Sporta Exercise Referral Network
Wednesday 6th April 2016
Notes

Background
The idea to establish an Exercise Referral Network (ERN) within Sporta came by a member trust. The importance of such a network heightened after the NICE (now known as NIHCE – the National Institute for Health and Care Excellence) recommendations for exercise referral and the huge impact this is having on trust members.

NIHCE's guidance PH54, recommended that

1. Policy makers and commissioners should not fund exercise referral schemes for sedentary or inactive but otherwise apparently healthy
2. Primary care should not refer people who are sedentary or inactive but otherwise healthy
3. Policymakers and commissioners should only fund ER for people who are sedentary or inactive and have existing health conditions or other factors that put them at increased risk of ill health

However many members are reporting successes in terms of delivering high quality outputs and outcomes through their ER schemes for specialist population groups.

Aim
The aim of the ERN within Sporta would be to support the development of a trust focused ER model that is evidence based, effective, value for money and self-sustaining because it would be business viable.

The aim of an ERN would focus on developing a network of trust lead professionals for ER, to

- share information
- contribute ideas and learning
- share their trust's model of ER
- develop best practice

Attending
Attending the meeting were representatives from Sheffield International Venues, Everybody Sport & Recreation, Mytime Active, Aspire Sports and Cultural Trust, Active Tameside, Vivacity, and Fusion Lifestyle. Sporta administered the meeting and Elaine McNish, Director at the British Heart Foundation National Centre.

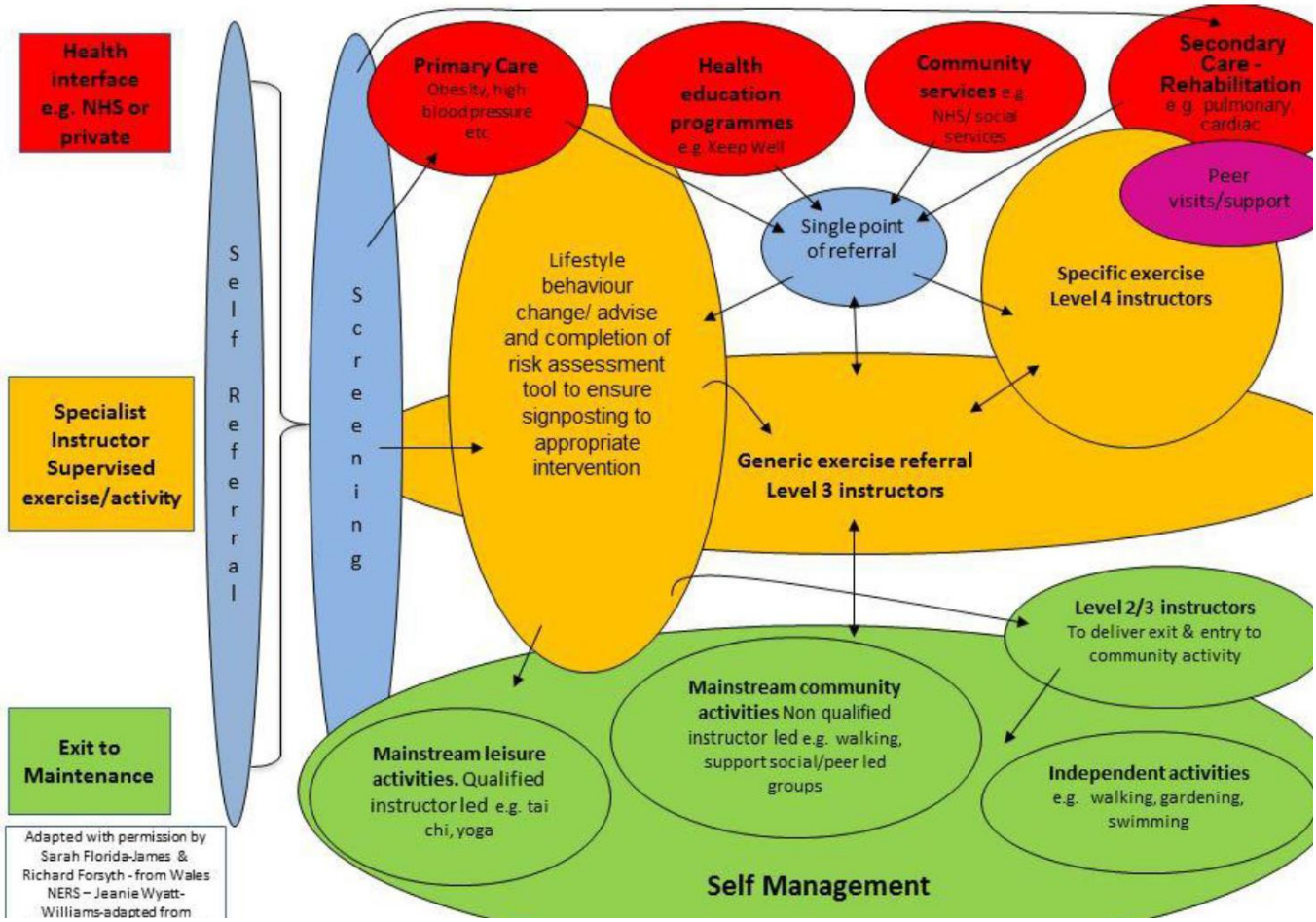
Key messages: in terms of delivering evidence based, effective and value for money ER scheme
Elaine McNish, Director, BHFNC
From the BHFNC's discussions with NIHCE, the recommendations from NIHCE and the BHFNC's role in developing Exercise Referral resources and toolkits; there are real opportunities and practical steps that can be taken to deliver an evidence based, effective and value for money ER scheme.

