NHS Health Scotland

Audit of Exercise Referral Schemes in Scotland:

A snapshot of current practice

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Executive summary

This report outlines the findings of an audit of exercise referral scheme provision in Scotland which was undertaken in April – June 2018.

Aims

The overall aim of the audit was to identify exercise referral schemes operating in Scotland and ascertain the size, scope and nature of these schemes.

Definition of exercise referral

For the purpose of this audit an exercise referral scheme was defined as "*any physical activity and exercise intervention which included a referral by a healthcare professional to either a physical activity specialist or third-party physical activity/exercise service provider; an initial, individualised assessment to determine what type of physical activity to recommend for the individual's specific needs and an opportunity to participate in a tailored programme of physical activity, exercise or sport*".

Methods

A range of methods were used to identify schemes including direct communication to existing contacts and snowballing via contacts and key national partners. Data was collected via an online survey and collated in an excel spreadsheet for descriptive analysis.

Key findings

Twenty-six exercise referral schemes met the inclusion criteria for the audit. Seven respondents were excluded from completing the survey as they did not meet the inclusion criteria. Of those schemes that were excluded, two did not include a referral by a healthcare professional to a physical activity specialist or third-party physical activity/exercise service provider; four did not include an initial, individualised assessment; and one did not meet any of the inclusion criteria.

The results show that there are various approaches to delivering exercise referral schemes in Scotland; schemes operate at different capacities, with a range of partners, and different operational structures and standards.

The survey found that most geographical locations across Scotland are covered by schemes. It also revealed several areas which were not covered by a scheme, however it must be acknowledged that this may reflect a non-response rather than a lack of provision.

Although the specific aim(s) of schemes varied from one scheme to another, the overall aim for most schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities to increase physical activity.

Most schemes reported that they conduct an evaluation of their scheme and where impact data was available it was reported that physical activity levels have increased between 27-80% at 12 months.

Recommendations

A central database of exercise referral schemes operating across Scotland does not exist, thus the mechanism for identifying professionals responsible for schemes relied on third party sources of knowledge and information. Although every effort was made to cascade the survey to as many people involved in the delivery and coordination of exercise referral schemes as possible, there is no guarantee that the survey reached all relevant parties and it is possible that some schemes may be missing from this mapping exercise.

It is recommended that any future audit work is supported by a research assistant who takes responsibility for compiling the database by making direct contact with each health board, local authority and leisure trust within Scotland.

The audit of exercise referral schemes undertaken in 2010 identified more schemes than the present survey, consequently this raises the question whether this mapping exercise has failed to capture the true extent of exercise referral scheme provision in Scotland and/or whether several schemes no longer exist.

It is recommended that the findings from this report are mapped against the 2010 audit data to identify whether any schemes still exist and if not explore the reasons for their demise.

It is also recommended that further research is undertaken to identify the nature and extent of the physical activity interventions which fell outside the scope of this audit, this could provide useful information for the ongoing delivery and implementation of the National Physical Activity Pathway in Scotland.

The audit identified that schemes are being delivered, implemented and evaluated in different ways and there could be merit in sharing some of this practice and experience amongst those professionals responsible for the delivery, coordination and evaluation of schemes. For example, almost a third of schemes reported that 80-100% of GP practices in their locality referred into their scheme. Some schemes might find it useful to learn more about the key factors that enabled them to achieve greater buy in than others.

It is therefore recommended that opportunities for sharing practice and learning between schemes are explored and supported.

In the past there have been criticisms that demographic data on the people attending exercise referral schemes has not been routinely collected, consequently it has been difficult to determine whether schemes are reaching their target audience and representative of their local population. This audit found that most schemes (96%) are now collecting data on age and gender of scheme participants, however other demographic data on ethnicity, disability and socio-economic status are less frequently collected. It is still unknown how widely schemes reach people from different socio-economic and ethnic groups and whether schemes are helping to reduce inequalities within their local communities.

It is recommended that further consideration is given to how schemes could be supported to capture this important demographic data so that they are able to determine whether their schemes are reaching their key target audience and those in most need.

The overall aim for most schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities to increase physical activity. Whilst many schemes are collecting baseline and follow-up data on physical activity as part of their evaluation, it must be acknowledged that several schemes, for various reasons, are not undertaking any evaluation activities, a few are not collecting any physical activity data, and a few are not collecting any follow-up data. The impact of exercise referral schemes has come under immense scrutiny over the past two decades and their effectiveness continues to be questioned.[1] Lack of staff capacity and training in evaluation is often cited as one of the challenges to undertaking high quality evaluation of exercise referral schemes.

It is therefore recommended that exercise referral professionals responsible for scheme evaluation are offered support and/or training on how to undertake high quality and robust evaluation of an exercise referral scheme. Sharing examples of evaluation practices across schemes might also be valuable to others who are less experienced in this field.

The audit found that several schemes had developed links with secondary care services and/or other services offering behavioural interventions. There is significant potential for exercise referral schemes to grow as an exit strategy from secondary care and/or as a referral option from other behaviour change programmes. It might be valuable to explore how these connections have been harnessed and how these opportunities could be developed by other schemes.

It is recommended that opportunities for sharing this learning are facilitated by NHS Health Scotland.

The audit revealed that most schemes provided continuing professional development opportunities for the exercise referral instructors and other people delivering or leading the physical activity sessions within their scheme, however there was considerable variability with regards to the opportunities on offer.

Exercise referral scheme providers need to ensure that their workforce is equipped with the necessary knowledge, skills and behaviours to facilitate long-term behaviour change of those people attending their scheme and it is recommended that they continue to provide appropriate and, where relevant accredited CPD opportunities for anyone delivering activities within their scheme.

Section 1 - Introduction

Interventions to promote increased levels of physical activity require a wide variety of approaches, these may include interventions targeted at the population level, such as changes in the environment as well as interventions targeted at the individual level, such as brief advice delivered in primary care or referral to a structured exercise programme, such as an exercise referral scheme.[1]

Exercise referral schemes operate in various ways; typically schemes involve a partnership between multiple agencies such as local NHS health boards, general practices, community health partnerships, local authorities and leisure service providers. In the main schemes involve a member of the primary care team or another healthcare professional referring a patient to a suitably qualified exercise professional for an assessment of the patient's needs and the development of a tailored exercise programme. Historically the exercise programme has taken place in a leisure centre, swimming pool or gym, however many schemes now offer a range of community-based activities, such as tai-chi, cycling, led-walks, green-gyms, and conservation work. Scheme participants are predominantly recruited during consultations within primary care, although some participants are now being referred by allied healthcare professionals.

In the UK exercise referral schemes are one of the most popular interventions used by healthcare professionals to encourage inactive individuals who are at risk of developing, or living with, a long-term condition to become more physically active.

The first exercise referral scheme was set up in the late 1980's and until the publication of the NICE Public Health Guidance on Exercise Referral Schemes in 2006 there had been a significant and sustained growth in the number of schemes operating across the United Kingdom.[2] Whilst the NICE guidance resulted in a loss of funding for a small number of exercise referral schemes overall it appeared to have little impact on the provision of schemes at a national level.[3]

In 2010, NHS Health Scotland published a report outlining the findings of an audit of exercise referral scheme provision in Scotland.[4] The audit identified 49 primary care exercise referral schemes, however since then there have been significant cuts in local government funding and changes in the health and public health landscape and it is uncertain how many exercise referral schemes now exist in Scotland.

In March 2018 NHS Health Scotland commissioned the School of Sport, Exercise and Health Sciences at Loughborough University to conduct an audit of exercise referral schemes in Scotland. This audit is also part of NHS Health Scotland's ongoing commitment to the delivery and implementation of the National Physical Activity Pathway in Scotland.

1.1. Definition of exercise referral schemes

For the purpose of this audit we adopted a definition of exercise referral schemes based on definitions used in previous research and public health guidance.[5,6] This definition embraced any physical activity and exercise intervention which included the following 3 components:

1. *A referral by a healthcare professional to either a physical activity specialist or third-party physical activity/exercise service provider.*
2. *An initial, individualised assessment to determine what type of physical activity to recommend for the individual's specific needs.*
3. *An opportunity to participate in a tailored programme of physical activity, exercise or sport.*

The audit excluded physical activity interventions which focused solely on a verbal recommendation to increase physical activity; sign-posting to local physical activity opportunities; and exercise programmes which were explicitly designed for the rehabilitation and/or management of long-term conditions such as cancer, heart disease, respiratory disease.

1.2. Aims and objectives of the audit

The overall aim of the audit was to identify exercise referral schemes operating in Scotland and ascertain the nature and extent of existing service provision.

The specific objectives of the audit were to:

- map the reach of exercise referral schemes across Scotland
- document the key features of exercise referral schemes presently operating in Scotland and
- identify if there have been any changes in the extent of provision in comparison to previous audits.

The audit also sought to build upon previous work undertaken by the former British Heart Foundation National Centre for Physical Activity and Health, Loughborough University and NHS Health Scotland.

Section 2 - Methods

2.1. Identifying potential relevant schemes

To try to identify as many schemes as possible NHS Health Scotland sent out an email to the Physical Activity leads within the Health Boards asking for their help in identifying existing exercise referral schemes within their local area. The email was also sent to several national partners who subsequently cascaded information about the audit to their networks across Scotland. The email set out the rationale for the audit and invited anyone who would like to take part in the forthcoming audit/survey to register their contact details online. Information about the proposed audit and the development of the database was also disseminated to Physical Activity and Health Professionals who were registered on the School of Sport Exercise and Health Sciences Active (SSEHS-Active) database and working in Scotland. Thirty-six professionals registered on the online database.

2.2. Data collection

A 60-item questionnaire which sought to capture detailed information about the nature and scope of each exercise referral scheme was developed in consultation with several professionals engaged in the delivery of exercise referral schemes in Scotland and NHS Health Scotland.

The questions were grouped into several themes and transferred onto an online survey platform (Qualtrics 2018). An overview of the information collected via the online survey is outlined in box 1 below.

Box 1: Information collected in the audit

- **Contact details of lead person/title of scheme**
- **Scale of the scheme**
  Geographical location, size of scheme
- **Scheme Provision**
  Lead agency, funders, length of time the scheme has been running
- **Aims and objectives**
- **Target population**
  Target population, inclusion/exclusion criteria, screening
- **Scheme Characteristics**
  Recruitment and referral methods, referring healthcare professionals, frequency and nature of contacts with participants, duration of the scheme
- **Scheme delivery and costs**
  Type of service provider(s), settings and types of activities on offer to participants, participant costs, concessions
- **Links to other services**
  Types of services and how this works
- **Workforce**
  Qualifications of exercise professionals, development opportunities
- **Key Performance Indicators, Monitoring and Evaluation**
  KPIs, programme reach, scheme throughput, completion rates, types of outcome indicators assessed, when and how, data on changes in physical activity levels of participants

A link to the online survey was disseminated via email to everyone who had registered on the contact database. It was also disseminated to relevant sport, leisure and physical activity professionals who were known to the physical activity team within NHS Health Scotland. In addition, an email about the survey was sent to several professionals who had completed a questionnaire about the British Heart Foundation National Centre for Physical Activity and Health Exercise Referral Toolkit in 2017. A reminder email was sent to all contacts 2 weeks after the initial email. The survey was live for 4 weeks.

2.3. Data analysis and interpretation

Data was exported from the online survey platform into excel for descriptive analysis and key themes relating to the implementation, delivery and evaluation of schemes were drawn out of the survey responses.

2.4. Data protection and confidentiality

All personal contact details will be stored securely in accordance with the General Data Protection Regulations (GDPR, 2018) and only used for the purposes for which they were collected. Survey data will be held on a secure, password protected computer for six years and only the research team at LU and the accountable person at NHS Health Scotland will have access to the survey data at any time. Survey responses will be aggregated into a report for NHS Health Scotland, however because this is an audit results will not be anonymised.

2.5. Limitations of the audit

The methodology used to undertake this audit is not without limitations. A central database of exercise referral schemes operating across Scotland does not exist, thus the mechanism for identifying professionals responsible for schemes relied on third party sources of knowledge and information. Although every effort was made to cascade the survey to as many exercise referral professionals as possible, there is no guarantee that the survey reached all relevant parties.

The audit of exercise referral schemes which was undertaken in 2010 identified 49 primary care exercise referral schemes.[4] In contrast this audit exercise uncovered a much smaller number of schemes (n=26). Consequently, this raises the question whether the present mapping exercise has failed to capture the true extent of exercise referral scheme provision in Scotland or whether several schemes no longer exist. However, there is a plausible explanation for the different figures presented in this report compared to the former audit report as the definition of what constitutes an exercise referral scheme was more formal in this audit.

A self-report questionnaire was used to gather information about schemes, however there are limitations to using questionnaires to collect data, which must be taken into consideration. It is possible that there is a real difference between those who respond to surveys and those who do not, thus the problem of a self-selecting sample is particularly apparent in relation to questionnaire-based surveys. Resultantly, there may be a response bias which may over or under-represent the issue being investigated.

