Exercise by Referral in Derbyshire

Active Derbyshire commissioned Move Consulting to review the Exercise by Referral service in Derbyshire to understand potential for reducing complexity, identifying opportunities to improve and make services more accessible.

Review Report

February 2025

MOVE consulting

Contents

1.0 Introduction

This report is produced by Move Consulting resulting from our review of the exercise by referral scheme across the county between July 2024 – January 2025.

1.1 Background

The Physical Activity Partnership Agreement between Derbyshire County Council Public Health and Active Partners Trust enables Active Derbyshire to strategically lead the priority of increasing physical activity levels across the county. As part of this remit Active Derbyshire are supporting local system partners to create a connected system with co-produced physical activity services that can support residents to lead active lives, to improve or maintain good health.

1.2 Commission

Move Consulting were commissioned by Active Derbyshire between July – December 2024, to undertake a review of the current Exercise by Referral service, while considering other services such as Live Life Better Derbyshire, Falls Prevention and other localised initiatives which operate across the 8 district areas in Derbyshire.

The fundamental objective was to highlight a series of considerations and recommendations to support the co-design of exercise by referral services across Derbyshire and to identify:

- What is working well within the current system and for stakeholders?
- Where are the opportunities to enhance what is currently in place?
- What more needs to be considered to ensure a high-quality service?

1.3 Approach

The project followed a collaborative development and delivery process, which was inclusive of four principal stages.

Figure 1: *principal project delivery stages*

Further information on the specific details within each stage can be seen below.

Co-Design

In this phase, we worked with the project's commissioners to agree the final scope of the project, clarifying the initial proposal outlined in the application to the project tender. Together, we identified potential project collaborators, highlighted key stakeholders to contribute to any consultations and co-developed a work plan with timings for the project to ensure we reached the agreed objectives in a timely manner.

Co-Deliver

Desktop review

In this phase, we completed detailed desktop research and reviewed all available documentation, data and insight provided by the commissioner. This included existing strategic documentation, procedural manuals, previous evaluation reports, observations from data reviews and feedback from system stakeholders. This process helped to identify initial insights to inform us about the next steps in project delivery.

System partner consultations

We used a face-to-face workshop with two cohorts of stakeholders from across the 8 areas to consult on the co-design of potential project outcomes, exploring the successes, challenges and needs felt in the delivery of services. The workshops were attended by 52 people from 30 different organisations across the health and physical activity sector. This included representation from local authorities, leisure trusts, community development, social prescribing, public health and social and primary care.

Service delivery partners

Building beyond this initial engagement, next we facilitated specific focused consultations with key stakeholders including public health teams from the County Council and place-based service providers from across the 8 district areas. We used a co-designed survey to prime the consultations with the district leads, seeking to understand more about specific insights and trends beginning to emerge from the review.

Co-Develop

In this phase, we engaged with the commissioners in a series of online meetings to present emerging insights from the project. This provided the opportunity to keep everyone informed on project health, as well as areas of need in support of the project's outcomes. We used these opportunities to co-develop recommendations, helping to ensure they remained pragmatic and aligned with wider changes outside of the scope of this project.

Co-Produce

In this phase, we built on the co-development phase to create the final report, and recommendations. The project commissioner stakeholder group was utilised as a check and challenge group to ensure that the final project report provided the details required to meet the agreed outcomes and remained reflective of learnings throughout the project's delivery.

2.0 Our review

The following section highlights the findings from our research into National policy and other relevant project themes that may impact on considerations for local system and service development.

2.1 National areas of interest

To support the review of local systems and services it is important to understand the ecosystem that Exercise by Referral is part of, the changing narratives, and the evidence base that is driving change.

The below sections highlight the national areas of interest that provide context to some of the recommendations developed through this review.

2.1.1 The role of physical activity and long-term health conditions

Physical activity spectrum

The physical activity spectrum helps to define what we mean by physical activity. The spectrum encompasses all forms of movement such as walking to the shops or gardening, structured exercise like fitness classes or gym sessions, and organised sports such as football or tennis. In essence, it includes all forms of physical movement, from gentle to vigorous, that contribute to health and well-being.

Physical activity, in which ever form it takes, is widely known as an effective prevention and management tool for a wide range of chronic health conditions and non-communicable diseases (Pavey, et al. 2011; Pederson & Denollet 2003; Pederson & Saltin 2015).

