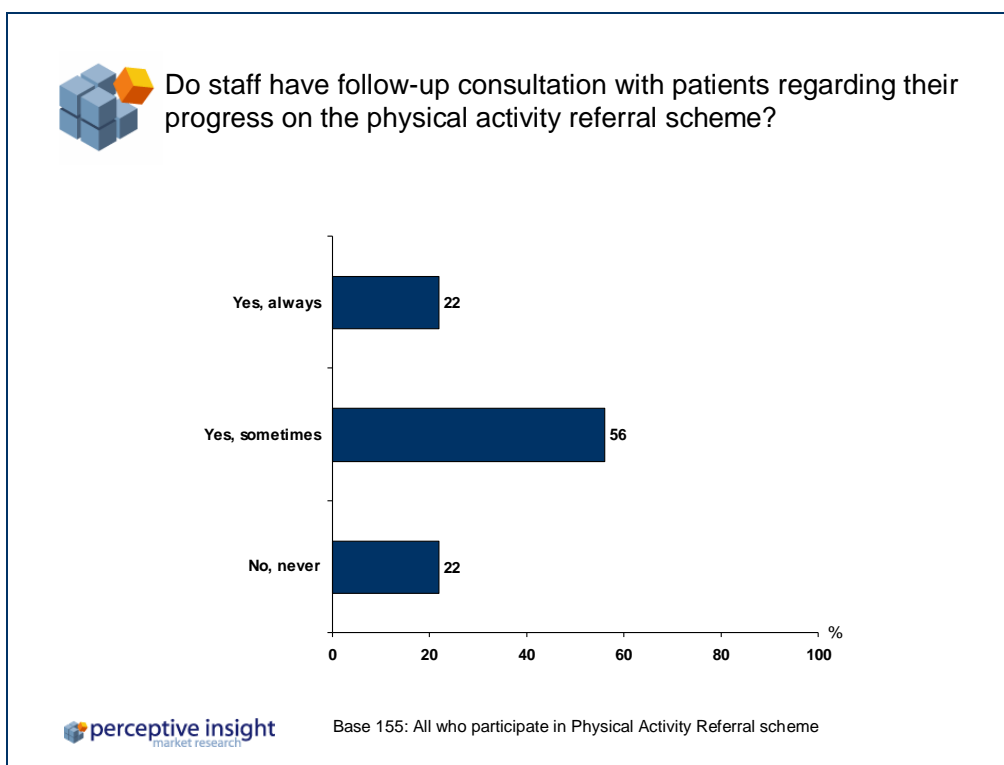
NICE guideline recommend that goals and targets are set with patients. However, almost one in eight (12%) always set goals or targets with the patients that they refer (Figure 3.11). A further 43% reported that they sometimes do this. However, 45% do not set goals or targets.

Figure 3.11: Incidence of setting goals or targets with referred patients



The lack of ‘goal setting’ activity may be due to the low levels of follow-up consultations (Figure 3.12). Just over two in ten (22%) reported that they always had follow-up consultations with their patients regarding their progress on the scheme. A further 56% said that they sometimes did this. However, 22% stated that they did not undertake follow-ups to their referrals.

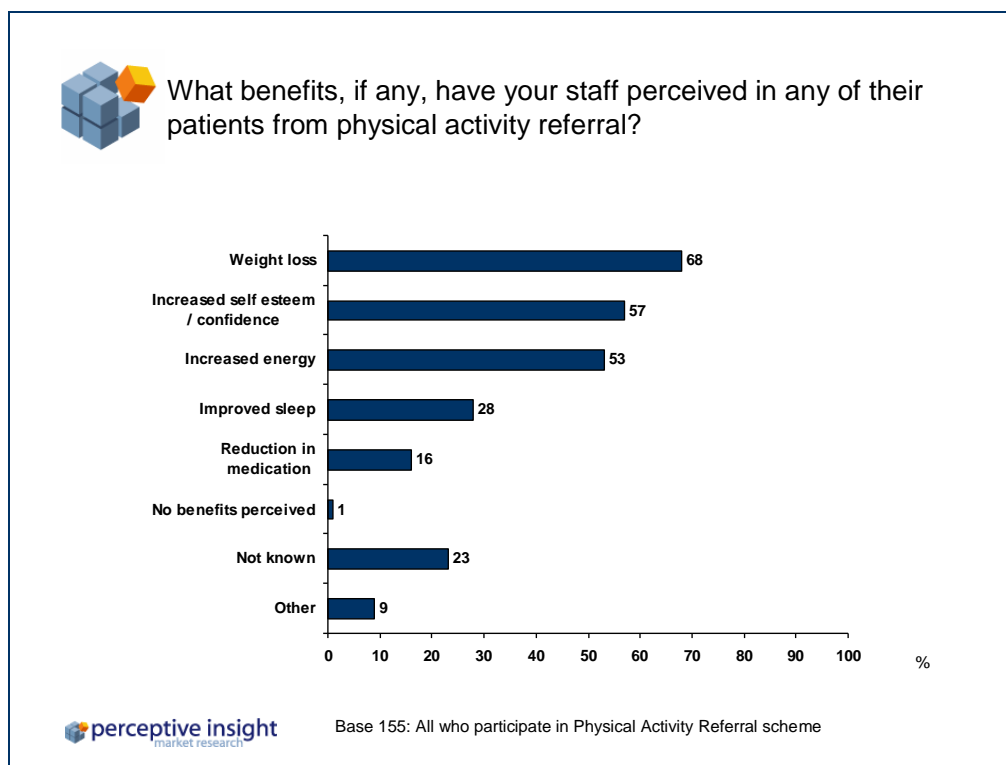
Figure 3.12: Incidence of undertaking follow-up consultations



Those who always have follow-up consultations with patients are much more likely to either always (32%) or sometimes (50%) set goals (compared to 12% and 43% respectively on average).

All those who refer to the scheme were asked what were the perceived benefits to their patients (Figure 3.13). Over two thirds (68%) reported weight loss as the main benefit and a further 57% reported improved confidence and self-esteem. A further 53% had noted increased levels of energy. Other benefits included improved sleep (28%) and a reduction in medication (16%). However, nearly one quarter (23%) reported that the benefits were not known to them.

Figure 3.13: Perceived benefits to patients

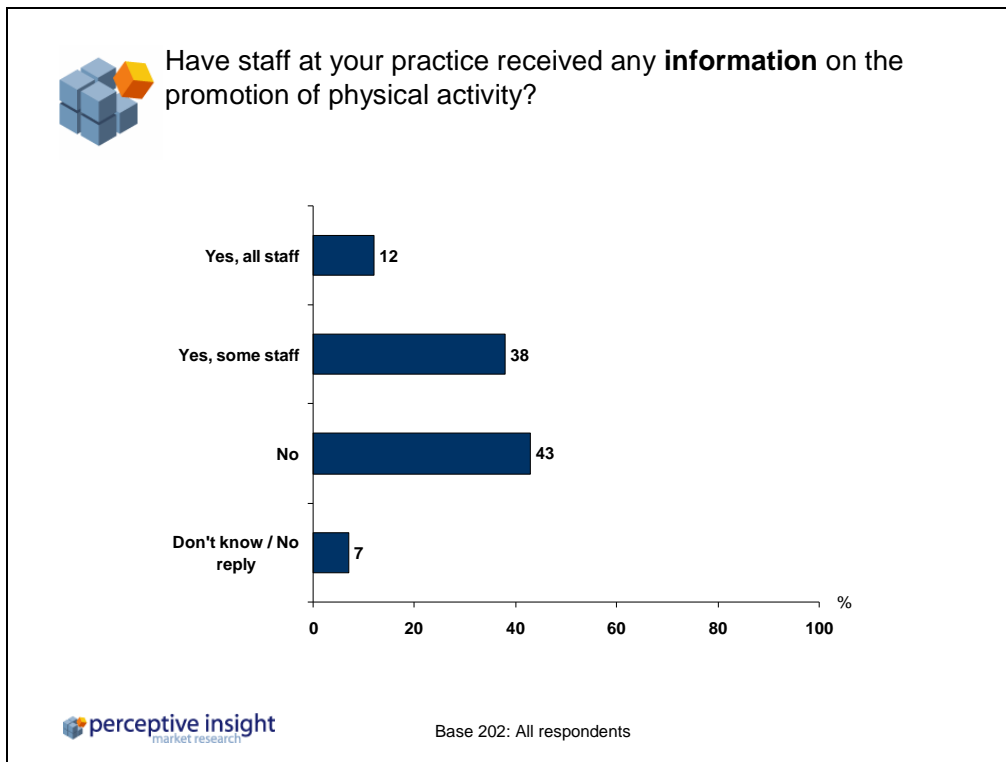


Training and information

GP practices were asked a number of questions to assess the training and information they received in relation to physical activity.

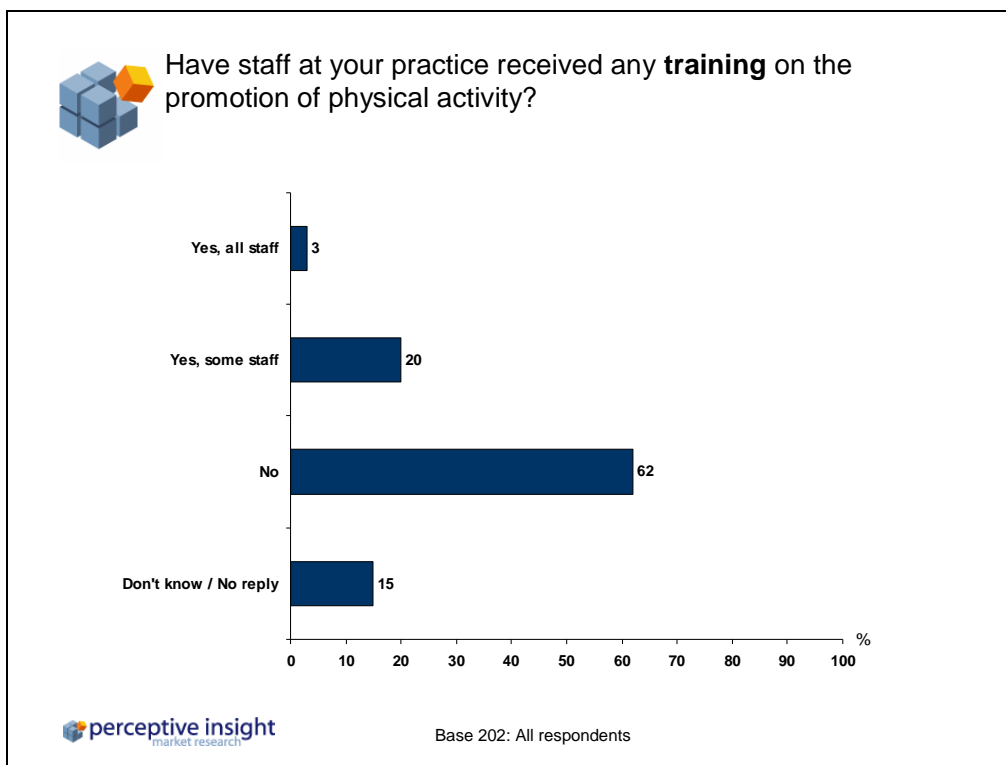
The number of GP practices that reported receiving information on the promotion of physical activity was relatively low. Half of GP practices (50%) stated that they had received information, with only 12 % saying all their staff had got this information. 43% of practices said they had not received any information at all and a further 7% did not know or gave no reply (Figure 3.14).

Figure 3.14: Incidence of receiving information on the promotion of physical activity



The number of practices which reported receiving **training** on the promotion of physical activity was even lower. Only 3% said all their staff had been trained, with 20% stating that some of the practice staff had received training. 62% of GP practices confirmed that they had no formal training on the promotion of physical activity (*Figure 3.15*).