These include

- Incorporating the core techniques of NIHCE 'Behaviour Change' Guidance PH49
- Collecting data in line with the essential criteria outlined in National Obesity Observatory 'Standard Evaluation Framework for physical activity interventions'
- Makes the data collected available for analysis, monitoring and research to inform future practice
- The ER scheme having a strong focus on supporting the patients/customers to self-manage. Importantly reducing the over reliance often seen in some ER schemes, from the patient/customer towards the

instructor/ER scheme. The ultimate aim of any ER scheme should be to develop independent and active people.

A good example is seen in the example model below developed in Scotland by the BHF Scotland, British Lung Foundation Scotland and Chest, Heart and Stroke Scotland



- Carrying out effective screening to ensure appropriate screening and signposting - through the PAR-Q
- Delivering evidence based practice
- Ensuring that the right intervention and level of intervention, is offered and delivered to the right person – not a one scheme fits all
- Making it as easy as possible for the health professional to understand the trusts' ER scheme and refer – potentially to support the health professional's workforce training
- Understand the needs of the inactives and meet their needs e.g. what are their needs, what is their demand
- Collect evidence of the impacts made

Self-management and exit to maintenance

The topic of encouraging and enabling self-management amongst patients/customers developed into further discussions. Some member's felt they exercised self-management and exiting well; others felt there was room for learning. Over reliance from patients/customers, therefore blocking referral spaces, is one of the biggest risks for their ER scheme.

For ER schemes to enable self-management/exiting to take place effectively, it has to be built into the planning and delivery phases of the ER scheme.

The main way self-management and exiting can be achieved is through using the patient's motivations to engage, motivate and move them on. This essentially is driven by the skills of staff delivering ER. The most important skills of

the staff (unanimously confirmed by all meeting members) were the softer skills particularly empathy; and their understanding of effecting long term behaviour change.

The afternoon of the meeting focussed on creating a self-sustaining model, based on all the discussion and evidence presented in the morning.

What are the component parts of an effective, evidence based, value for money ER scheme?
As a starting point, member's views concluded that a self-sustaining ER scheme would need to consider: culture and workforce; price points; GP / health professional communications; the referral system; KPIs; self-management and sustainability; evaluation; and integration.

1. Culture and workforce
   - Need CEO/MD/senior management buy in as to the business case of ER
   - Strong view that delivering health focused outcomes and programmes/schemes, can have great impact on the environment and culture within a trust and gym. Having a 'health focus' makes the trust and gym environment more welcoming to all, not just ER patients.
   - The focus of the gym should not be on 'gym bunnies' and this may mean reshaping and/or retraining gym instructors etc
   - Re-modelling the workforce to become less about coaching and training; more about wellbeing, health and behaviour change
   - Peer mentoring is an effective method of supporting workforces to see different viewpoints and priorities
   - Changing the recruitment priorities/methods of the trust to be focused on the softer skills, particularly communication and empathy; and understanding the importance of behaviour change and the principles
   - Enabling previous or exiting patients/customers to become deliverers/instructors/peer buddies. This new deliverer is trained by the trust to the appropriate standard, some of which is pre-funded and some the trust fund. They then become the best advocates of healthy lifestyles, rehabilitation, self-management etc

2. Price points
   - Most trusts were working on developing the right price point, but there was definite agreement that the scheme should be paid for by the patient/customer.
   - Successful models in terms of finance viability and sustainability have been based on the concession price/membership at the trust. Therefore when exiting the ER scheme they pay exactly the same price, no sudden increases or from £0 to a price.
   - Trusts have created a membership on the software system so that all patients/customers can be tracked and monitored. This also supports with sustainability – they are already used to a swipe card, they are already used to paying concession prices