Section 3 - Results

In total there were 36 responses to the survey, however data is only reported for 26 schemes as there were multiple submissions for two of the schemes. Seven respondents were excluded from completing the survey as they did not meet the inclusion criteria. Of those schemes that were excluded, two did not include a referral by a healthcare professional to a physical activity specialist or third-party physical activity/exercise service provider; four did not include an initial, individualised assessment; and one did not meet any of the inclusion criteria.

3.1. Scale of the scheme

3.1.1. Geographical location of schemes

Respondents were asked about the geographical location of their scheme. Table 1 below, shows details of the schemes coverage and the NHS Health Board area where the scheme is located.

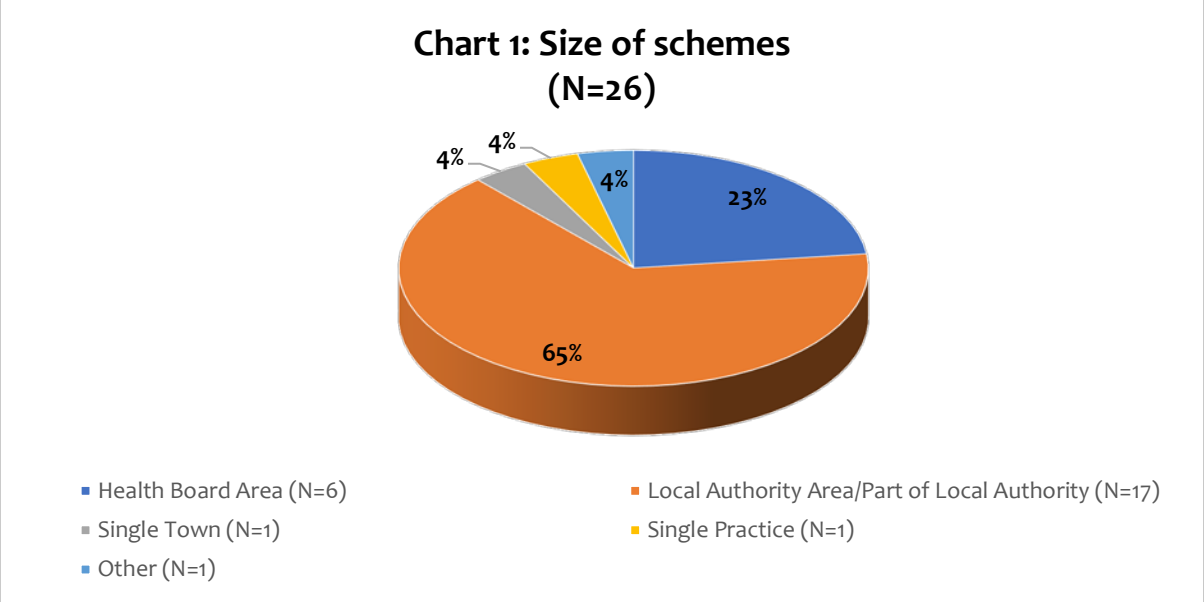
Table 1: Geographical coverage of schemes

Health Board Area	Geographical coverage
Ayrshire & Aran	North and South Ayrshire
Borders	Whole of Borders/ Galashiels
Dumfries & Galloway	Whole of Dumfries & Galloway
Fife	Whole of Fife
Forth Valley	Stirling, Falkirk and Forth Valley
Grampian	Aberdeenshire, Mintlaw, Peterhead and surrounding area
Greater Glasgow & Clyde	Glasgow City, East and West Dunbartonshire, East Renfrewshire, Renfrewshire and Inverclyde
Highland	No ERS provision identified
Lanarkshire	North and South Lanarkshire
Lothian	City of Edinburgh and Lothians
Orkney	No ERS provision on the Orkney Isles
Shetland	No ERS provision identified in the Shetland Isles
Tayside	Perth and Kinross all localities, Angus and Dundee
Western Isles	Outer Hebrides

As can be seen in table 1, the audit found that some areas in Scotland are not covered by an exercise referral scheme, however it should be acknowledged that this summary is based on the responses to the survey, there may be some areas where schemes currently operate but their information was not captured in the audit.

3.1.2. Size of schemes

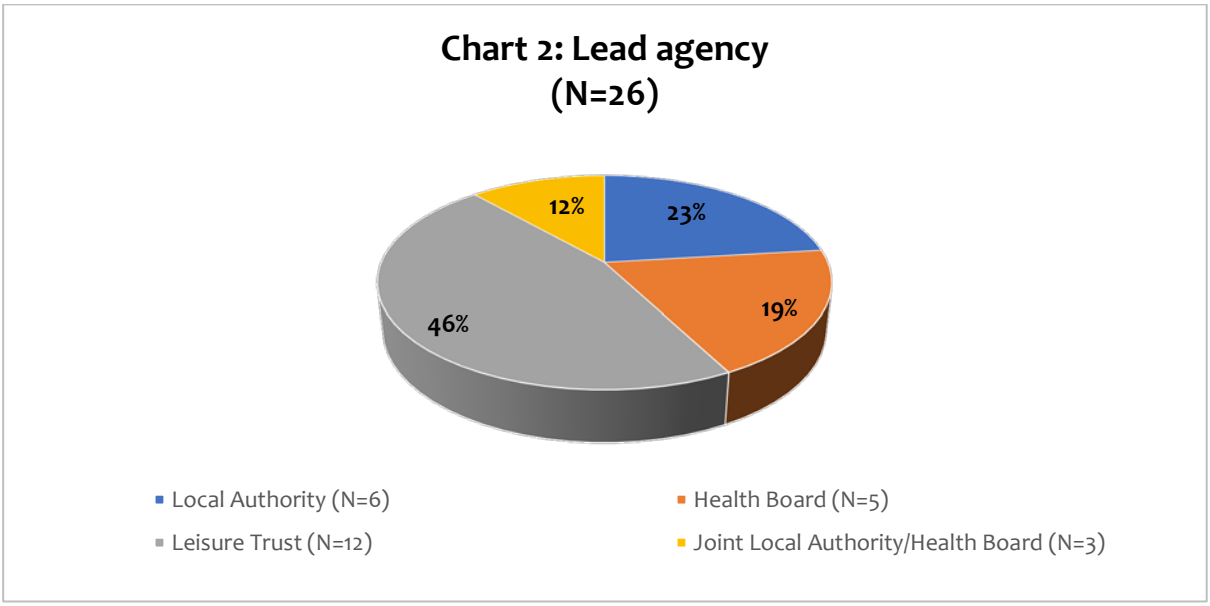
Respondents were asked about the size of their scheme, data highlighted that schemes are delivered in various sizes. As shown in chart 1, most schemes operate across a local authority area or part of a local authority (65%, N=17), however, there were also 6 larger schemes (23%) that covered a whole health board area, with two of these larger schemes operating in Fife. One scheme covered a single town, and another scheme solely covered one general practice.



3.2. Scheme provision

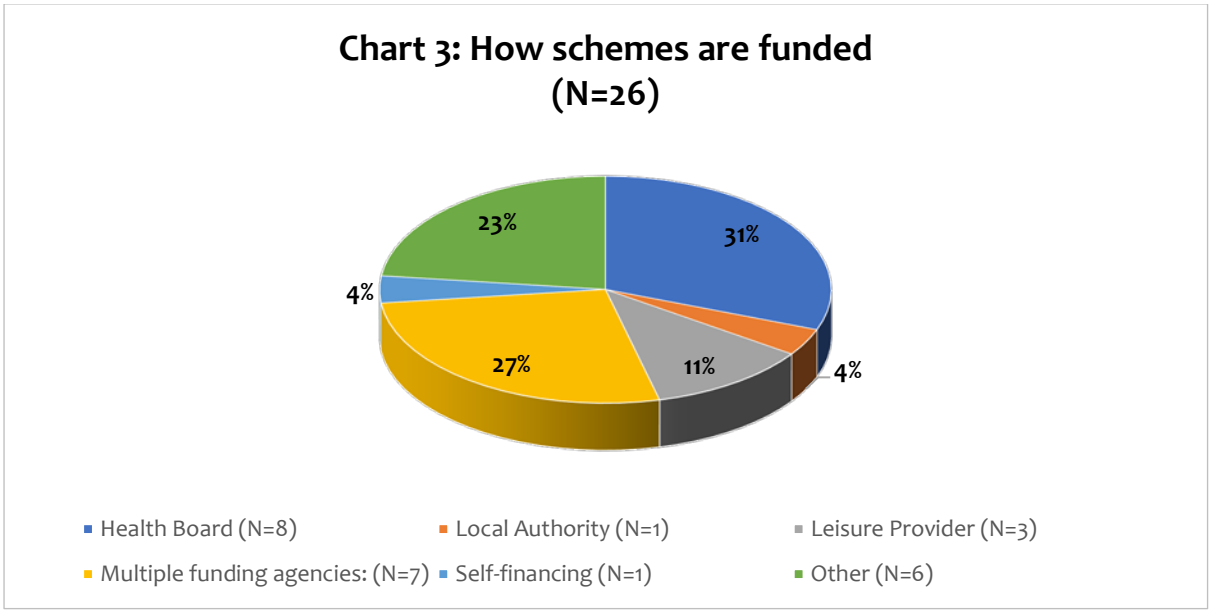
3.2.1. Responsibility for schemes

Respondents were asked to indicate who had the lead responsibility for their exercise referral scheme. Whilst there were some slight variations in the lead agencies for schemes, chart 2 below shows that most schemes are led by leisure trusts (46%, N=12). The audit also found that local authorities were named as the lead agency for 23% of schemes (N=6) and health boards led 19% of schemes (N=5). The remaining 12% of schemes (N=3) were jointly led by local authorities and health boards.



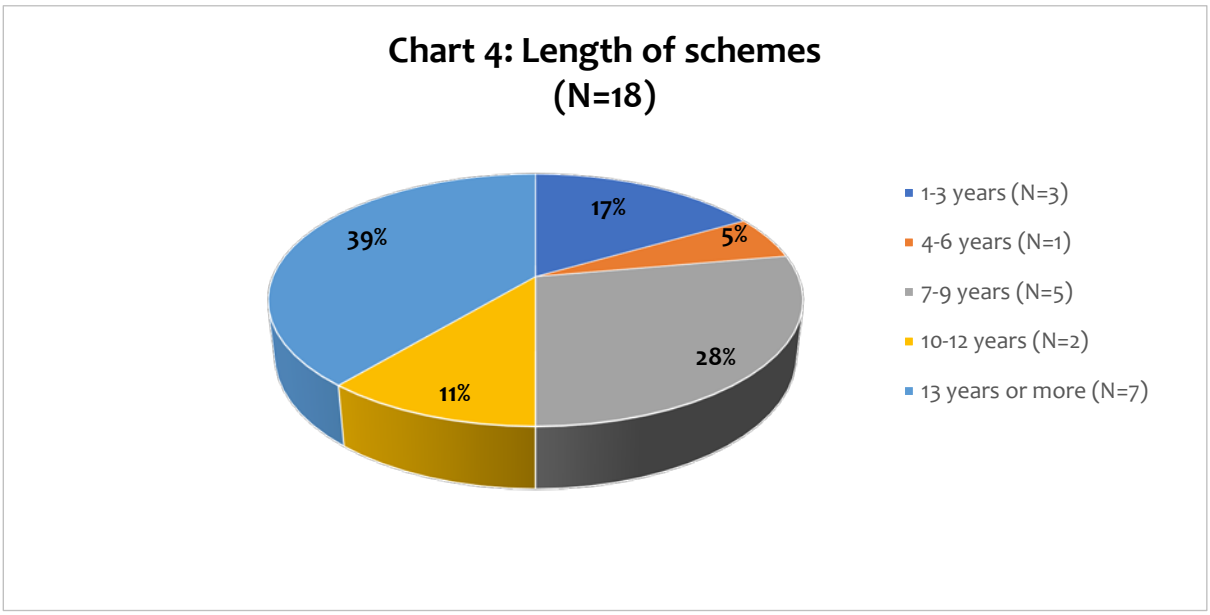
3.2.2. Funding of schemes

Respondents were asked to indicate how their scheme is funded. There was variability in the responses; as shown in chart 3, the largest single funders are Health Boards (31%, N=8), however many schemes are funded by multiple funding agencies (27%, N=7). Agencies involved in jointly funding schemes included health boards, local authorities, health and social care partnerships and leisure providers. In addition, Macmillan and Paths for All were identified as other funders.



3.2.3. Length of schemes

To gain a picture of the development of schemes over time respondents were asked how long their scheme has been in action. Eight respondents were unsure of the start date for their scheme but, as can be seen from chart 4 below, of those schemes which did provide data, most schemes (83%, N=15) are well established and have been operating for at least 4 years. Over a third of schemes (39%, N=7) have been in existence for more than 13 years making them some of the longest running schemes in the UK. Several schemes (17%, N=3) have been established for 1 – 3 years, but there were no schemes that had been operating less than a year.