As part of the broad umbrella of physical activity, exercise encompasses a succession of structured and repetitive physical activities, with the overall aim of maintaining or improving physical fitness (Caspersen, et al. 1985).

Physical fitness, though not an intended outcome of physical activity more broadly, may also be an associated outcome. It can be conducted in many ways, including unstructured activities as part of an individual's daily living, leisure activities or occupation, and without the desired goal of improving fitness. Improving health and fitness can be a by-product of these unstructured activities, although unstructured physical activity is decreasing within the modern era (Booth, et al. 2012).

Preventative approach

The NHS Long Term Plan published in 2019, focused on **moving away from treatment to prevention**, which physical activity can support (NHS, 2019). In addition, the national narrative from leading bodies highlights a greater importance on the role of physical activity to come in future key health strategies, with the NHS 10 Year plan currently being developed.

Irrespective of future messages, in fact, current NICE guidance suggests the primary aim of exercise referral schemes is to **manage and treat long-term conditions** (BHFNC, 2010; Blumenthal, et al., 1999; Fox, et al., 1997; NICE, 2014; Pavey, et al. 2011) and there is a wealth of

research to show that physical activity interventions are similar or more effective than drug treatment for a range of conditions (Naci & Ioannidis, 2013). Physical activity can be used to:

- **Improve mental health and symptoms** (Mental Health Foundation, 2018;2020; Raglin & Wilson, 2018).
- **Reduce depressive symptoms** (Blumenthal, et al. 1999; Carney 1987; Dunn, et al. 2005; NICE 2009; North, et al.1990).
- **Improve cardiovascular conditions** (Jackson, et al. 2005).
- **Reduce pain symptoms in those with MSK conditions** (Rasotto, et al. 2015).
- **Prevent a host of long-term conditions** (Krismer, 2007).
- **Manage or reverse type 2 diabetes** (Bouchard, et al. 2018).
- **Reduce negative impacts** of health conditions (Jones, et al. 2005).
- Demonstrate greater **efficacy in longer schemes for improving symptoms** (Webb, et al. 2016).

2.1.2 The benefits outweigh the risks

The publication of the *Benefits outweighs the risks: a consensus statement on the risks of physical activity for people living with long-term conditions (Reid et al 2022)* outlined clear statements for use by healthcare professionals about medical risks of physical activity for people living with long-term conditions through expert consensus.

This publication held the potential to pave the way for creating greater access to support to move more often for people living with long-term conditions. It created the potential for greater access to physical activity options, enablement of a broader skilled and professional workforce to engage with a wider population of people and the continued shift towards a preventative model of health.

Since the release of the statement, challenges remain as current policy has not kept up with evidence. Policy relating to inclusion criteria and workforce have been slow to respond. The lack of policy level changes has meant that there has been little impact at a practical level.

Opportunities to provide greater access and support to a wider population through available assets and resources across communities is continuing to develop, with several exercise referral schemes expanding their offer, or new, more holistic pathways being developed, however progress is slower than anticipated as the systems mature.

2.1.3 PROACTIVE report

Understanding that more needed to be done, in 2024, The Faculty of Sport and Exercise Medicine (FSEM), commissioned by Sport England, undertook a review to determine what actions were still required to redress the way that risk was considered in relation to physical activity.

The product of the review was an internal report (PROACTIVE Report), which outlined key activities to address a change in policy and implementation to a less risk adverse patient centred model across England. This includes consideration of the following areas:

- Development of guidelines on screening based upon current evidence.
- Increasing awareness for the health and physical activity sector.
- Clarity on medico-legal liability and physical activity provider liability.
- Ensuring alignment to the broader pathways work.

The report also included a 'road map' with the ambition to support change across the health and physical activity sector, shifting from a model of medical clearance to guidance, when supporting people to engage with opportunities to move more often in a way that works for them.

2.1.4 Physical activity pathways for health

In 2024, Move Consulting, working in partnership with the Active Partnerships National Organisation embarked on a project to explore how to embed physical activity into health and care systems.

The project seeks to identify the evidence base, examples of common practice and conditions for success, when creating stronger links between the physical activity and health sectors. The project hopes to identify a framework of considerations in developing Physical Activity for Health Pathways at place, highlighting key information, tools and guidance on key elements.