Figure 3.15: Incidence of receiving training on the promotion of physical activity



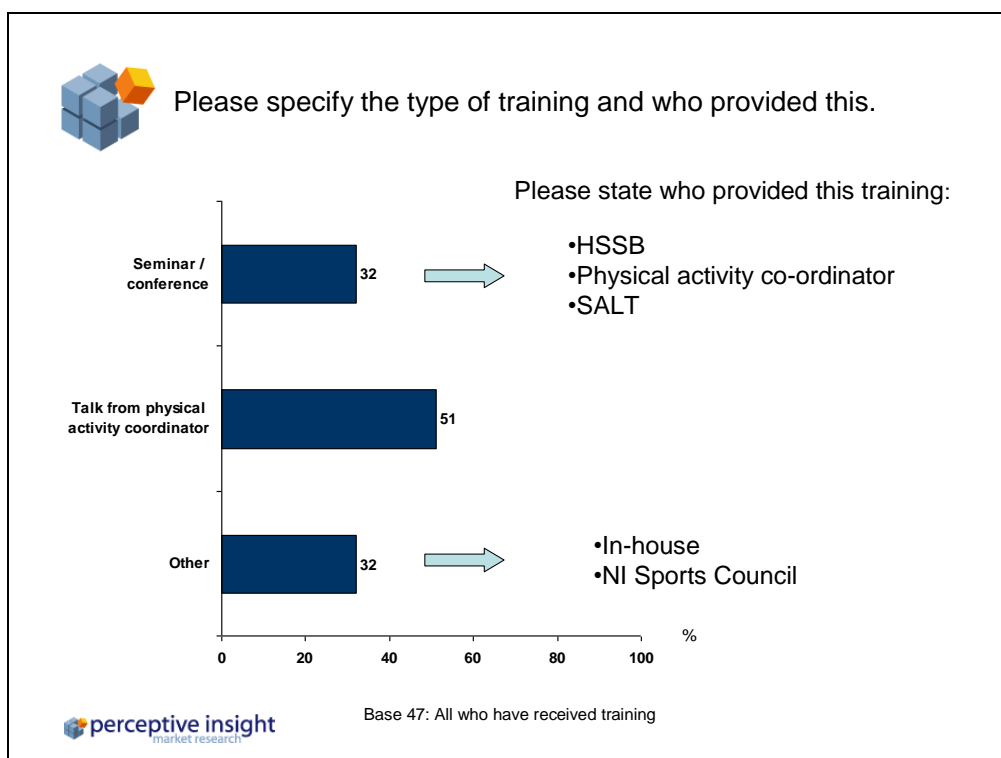
The following table presents the breakdown of the incidence of receiving training by Board area. Those located in the SHSSB and EHSSB areas are least likely to have undergone any training, whilst those in the NHSSB and WHSSB areas are most likely to have done so.

Table 3.3: Incidence of receiving training on the promotion of physical activity by Board area

Base	EHSSB % (88)	SHSSB % (45)	WHSSB % (26)	NHSSB % (42)	Total % (202)
Yes, all staff	2%	2%	4%	5%	3%
Yes, some staff	18%	16%	27%	26%	20%
No	65%	67%	58%	50%	61%
Don't know / no reply	15%	16%	12%	19%	9%
<i>Total</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>

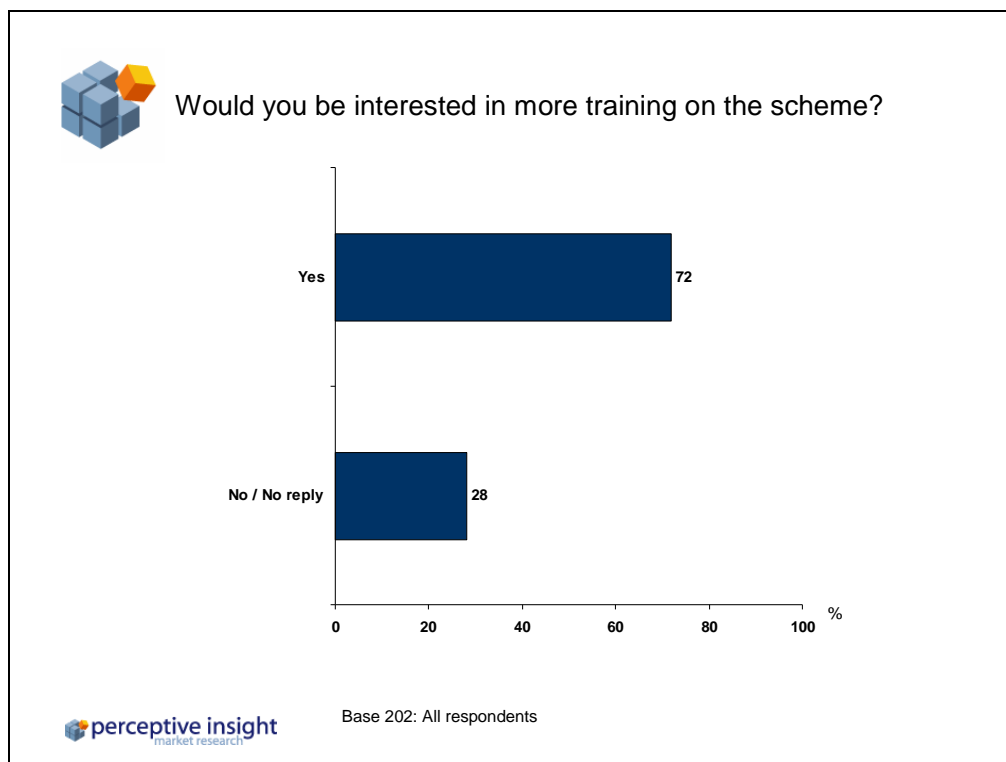
Of those who had received training ($n=47$), 32% said they had attended a seminar or conference hosted by the HSSB, a physical activity coordinator or Southern Area Learning as a Team (SALT), 51% had received a talk from a physical activity coordinator and 32% quoted other sources for the provision of training including in-house and the NI Sports Council (Figure 3.16).

Figure 3.16: Type of training undertaken



Almost three quarters (73%) of GP practices stated they would be interested in more training on the physical activity scheme (Figure 3.17).

Figure 3.17: Interest in further training



When asked about who should provide the training a range of suggestions were put forward including the Boards (20 responses), anyone with the appropriate qualifications (18 responses), leisure centre staff (15 responses), the Physical Activity Co-ordinator (7 responses), the HPA (5 responses), and SALT (5 responses).

“Health Board”

“Someone who understands ordinary people”

“HPA”

“Leisure Centre”

“Physical Activity Co-ordinator”

“Anyone qualified”

“SALT”

4. Views of Leisure Centre Managers

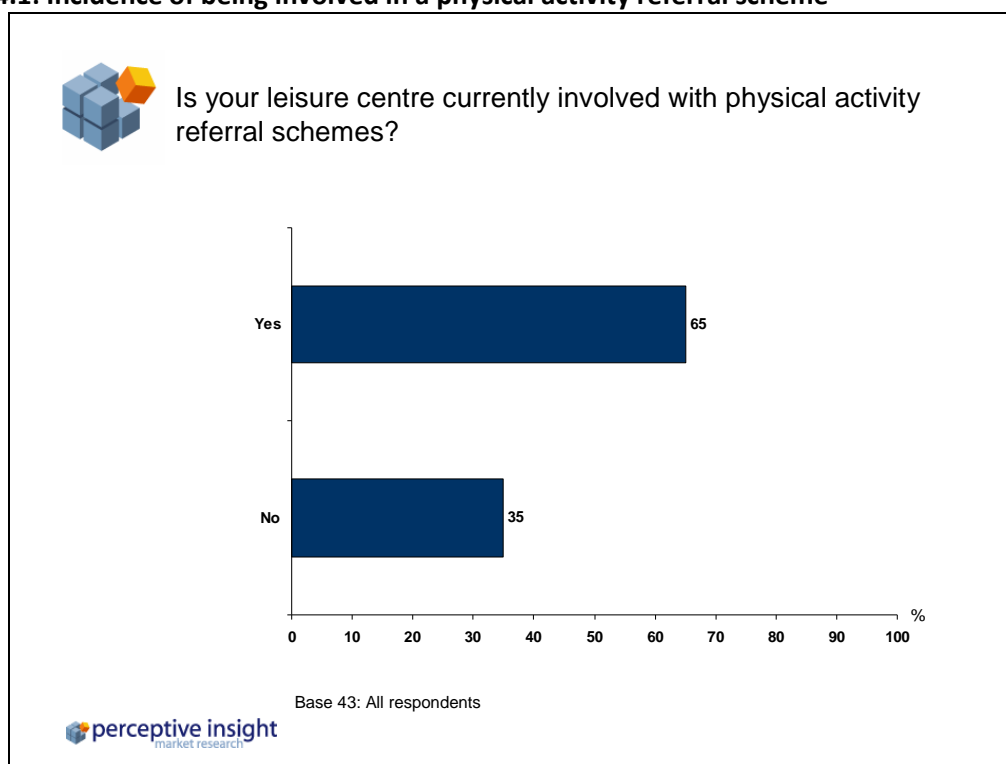
In this section we summarise the findings from the survey of leisure centres. Where relevant we have included views expressed during the group discussions with exercise co-ordinators. The findings are presented under the following headings:

- Background and information about the scheme;
- The scheme in practice;
- Funding;
- Staff and training; and
- Monitoring and evaluation.

Background and information about the scheme

The majority of respondents (65%) reported that their leisure centre was currently involved in the physical activity referral scheme (Figure 4.1).

Figure 4.1: Incidence of being involved in a physical activity referral scheme



The main reasons given for not participating referred to the centre being too small or not suitable (6 responses), not having trained staff (7 responses) or enough staff (3 responses) and not being approached to participate (1 response).

“No trained staff and the centre is too small to cope with the referral scheme”

“Just finished a pilot scheme last summer and awaiting staff training and the council to agree their participation”

“No one has contacted us or provided information of how to set up a referral scheme, but we would be interested in it”

“No one qualified for referral clients. Also the premises would not be equipped for GP referrals”

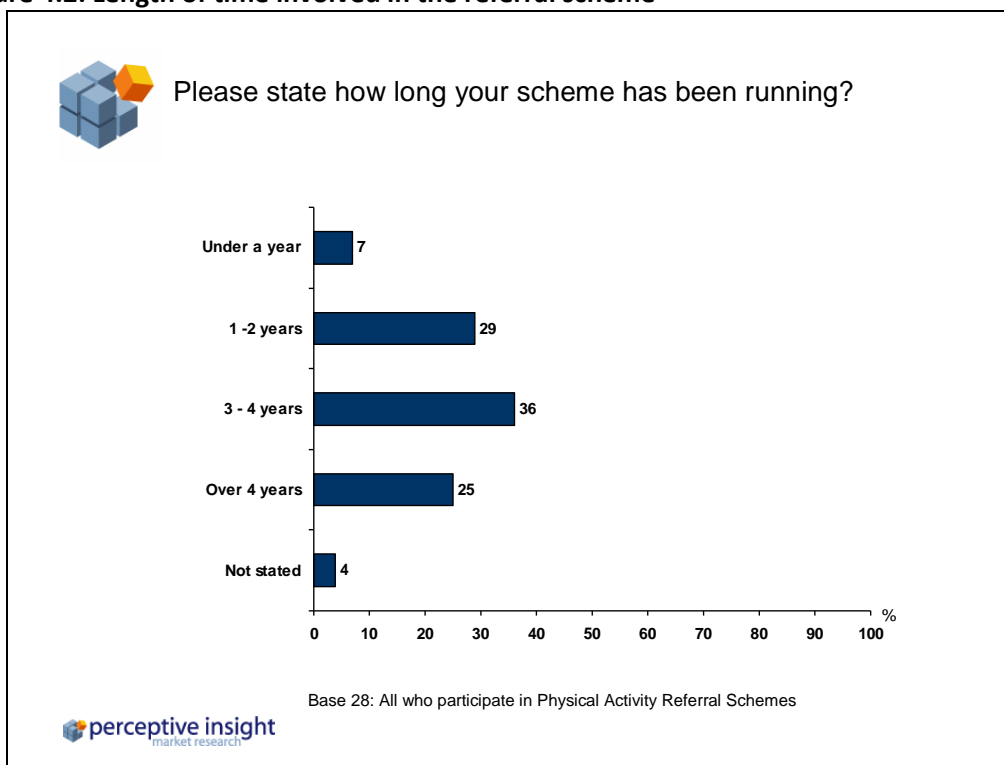
“We are in process of staff training and gym refurbishment before we begin referrals”

A variety of titles are used for the promotion of the physical activity referral schemes depending on which Local Council area or Health and Social Services Board. The examples given through the survey include:

“Over to you programme”
“Fermanagh active living”
“Fit for life”
“Healthwise physical activity scheme”
“Healthwise Active living weeks”
“Exercise for health”
“GP Referral”
“Fit N Well”

Just less than one quarter (24%) reported that their leisure centre has been involved in the referral scheme for over four years (Figure 4.2). A further 36% have been involved for three to four years and 29% for one to two years. Seven per cent were involved in running a physical activity referral scheme for less than a year.