3.3. Overall aim of schemes

Although the specific aim(s) of schemes varied from one scheme to another, the overall aim for most schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities to increase physical activity.

Most schemes had more than one aim; further aims for many schemes were to:

- Increase physical activity levels amongst the most inactive groups.
- Provide opportunities and support for people with underlying medical conditions to become more active.
- Equip patients with the knowledge, skills and confidence to become more active.
- Promote lifestyle change and provide behaviour change support.
- Support the rehabilitation of individuals who have a musculoskeletal injury or are post-surgery.
- Improve weight management.
- Improve mental health through physical activity.

3.4. Target population

3.4.1.Population groups targeted by the schemes

Respondents were asked who the target population group was for their scheme. In line with the aims identified above, many of the schemes are targeting individuals at risk of, or living with, a long-term condition. Other schemes are targeting inactive/sedentary individuals who could improve their health by increasing their activity levels.

One scheme was specifically targeting inactive individuals living with mild to moderate mental health conditions and another was focussing on individuals recovering from musculoskeletal injuries. A few of the respondents identified the age group their scheme targets; three schemes were targeting adults (16 plus); one scheme was focussing on children (aged 5-18), families and adults; and another had older adults (50 years plus) as their target group.

Respondents stated that their scheme inclusion/exclusion criteria further defined who was eligible for the scheme and these are considered in the next section.

3.4.2. Inclusion criteria

The referral inclusion criteria differed from scheme to scheme depending on several factors, such as scheme aims, exercise referral staff experience and qualifications and the range of healthcare professionals referring into the scheme.

Forty-two percent of schemes (N=11) stated that being 'inactive' was an inclusion criterion for their scheme, however only a few of these schemes (N=3) specifically defined what they meant by inactive, i.e. not meeting the recommended 150 minutes of physical activity per week.

Most schemes (67%, N=17) accept patients with a wide range of long term conditions, ranging from:

- CHD risk factors, for example hypertension, raised blood cholesterol; family history, smoker.
- Mental health problems, for example, anxiety, depression, stress.
- Musculoskeletal conditions, for example, back pain, arthritis, osteoarthritis, osteoporosis, multiple sclerosis.
- Respiratory conditions, for example, asthma, COPD.
- Neurological conditions, for example, epilepsy, Parkinson's disease.
- Metabolic/endocrine problems, for example, diabetes, thyroid disease.

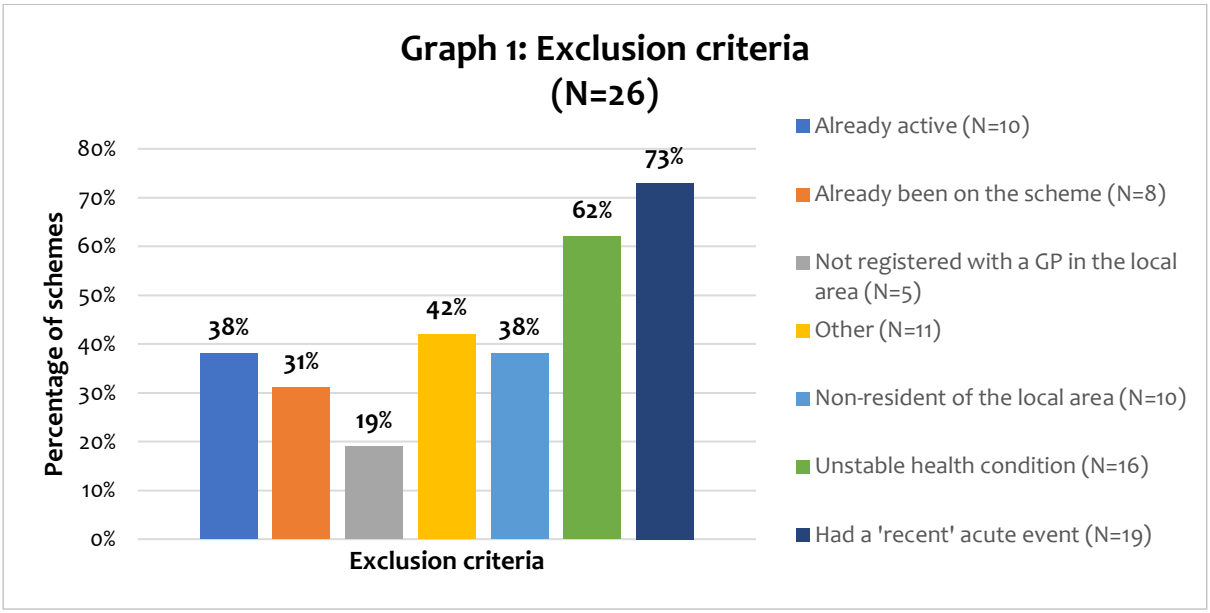
A few schemes (N=5) specifically focused on a single long-term condition, such as cancer, high blood pressure, musculoskeletal injury, obesity and severe and enduring mental health conditions.

Some of the other inclusion criteria cited by respondents included needing support to become more active; requiring a specific exercise prescription due to a medical condition; being motivated to increase physical activity levels; requiring support to return to work and support to combat addictions.

3.4.3. Exclusion criteria

Respondents were asked to indicate what excludes individuals from being referred into their scheme. All schemes reported they have exclusion criteria with many basing these on a range of factors. Graph 1 below shows a breakdown of the variety of exclusion criteria being used by schemes; the most commonly reported exclusion criterion was a client having had a 'recent' acute event (73%, N=19), followed by the presence of an unstable health condition (62%, N=16). Already regularly active, previous participation in the scheme and not living in the designated area were also reported as exclusion criteria.

Some schemes had more specific criteria in relation to certain physiological measurements which were identified as contraindications to exercise, for example high blood pressure, unstable diabetes. In addition, one scheme excluded individuals who are not motivated to increase their physical activity, and another excluded those who required 1:1 supervision from a fitness instructor.



As well as having inclusion/exclusion criteria, 69% of the schemes (N=18) provided referrers with additional guidance/documentation about who is most suited to the scheme. Information provided includes advice on identifying people at the most appropriate stage of behaviour change; guidance on the suitability of individuals on the periphery of the criteria; detailed description of the scheme, it's referral pathway and the content of specific classes/ programmes offered.

3.4.4. Pre-exercise screening

In addition to having inclusion/exclusion criteria, 85% (N=22) of the schemes used some form of pre-exercise health screening tool. These included:

- PAR-Q (this was the most frequently mentioned)
- Warwick-Edinburgh Mental Well-being scale (WEMWEB)
- Lifestyle questionnaires
- Scheme-specific questionnaires/referral forms
- Patient Health Questionnaire 9 (PHQ9)
- Scottish Physical Activity Screening Questionnaire (Scot-PASQ)
- FACIT Fatigue Scale
- EQ5-3DL
- General Self-Efficacy Questionnaire
- Bio-electrical impedance measurements

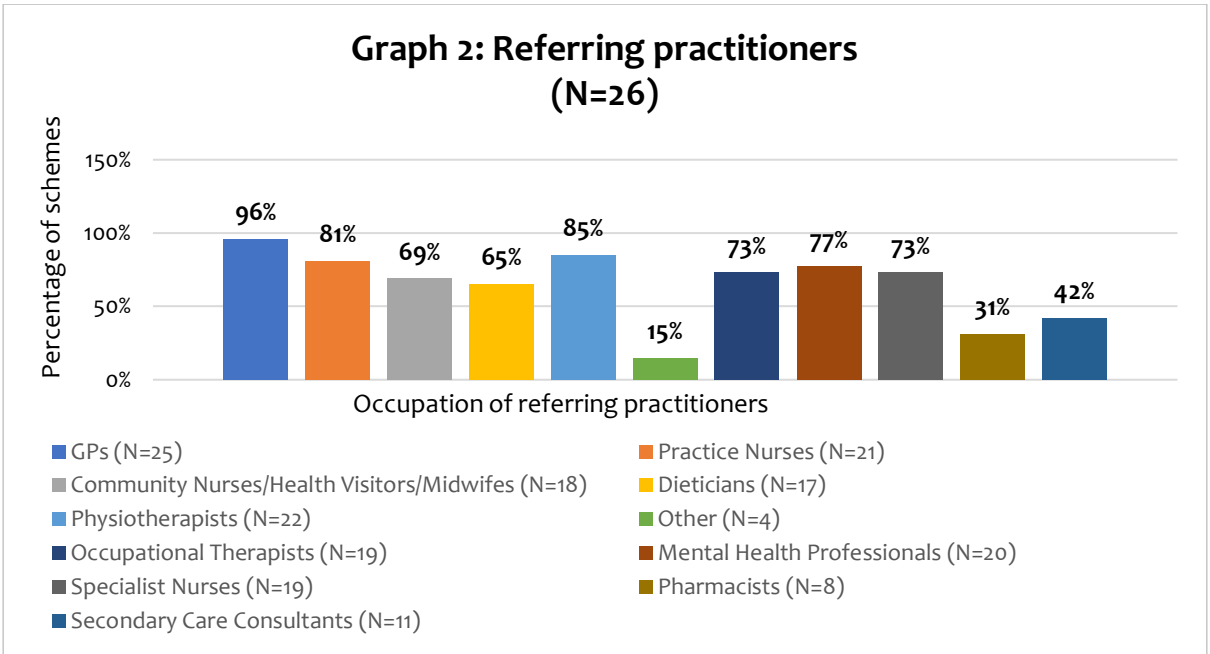
Respondents were also asked to indicate when they used the pre-exercise screening tools; whilst not many answered this part of the question, there were a range of responses from those who did. Schemes most frequently conducted pre-exercise screening as part of a baseline consultation/initial appointment/induction before an individual commences any exercise. A couple of schemes carried out screening both before and after referral and one scheme carried out this process before referral, however it was not specified who conducts this pre-exercise screening before the referral.

3.5. Characteristics of schemes

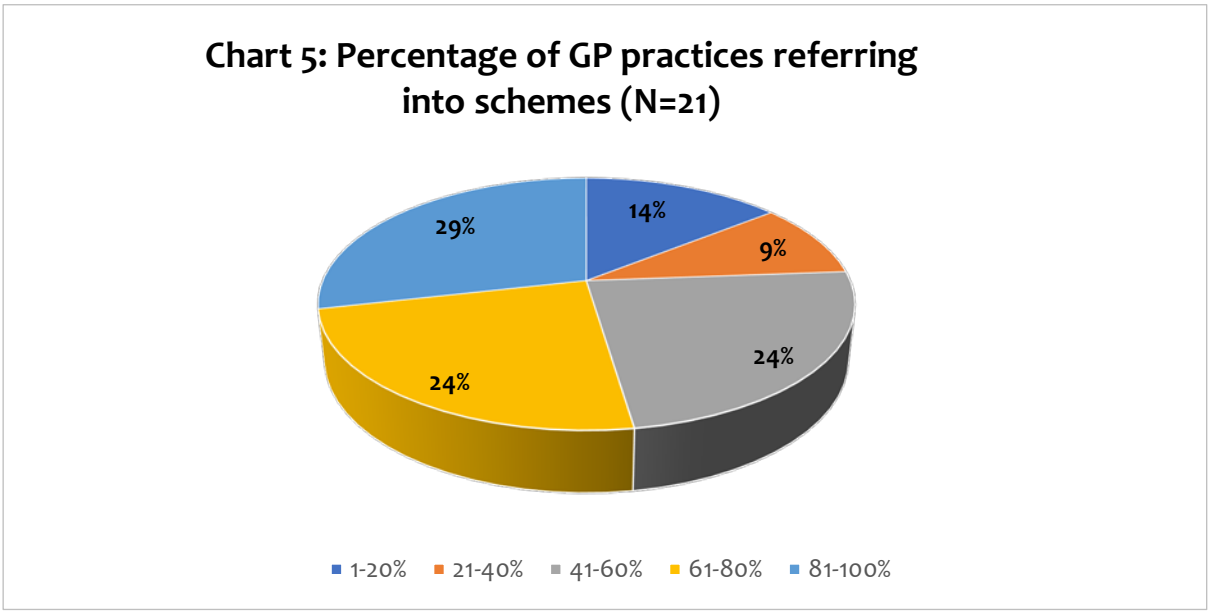
3.5.1. Referring practitioners

Historically, GPs were the main referrers into schemes and this review shows that GP referrals are still prominent in most schemes. However, since the initial development of exercise referral schemes the range of healthcare practitioners referring into schemes has grown. Graph 2 below, shows that most schemes are now accepting referrals from many different healthcare professionals such as physiotherapists, practice nurses, mental health professionals, specialist nurses, occupational therapists, community nurses/health visitors/midwives and dietitians.

The audit also identified one scheme that only accepted referrals from physiotherapists as the scheme specifically supports the rehabilitation of those with musculoskeletal injuries. While some schemes indicated that they accepted referrals from pharmacists and secondary care consultants, however these referral routes appeared less utilised. In addition to accepting referrals from healthcare professionals, 38% of schemes (N=10) also accepted self-referrals.