For context to the Pathways Project, the Exercise Referral Systems: National Quality Assurance Framework (2001) (NQAF) provides guidance on the level of support required for patients with varying health conditions, however it is recognised that this framework needs to be updated to better reflect new evidence and changes in practice since its publication.

More recently, the Scottish Physical Activity Standards (2022), taking inspiration from NQAF, presents a tiered model to stratify physical activity interventions. The model developed through consultation with specific input from partners across Scotland, highlights the core characteristics of interventions at respective tiers, expanding beyond more traditional exercise by referral models, presenting one wider physical activity system.

> ***Please Note:*** *This model has been developed to reflect the Scottish system and is not directly relatable to current practice in England. At the point of writing this report, any guidance is yet to be published.*

Early analysis from the Pathways Project suggests that there are similar considerations to be taken when developing systems and pathways in England. Any approach needs to incorporate nuances to suit a broad range of environments from open community-based activity to primary care, to highlight opportunities to expand existing schemes and achieve wider outcomes for the system at place.

The Pathways Project is still under development and specific details relating to the identified development consideration and core design features of pathways are yet to be finalized. However, consultations with physical activity and health system partners uncovered positive support to developing this kind of structure for the sector and those developing pathways; for example, it will help to:

- Encourage greater collaboration between the health and physical activity sectors.
- Offer proportionate patient-centred support to those who need it.
- Enhance the potential for the improved use of available assets and resources.

- Offer frictionless, seamless service to meet people's changing needs.

More information relating to this project and details on the initial development considerations and core design features can be found via www.moveconsulting.co.uk/pathways

2.1.5 Workforce

CIMSPA

The Chartered Institute for the Management of Sport and Physical Activity (CIMSPA) are the professional body for the sport, fitness, and physical activity sector in the United Kingdom. They support and regulate education and training across the sector through developing training standards, career development frameworks, and professional recognition for individuals and organisations within the sector.
Working closely with employers, training providers, and educational institutions, CIMSPA seek to ensure the workforce meets industry standards, enabling safe and effective delivery of services in areas such as fitness training, coaching, and health promotion.

Making support more accessible

The current landscape relating to workforce development is changing. Current deployment policies are designed around a general medical model for health, which has resulted in an overly risk adverse approach to workforce deployment, creating a system where specific areas of the workforce are only made accessible to people based on the level of qualification an individual holds. For example: someone with a long-term health condition may only be offered an activity delivered by an exercise referral specialist.

The impact of this approach in practical terms means that capacity and asset management become a logistical challenge, as greater numbers of people are meeting qualifying criteria to access these types of services, where resources are typically limited. Fundamentally, demand is overwhelming supply.

Other challenges created by the application of policies like this is the environments in which activity may end up taking place. For example, the exercise referral specialist professional development pathway has a typical starting point of fitness instructor qualification. As a result, the majority of 'schemes' are seen delivered within a leisure environment. There are some examples of innovative practice, where shared spaces and co-delivery models are being used to good effect, but this is not a common practice. (See Sport for Confidence)

Developing areas

Considering changes in evidence and calls to action from the physical activity system, there is a need to review this system and policy area to support a more empowered, person centred approach for people to engage with the right level of support to meet their needs and aspirations.

As mentioned, change is happening across the system relating to workforce development in this specific arena. CIMSPA will share further updates relating to their work and role in supporting the sector in due course. We would recommend further reading via the CIMSPA website on current guidance.

Recognition & Status – to understand the strategic direction relating to how to recognise the skill sets of individuals within the workforce and greater alignment with other industries.

Professions & Pathways – to understand the current professional development pathways available for varying occupations.

> **Please Note:** Linked to workforce development see section 2.1.8 National models, initiative and resources, for examples of specific resources for consideration for the design and delivery of services.

2.1.6 Open data

Open Data Institute

The Open Data Institute (ODI) works to support industries in the UK to utilise data. They advocate for the sharing and use of public data to increase transparency, innovation, and economic growth.

OpenActive Project

Since 2017, the ODI have been working with Sport England to bring greater data innovation to the physical activity sector. The OpenActive Project, a collaboration between Sport England and ODI, aims to make it easier for people to find and take part in opportunities to become active. The project sought to:

- Increase the physical activity sectors understanding of data and its applications.
- Create a standardised framework for data to support collaboration and use.
- Encourage organisations to sign up to the Open Data Agreement.