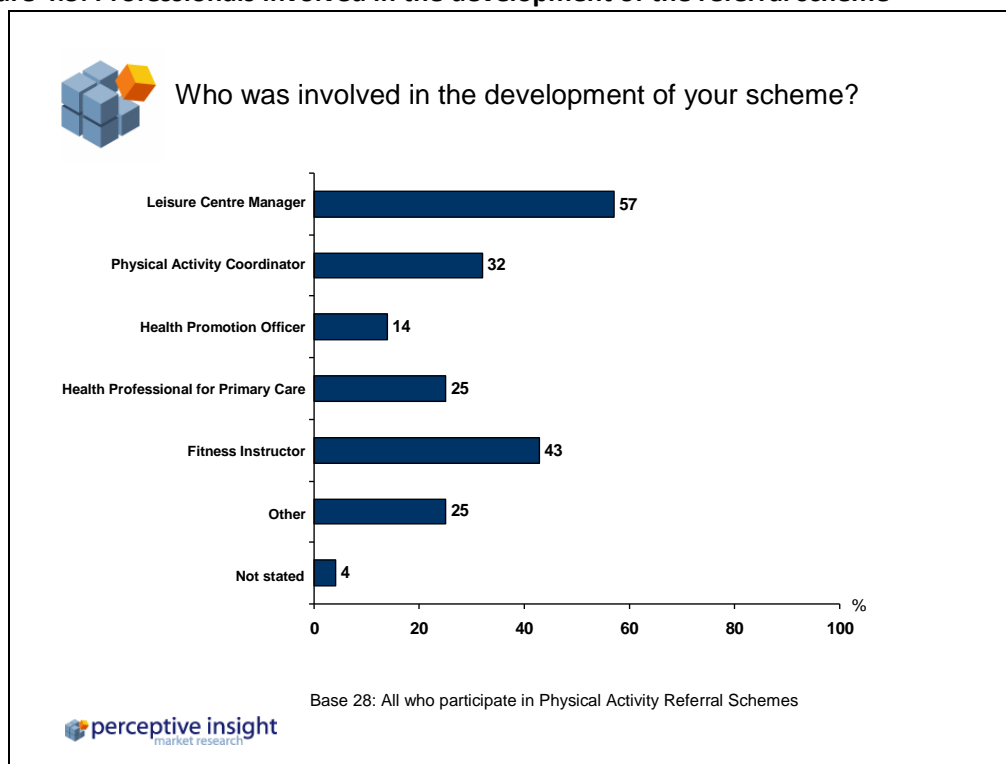
Figure 4.2: Length of time involved in the referral scheme



Leisure centre managers were asked who was involved in the development of their referral scheme. 57% of leisure centre managers said that they themselves had been involved in its development and 43% reported that fitness instructors had contributed. In just less than

one third of cases (32%) a physical activity co-ordinator had assisted with the development of the scheme and 25% benefited from the contribution of a primary health care professional. A further 14% said that a Health Promotion Officer had helped with their scheme. Among the the ‘others’ were the Health and social Services Trust (2 responses), Sports Development Officer/section (3 response), the local council (1 response) and the Board (1 response).

Figure 4.3: Professionals involved in the development of the referral scheme



Although 89% reported that their scheme had an overall co-ordinator or lead contact, when asked to provide details about their role it was clear that the co-ordinators referred to have different roles within the schemes. Also in 15 cases a named person was given rather than a description of their role. These named contacts had a variety of job titles including centre manager, sports development officer, Council leisure officer, physical activity co-ordinator and centre administrator.

“Co-ordinator between all parties and is responsible for growing funding”

“Greet and interview clients on arrival. Arrange exercise programs with gym instructors”

“Co-ordinates between health centre, clients and leisure centre. Also works with client designing programme of work”

“Fitness instructor liaises with scheme co-ordinator and health bodies”

“Fitness instructors share responsibility so as not to over burden any one instructor. They all have their own clients to look after and monitor”

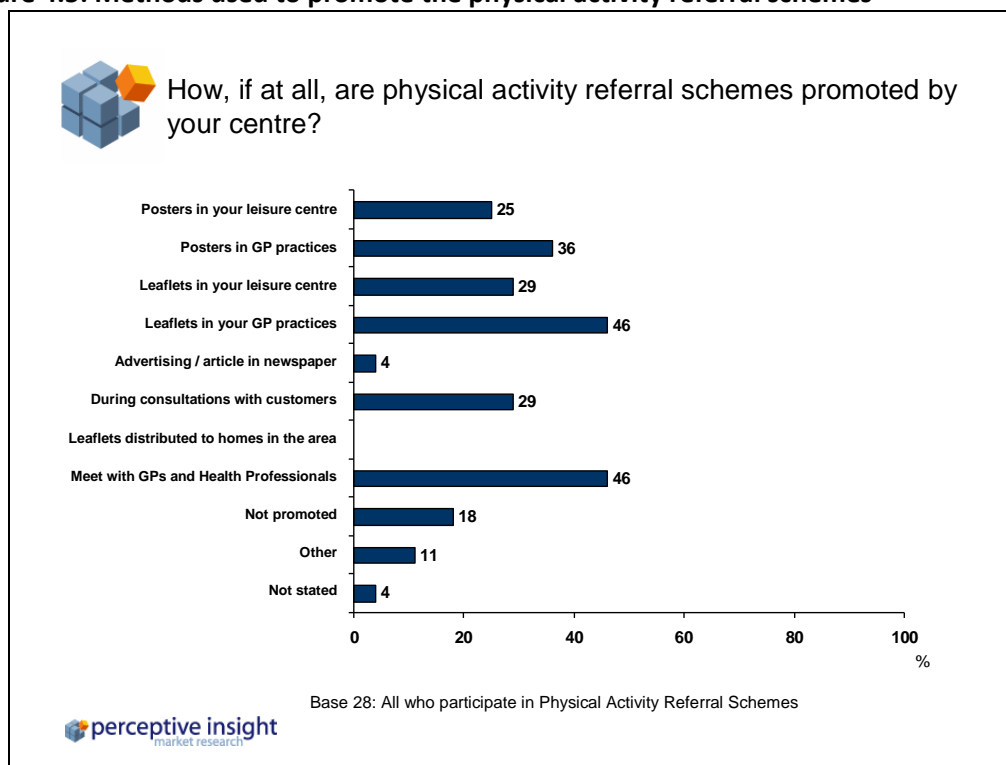
Leisure centre managers were asked the catchment areas for the referral scheme that they operated. Taking this information, along with the information provided by the GP practices

and from the co-ordinators we have depicted the extent of schemes across Northern Ireland (*Figure 4.4*).

From the map it is clear that there are some areas which the GP referral scheme does not operate. Coleraine, Dungannon (apart from South Tyrone Hospital), Cookstown, Omagh and Ballycastle appear to be the main areas without a scheme.

Leisure centre managers report using a variety of methods to promote the referral scheme. Just less than half (46%) meet with GPs and health professionals or provide leaflets to GP practices (*Figure 4.5*). Over one third (36%) have placed posters in GP practices and 25% have placed them in the leisure centre itself. 29% also used posters in their leisure centre or during consultations with customers. 18% reported that they did not promote their scheme. This may be to avoid inappropriate self referral by some patients who want to avail of subsidise leisure centre rates as identified in the group discussions. Among the ‘other’ responses were via the Council website, during the GP/patient consultation and by keeping Practice Nurses informed.

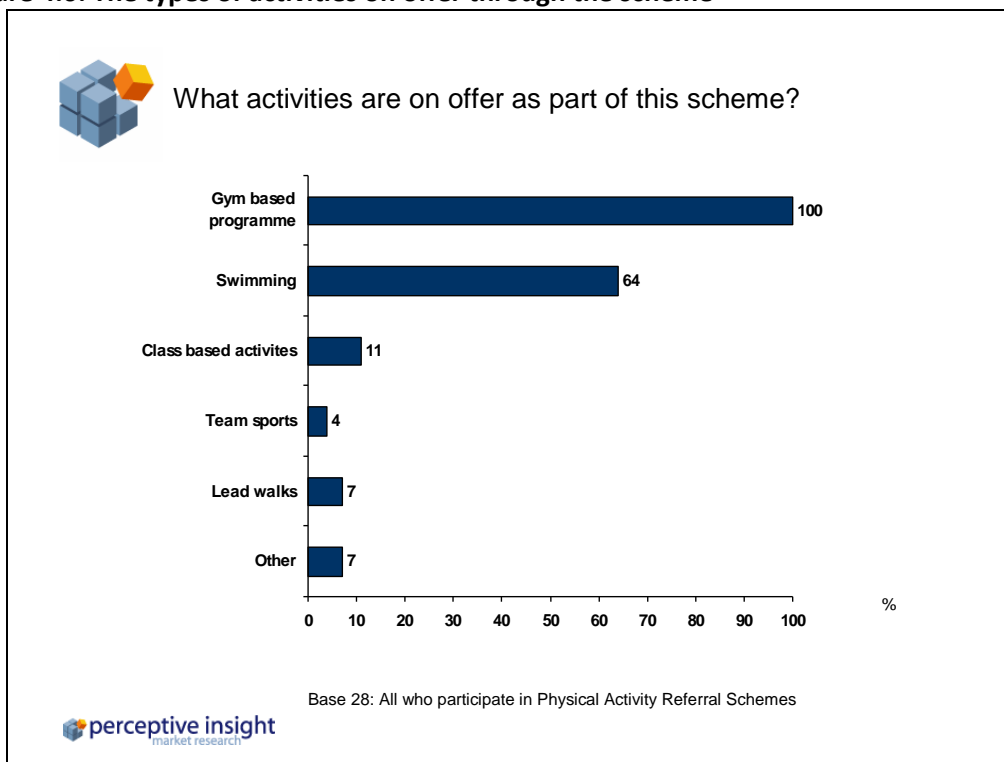
Figure 4.5: Methods used to promote the physical activity referral schemes



The scheme in practice

All leisure centre managers reported that they used a gym based programme as part of their referral scheme. In addition almost two thirds (64%) also provided swimming (*Figure 4.6*). The provision of other activities was less common with 11% offering class based activities, 7% lead walks and 4% team sports. One respondent reported that they provided boxercise and team sport, while another stated that all sports were an option but that it depended on the ability of the person.