Respondents were also asked approximately what percentage of GP practices in their locality referred into the scheme. Five schemes were unable to answer this question but, of those that did, the majority (53%) reported that they have at least 60% of practices in their locality signed up to refer into the scheme with 29% of schemes having buy in from 81-100% of general practices in their locality (see chart 5). A further 24% of schemes reported having over 40% of GP practices linked in, while 14% had less than 20% of their GP practices signed up.



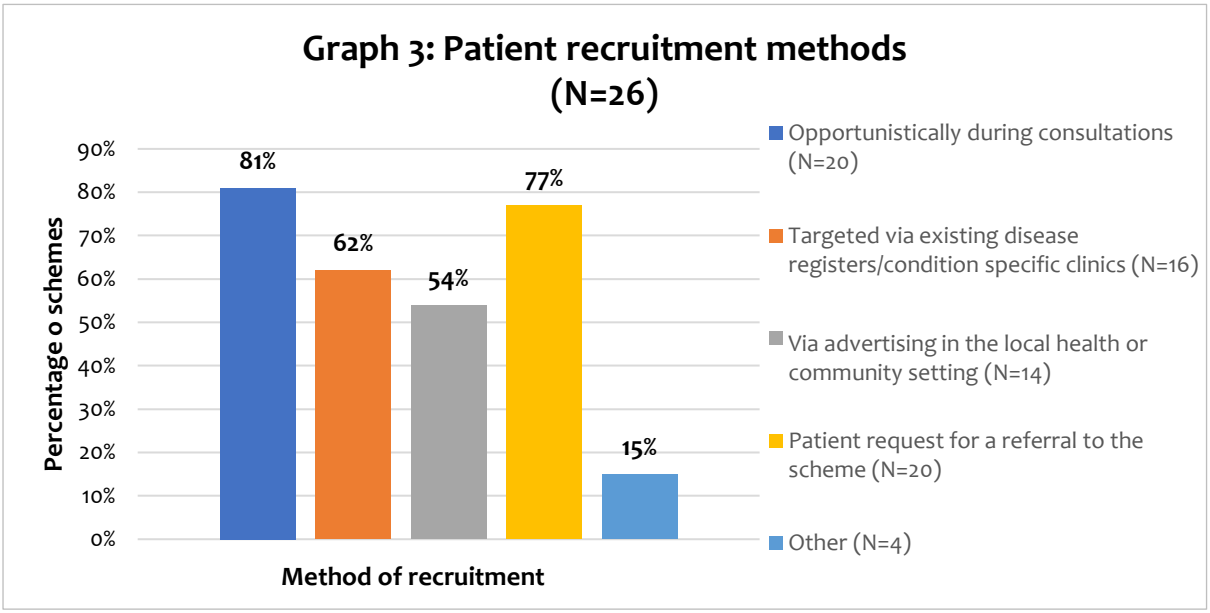
3.5.2. Patient recruitment methods

Most schemes adopted a range of methods for recruiting patients, typically these included:

- Opportunistic recruitment during routine consultations, health screening clinics or new patient consultations.
- Targeted recruitment via existing disease registers or condition specific clinics.

- Open recruitment via advertising in the local health or community setting.
- Patient initiated requests for referral.

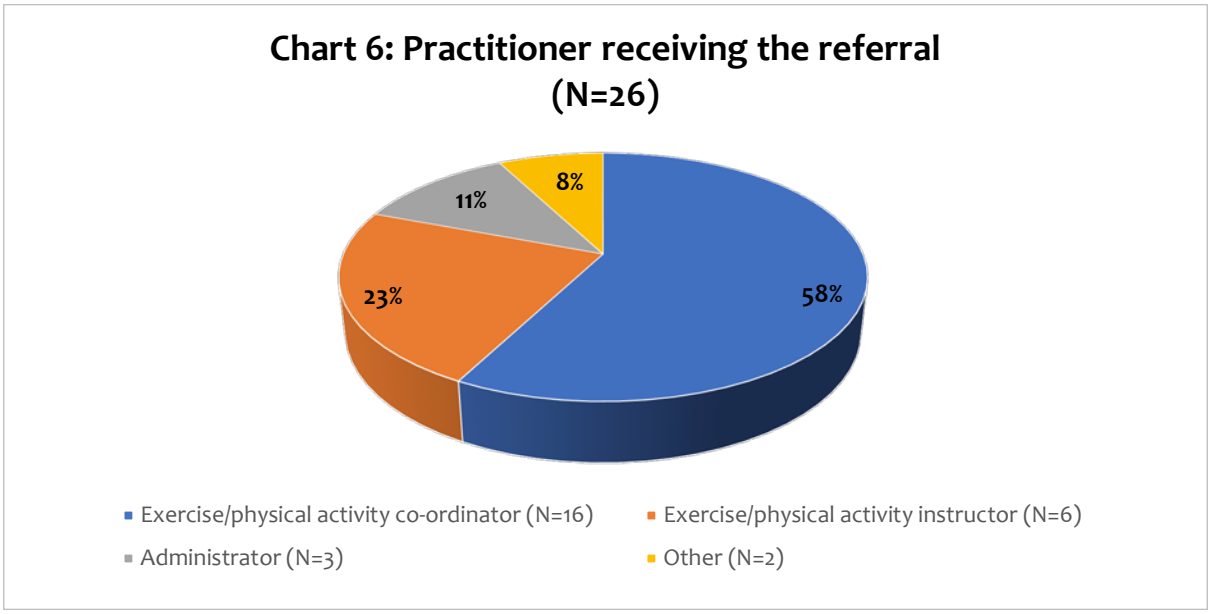
Graph 3 below, shows a breakdown of the variety of participant recruitment methods being used by schemes. The most commonly reported recruitment methods were via referrals initiated by a healthcare professional during routine consultations (81%), followed by patient-initiated requests (77%). Other methods mentioned included targeted recruitment via existing disease registers and condition specific clinics and through information on the practice website/social media.



3.5.3. Referral pathway

Respondents were asked to describe the referral processes for their scheme. Most of the responses focussed on the method used to transfer information with over half (54%, N=14) indicating that a paper referral form was used. Other schemes used electronic referrals via the NHS system (12%, N=3) or a combination of paper and electronic formats to transfer participant information (31%, N=8). One scheme reported that they did not have a referral form, participants can just turn up at activities. Two of the schemes which reported using paper referrals stated that they only use these for those considered 'high risk' and referral vouchers are used for all other referrals.

Respondents were also specifically asked who receives the referrals and, as chart 6 shows, in most schemes this was an exercise/physical activity co-ordinator (58%, N=16), followed by an exercise/physical activity instructor (23%, N=6).

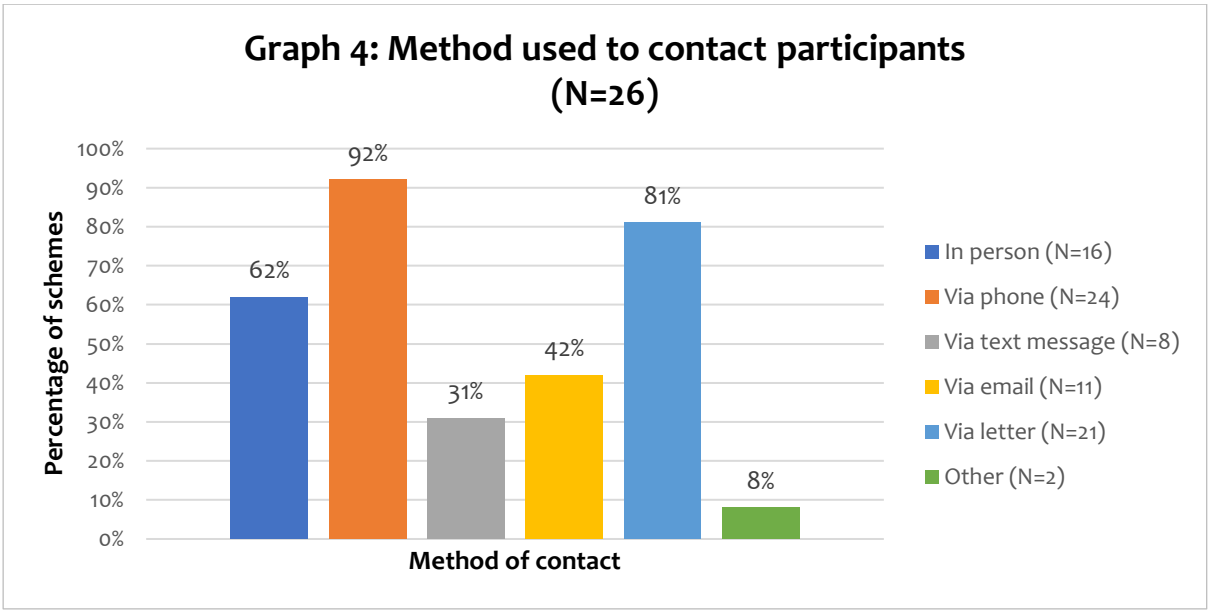


3.5.4. Contact with participants

Respondents were asked to describe when contact takes place with participants during the scheme. Unsurprisingly the timing and number of the contact points with participants varied from one scheme to another. All schemes reported that they conduct an initial consultation with participants at the start of the exercise referral programme, ie day 1 or week 1. A third of schemes (N=9) reported that they contact participants to make an appointment upon receipt of the referral. Six schemes reported that they have contact with participants at least once per week whilst they are on the scheme. Most schemes reported that they have between 2-5 locked in touch points with participants at different time intervals. Although there were some common touch points across schemes, for example at the start and end of the referral period, there was also considerable variability with contact points occurring anywhere from 2, 4, 6 or 8 weeks to 3,6,9, or 12 months. A couple of schemes reported that the frequency of contact with participants was dependent upon the needs of the individual, and one scheme reported that they did not have any follow-up contact with participants due to limited resources.

3.5.5. Communication methods

The methods used to contact participants also differed across schemes, graph 4 shows a breakdown of the variety of methods employed. The most frequently used contact method was via phone (92%, N=24), followed by letter (81%, N=21) and in person (62%, N=16). Text messages and email were used by some schemes but always alongside other methods of contact; with most schemes adopting a combination of methods. Two schemes asked individuals how they would like to be contacted rather than having set methods.



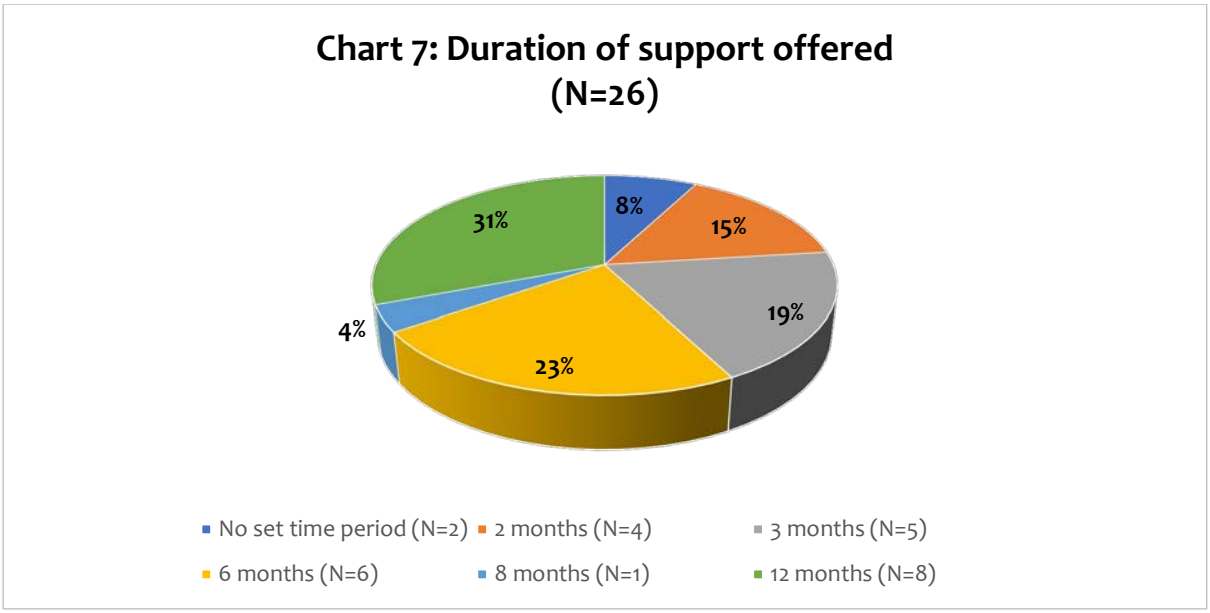
3.5.6. Initial consultation

Respondents were asked to describe what happens during their first consultation with a scheme participant, the findings revealed that this varied across schemes. Almost two-thirds of schemes (N=17) reported that they reviewed the participants medications and medical history during the initial consultation and half reported that they discussed the participants exercise history (N=13). Most schemes (81%; N=21) stated that they set goals with participants during the first consultation and 40% of schemes (N=11) reported that they have conversations with participants about their activity interests and preferences before developing their exercise programme. Several schemes (N=8) indicated that they also take physiological measurements during their initial consultation which included measurements such as height, weight, BMI, percentage body fat, blood pressure, peak flow, sit-to-stand, walk-test, balance and stability tests. Some schemes (N=9) also reported that they ask participants to complete different questionnaires either prior to, or during their first consultation; the range of questionnaires used include PAR-Q, Stage of Change, EQ5D, SF36, WEMWBS, Health State Scale, 7-day physical activity recall, diet/healthy eating, Fear of Falling Scale, Decisional Balance. One scheme indicated that the content of the first consultation and the associated assessments varied according to the reason for referral and one scheme stated that it only offered volunteer led activities, therefore it did not record any previous exercise history or undertake any goal setting.