Fundamentally, the project encourages organisations, like gyms and sports clubs, to publish their schedules as open data in a standardised format. This data can then be used by apps and websites to help people discover activities near them, such as yoga classes, running groups, or swimming sessions.

There are growing opportunities and applications for the use of data to drive participation in this way. Through sharing data (connecting systems) it can make activity information accessible, helping more people to reach organisations through greater availability of information.

2.1.7 Exercise referral to support behaviour change

Exercise Referral Schemes (ERSs) were designed to facilitate long-term behaviour change, increase physical activity levels and manage specific health conditions. Their primary objective is to help participants transition from physical inactivity to maintaining regular physical activity.

NICE Guidance Framework

The National Institute for Health & Care Excellence recommends incorporating several core behaviour change techniques into ERSs:

- Recognising opportune moments for change.
- Establishing goals and action plans.
- Arranging social support structures.
- Tailoring interventions to individual needs.

- Providing progress monitoring and feedback.
- Developing relapse prevention strategies.

Implementation Challenges

Despite clear guidance, there has been inconsistent application of behaviour change theory in practice. Research indicates a gap between theoretical recommendations and actual implementation, with insufficient training for practitioners being a significant factor. Evidence suggests that exercise referral practitioners would benefit from formal training in behaviour change techniques to effectively embed these principles into programme design.

Evidence-Based Approaches

The Behaviour Change Wheel (BCW) is identified as the gold standard framework for implementing behaviour change interventions. This systematic approach helps practitioners select appropriate techniques from the Behaviour Change Taxonomy to support sustainable behaviour change.

Several specific behaviour change techniques have demonstrated effectiveness in ERSs:

- Goal setting and action planning.
- Social support mechanisms.
- Diary keeping for self-monitoring.
- Problem-solving strategies.
- Motivational interviewing.
- Educational components.

Recent trends show increased interest in systematically implementing behaviour change techniques in ERSs and recommendations include:

- Conducting fidelity checks to ensure proper implementation.
- Shifting focus from treatment to prevention.
- Considering longer programme durations beyond the typical 12 weeks.
- Applying behavioural insights to marketing materials to improve uptake.

ERSs across the UK have expressed interest in more systematically embedding behaviour change techniques compared to previous approaches, indicating a positive shift in this area.

2.1.8 National models, initiatives and resources

The traditional model of exercise referral has been around since the early 1990s, and in recent years, especially since the Covid-19 pandemic, schemes have started evolving for several reasons including economic, technological, and social changes.

Where schemes exist, they are typically expanded to include more activities, more options for more people to focus on increasing their physical activity levels. Specific schemes are being incorporated into more system-wide physical activity pathways with the intention of providing greater choice and proportionate support for long-term sustained activity habits.

NICE Guidance

A recent literature review undertaken by Sport England of condition specific NICE Clinical guidance, NICE guidance and quality standards, has highlighted over 100 documents that have physical activity or community rehabilitation components.

In reviewing the physical activity requirements, NICE guidelines, key design characteristic for exercise by referral include:

- Structured/Tailored programmes.
- Monitoring progress.
- Education components.
- Behaviour change support to raise confidence and support long term change.

Delivery models

There are differences in delivery models everywhere you look, this is as a result of their design being influenced by the specific conditions of each place and the scale of delivery. It is essential to consider the principles within different models to understand how applicable they are to local systems.

National Scale Example

National Exercise Referral Scheme (Wales): is a chronic condition prevention and management programme which aims to improve the health and wellbeing of sedentary and inactive adults who are at risk of developing or who have an existing chronic condition.

- 16-week programme of physical activity.
- Open to 18yrs+.
- Referral by NHS health professionals.
- Use behaviour change techniques to embed positive habits.
- Delivery in controlled and prescribed way.

County-Wide Example

Move Together (Oxfordshire): a county-wide pathway into physical activity, designed to provide support, advice and guidance to people living with long-term health conditions, helping them to move more and improve their physical and mental health and well-being. The pathway was designed independent of existing exercise referral schemes, later incorporating them to create a single pathway inclusive of all activity options.

- Open to 16yrs+, inactive, living with LTHC.
- Guided access to intervention type (including referral pathways).
- Personalised support, advice and guidance.
- Local area coordination of service (local coordinator roles).

Supporting initiative and resources

There is a range of initiatives and resources available that are relevant to the general area of utilising physical activity as part of preventative care. These are also important for consideration in the development of initiatives locally.