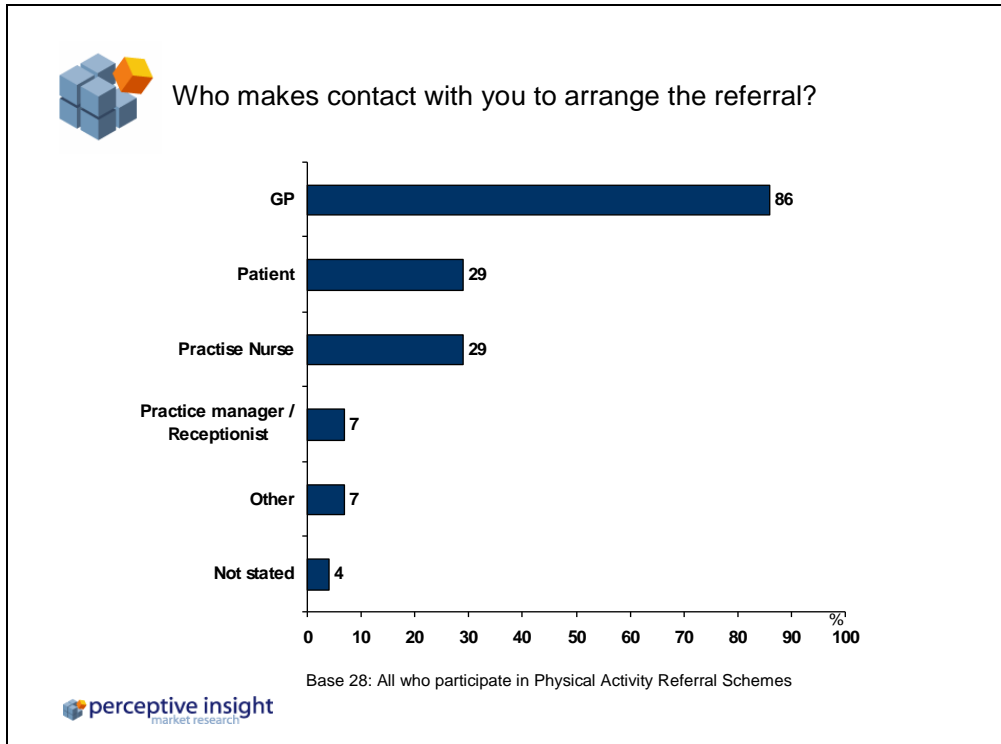
Figure 4.6: The types of activities on offer through the scheme



The vast majority (93%) said that they receive referrals to their scheme on paper, 11% in person, 4% by telephone and 4% by email.

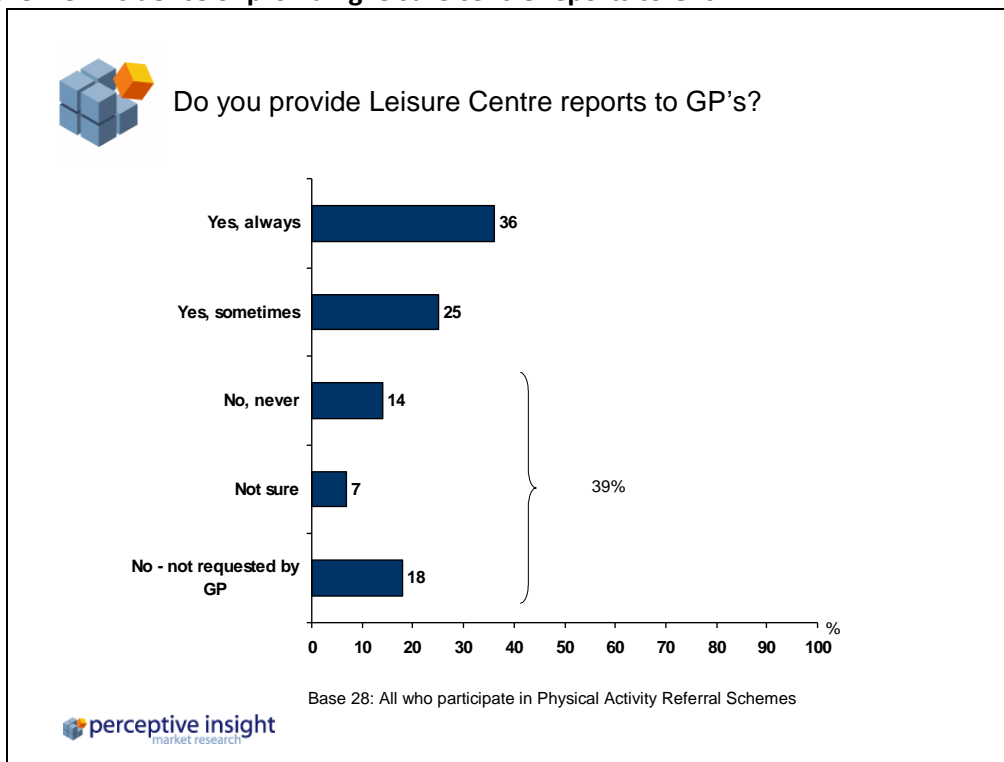
In most cases (86%) it is the GP who makes contact with the leisure centre (*Figure 4.7*). However, 29% reported that the practice nurse made the contact and another 29% said that the referral came through the patient. 7% received referrals from practice managers or receptionists. Among the 'other' responses were the physiotherapist and the 'Fit n Well HQ'.

Figure 4.7: Person who contacts the leisure centre with the referral



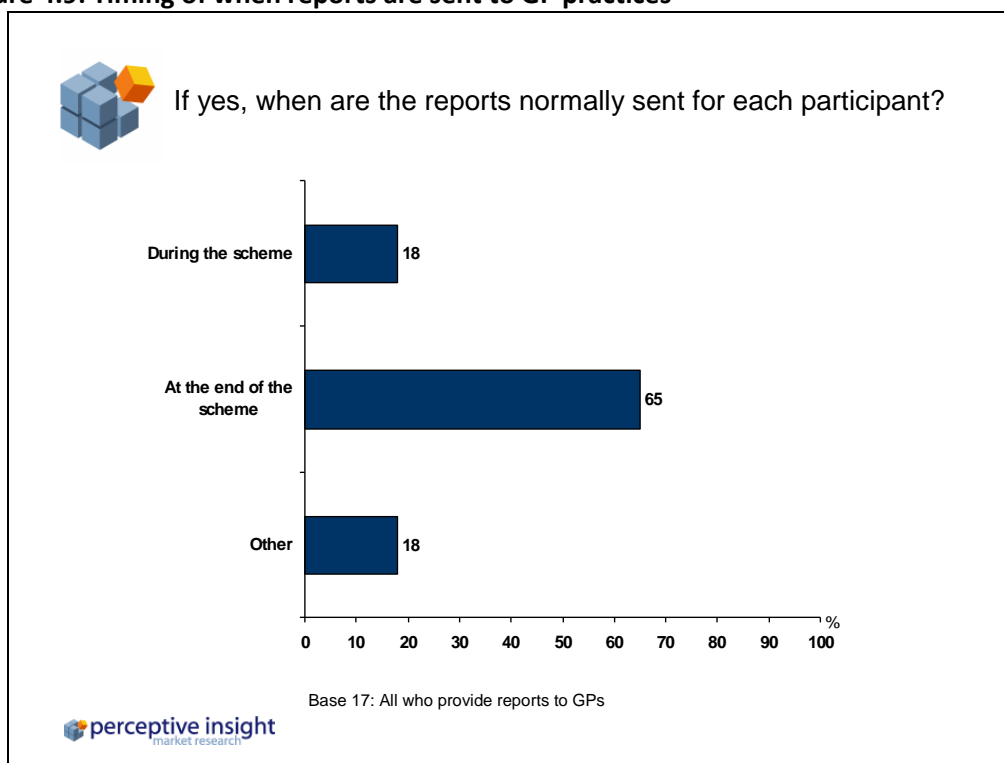
The incidence of leisure centres providing reports to GPs varied (*Figure 4.8*). While 36% said that they always provided reports and 25% reported that they did this sometimes a total of 39% stated that either they did not provide them, they were unsure if they were provided or that they were not requested by the GP practice.

Figure 4.8: Incidence of providing leisure centre reports to GPs



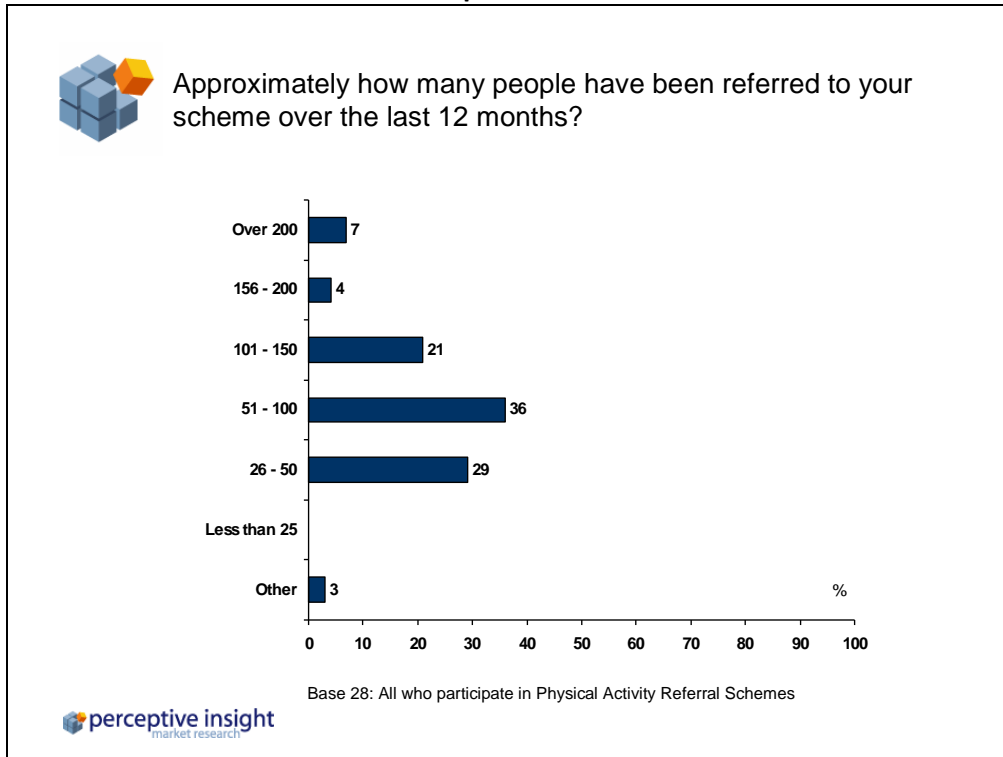
Of those providing reports, the majority provide them at the end of the scheme (65%) while 18% provide them during the scheme (Figure 4.9). 18% report that this happened in some other way.

Figure 4.9: Timing of when reports are sent to GP practices



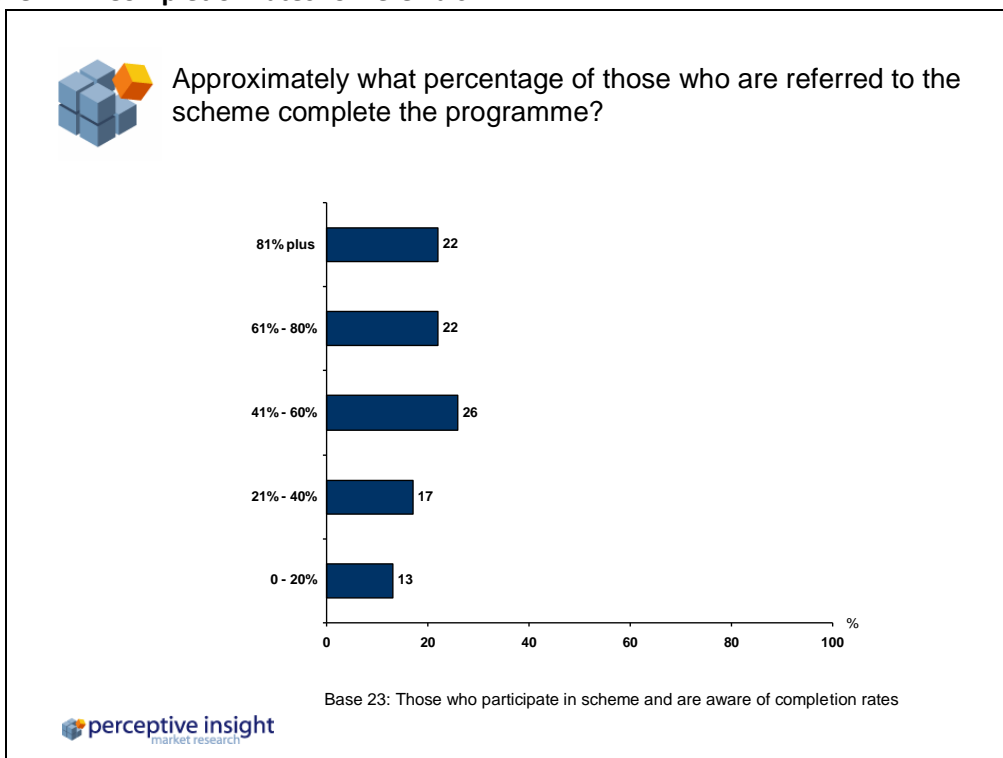
The numbers being referred to the scheme over the course of the last year varied. While the majority had between 26 and 150 referrals, approximately one in ten (11%) had more than this (Figure 4.10). The 'other' response refers to a centre which is about to commence the scheme.