3.5.7. Duration of the scheme

Respondents were asked to indicate how long support was offered to participants within their scheme. Chart 7 shows that over half the schemes provided support for 6 months or more (58%; N=15), and of these nearly a third offered (31%, N=8) continuing support for a year. The support period ranged from 8 weeks/2 months to 1 year and two schemes did not specify the length of time they support participants.

Typically, those schemes offering support for a longer period provided more intensive support for the first 8-12 weeks, in the form of activity sessions and/or 1:1 input, followed by a period of reduced support.



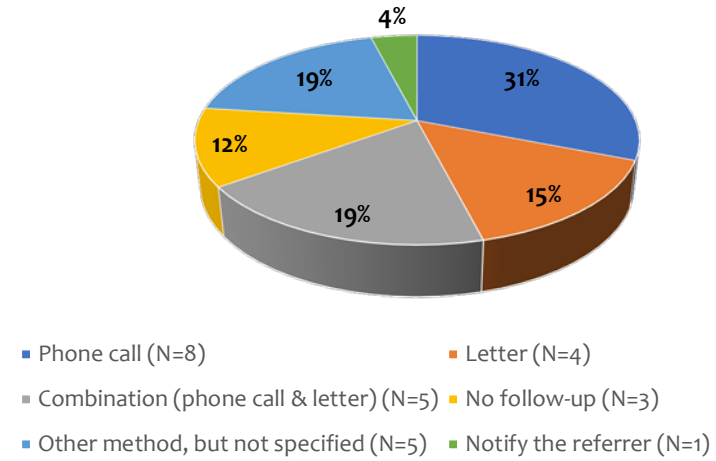
3.5.8. Patient progress

Just under half of the schemes (46%, N=12) reported that they provided feedback to the referrer about a participant's progress during or after the scheme. These schemes were asked how and when this information was fed back to the referrer. Limited information was provided and there was variability between schemes: feedback tended to be provided at key points of the scheme, including at baseline, mid-point, and/or end of the scheme; or at specific time points, for example, 3, 6 and/or 12 months and some schemes reported that they only provided feedback on request. Only a few respondents (N=5) outlined the format of this feedback of these, three provided specific written reports; one reported via an annual report; and one provided statistics at 12 months.

3.5.9. Managing drop-out

Respondents were asked to outline what action is taken when people drop out of their scheme; except for three schemes all other schemes reported that they followed-up participants who dropped out of their scheme. As can be seen from chart 8, most schemes (N=8; 31%) attempted to contact people who dropped out by telephone, followed by a combination of phone calls and letters. Several schemes (N=5; 19%) reported that they followed-up participants but did not describe how this was done. One scheme reported that it simply notified the referrer that their patient had dropped out. The number of times schemes attempted to contact participants who dropped out varied slightly, but most schemes tried 2-3 times. One scheme reported that its advisors tried to engage with clients throughout the 12-month period via phone calls and letters. A quarter of schemes (N=7) stated that they also notified the referrer where they were unable to re-engage a participant after a follow-up call or letter.

Chart 8: Follow-up activities for participants who drop out of the scheme (N=26)

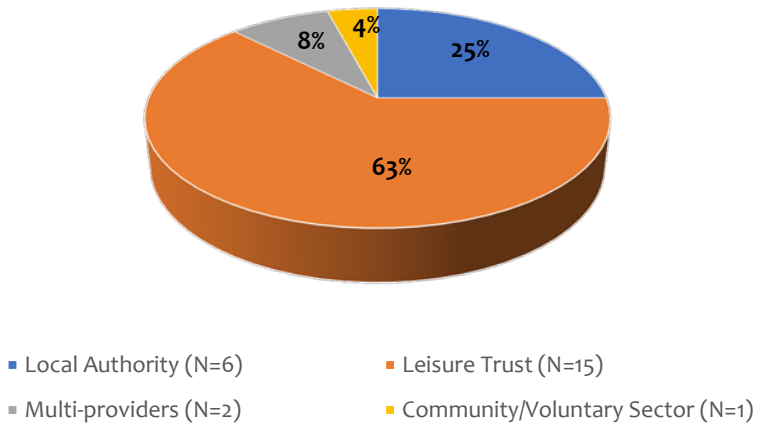


3.6. Scheme delivery

3.6.1.Service providers

As can be seen in chart 9 below, leisure trusts were the main service providers in nearly two thirds of schemes (63%, N=15), followed by local authorities who provided services for a quarter of the schemes (25%, N=6). Two of the schemes had multiple service providers; in one the services were provided by the leisure trust and the community/voluntary sector and in the other the scheme services were provided by the local authority and local providers.

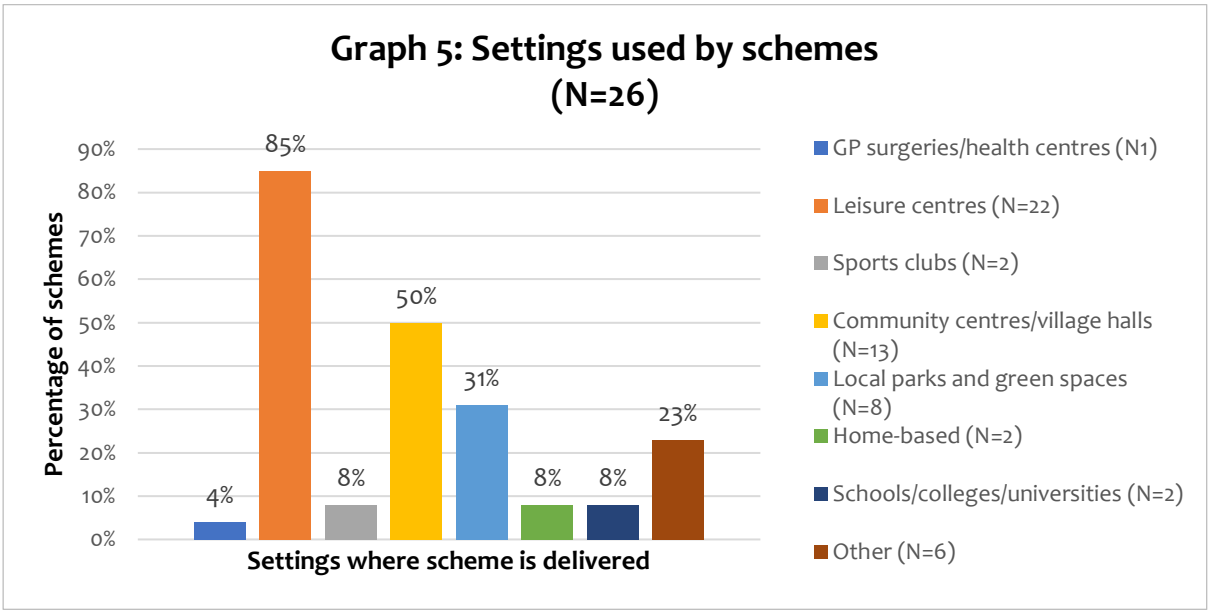
Chart 9: Main service providers (N=24)



3.6.2. Settings used to deliver the scheme

In previous reviews it has been found that schemes centred activities mainly within local leisure facilities, with some exceptions. While this audit found that leisure centres were still the most popular setting in the schemes identified (85%, N=22), it also revealed that many schemes are now delivering activities in range of other settings.

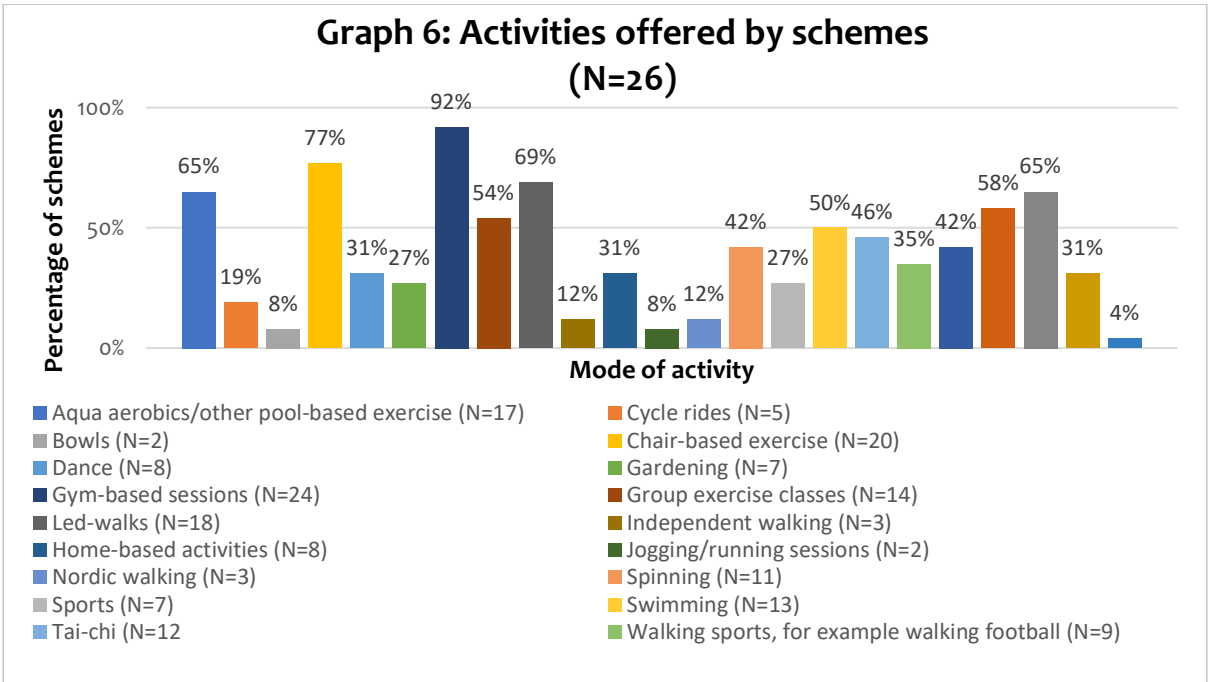
Over half of the schemes reported that they are utilising two or more settings for the delivery of their exercise referral programme, these other settings included sports clubs (8%, N=2); community venues (50%, N=13); local parks and green spaces (31%, N=8); schools/colleges/ universities (8%, N=2); and the home (8%, N=2). Several schemes (23%, N=6) also reported using 'other' settings for the delivery of their programme; these included a GP surgery/health centre, a hospital, a physiotherapy department and a care home. Graph 5 below, shows the range of settings being utilised by schemes in Scotland.



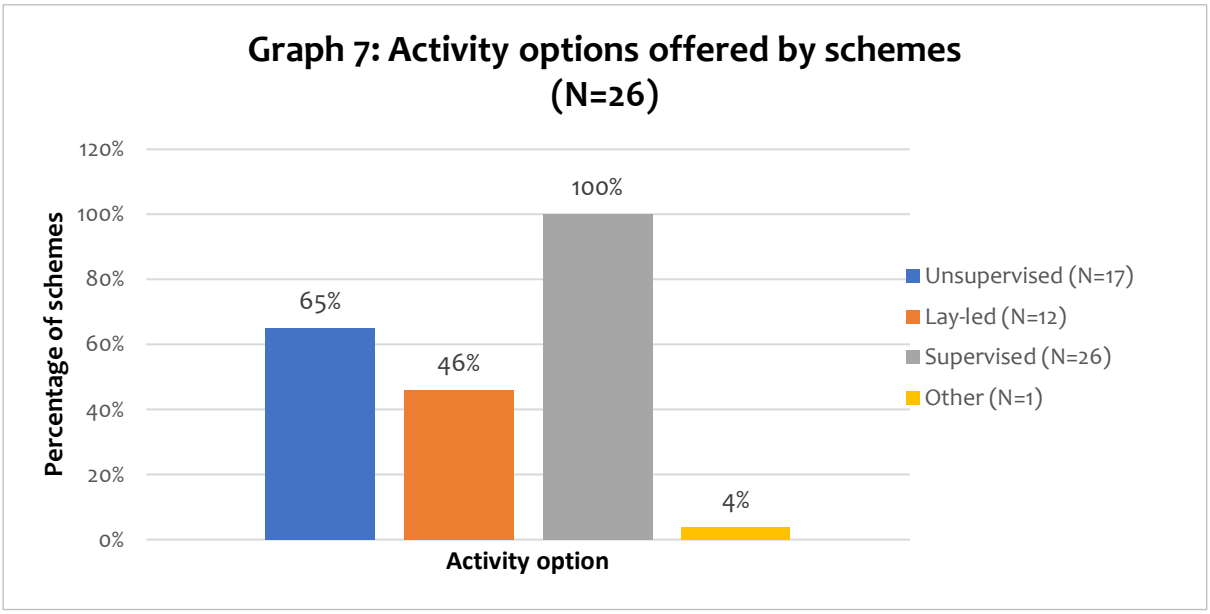
3.6.3. Activities on offer

The wider range of settings being utilised by schemes has enabled many to move away from traditional leisure centre-based activities and to expand the range of activity options available for referred patients. Although the activity options differed from scheme to scheme, nearly all schemes provided a wide range of activities, typically including both indoor and outdoor options. Nearly all schemes offered more than 3 activities (92%, N=24) with 50% (N=13) offering 10 or more different activities for patients involved in the exercise referral programme.