Moving Medicine is a national programme from the Faculty of Sport and Exercise Medicine (FSEM) that helps healthcare professionals have better conversations with patients about physical activity. It provides easy-to-use, evidence-based tools and resources that explain

how getting active can improve or manage various health conditions, such as diabetes, heart disease, or mental health issues.

Moving Healthcare Professionals is a national programme, led by the Office for Health Improvement and Disparities (OHID), funded by Sport England. The programme supports healthcare professionals to increase their knowledge and skills and incorporate physical activity within routine care to support quality improvement and better patient outcomes.

Active Hospitals and Prescribing Movement focus on helping healthcare professionals to integrate physical activity conversations into routine clinical care.

All Our Health is a resource which helps health professionals prevent ill health and promote wellbeing as part of their everyday practice. They provide information that will help frontline health and care staff use their trusted relationships with patients, families and communities to promote the benefits of physical activity.

3.0 Exercise by Referral in Derbyshire Review

3.1 Thematic areas

Integration

Proportionate Universalism

Simplicity

Evaluation & Learning

Autonomy

From the initial review of documentation and the consultations completed as part of the project, a range of insights suggest the wish to continue and build further on opportunities to collaborate as a system.

Emerging from this were key insights relating to **the system and the service.** For example, things the system requires to deliver services, and those relating to the service provided itself, such as supporting the experience(s) and outcome(s) for service users.

> ***Please Note:*** *The scope of the consultations completed as part of this project focused on stakeholders working across physical activity and health systems at place. We sought insights from service users held by stakeholders at all points of our consultation and would advise further direct consultation with service users to ensure participant voice is heard in the design of future services.*

Integration

There is a clear ambition to establish a seamless, integrated referral system linking health and physical activity sectors across Derbyshire.

This theme is present with local delivery providers across the county, who want to better connect with local services as one system. Integration is also a general thematic outcome within strategic documents from system partners. Added to this, this ambition also echoes efforts to integrate physical activity into health and care systems at a national level.

Proportionate Universalism

There is a high level of interest in maintaining and continuing to strengthen the ability to provide a proportionate service level offer.

It is recognised that although the current exercise by referral scheme is offered across the 8 district areas - which each hold their own unique characteristics and varying levels of need (system & residents) - continuing to strengthen the core characteristics of the service level offered is important for growing salience in local communities.

Simplicity

There is a clear need to ensure that the system created is simple to engage with for people utilising services, as well as stakeholders across a range of levels.

To support the ambition of an integrated service offer, supporting a wider range of community-based organisations and groups to contribute to a unified offer is essential. To achieve this there needs to be co-designed, clear criteria and consistent application of processes to support the development and delivery of the service for users.

Evaluation & Learning

There is a primary interest in ensuring that services can be shown to support positive outcomes for everyone engaged, including stakeholders and service users.

For all stakeholders involved, it is important that they can understand what is working and what needs to change. Ensuring relevant data is collected and used to offer information and insight is essential to ensure that the scheme is engaging its priority audience and delivering sustainably on key outcomes.

Autonomy

There is a clear need for any system to be able to offer a menu of opportunities alongside appropriate support to create lasting change and supporting people to become more active.

It was apparent in several key strategic documents and consultations with system stakeholders that improving service user choice and general empowerment in decision making was essential. This concept echo's themes at a national level linking to the imminent NHS 10-Year Plan and guidance issued by the NHS on shared decision making (NHS 2019). Linking to greater collaboration with public health services at place, also chimes with literature reviews carried out to identify key considerations for design of exercise by referral.

3.2 Strategic considerations

Building on the general thematic areas identified, there are a number of key questions we considered in helping to shape some of the further details we have included:

- Why is the programme operating across Derbyshire - what is its purpose?
- How are stakeholders working together – what are the principles of working?
- Who does the programme seek to engage – what is its scope?
- What are the operating elements that need consideration?

Clarity of purpose

When working as part of a complex system developing a clear vision is an important foundation. It is essential that a vision has been co-developed with its stakeholders and articulates the shared view of all involved in an engaging way.

Across a system, stakeholders should be able to identify with the vision and clearly articulate their role (mission) in contributing to its end in a proportionate way. Importantly, not all stakeholders need to contribute in the same way, although there may be some universal elements to everyone's engagement with a vision. Equally, opportunities to collaborate between missions can also play a role in helping to work towards a vision too.