3. GP / health professional communications
   - Majority of trusts used 'Refer All' software to manage referrals, communications etc
   - Trusts have seen success with improved GP communication, by providing feedback by letter on each of their patients
   - Becoming a 'bolt on' clinic alongside the LTC nurse within GP surgeries has dramatically increased referrals and has made it easier for the GP / health professional to refer:

     Patient goes to diabetes clinic --- see the nurse --- goes to the foot care clinic ---- see the nurse ---- goes to the trust ER clinic ---- see the trust instructor

   - Potential for the ER scheme lead/instructor to be sat with the nurse together, in the same room at the same time, with the patient. This has certainly improved communication, referrals, uptake and importantly, increased their trust and confidence with the ER scheme
   - Engaging with the Public Health England's GP Clinical Champions project in the trust's locality, and supporting the local GP Champion

4. Referral system
    - Potential for the trusts to receive all referrals. The trust then decides the best intervention for the patient depending on the screening outcomes. If specialist service is needed they are signposted to the ER scheme. If generally inactive they are signposted into community based, generic activity projects. But the trust makes the decision i.e. making it easier for the health professional

5. KPIs
    - Embedding ER scheme KPIs into business plans. However some are more output focused than outcome and process led.
    - KPI collection included: number of referrals; completion at 12 weeks; % converting to memberships etc
    - Potential development of KPIs around embedding into the trust, workforce development, process learning etc
    - A need to carry out a benchmarking exercise within the Sporta ER Network to establish member's KPIs, performance, associated learning and sharing amongst the network

6. Self-management and sustainability
    - Over reliance on the ER scheme was identified as one of the biggest risks to an effective self-sustained ER scheme.
    - Needs to be considered in the planning stages of any ER scheme
    - Based on behaviour change principles and techniques used by the staff
    - Building patients/customers confidence to become self-managing of their physical activity, needs to be core focus within the delivery phases of the ER scheme
    - Successes built on the patient's individual motivations to engage, motivate and move them on.
    - A link between sustainability and pricing policy
    - A link between sustainability and creating the right "offer" to the patient/customer at the end of the ER scheme, rather than a blanket approach
    - An example of success was through using Myzone as a method of encouraging self-management with a cardiac rehabilitation group. The instructor can cap the heart rate levels, the individual monitors their heart rate and therefore develops the belief and confidence to exercise on their own, the confidence then develops enough where a high percentage of patients then move out of the ER scheme and exercise solely.

7. Evaluation
    - Embedding the Standard Evaluation Framework into the ER scheme. Collecting the right information and reporting at the right points
    - Not collecting and evaluating everything under the sun. This has been the case with some trusts who are commissioned for ER. Collecting blood sugars, cholesterol etc is not the role of an ER scheme; however recording these measures may support developing a positive relationship with your GP/health professional.
    - Being self-sustaining enables autonomy and clear decisions around appropriate evaluation.
    - Using the PAR-Q (this is being redeveloped by the BHFNC)
    - Success where trusts are carrying out baseline measures at the GP surgeries or health centres. This has delivered a much higher uptake
    - Perhaps taking a trust wide view about the data you wish to collect on all your customers and importantly why; will support with identifying what the core data is, what outcomes it will show and the value of what the trust is delivering
    - Embedding process evaluation is important. Evaluating the planning, implementation and delivery of the ER scheme.
    - Delivering effective follow up surveys and data collection. This is challenging and administratively heavy. A mixed methodology is working best – face to face, telephone
    - Adding in additional follow up or contact points from ER staff at the time points with the highest risk of drop off e.g. at 6 weeks of joining the ER scheme
    - Engaging with local PhD students and academic institutions to carry out research and analysis of impacts on the trust's ER scheme

8. Integration
    - Strong relationship between a successful self-sustained ER scheme and it's integration into the trust's programming and priorities
    - If ER sits separately within a trust, then the scheme will not deliver and sustain effectively
    - Equally if the trust and/or staff separate ER within the gym environment or do not see ER are a core part of the trust, this can be detrimental to the success
    - Strong links between the culture of the trust and workforce, and the likelihood of an effective sustained ER scheme

Next steps

Following the meeting and discussions, there were some clear actions to be progressed. These included

- Sporta to work with BHFNC to discuss the timings of the new ER toolkit and the engagement with members to ensure their full involvement
- Sporta to scope the learning from Scotland around ER models and workforce training
- Develop, with the network, a benchmarking survey on ER. This will then form a focal point for the ER network by members supporting each other, discussing variances and learning points etc
- Sporta to develop the discussion around workforce recruitment, skills and training. Potentially with NIHCE (through the BHFNC) and CIMSPA (who are leading on standards through the DCMS strategy)
- Programme a second meeting later in the year to:
    - enable BHFNC to work with members on the new ER toolkit
    - discuss the findings of the benchmarking survey
    - workforce discussion around needs/recruitment/skills required with CIMSPA

End.
April 2016