Figure 4.10: Number of referrals over the past 12 months



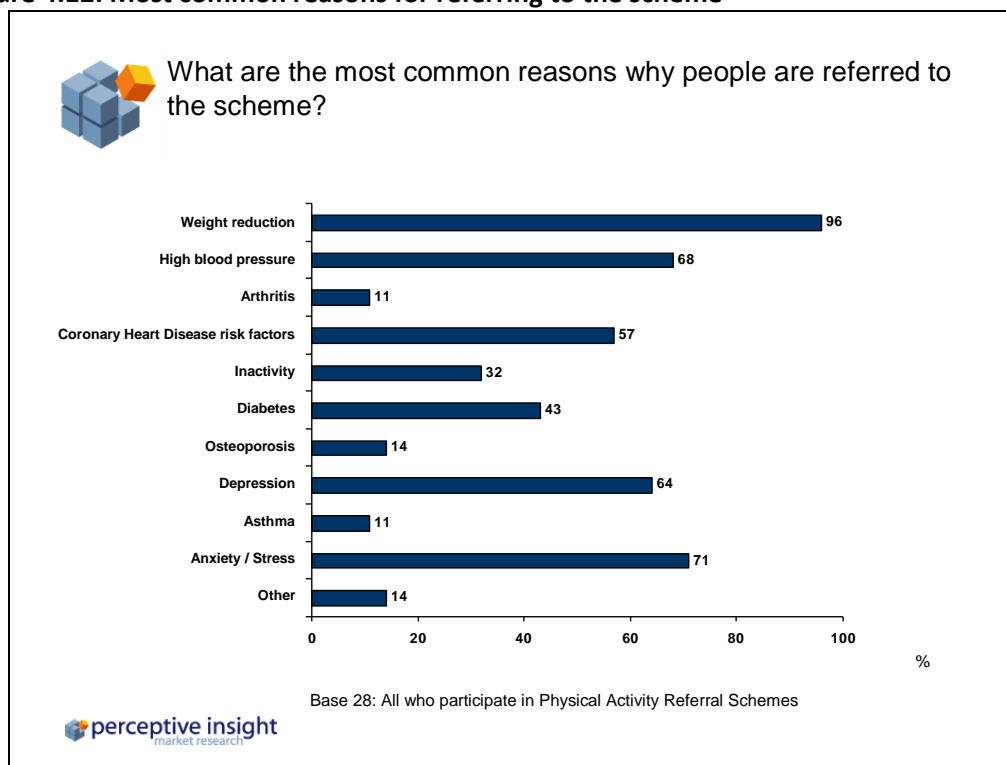
Completion rates for the scheme also varied considerably (*Figure 4.11*). While 22% reported that over 80% of referrals completed and 22% reported that between 61% and 80% were successful, well over half (56%) reported a completion rates of 60% or less. Indeed 13% reported that 20% or less of those referred to the scheme made it to the end. Care should be taken in interpreting these results to the overall scheme given the low base of responses to the question.

Figure 4.11: Completion rates for referrals



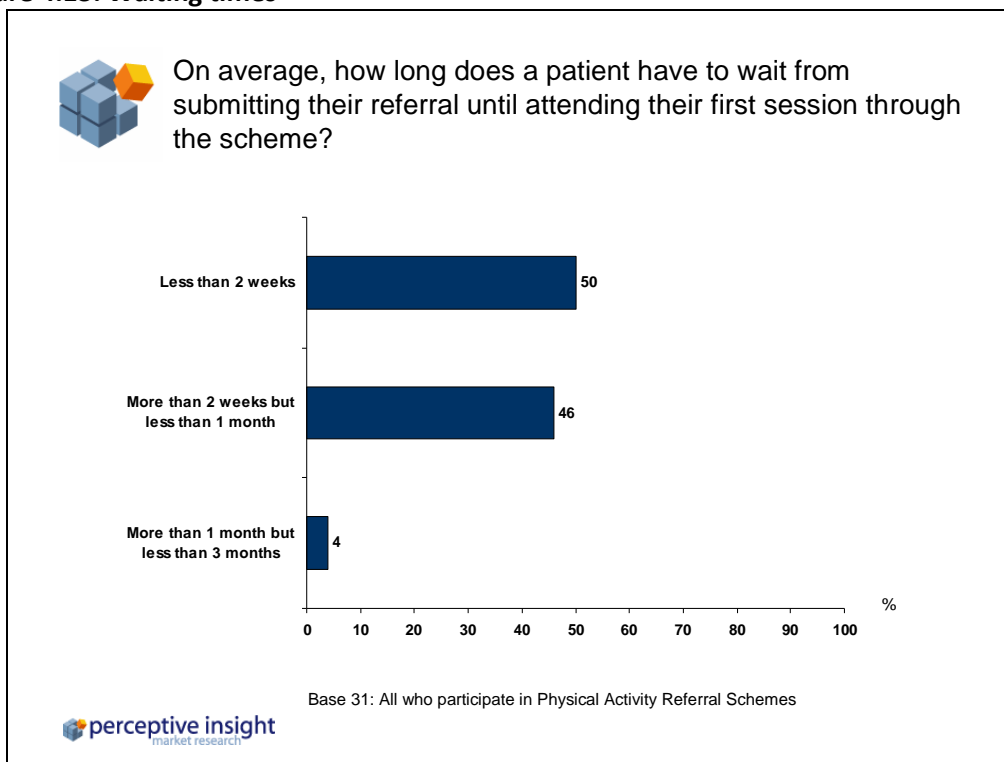
According to leisure centre managers the most common reasons for referring to the scheme was weight reduction (96%), anxiety or stress (71%), high blood pressure (68%), depression (64%) and coronary heart disease risk factors (57%) (Figure 4.12). Other responses included rehabilitation after fractures, joint pain and respiratory problems.

Figure 4.12: Most common reasons for referring to the scheme



Waiting lists appear to be minimal with one half reporting that referrals are usually seen within two weeks and further 46% reporting waiting times of no longer than a month (Figure 4.13). Only 4% report waiting times of longer than this. According to those who participated in the focus groups waiting times appears to have been a problem in some areas in the past. Indeed one centre reported actively managing their waiting times by allocating dedicated staff to the scheme to address backlogs.

Figure 4.13: Waiting times



Funding

Leisure centre managers were asked how their referral scheme was funded. A variety of sources were used.

“Big lottery funding”

“Government main stream funding”

“Local council and Health service board”

“It is not funded – referrals pay £2 per visit for 15 weeks and then get membership to the gym for £15 per month”

“Initially the health service, but now part patient - £1.50 per session off peak, £2 peak. Part our centre £1.40”

“New Opportunities Funding”

The majority (86%) reported that all participants in the scheme received subsidised rates while 7% said that this was available to some participants and 7% state that no subsidies were available and participants paid the full price.

Of those who provided figures on how much their scheme cost, 12 of 14 responses said that their scheme was free, one reported that it cost £2 and another one said £3.

A number provided promotional offers including:

“12 free passes for use of leisure centre once referral course has been completed. Then reduced rate of membership”

“No promotional offers yet but patients/clients don’t pay for their programme as HPA pay £60 per treatment course for those who complete”

“Boost card – 50p a session”

“No joining fees for gym membership afterwards”

“None yet, but working on free membership to centre”

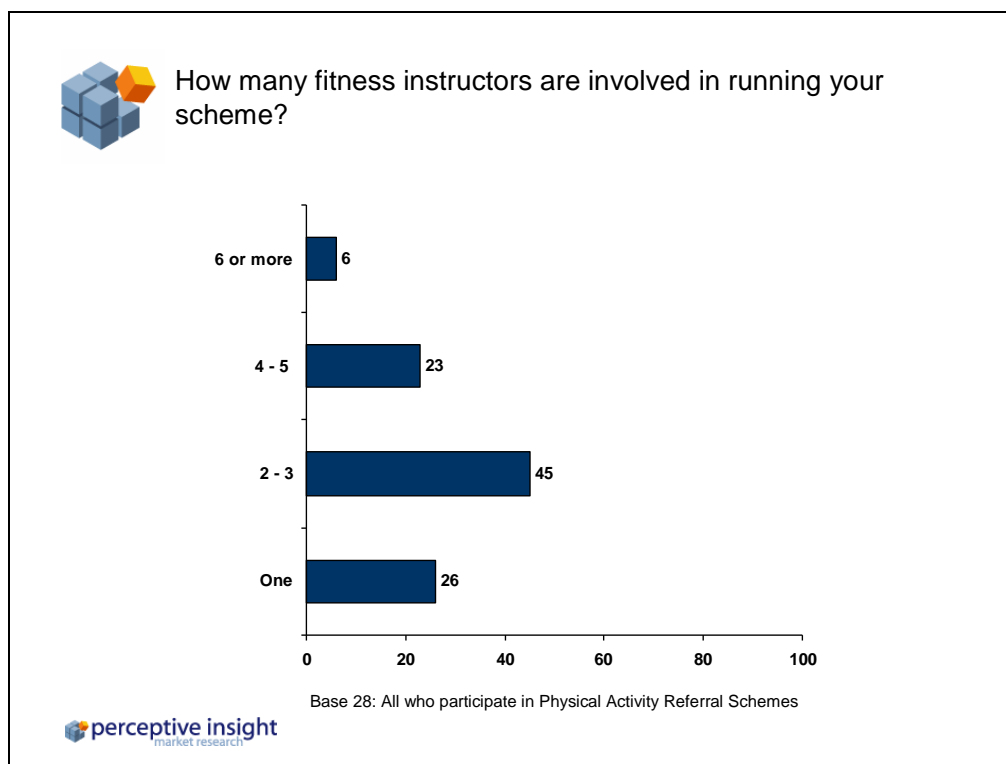
“Block sessions – 12 sessions for the concession price of £26.50”

During the focus groups the view was expressed that by introducing a fee for participating in the scheme there was less incidence of inappropriate referrals.

Staff and training

Leisure centre managers were asked how many fitness instructors were involved in running their scheme. Just over one quarter (26%) reported that they had one instructor and 45% had either two or three instructors (Figure 4.14). There were a number of larger schemes with 23% reporting that they had either four or five instructors and 6% saying that they had six or more.

Figure 4.14: Number of fitness instructors involved in running the referral scheme



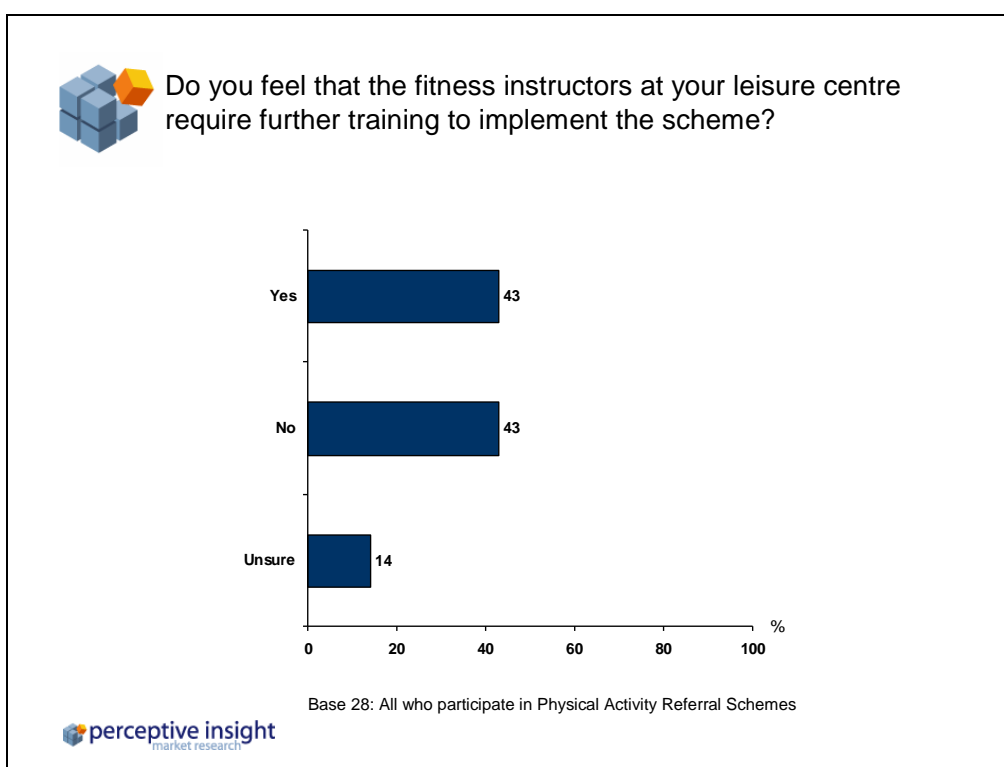
All reported that any fitness instructors involved in delivering the scheme had receiving training in exercise referral.