Graph 6 overleaf, shows the type of activities offered by schemes: gym- based sessions, chair-based exercise, led walks, aqua-aerobics/other pool-based exercise and classes for those with multiple long-term conditions were the most common activities. Ninety-two percent of schemes offered gym-based activities (N=24); seventy-seven percent offered chair-based exercise (N=20) sixty-nine percent offered led walks (N=18) and a further sixty-five percent offered aqua-aerobics/pool-based exercise (N=17) and/or classes for those with multiple long-term conditions (N=17). Condition specific classes, group exercise classes, swimming, Tai-chi, spinning, and yoga/Pilates were also offered by over 40% of schemes. A small number of schemes also offered alternative activities such dance, sports, walking sports, home-based activities, gardening, functional/ symptom limitation classes, Nordic walking, independent walking, cycle rides and bowls.



Respondents were also asked whether they offered activities that were supervised (i.e. under the supervision of a qualified exercise instructor/physical activity leader), unsupervised (i.e. independent of an exercise instructor/physical activity leader and/or lay-led (i.e. led by a volunteer). Graph 7 shows the type of activity options schemes offered: all the schemes provided supervised activities, about two-thirds (65%, N=17) also offered unsupervised options and just under half (46%, N=12) also included lay-led activities.



3.6.4. Patient charges

The charges made to patients accessing programmes varied considerably, from scheme to scheme. Just over half of the schemes (54%, N=14) reported that they do not charge patients anything during the referral period. The remaining 46% (N=11) of schemes reported charging

patients either a one-off fee for the referral period or a discounted rate per activity session during the referral period. The one-off charges differed across schemes starting from £13.00 for a 12-week programme to £50.00 for a 12-week programme (those on income support accessed this scheme free of charge). The charge to patients, per session during the referral period also varied from scheme to scheme, ranging from 50p to £7.50 (the average charge levied by schemes, per session was between £1.00 and £4.64). A couple of schemes also offered monthly payment options.

Half the schemes (N=13) offered concessionary rates and the charges patients incurred during the referral period were variable depending on whether the patient was entitled to concessions. The criteria for concessions varied from scheme to scheme but where these were reported it included: all participants who were referred; those on low income/obtaining benefits; students; and those aged over 60 years.

3.7. Links to other services

Respondents were asked to indicate whether their scheme forms part of an exit pathway for secondary care rehabilitation services and/or whether it links to any other physical activity or behaviour change programme.

The audit revealed that 65% of schemes (N=17) were part of an exit pathway for secondary care rehabilitation services, these services ranged from hospital-based stroke, cardiac, pulmonary or falls rehabilitation to cancer care, pain management, dietetics and physiotherapy. These schemes reported that they received referrals from allied healthcare professionals working in secondary care and offered individuals additional and ongoing support with their rehabilitation and physical activity journey. The findings also revealed that the secondary care exit pathway into the different schemes was often dependent upon the staffing and resources available locally. The remaining 35% of schemes (N=9) were either not part of an exit pathway for secondary care services or the respondent did not know whether their scheme formed part of an exit pathway. One scheme indicated that the main exit route has now ceased to exist as a lack of resources does not allow for any community follow up.

In addition, the audit found that 56% of schemes (N=14) linked to other physical activity or behaviour change programmes. Of these 64% (N=9) linked to smoking cessation services and 50% (N=7) linked to weight management programmes. Other links that were identified included addiction support, mental health support and diabetes prevention/education classes.

3.8. Exercise referral workforce

3.8.1.Qualifications

Respondents were asked whether their scheme has a minimum level of qualification for instructors working with referred patients. All the schemes stipulated that people leading activities have a minimum level of qualification, but the type and level required varied between schemes. Seventy-seven percent of the schemes (N=20) stipulated that instructors must have a minimum of a REPs level 3 qualification; three schemes reported that instructors required a REPs level 4 exercise qualification as the minimum; one stipulated a REPs level 2 qualification; one scheme delivered by the voluntary/community sector required walk/cycle leader and chair-based exercise qualifications; and one didn't respond to this question. Several schemes reported a range of other qualifications as their minimum, for example three schemes required behaviour

change techniques to be possessed by their workforce as a minimum and some stated that the minimum level of qualification was dependent on the type of activity being delivered.

3.8.2. Continuing Professional Development (CPD)

Eighty-four percent of respondents (n=21) reported that continuing professional development was encouraged and provided for the exercise referral instructors and other people delivering or leading the physical activity sessions. The audit revealed that the CPD opportunities offered to staff varied across schemes; it included activities such as 'in-house' training, training delivered by local healthcare professionals, externally commissioned training courses around topics such as behaviour change, mental health and more formal level 4 exercise instructor qualifications, such as cardiac, stroke, pulmonary rehab. One respondent reported that CPD opportunities were not provided because the people delivering the activities were independent providers and not employed by them. The remaining respondents (N=4) either did not know whether CPD opportunities were provided or failed to answer this question.

3.9. Key Performance Indicators

Respondents were asked to list the Key Performance Indicators (KPIs) for their scheme. The types of indicators that were listed in response to this question are shown in box 2 below.

Box 2: Scheme Performance Indicators

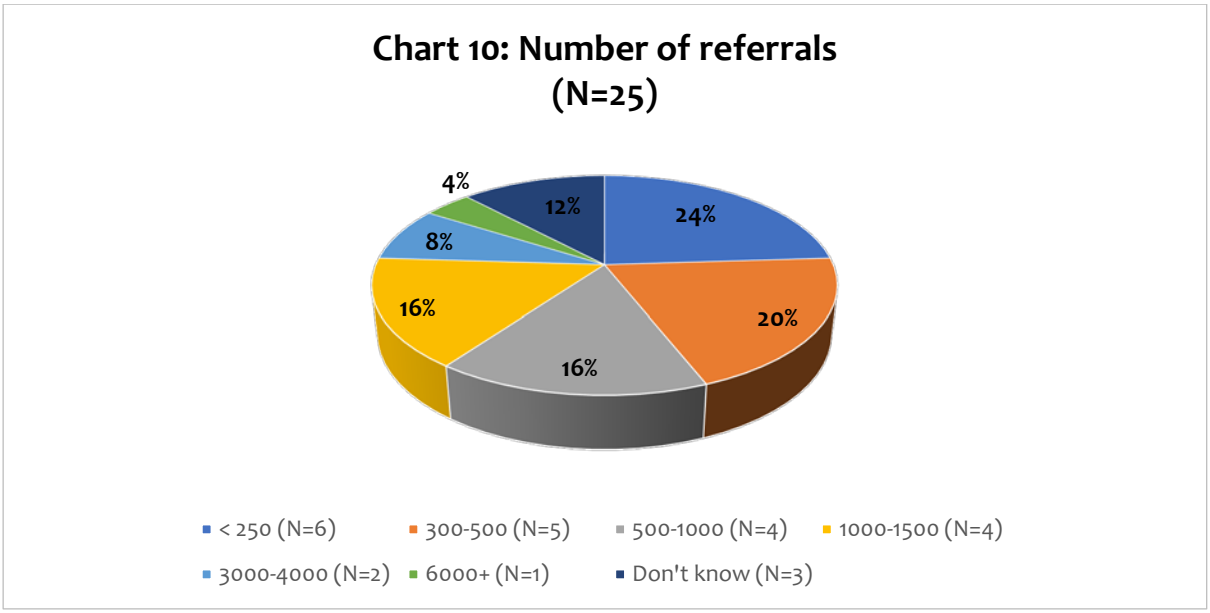
- Number of people referred to the scheme
- Number/percentage of people taking up the referral
- Number/percentage of people completing the programme
- Number of activity sessions attended
- Number/percentage of people dropping out of the scheme
- Number of people active at specific time points
- Number of people taking out memberships after the programme
- Number of follow-up contact appointments attended
- Number and range of healthcare professionals referring into the scheme

Apart from three schemes all other schemes (N=23) had specific KPIs. Of these schemes, 91% (N=21) had at least two KPIs and 22% of schemes (N=5) had 4 or more. Eighty-seven percent of schemes (N=20) had KPIs for the number of people referred; seventeen percent (N=4) had KPIs for the number or percentage of people taking up the referral or attending baseline consultations; thirty-nine percent (N=9) had the number or percentage of people completing the programme as a KPI and 52% of schemes (N=12) had KPIs relating to changes in physical activity behaviour.

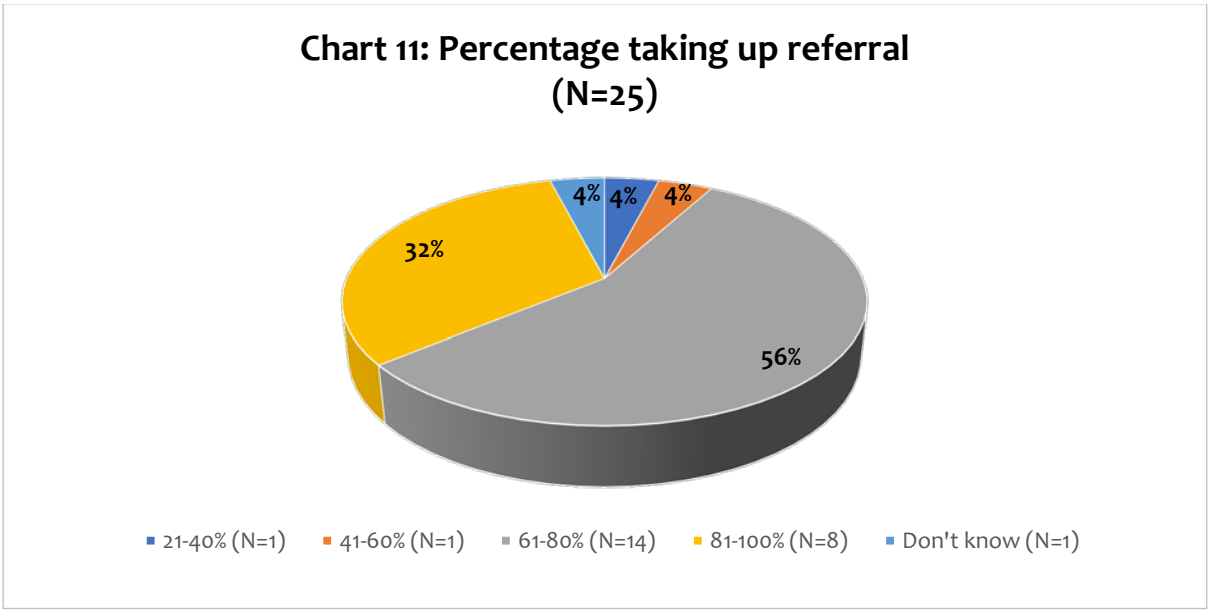
3.10. Monitoring and evaluation

3.10.1. Referral numbers and uptake

Chart 10 shows the number of referrals schemes received annually. Forty-four percent (N=11) of the schemes had referral numbers up to 500; 32% of schemes (N=8) annually received between 500 and 1500 referrals and 12% (N=3) had over 3000 referrals. There was a wide range in the number of annual referrals received by schemes; the smallest number reported was 30 in a scheme covering a local authority area and the largest was in a scheme covering a health board area receiving 6600 plus referrals.



Respondents were also asked approximately what percentage of those referred to the scheme take up the referral offer and chart 11 below shows the breakdown of responses. Thirty-two percent of schemes (N=8) reported an uptake rate of 81-100% and a further 56% (N=14) estimated that 61-80% of those given a referral were taking this up.



Respondents were also asked to provide some further statistics on participants' progression through the scheme, i.e., from initial consultation to scheme completion. Specifically, respondents were asked:

- Of those people who attend the initial consultation what percentage start the scheme; and
- Of those who start, what percentage drop out; and
- Of those who start what percentage complete the scheme.

Starter, drop-out and completion figures are shown in Table 2.