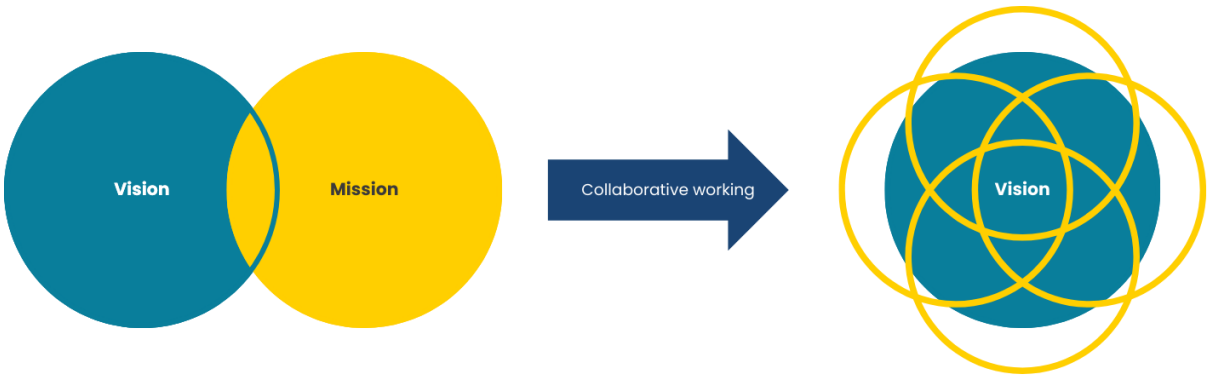

Figure 2: Coordinating delivery under a unified vision

Vision & mission definition

From our review of the documentation provided, there is no clearly defined vision for Exercise by Referral in Derbyshire. There is, however, a varied range of mission language being used, which helps to highlight what organisations aim to do. Some examples are listed below:

"To provide high quality physical activity services to address inequality and support people living with long term conditions in a way that works for them".

(Physical activity collaborative grant, Active Derbyshire)

"Maximising the potential of being active to improve physical and mental health".

(Making our Move, Active Derbyshire & Active Notts)

"To support people to live healthier lives across Derbyshire through increasing activity levels and decreasing physical inactivity and sedentary behaviour, by equipping individuals living with long term conditions with the knowledge, skills, confidence and self-efficacy to maintain long term physical activity behaviour change".

(Exercise by Referral Framework Schedule)

Developing a unified vision

As part of the consultations, it was clear that stakeholders saw the value in defining a common vision across the county, and in doing so this could help to galvanise the potential for stronger collaboration.

We ran an activity as part of the consultation event to explore some of the potential vision language, by analysing the terms and phrasing, the following DRAFT vision was suggested which focuses in on the strongest themes of collaborative working to empowerment, readiness for change, and self-efficacy.

DRAFT Vision Statement

"A healthier, happier Derbyshire where physical activity is the foundation of wellbeing and residents are empowered to lead active lives."

Expanding on our vision

"Exercise by Referral is a nationally recognised physical activity referral programme, delivered through a collaborative, outcome-focused approach, serves communities across Derbyshire. As a preventative care tool within the local system, the programme is helping reduce the impacts of long-term conditions, lessening demands on healthcare services and empowering residents to lead active lives."

Please Note: *We recommend further refinement of vision and mission language with key system partners and highlighting appropriate connections with some of the stakeholders and strategy documents reference earlier.*

3.3 Principles of working

Building beyond having a clear vision (The What), the next area for consideration is How? From our review of existing documentation and the consultation event, we identified several terms that are being used to define and shape the principles of working.

Figure 3: *Principles of working highlighted in project*

We have provided a synopsis for each of the identified principles below:

1. Collaborative
   Emphasises the importance of working together, pooling resources, and fostering co-production, with a collective responsibility for outcomes.
2. Insight-Driven
   Highlights the need for data-informed decisions, with mechanisms for ongoing monitoring, evaluation, and continuous learning.