The majority (89%) had used Wright Foundation for the provision of training and 11% had used the Gayton Group.

The majority (79%) also reported that their fitness instructors are registered on the Register of Exercise Professionals (REPS). 18% said none are registered.

In relation to the need for further training to implement the scheme 43% thought that this was required whereas 43% did not see this as a need. A further 14% were unsure.

Figure 4.15: The need for further training



Those that felt further training was necessary were particularly interested in refresher courses (4 responses) and more specialist training (eg Rehab and for obese children) (5 responses). The type of additional training required included:

“Any Wright foundation training and courses”

“Cardiac Rehab”

“Any relevant training would be looked at”

“More depth training for each health situation”

“More people trained up in exercise referral”

“Refresher training to keep qualifications up to date with new drugs (etc)”

“Patient referral problems are changing – more mental health / drug abuse being referred, and staff would need specific training to aid patient progress”

Monitoring and evaluation

Leisure centre managers were asked if they carried out routine monitoring and evaluation as part of the referral scheme. The majority (82%) said that they did while the remainder either said that they did not or were unsure. However, the monitoring activity seems primarily to reflect the individual patient level as compared to monitoring at leisure centre level.

The type of information gathered for monitoring purposes included:

“Questionnaire for clients – Health check; weight, height, BMI, blood pressure and so on”

“Health and physical ability”

“Every quarter – who has turned up, client number and progress, complaints, BMI, blood pressure, regular check, weight loss etc”

“General feeling and wellbeing”

“Patients assessed before, during and after the scheme”

“Medical stats, financial reports”

“Monthly and quarterly monitoring and annual evaluation”

When asked about the benefits of running a referral scheme the responses included benefits for the leisure centre, the patient and the wider population:

“Increased membership and promotion of the leisure centre. Promotion of healthier living”

“Integration of people, confidence building and promotion of healthy living”

“Profit, promotion of facilities and exercise awareness”

“Helps government targets for health of the nation. Reduces costs of NHS treatment”

“Service the community. Tick box for adhering to government initiatives income. Membership stimulation”

“Allows opportunity, support & guidance to people who do not regularly participate in physical activity”

The main difficulties encountered in implementing the referral scheme included funding, lack of qualified staff, and administration:

“Offered the scheme too late as leisure centre was already planned to close”

“Funding, lack of motivation from staff, funders, GPs and other authorities”

“Qualified staff to take the scheme, admin/commutative problem, time allowed for processing referrals”

“Some teething problems, although nothing that was not quickly rectified.”

“Limitations, board targets and low funding”

“Uncertainty of funding and making long term plans. Time consuming and frustrating”

“Cost of training instructors. Administration requirements, both in set up and maintaining”

5. Views of co-ordinators

When conducting the group discussions with the physical activity co-ordinators and exercise referral co-ordinators a number of issues were identified around the following themes:

- Funding of the programme;
- Co-ordination of the programme;
- Co-ordination of referrals;
- Inappropriate referral; and
- Training.

These issues are discussed in the following paragraphs.

Funding of programme

There appear to be inconsistencies in relation to how the referral scheme is funded across Northern Ireland. While some areas have received funding through the Big Lottery or other sources, a third group have been joint funded from their HSSB and Local Council, while others appear to be sponsored only by their Local Council.

The point was made that, for some, there was a continual process of applying for funding which was distracting from the overall implementation of the scheme. In addition, even where the scheme had been set up and was working well, the next application for funding would have to meet other criteria and therefore it was difficult to continue with the scheme in its current format.

Some reported that a number of Local Councils were not interested in the scheme and did not provide financial support. Therefore the scheme did not operate in those areas.

Not only is there an inconsistency in how the schemes are supported across Northern Ireland there is also a difference in the cost of participating in the scheme. While some who have appropriate funding can offer the scheme free of charge others have had to introduce charging. The amount charged varies from council to council.

“Our health trust has put in a wee bit of money to keep it going for a couple of months between the two funding pots”

“Our first application in 2002 was to NOF and that was for a year. Then we got additional funding from the Big Lottery and now we are funded from the Board to last April last year. Then eventually we got joint recurring funding from the Board and Council.”

“You put lots of work into getting funding. Then it’s such a short period of time – its frustrating.”

“What’s frustrating is that there is no sustaining pot of money and you go through the whole process and call it another sexy name – you have to change it to make it fit.”

Co-ordination of the programme

There appears to be little uniformity in relation to the implementation of the programme across Northern Ireland. Various brand names are being used, different charging structures are in place, some have a dedicated resource for implementing the scheme while others do

not. In addition there is no central co-ordination of training with individual councils arranging it themselves as they need it. There appears to be some informal communications between the councils to source advice on best practice but again this is not co-ordinated centrally.

The source of this lack of co-ordination appears to be due to a number of reasons: a lack of direct NI policy for this area; a lack of consistency in funding arrangements; and the number of individual organisations involved in its implementation. Another issue that appears to be impacting on the organisation of the schemes is staff changes among those who work in the co-ordination role. This has meant that some initial practices that were established, such as the co-ordination of training, have been lost over time.

It was recognised during the groups that there could be benefits from having a more consistent approach to the scheme, particularly in relation to branding, training and dissemination of best practice. However, it was also recognised that the programme benefited from being able to adapt to the needs of the communities it served.

“I think there should be some uniformity throughout NI but I do think that there should still be some slight difference because what we might be able to charge those in other areas might not be able to – but I think you should have to pay something”

“If there was parity across the board in how programmes are funded, how they are run, are they full-time dedicated or part-time. If they were on a level playing field it would probably help.

Co-ordination of the referral schemes

The way in which the schemes are co-ordinated on the ground also varies. While some Councils and individual leisure centres have actively invested in central co-ordination or a dedicated resource for their scheme others have not.

Where there is a dedicated central resource for organising referrals the scheme appears to be working better and is more effective. They appear to be more pro-active in informing GPs about the scheme, approaching clients, screening them for their suitability for the scheme, monitoring their progress and in achieving more positive outcomes in terms of keeping clients on the scheme.

Where there is no central resource, it appears that there are more ‘inappropriate referrals’², and some exercise referral co-ordinators have reported more stress in having to deal with the administrative side limiting their time with the clients.

Those schemes that have a dedicated central resource appear to have more buy-in and commitment from their senior management teams.

“there should be staff appointed in each centre to cope with a scheme like this”

“if there is a champion it tends to work well in that centre!”

“In one centre one girl is injured and unable to deliver training. She is co-ordinating referrals and induction appointments – they are ticking over better”

² See overleaf for explanation of ‘inappropriate referrals’

Recognition

The way in which fitness instructors, who have been trained to deliver the physical activity referral scheme, are recognised through pay structures, was highlighted as an issue. Indeed there appears to be no consistent approach across the Councils in relation to this.

The debate centres around whether or not instructors should receive additional recognition. While some Councils take the view that the schemes are part of the instructors overall job, instructors themselves are more likely to disagree. They consider that, when working on the scheme, they are working with a higher risk group of clients and they need a higher level of qualification to enable them to do this. The qualification is reportedly quite difficult to attain, and in other jobs if you are higher qualified you can command a higher wage. For example, those working on the scheme require a Level 3 qualification. However, they are being paid the same as colleagues who are qualified to Level 2 and who are not eligible to work on the scheme. Indeed some of their colleagues have opted not to

Some of those who took part in the discussions were quite passionate about the issue as it related to them. It was reported that the issue has impacted on morale in some centres.

“if you have done the course and you are taking on higher risk patients you are putting yourself on the line”

“Other centres are saying that this is part of your job to promote health and well-being so get on and do it”

Inappropriate referral

One of the key issues impacting on the effectiveness of the scheme appears to be inappropriate referral. It was reported that inappropriate referrals can come from a number of sources:

- Patient self-referral through GPs;
- GPs referring patients that are not motivated for the scheme; and
- GPs referring patients who health problems are not appropriate for the scheme.

In relation to the self-referral of patients, this has come about due to the free and subsidised rates for using the leisure centre. People have become aware of this and then approached their GP to get referred, even if they do not meet the scheme’s criteria, so that they can avail of the free or subsidised rates. It was reported that some leisure centre members had cancelled their membership and re-joined at the subsidised rates. Others reported having referrals for people whose BMI was meant to be over 25 but when they were assessed at the leisure centre this was not the case. Where there are stricter criteria and a dedicated resource in place, this type of inappropriate referral appears to be less common.

Those implementing the scheme recognise the importance of motivation of the patient in relation to obtaining a positive outcome from the scheme. However, they report that they often come across clients who are not willing to tell their GP that they did not want to take part but when approached by the leisure centre they then decline the scheme.

The exercise co-ordinators also report patients being referred who the instructors are not qualified to deal with. In most cases the patient was referred back to their GP. However, in some schemes the instructors felt that they lacked the authority to re-refer. It was acknowledged that a lack of understanding of the scheme on the part of the GP was the reason why such referrals were made.

“Doctors are referring people with BMI over 30 and when we weight them this is not the case”

“70%/35% of our referrals would fall into the inappropriate referral bracket”

“People are coming back with 2nd and 3rd time referrals”

“People are afraid to say no or not interested to GPs – but are quite happy to tell us they don’t want to take part”

“We have tried to say to doctors that these people should be prepared to make a lifestyle change – you think you’re making it clear who you want but it doesn’t seem to work”

Training

All those operating the schemes have staff who have been trained in its delivery. While at some leisure centres all staff have been trained, at others only a selected few have undergone training.

Training is seen as a big commitment both on the behalf of the Councils and the staff who go through it. The consensus was that the training was very comprehensive and accreditation required staff to spend considerable resource in meeting its requirements.

The costs of training was also an issue, particularly among the smaller Councils, as was the issue of releasing staff to attend. It was suggested that there would be benefit in co-ordinating the training centrally with the Wright Foundation so that courses could be fully attended and therefore, the economies of scale would reduce the cost per participant. This was thought of as particularly beneficial for smaller Councils. The Physical Activity Co-ordinators reported that training had been organised centrally through them previously but having gone through a period of staff changes this was now something that had been lost. However, they were happy to consider re-establishing this practice.

The Co-ordinators report a desire for further additional training, both in relation to refresher courses and higher level/targeted courses such as in relation to obese children and cardiac rehab .

“as a nurse it wasn’t an easy course”

“we need to be up-dated – we’re three years into the Wright Foundation course”

“surely every two years there should be a one day refresher”

“The Wright foundation is fine but there are so many add-ons taking up to 3 or 4 days and costing hundreds of pounds”

“It needs to be organised on a Province-wide basis”

6. Conclusions and recommendations

In this section we bring together the key findings across each strand of the research to draw conclusions on the way forward. The conclusions are structured around the terms of reference for the study as detailed at Section 1.

GP Practices

Number and type of health professionals referring

Just over three quarters of GP practices who responded to our study are referring to the Physical Activity Referral Scheme. However, 17% have referred in the past but no longer do so. Only 7% reported that they had not been involved in the scheme.

There are regional differences in referral activity. Those located in the EHSSB are much more likely to be actively referring. This is most likely to be because of the Healthwise scheme that operates across the Board's area. Those located in the NHSSB area are most likely to have referred in the past but no longer do so. As we understand it a pilot scheme had operated in the area previously but is no longer funded. This may account for the decreased referral activity. Those located in the SHSSB are most likely to have never referred.