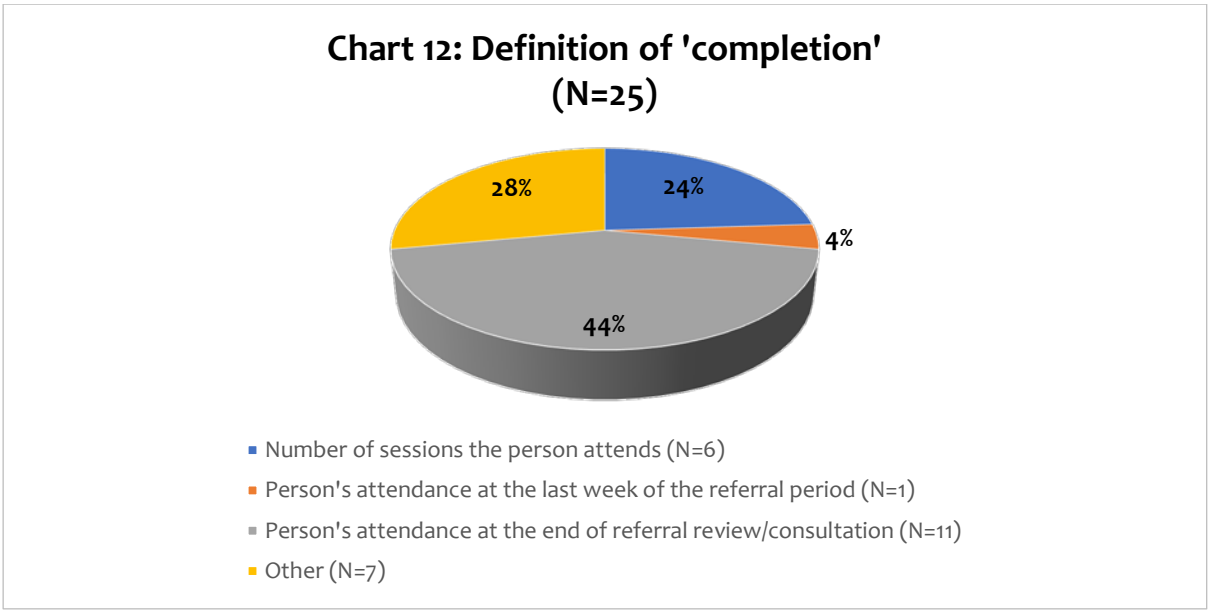
Thirty-six percent of schemes (N=9) estimated that 61-80% of participants who attended the initial consultation start the scheme with a further 36% (N=9) reporting that over 81% of participants started the scheme. Of those who started the programme, there was considerable variation in the numbers dropping out and the numbers completing the scheme. Over half the schemes (56%, N=14) reported that less than 40% of people dropped out of the programme once they have started and just under half (48%, N=12) estimated that over 40% completed the scheme.

Drop-out rates varied across schemes ranging from 1-20% of participants up to 61-80%, and completion rates ranged from less than 20% of participants completing the scheme through to 81-100%.

Table 2. Scheme progression rates

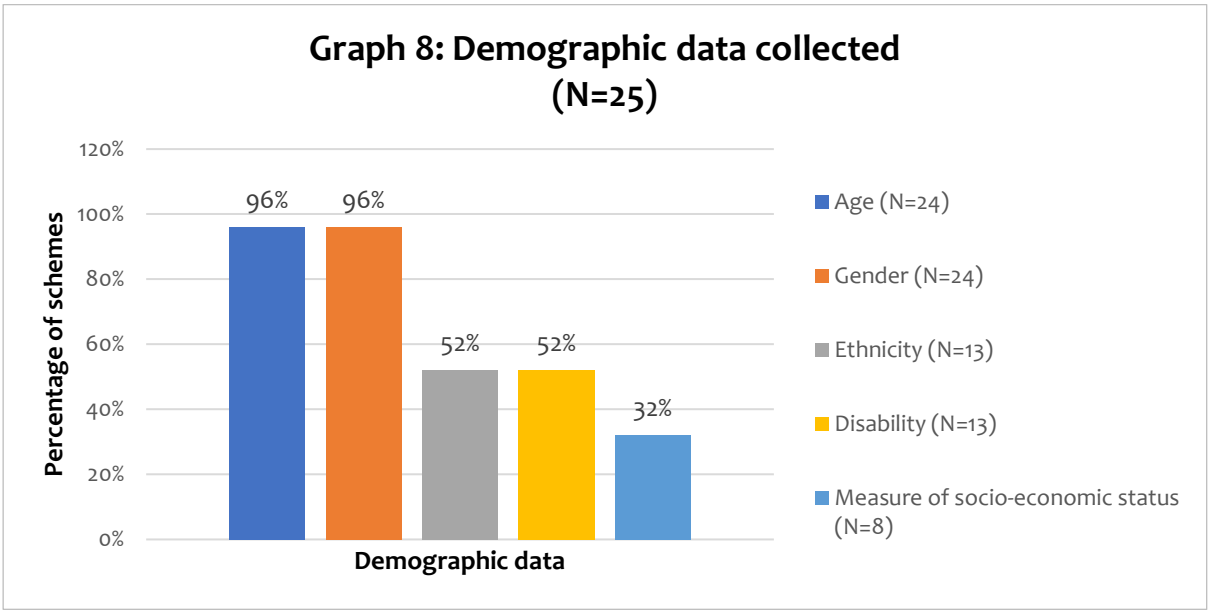
Percentage of people	Of those attending the initial consultation, % who start the scheme (% of schemes, N=25)	Of those who start the scheme, % who drop out (% of schemes, N=25)	Of those who start the scheme, % who complete it (% of schemes, N=25)
1-20%	0	28% (N=7)	4% (N=1)
21-40%	4% (N=1)	28% (N=7)	16% (N=4)
41-60%	4% (N=1)	12% (N=3)	24% (N=6)
61-80%	36% (N=9)	12% (N=3)	12% (N=3)
81-100%	36% (N=9)	0	12% (N=3)
Don't know	20% (N=5)	20% (N=5)	32% (N=8)

Respondents were asked to indicate how they defined 'completion' and a breakdown of responses is shown in chart 12 below. The most common method of defining completion was by a person's attendance at the end of referral review/consultation (44%, N=11) followed by the number of sessions a person attends (24%, N=6). Just over a quarter of schemes (28%, N=7) adopted 'other' methods to define completion, with the main alternative being participants continuing to be active beyond the programme through sessions provided locally or exercising on their own. Two schemes were not time limited and therefore did not define completion rates.



3.10.2. Programme reach

Respondents were asked to indicate what demographic data they collected as part of their scheme monitoring. Graph 8 below shows a breakdown of the data being collected by schemes. One scheme did not answer this question but, of those that did, the most commonly collected demographic data was age and gender with 96% (N=24) of schemes collecting this information. Slightly more than half of the schemes (52%, N=13) also collected data on ethnicity and disability and just under a third (32%, N=8) collected data on socio-economic status.



3.10.3. Evaluation

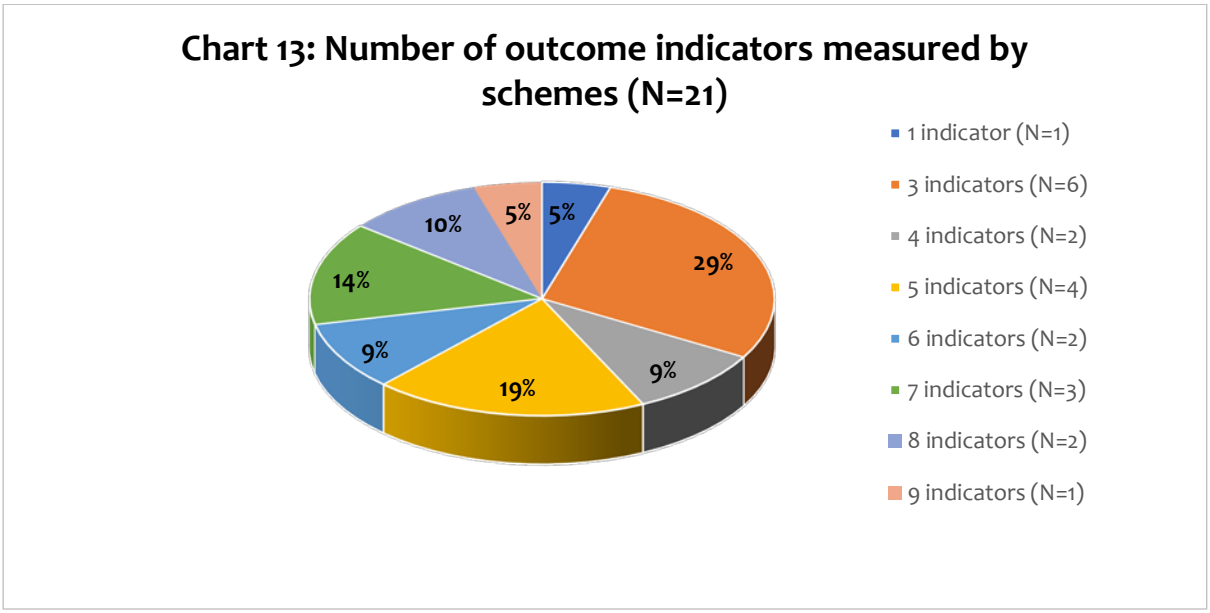
Eighty-four percent of respondents (N=21) reported that they evaluate their schemes and the remaining 16% (N=4) indicated that their scheme was not evaluated. The reasons given for not evaluating the scheme included lack of staff (N=2), difficulties collating the data accurately (N=1) and the absence of a policy/evaluation process (N=1). Where respondents indicated that their scheme was not evaluated they were asked to estimate what percentage of people leaving the scheme are more active, however none of these schemes were able to provide an estimate.

3.10.4. Outcome data collected

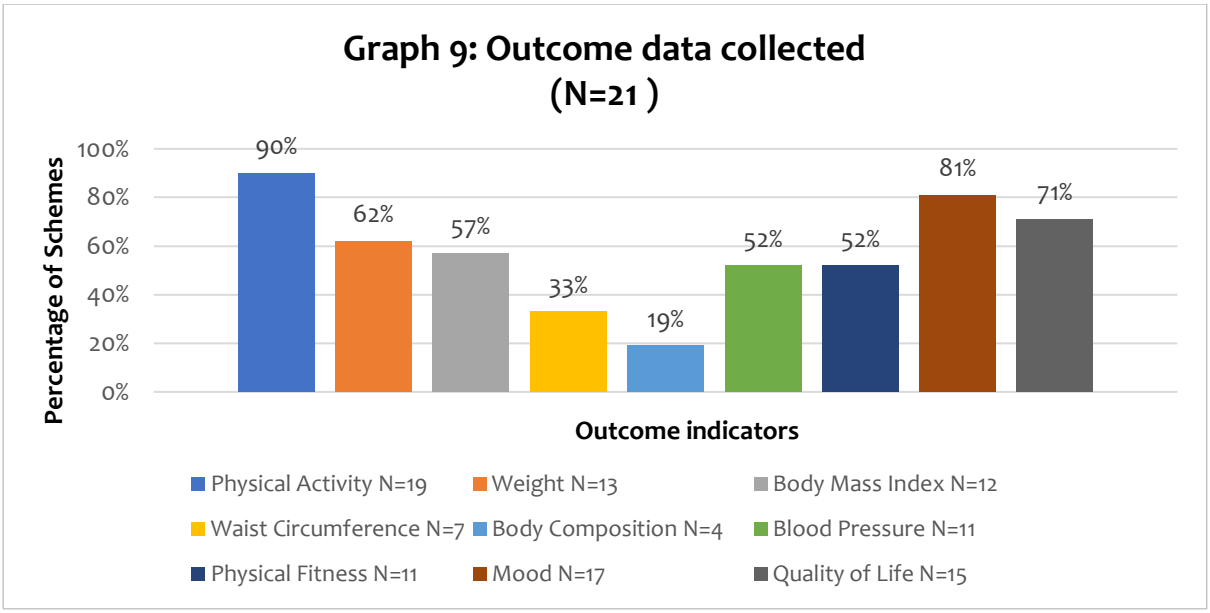
Where evaluation was taking place, schemes reported that they collected data on a range of physical, psychological or fitness indicators and physical activity at some point during the referral programme. Across schemes there were variations in terms of what and when data was collected. For example, 90% (N=19) of schemes indicated that they collect data on physical activity, however of these schemes 16% (N=3) only collected physical activity data at baseline; 11% (N=2) collected data at baseline and at 3 months; 21% (N=4) collected data at baseline, at 3 months and at 6 months; 21% (N=4) collected data at baseline and 3, 6 and 12 months; a further 11% (N=2) collected physical activity data at baseline, at 6 and 12 months. One scheme collected baseline and 12-month follow-up data; and the remaining 16% (N=3) collected physical activity data at baseline and 3, 6, 9 and 12 months. Ten percent of schemes (N=2) reported that they did not collect any physical activity data.

The survey found that schemes collected data on a combination of outcome and as can be seen from chart 13, most schemes were collecting data on at least 3 or more indicators (95%, N=20). Some schemes (29%; N=6) were collecting data on 7, 8 or 9 outcome indicators. Except for one

scheme all other schemes collected data which allowed pre-post comparisons of the outcome data.



Graph 9 shows the range of, and the most popular indicators assessed by exercise referral schemes in Scotland. As previously noted 90% of schemes reported that they measure physical activity. Mood and quality of life were the next most commonly assessed indicators ([81%, N=17] and [71%, N=15] respectively), followed by weight (62%, N=13) and Body Mass Index (57%, N=12), and between 20-50% of schemes collected data on body composition, waist circumference, physical fitness and blood pressure. Finally, a third of schemes collected 'other' types of outcome data such as stage of change, self-efficacy, confidence to exercise, attitudes towards physical activity, use of medication, screen time/sedentary behaviour, falls history, knowledge of healthy lifestyles, fatigue, pain levels, social connectedness.



3.10.5. Measurement tools

The audit revealed that most evaluation data is collected via questionnaires and is predominantly collected by the scheme coordinator and/or the exercise instructors/advisors. Some schemes also reported that they work with their NHS partners to undertake evaluation, and one scheme reported that it analyses evaluation data with guidance from a local university. The number, and focus, of the questionnaires used to collect outcome data varied from one scheme to another. However, there were some common tools in use across schemes such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), Scottish Physical Activity Screening Questionnaire (Scot-PASQ), Physical Activity Readiness Questionnaire (PARQ), Physical Activity and Lifestyle Questionnaires, Quality of Life Scales (i.e. EQ-5D/EQ-5D-3L), General Self-Efficacy Questionnaires. Several schemes (N=4) used programme specific questionnaires to collect evaluation data and a couple of schemes were using functional tests (such as sit-to-stand, step-test) and biometric tests to assess body composition.

3.10.6. Impact

Sixteen respondents reported that their scheme collected follow-up physical activity data at some point during or after the scheme, i.e., at 3, 6, 9 and/or 12 months from baseline. These respondents were subsequently asked about the impact of their scheme on physical activity levels of participants at these different time points.

Thirteen schemes reported collecting 3-month follow up data. Of these 3 did not have any data to share at the time of the audit; one reported that some participant's activity levels were similar to baseline because they were not progressed during treatment; the remaining 9 schemes reported that the percentage of people who were more active at 3 months ranged from between 51% to 90% with an average of 71% of participants more active at 3 months.

Thirteen schemes also reported collecting physical activity data at 6 months: Of these 4 stated that they were unable to provide any figures, or the data was not available; 2 responses were missing, and the remaining 7 schemes reported that the percentage of people more active at 6 months ranged between 45-80% (average 55%).

Three schemes reported collecting follow up data on physical activity at 9 months: Of these one reported that 80% of people were more active at this time; one reported that approximately 60% of people were more active and one scheme did not have any data available because it had not started yet.

Finally, 10 schemes reported collecting 12-month follow-up data on physical activity. Six of these schemes provided data on the percentage of people more active at 12 months, three reported that they did not have any data available at the time of the audit and data was missing for one scheme. Across the schemes (N=6) reporting 12-month follow-up data an average of 53% of people were more active (range 27% to 80%).

3.10.7. Cost effectiveness

Respondents were asked whether a cost-effectiveness analysis had ever been undertaken for their scheme. Four respondents answered 'yes' to this question: one provided detailed figures about the social return on investment for their scheme; one reported that the NHS Health Board had written a paper about the cost-effectiveness of their scheme; one reported information

about the changing charging model following a review and the final one reported general information about the cost-savings to the NHS.

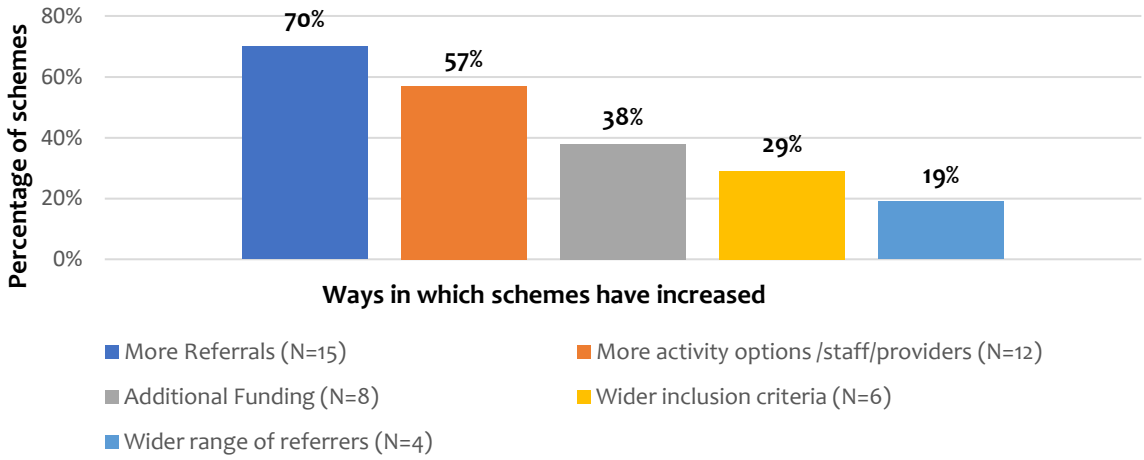
3.11. Changing face of exercise referral scheme provision

3.11.1. Changes in size and/or scope of provision

Respondents were asked whether the size and/or scope of their scheme had changed during its lifespan. Four respondents reported that there had been no changes to either the size and/or scope of their scheme; one reported that their scheme had decreased due to staff not being replaced and the scheme was not being managed, developed and promoted effectively. Twenty-one respondents reported that the size and/or scope of their scheme had increased. Graph 10 shows some of the ways in which these schemes have increased.

Most schemes had expanded in several of ways, for example an increase in the number and range of referrals. Seventy percent of schemes (N=15) reported that their scheme now has more referrals and fifty-seventy percent (N=12) reported that their scheme now provides more activity options due to an increase in the number of qualified staff and/or service providers. Almost two-fifths (38%, N=8) of schemes reported they had received additional funding to enable the scope of their scheme to increase. Just over a quarter of respondents (29%, N=6) reported that their scheme has widened its inclusion criteria and one-fifth (19%, N=4) reported an increase in the range of healthcare professionals referring into their scheme.

Graph 10: Increases in size and/or scope of schemes (N=21)



3.11.2. Future of schemes

Respondents were asked what do you see as being the future of the scheme. Twenty-four responses were recorded for this question: of these 63% (N=15) indicated that their scheme provision will be continuing; 25% (N=6) stated that the future of their scheme was unclear as provision is being reviewed and 13% (N=3) provided alternative responses. The alternative responses included: funding being under review; enhancement of the scheme which would be reviewed over the duration of the current funding, and would like to adjust, improve and target provision more effectively, but bound by the Health Board's aims and objectives.

Three respondents indicated that their scheme would end at some point in the next 12 to 18 months due to funding coming to an end and one scheme reported that it was scheduled to end in 2019 due to it being a one-year project.

3.12.Key success features

Respondents were asked whether there were any features of their scheme that they thought were key to its success. Several common success features emerged from the responses, these included factors such as the quality of staff, participant support, flexibility in the exercise referral offer, duration of the programme and links with healthcare professionals. Box 3 below includes a few of the comments made by respondents.

Box 3. Selection of key success features

"More qualified staff".

"Quality of staff and facilities".

"Person centred approach, delivered city wide so accessible across the City".

"On-going support and feedback".

"Volunteer support and peer mentoring".

"Focused on the whole person, rather than just their condition"

"Multi-referral pathway which allows the individual to participate in a… pathway depending on their needs".

"Flexibility to go in to core referral programme or straight to community".

"Behavioural intervention which is client led and 12 months long".

"Length of scheme allows time for instructors to educate services users about exercise and build their confidence to exercise".

"Maintenance of relationships/links with healthcare professionals and other referring agencies".

"Instructor confidence and the way they work with customers is one of the most important aspects, build rapport with individuals".

"More emphasis on delivery of physical activity… less time on measuring outputs".

3.13.Summary

This audit provides a snapshot of the nature and extent of exercise referral schemes being delivered across Scotland in 2018.

The findings highlight that there are various approaches to the way in which exercise referral schemes are being delivered across Scotland. It shows that schemes operate at different capacities, with a range of partners and with different operational structures and standards.

It is clear from the evidence gathered that exercise referral schemes in Scotland are not delivered as a 'one size fits all' and it is evident from the audit that schemes are tailored to the needs, capacity, resources and funding available locally and/or regionally.

Section 4 - Recommendations

A central database of exercise referral schemes operating across Scotland does not exist, thus the mechanism for identifying professionals responsible for schemes relied on third party sources of knowledge and information. Although every effort was made to cascade the survey to as many people involved in the delivery and coordination of exercise referral schemes as possible, there is no guarantee that the survey reached all relevant parties and it is possible that some schemes may be missing from this mapping exercise.

It is recommended that any future audit work is supported by a research assistant who takes responsibility for compiling the database by making direct contact with each health board, local authority and leisure trust within Scotland.

The audit of exercise referral schemes undertaken in 2010 identified more schemes than the present survey, consequently this raises the question whether this mapping exercise has failed to capture the true extent of exercise referral scheme provision in Scotland and/or whether several schemes no longer exist.

It is recommended that the findings from this report are mapped against the 2010 audit data to identify whether any schemes still exist and if not explore the reasons for their demise.

It is also recommended that further research is undertaken to identify the nature and extent of the physical activity interventions which fell outside the scope of this audit, this could provide useful information for the ongoing delivery and implementation of the National Physical Activity Pathway in Scotland.

The audit identified that schemes are being delivered, implemented and evaluated in different ways and there could be merit in sharing some of this practice and experience amongst those professionals responsible for the delivery, coordination and evaluation of schemes. For example, almost a third of schemes reported that 80-100% of GP practices in their locality referred into their scheme. Some schemes might find it useful to learn more about the key factors that enabled them to achieve greater buy in than others.

It is therefore recommended that opportunities for sharing practice and learning between schemes are explored and supported.

In the past there have been criticisms that demographic data on the people attending exercise referral schemes has not been routinely collected, consequently it has been difficult to determine whether schemes are reaching their target audience and representative of their local population. This audit found that most schemes (96%) are now collecting data on age and gender of scheme participants, however other demographic data on ethnicity, disability and socio-economic status are less frequently collected. It is still unknown how widely schemes reach people from different socio-economic and ethnic groups and whether schemes are helping to reduce inequalities within their local communities.

It is recommended that further consideration is given to how schemes could be supported to capture this important demographic data so that they are able to determine whether their schemes are reaching their key target audience and those in most need.

The overall aim for most schemes was to improve the health and wellbeing of the local population by promoting and providing opportunities to increase physical activity. Whilst many schemes are collecting baseline and follow-up data on physical activity as part of their evaluation, it must be acknowledged that several schemes, for various reasons, are not undertaking any evaluation activities, a few are not collecting any physical activity data, and a few are not collecting any follow-up data. The impact of exercise referral schemes has come under immense scrutiny over the past two decades and their effectiveness continues to be questioned.[1] Lack of staff capacity and training in evaluation is often cited as one of the challenges to undertaking high quality evaluation of exercise referral schemes.

It is therefore recommended that exercise referral professionals responsible for scheme evaluation are offered support and/or training on how to undertake high quality and robust evaluation of an exercise referral scheme. Sharing examples of evaluation practices across schemes might also be valuable to others who are less experienced in this field.

The audit found that several schemes had developed links with secondary care services and/or other services offering behavioural interventions. There is significant potential for exercise referral schemes to grow as an exit strategy from secondary care and/or as a referral option from other behaviour change programmes. It might be valuable to explore how these connections have been harnessed and how these opportunities could be developed by other schemes.

It is recommended that opportunities for sharing this learning are facilitated by NHS Health Scotland.

The audit revealed that most schemes provided continuing professional development opportunities for the exercise referral instructors and other people delivering or leading the physical activity sessions within their scheme, however there was considerable variability with regards to the opportunities on offer.

Exercise referral scheme providers need to ensure that their workforce is equipped with the necessary knowledge, skills and behaviours to facilitate long-term behaviour change of those people attending their scheme and it is recommended that they continue to provide appropriate and, where relevant accredited CPD opportunities for anyone delivering activities within their scheme.

Section 5 - References

1. NICE (2014) Public Health Guidance No. 54: Exercise Referral Schemes to promote physical activity. London: NICE.

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3. Sowden, S.L. & Raine, R. (2008) Running along parallel lines: How political reality impedes the evaluation of public health interventions. A case study of exercise referral schemes in England. Journal of Epidemiology and Community Health; 62: 835-841.

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5. Pavey, T.G., Anokye, N., Taylor, A.H. et al. (2011) The clinical effectiveness and cost effectiveness of exercise referral schemes: a systematic review and economic evaluation. Health Technology Assessment Vol. 15: No. 44.

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