Based on the information provided through the group discussions and surveys we have identified a lack of referral activity in the following specific locations:

- Coleraine;
- Dungannon;
- Cookstown;
- Omagh; and
- Ballycastle.

Not surprisingly it is the GPs who are most likely to make the referrals. However, among those practices involved in the scheme 62% have Practice Nurses who make referrals. There are a number of schemes operating which are slightly different. For example, in Newry the referrals are made through the Physiotherapists and at Antrim Hospital the cardiac rehab nurses make referrals and are actively involved in the scheme.

Adherence to NICE guidelines

The National Institute for Health and Clinical Excellence has issued guidelines aimed at health professionals, local authorities and the voluntary sector with direct or indirect responsibility for physical activity. The recommendations include:

- Primary care practitioners should take the opportunity, wherever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity, five days per week.
- They should agree goals with the individual and provide written information about the benefits of activity and the local opportunities to be active. They should follow them up at appropriate intervals over a 3 to 6 month period.

The survey of GP practices identified that 91% actively promote physical activity and that this mainly takes place opportunistically during consultations. Over two thirds (68%) provide

written information in leaflet format. However only 12% always set goals, 22% always keep leisure centre records on file and 22% always have a follow up consultation.

These results indicate that most GP practices are adhering to the NICE guidelines in relation to identifying those who might benefit most from increased levels of physical activity. However, more could be done in relation to following up the initial contact and advice. Not following up the initial contact shows a lack of adherence to the guidelines in this respect.

Main reasons for referring to the scheme

GP practices reported referring patients to the scheme based on a number of reasons. The most common reasons include:

- BMI greater than 25;
- Diabetes;
- Risk of CHD;
- Depression;
- Hypertension; and
- Anxiety and stress.

Despite the low level of goal-setting and record keeping, a number of perceived benefits of taking part in the scheme have been noted. These include weight loss, increased self confidence and increased energy. Only 16% noted a reduction in medication. Based on these findings it appears that some perceive participation in the scheme helps to alleviate some of the symptoms associated with mental health problems.

Barriers to referring

A number of issues were identified by GP practices that were considered barriers to participating in the referral scheme. These included time constraints, the lack of motivation among patients and a lack of awareness of schemes and the ability of leisure centre staff.

There are a number of actions that HPA could consider in helping to address or mitigate against these barriers. For example, reviewing the referral process to ensure that it is as streamlined and easy to complete as possible may help to alleviate the time taken to make a referral. Also undertaking activities to increase the awareness and understanding of the scheme may help to reduce the level of inappropriate referral and help GP practices to select those patients that are most likely to benefit from the scheme.

If barriers to referral are addressed, account should be taken of the impact this might have on throughput of patients. Therefore it will be important access and address any likely resourcing /staffing issues.

Leisure Centre Managers

Current mechanisms of delivering schemes

The methods used to deliver the referral scheme vary from leisure centre to leisure centre. Some centres appear to have more management 'buy-in' than others. These also appear to be the centres that are more likely to have a dedicated co-ordinator, and based on the groups discussions, more effective monitoring of the scheme and more effective outcomes from participation.

The referral schemes on offer at most centres appear to last 12 weeks although in some areas the schemes last 8 weeks.

Participation in most schemes is free of charge although there appears to be a move in some areas towards introducing a nominal fee for participation. It is common for leisure centres to offer a subsidised rate for those who have completed the scheme to encourage them to continue their physical activity programme.

Opinions of running the schemes

From the perception of the leisure centre managers and exercise co-ordinators the main benefits of participating in the scheme include increased revenue from membership, and promotion of a healthier lifestyle to those who do not regularly participate in physical activity. It is clear from the findings that the 'business' of running a leisure centre is of equal if not higher importance to some managers compared with promoting the healthier lifestyle. Either way we conclude that the scheme needs to make business sense to the centres to encourage their support.

The centres report a number of difficulties in running the scheme. For some uncertainty over funding and having to make regular applications for funding appears to be taking up resources that might be better spent in developing the scheme. The administrative burden, where it is undertaken by the fitness instructors, is reportedly causing resentment in some areas. Other difficulties include the cost of training, the levels of inappropriate referrals in some areas and low staff morale due to issues over pay scale recognition.

Where there is a dedicated co-ordinator and management support for the scheme a lot of these issues and difficulties appear to have been addressed. In addition staff appear to be more motivated or dedicated to what they are doing. Promotion among GP practices also appears to be more prevalent and effective.

Training

Some leisure centres have opted to train all their fitness instructors in delivering the scheme while others have selected a number of individuals. Those who took part in the group discussions were of the opinion that the training was intensive and enabled them to conduct their job. However, a need has been identified among staff for refresher courses.

The exercise co-ordinators also saw a need to have training tailored for specific target groups, but recognised that this type of training was expensive and would require travel to England to avail of it.

It was felt that Councils would benefit from having the training organised centrally so that it was not up to each individual Council to arrange it for themselves. They considered that there would be cost savings as the courses would be more likely to have the maximum numbers attending and the financial burden of bringing the trainers from England would be shared across the participants.

Co-ordinators

Number of schemes operating and where located

It appears that most Councils have opted to participate in the referral scheme. However, Dungannon, Strabane, Omagh, Dungannon, Newtownabbey and Coleraine appear not to have schemes.

As mentioned previously there are some very focused schemes, particularly in Armagh and Newry. In addition Fermanagh and Antrim Councils have invested in having a central resource for the co-ordination of the scheme and some schemes are operated from hospitals including Cardiac Rehab at Antrim hospital and at South Tyrone Hospital.

Experience of the schemes

The Co-ordinators identified a number of recurring issues in running the scheme. These included funding, co-ordination, inappropriate referrals and access to training.

It was recognised that there are some examples of good practise among the schemes and that there may be benefits to be gained from sharing experiences. In particular, there are some good examples of operating in the following areas:

- Investment in co-ordination at a central level;
- Service level agreements between GPs and leisure centres;
- Communication with GPs and other health professionals;
- Buy-in from GP representatives;
- Criteria for referral; and
- Commitment of staff and management.

Recommendations

We consider that in some areas the scheme is operating very effectively and have observed the factors that contribute to this effectiveness. Our recommendations are based around identifying the examples of good practise and disseminating/training/persuading other areas to consider learning points for the operation of their scheme.

- Funding – we consider that funding is a core driver in the success of effective schemes. However, the distribution of funding is not consistent across Northern Ireland and continual applications for funding is tying up resources that could be used elsewhere. We recommend that the various agencies involved in the delivery of the scheme should review the funding arrangements in place to address these issues.
- Central co-ordination – we consider that the schemes would benefit from a degree of central co-ordination particularly in relation to training, branding and disseminating examples of good practice.
- Examples of good practice – we consider that HPA should help to facilitate the dissemination of good practise. It should aim to identify learning points from those schemes that are most effective in terms of outcomes. In particular the following areas should be considered:
 - Scheme co-ordination eg having a central resource dedicated to liaising with GPs and administering the scheme;
 - Criteria for referral;
 - Communication and awareness raising with GP Practices;
 - Charging structures;
 - Level of staffing and training; and
 - Monitoring and evaluation.
- Training – it is clear that some GPs require additional training or information in relation making appropriate referrals, setting targets and goals, and providing an understanding of what is provided by the scheme. In addition we recommend that consideration is given to re-establishing the central co-ordination of training for fitness instructors. In relation to the leisure centres it may be worth undertaking a training needs assessment of instructors to review the need for refresher training and more specific training.

Appendix A – Questionnaires

Finding out about physical activity referral schemes

What this audit is about

The **Health Promotion Agency** is looking at ways of developing and improving the **Physical Activity Referral Scheme** across Northern Ireland. We would be grateful if you could take a few moments to complete this short audit questionnaire. You may need to consult with medical and nursing staff in your practice to answer some questions.

All those who return a completed questionnaire by the closing date will be entered into a **PRIZE DRAW** for **£200** of **retail gift vouchers**.

Once you have completed this **audit questionnaire**, please return it in the provided FREEPOST envelope to Perceptive Insight by **Friday 8th February 2008**.

Section A - About your practice

A1. In which Health Board is your practice located?
Tick one only

- Eastern ₁
- Southern ₂
- Western ₃
- Northern ₄

A2. What type of community does your practice cover?
Tick one only

- Urban ₁
- Rural ₂
- Mixed ₃

A3. What is the size of the population your practice covers?
Please give your answer in thousands

A4. How many staff and partners work in your practice as part of the following professional groups?
Please provide details of whole time equivalents WTE

GP	
Practice Nurse	
Nurse Specialist/Practitioner	
Other, <i>please specify</i>	

Section B - Promoting physical activity

B1. How active, if at all, is your practice in promoting physical activity to your patients?

- Very active ₁ →
- Quite active ₂ →
- Not very active ₃ →
- Not at all active ₄ **Go to B3**

B2. How is physical activity currently promoted in your practice?
Please tick all that apply

- Opportunistic advice ₁
- Discussion during consultations ₂
- Providing leaflets to patients ₃
- Physical activity referral schemes ₄
- Pedometers ₅
- Posters ₆
- Not promoted at all ₇
- Other, *please specify* ₈

B3. To what extent, if at all, do the following prevent staff at your practice from promoting physical activity more than it does currently?

	Not at all	To some extent	To a major extent
Time constraints	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Patients' unwillingness to participate	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Lack of awareness of the ability of leisure centre staff	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Lack of confidence in ability of leisure centre staff	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Waiting times at leisure centres	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Lack of awareness of physical activity referral schemes	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
Other, <i>please specify</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

Section C - Physical activity referral schemes

C1a. Has anyone at your practice referred patients to a physical activity referral scheme in the last 2 years?

- Yes ₁ →
- No, not in the last 2 years ₂ **Go to D1**
- No, never ₃ **Go to D1**

C1b. If yes, please tell us how long your practice has been involved in physical activity referral.

- Less than 1 year ₁
- More than 1 year but less than 3 years ₂
- More than 3 years but less than 6 years ₃
- Longer ₄

C2. How did practice staff first learn about physical activity referral schemes?
Please tick all that apply

- | | | | |
|--------------------------------|---------------------------------------|-----------------------|---------------------------------------|
| HSS Board | <input type="checkbox"/> ₁ | A patient | <input type="checkbox"/> ₄ |
| Physical activity coordinator | <input type="checkbox"/> ₂ | Leisure service staff | <input type="checkbox"/> ₅ |
| Other health care professional | <input type="checkbox"/> ₃ | Not sure | <input type="checkbox"/> ₆ |
| Other, <i>please specify</i> | <input type="checkbox"/> ₇ | | |

C3a. Which members of your practice **discuss** the referral scheme with patients?
Please answer separately for each professional group

	All of staff group	Some of staff group	None of staff group	Not applicable
GP	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	
Practice Nurse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Nurse Specialist/Practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Other, <i>please specify</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	

C3b. Which members of the practice **refer** patients onto the scheme?
Please answer separately for each professional group

	All of staff group	Some of staff group	None of staff group	Not applicable
GP	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	
Practice Nurse	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Nurse Specialist/Practitioner	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Other, <i>please specify</i>	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	

C4. How are physical activity **referral schemes** promoted in your practice?

Please tick all that apply

- Posters 1
- Leaflets 2
- During consultations with patients 3
- Not promoted 4
- Other, *please specify* 5

C5. Please list the location of the schemes that your practice has referred patients to (ie which leisure centres) over the past 12 months:

Q6a. How are patients identified for possible participation in physical activity referral schemes?

C6b. What are the most common reasons why your staff refer patients to a physical activity referral scheme? And what are the three main reasons overall for referring patients to a scheme?

	Tick all reasons for referral	Tick three main reasons for referral
Hypertension	<input type="checkbox"/> 1	<input type="checkbox"/> 1
Diabetes	<input type="checkbox"/> 2	<input type="checkbox"/> 2
Asthma	<input type="checkbox"/> 3	<input type="checkbox"/> 3
Osteoporosis	<input type="checkbox"/> 4	<input type="checkbox"/> 4
BMI greater than 25 (weight reduction)	<input type="checkbox"/> 5	<input type="checkbox"/> 5
Risk of CHD	<input type="checkbox"/> 6	<input type="checkbox"/> 6
Depression	<input type="checkbox"/> 7	<input type="checkbox"/> 7
Anxiety/ Stress	<input type="checkbox"/> 8	<input type="checkbox"/> 8
Sedentary lifestyle	<input type="checkbox"/> 9	<input type="checkbox"/> 9
Osteoarthritis	<input type="checkbox"/> 10	<input type="checkbox"/> 10
Low confidence/self-esteem	<input type="checkbox"/> 11	<input type="checkbox"/> 11
Other, <i>please specify</i>	<input type="checkbox"/> 12	<input type="checkbox"/> 12

C7a. Do staff at your practice carry out an assessment of patients physical activity levels?

- Yes 1 →
- No 2 **Go to C8**
- Don't know 3

C7b. If yes, please tell us what method of assessment they use.

C8. Do staff at your practice set goals or targets with the patients that they refer to the scheme?

- Yes, always 1
- Yes, sometimes 2
- No 3

C9. On the patient's file, is there a record kept of patient referral forms, and leisure centre reports?

	Patient referral forms	Leisure centre reports
Yes, always	<input type="checkbox"/> ₁	<input type="checkbox"/> ₁
Yes, sometimes	<input type="checkbox"/> ₂	<input type="checkbox"/> ₂
No never	<input type="checkbox"/> ₃	<input type="checkbox"/> ₃
	<i>Do not receive leisure centre reports</i>	<input type="checkbox"/> ₄

C10. Do staff have follow-up consultations with patients regarding their progress on the physical activity referral scheme?

Yes, always ₁
 Yes, sometimes ₂
 No never ₃

C11. What benefits, if any, have your staff have perceived in any of their patients from physical activity referral? *Tick all that apply*

Weight loss	<input type="checkbox"/> ₁	Reduction in medication	<input type="checkbox"/> ₅
Increased self esteem/ confidence	<input type="checkbox"/> ₂	No benefits perceived	<input type="checkbox"/> ₆
Increased energy	<input type="checkbox"/> ₃	Not known	<input type="checkbox"/> ₇
Improved sleep	<input type="checkbox"/> ₄	Other, <i>please specify</i>	<input type="checkbox"/> ₈

Section D: Training and information

D1. Have staff at your practice received any information or training on the promotion of physical activity?

	Yes, all staff	Yes, some staff	No	Don't know
Information	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄
Training	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄

D2. If **yes** to training, please specify the type of training and who provided this.

	Tick all that apply	Please state who provided the training
Seminar/ conference	<input type="checkbox"/> ₁	
Talk from physical activity coordinator	<input type="checkbox"/> ₂	
Other (please specify)	<input type="checkbox"/> ₃	

D3 Would you be interested in more training on the scheme?

Yes ₁ →
 No ₂

D4 Who would you like to provide the training?

If you have any suggestions for the promotion of physical activity within primary care, please detail and attach on a separate page

Please return your completed questionnaire to:

FREEPOST Plus RRSZ-BTCA-AXLT
 Perceptive Insight Market Research,
 109 Bloomfield Avenue,
 Belfast
 BT5 5AB.

*If you would like to be entered for the **prize draw** please provide your name and contact number →*

Name:

Contact telephone number:

Health Promotion Agency

Finding out about physical activity referral schemes

What this survey is about

The **Health Promotion Agency** is looking at ways of developing and improving the **Physical Activity Referral Scheme** across Northern Ireland. We would be grateful if you could take a few moments to complete this short audit questionnaire.

Once you have completed the **questionnaire**, please return it in the provided FREEPOST envelope to Perceptive Insight by **Friday 8th February 2008**.

Section A – Background and information about the scheme

A1a. Is your leisure centre currently involved with physical activity referral schemes?

- No ₁ →
Yes ₂ ↓

A1b. If no, please detail below the reasons why there is no scheme.

Go to F1

A2. What is the name/title of your scheme?

A3. Please state how long your scheme has been running?

- Under a year ₁
1 – 2 years ₂
3 – 4 years ₃
Over 4 years ₄
Unsure ₅

A4. Who was involved in the development of your scheme?

Please tick all that apply

- Leisure Centre Manager ₁
Physical Activity Coordinator ₂
Health Promotion Officer ₃
Health Professional from Primary Care ₄
Fitness Instructors ₅
Other, *please specify* ₆

A5a. Does the scheme have an overall coordinator or lead contact?

- Yes ₁ →
No ₂ ↓
Unsure ₃ ↓

A5b. If yes, please provide some details about their role...

A6. What main towns or city locations are covered by your scheme? →

A7. How, if at all, are physical activity referral schemes promoted by your centre?

Please tick all that apply

- | | | | | | |
|-------------------------------------|--------------------------|---|--|--------------------------|----|
| Posters in your leisure centre | <input type="checkbox"/> | 1 | Leaflets distributed to homes in your area | <input type="checkbox"/> | 7 |
| Posters in GP practices | <input type="checkbox"/> | 2 | Meet with GPs and Health Professionals | <input type="checkbox"/> | 8 |
| Leaflets in your leisure centre | <input type="checkbox"/> | 3 | Not promoted | <input type="checkbox"/> | 9 |
| Leaflets in GP practices | <input type="checkbox"/> | 4 | Other, please specify | <input type="checkbox"/> | 10 |
| Advertising/article in newspaper | <input type="checkbox"/> | 5 | | | |
| During consultations with customers | <input type="checkbox"/> | 6 | | | |
-

Section B – The scheme in practice

B1. What activities are on offer as part of this scheme?

Please tick all that apply

- | | | | | | |
|------------------------|--------------------------|---|-----------------------|--------------------------|---|
| Gym based programme | <input type="checkbox"/> | 1 | Team sports | <input type="checkbox"/> | 4 |
| Swimming | <input type="checkbox"/> | 2 | Lead walks | <input type="checkbox"/> | 5 |
| Class based activities | <input type="checkbox"/> | 3 | Other, please specify | <input type="checkbox"/> | 6 |
-

B2. In which ways do you receive referrals to the scheme?

Please tick all that apply

- | | | |
|-----------------------|--------------------------|---|
| On paper | <input type="checkbox"/> | 1 |
| By telephone | <input type="checkbox"/> | 2 |
| By email | <input type="checkbox"/> | 3 |
| In person | <input type="checkbox"/> | 4 |
| Other, please specify | <input type="checkbox"/> | 5 |

B3. Who makes contact with you to arrange the referral?

Please tick all that apply

- | | | |
|-------------------------------|--------------------------|---|
| GP | <input type="checkbox"/> | 1 |
| Patient | <input type="checkbox"/> | 2 |
| Practise Nurse | <input type="checkbox"/> | 3 |
| Practice manager/receptionist | <input type="checkbox"/> | 4 |
| Other, please specify | <input type="checkbox"/> | 5 |
-

B4. Do you provide Leisure Centre reports to GP's?

- | | | | |
|--------------------------|--------------------------|---|---|
| Yes, always | <input type="checkbox"/> | 1 | → |
| Yes, sometimes | <input type="checkbox"/> | 2 | → |
| No, never | <input type="checkbox"/> | 3 | ↓ |
| Not sure | <input type="checkbox"/> | 4 | ↓ |
| No - not requested by GP | <input type="checkbox"/> | 5 | ↓ |

B4b. If yes, when are the reports normally sent for each participant?

- | | | |
|--------------------------|--------------------------|---|
| During the scheme | <input type="checkbox"/> | 1 |
| At the end of the scheme | <input type="checkbox"/> | 2 |
| Other, please specify | <input type="checkbox"/> | 3 |
-

B5. Approximately how many people have been referred to your scheme over the last 12 months?

Tick one only

- | | | | | | |
|--------------|--------------------------|---|-----------------------|--------------------------|---|
| Less than 25 | <input type="checkbox"/> | 1 | 156 - 200 | <input type="checkbox"/> | 1 |
| 26 - 50 | <input type="checkbox"/> | 2 | Over 200 | <input type="checkbox"/> | 2 |
| 51 - 100 | <input type="checkbox"/> | 3 | Other, please specify | <input type="checkbox"/> | 3 |
| 101 - 150 | <input type="checkbox"/> | 4 | | | |
-

B6. Approximately what percentage of those who are referred to the scheme complete the programme?

%

B7. What are the most common reasons why people are referred to the scheme?

Tick all that apply

- | | | | | | |
|-------------------------------------|--------------------------|---|------------------------------|--------------------------|----|
| Weight reduction | <input type="checkbox"/> | 1 | Osteoporosis | <input type="checkbox"/> | 7 |
| High blood pressure | <input type="checkbox"/> | 2 | Depression | <input type="checkbox"/> | 8 |
| Arthritis | <input type="checkbox"/> | 3 | Asthma | <input type="checkbox"/> | 9 |
| Coronary Heart Disease risk factors | <input type="checkbox"/> | 4 | Anxiety/ Stress | <input type="checkbox"/> | 10 |
| Inactivity | <input type="checkbox"/> | 5 | Other, <i>please specify</i> | <input type="checkbox"/> | 11 |
| Diabetes | <input type="checkbox"/> | 6 | | | |

B8. On average, how long does a patient have to wait from submitting their referral until attending their first session through the scheme?

Tick one only

- | | | |
|---|--------------------------|---|
| Less than 2 weeks | <input type="checkbox"/> | 1 |
| More than 2 weeks but less than 1 month | <input type="checkbox"/> | 2 |
| More than 1 month but less than 3 months | <input type="checkbox"/> | 3 |
| More than 3 months but less than 6 months | <input type="checkbox"/> | 4 |
| Longer | <input type="checkbox"/> | 5 |

Section C – Funding

C1. How is your scheme funded?

C2. Is there a subsidised rate for participants?

- | | | |
|---------------------------------|--------------------------|---|
| Yes, all participants | <input type="checkbox"/> | 1 |
| Yes, some participants | <input type="checkbox"/> | 2 |
| No, participants pay full price | <input type="checkbox"/> | 3 |
| Not sure | <input type="checkbox"/> | 4 |

C3. On average, how much do participants pay to attend the scheme?

£

- | | | |
|-------------|--------------------------|---|
| Per session | <input type="checkbox"/> | 1 |
| Per course | <input type="checkbox"/> | 2 |

C4. Please describe any promotional offers that are available to those who participate in the scheme?

Section D – Staff and training

D1. How many fitness instructors are involved in running your scheme?

D2a. Have these fitness instructors received training in Exercise Referral?

- | | | | |
|-----------|--------------------------|---|---|
| Yes, all | <input type="checkbox"/> | 1 | → |
| Yes, some | <input type="checkbox"/> | 2 | → |
| None | <input type="checkbox"/> | 3 | ↓ |
| Not sure | <input type="checkbox"/> | 4 | ↓ |

D2b. If yes, which training provider/s were used?
Tick all that apply

- | | | |
|------------------------------|--------------------------|---|
| Wright Foundation | <input type="checkbox"/> | 1 |
| Gayton Group | <input type="checkbox"/> | 2 |
| Other, <i>please specify</i> | <input type="checkbox"/> | 3 |

D3. Are the trained fitness instructors registered on the Register of Exercise Professionals (REPS)?

- Yes, all ₁
- Yes, some ₂
- None ₃
- Not sure ₄

D4a. Do you feel that the fitness instructors at your leisure centre require further training to implement the scheme?

- Yes ₁ →
- No ₂ ↓
- Unsure ₃ ↓

D4b. If yes, please outline what further training you feel is needed?

Section E – Monitoring and Evaluation

E1a. Do you carry out routine evaluation or monitoring as part of this scheme?

- Yes ₁ →
- No ₂ ↓F1
- Unsure ₃ ↓F1

E1b. If yes, please outline what information is collected?

E2. If applicable, how often is the scheme monitored or evaluated?

Section F – Opinions of the scheme

F1. In your opinion, what are the benefits, if any, of running a referral scheme?

F1. What have been the difficulties in implementing the scheme?

Name of Leisure Centre:

Council area:

Please return your completed questionnaire to:
FREEPOST Plus RRSZ-BTCA-AXLT,
Perceptive Insight Market Research,
109 Bloomfield Avenue, Belfast, BT5 5AB.