3. **Equitable**
   A commitment to addressing social and health inequalities, ensuring fair access and representation for all individuals and communities.
4. **Person-Centred**
   Focuses on treating everyone holistically, respecting their unique needs, circumstances, and experiences, and ensuring that care is centred on the individual rather than the condition.
5. **Flexible**
   Stresses adaptability, acknowledging that a one-size-fits-all solution is ineffective, with an emphasis on choice and accommodating non-linear, individualised pathways.
6. **Community Based**
   Builds on existing community assets, recognising and leveraging local strengths and working in partnership with the community.
7. **Accessible**
   Ensures that programmes are accessible to all, deeply rooted and seamlessly incorporated within the community, fostering sustained impact and accessibility.
8. **High-Quality Experiences**
   Prioritises the delivery of positive, valuable experiences for residents, reinforcing the programme's effectiveness and reputation.

These themes highlight a commitment to **community-centred, adaptive, and inclusive service delivery** that values collaboration, equity, and quality of experience.

As the above provide a thematic summary of terms, we recommend reviewing these with key system partners and to use them to co-develop refinements in the programme and working practices, holding each other to account in the collaborative delivery of services.

3.4 Scheme outcomes

There are several outcomes identified in both documentation and from the consultation event:

Individual

- Reduced physical inactivity and increase physical activity
- Improved management of long-term conditions including mental wellbeing through physical activity

System

- Clear and consistent pathways exist where resources are maximised, and duplication reduced.
- A fair and consistent offer for residents, which ensures value for money for organisations.
- Closer alignment between the health and the leisure sectors to enable a focus on people with the greatest need.

We recommend that once the delivery model has been agreed, outcomes need to be clarified, and a logic model should be developed to show alignment between inputs and outcomes.

3.5 Scope definition

From the strategic documents shared as part of this review, the identified scope for the Exercise by Referral Scheme in Derbyshire was defined as residents specifically being aimed at those living with long term conditions, which aligns with current NICE guidelines.

However, through the consultations with system stakeholders some referenced a wider prevention agenda, including those at risk of health conditions. Lack of clarity relating to scope can have resource implications and negatively impact on brand salience with residents. For example, challenges in being able to engage a target audience through programme marketing, or excess interest in referrals from a non-priority audience.

Key questions to consider in setting or refining scope in a person-centred way include:

- What is the change we are seeking to influence in people? (Outcome)
- Who do we want to see this change in? (Audience)
- How will we provide support for the change to service users (Approach)
- Where will we make the support available? This could also consider home based and digital offers (Geography)
- When will we make support available? (Programming)

From the consultations facilitated through the delivery of this review, the interests and motivations of stakeholders engaged suggest a broadening of the general audience to support a wider physical activity pathway. This suggested innovation in scope would be in step with the developing national narratives and previous examples of practice highlighted (See Move Together (Oxfordshire)).

It would be important to ensure that in broadening the scope any pathway did not lose the defined support offered by the exercise referral specialist workforce to people living with long-term conditions.

Further refinement in processes to understand how to best utilise this resource (specialist workforce) to provide proportionate support on a needs led basis would be also advised. Added to this, alignment with current NICE (PH54) guidelines in lieu of updates from national work.

3.6 Inclusion and exclusion criteria

The inclusion criteria for exercise referral schemes have traditionally been based on several national documents, these include:

- *National Quality Assurance Framework (2001) - The National Quality Assurance Framework (NQAF)* is a document that provides guidelines for exercise referral

systems. Its purpose is to improve the standards of existing exercise referral systems and to help develop new ones.

- Public health document *Physical activity: Exercise Referral schemes (PH54)* (2014) – designed to provide recommendations on the design, implementation, and evaluation of exercise referral schemes (ERS) aimed at improving health outcomes by encouraging physical activity among individuals with specific health conditions.

  Please Note: *PH45 excludes disease specific rehabilitation, e.g. cancer, pulmonary and cardiac and NICE guidance, (which have their own guidelines, further information on all above documents can be found in the appendices.)*

Existing inclusion criteria (Derbyshire EbR)

In comparing relevant policy guidance, the Derbyshire Exercise by Referral meets the current policy guidance (See appendices for more). There are some minor considerations around the delivery of support for people with cancer and other conditions, however it is acknowledged that these may be changing following national work being undertaken as in the section above.

Further consideration to ensure criteria can remain fit for purpose in light of future national development have been included in the recommendations section of this report.

3.7 Data and monitoring

We used the data provided to make observations that can support potential areas for improvement across the scheme which can be seen below.

> ***Please note:*** *observations are based on whole scheme data with all areas combined. A comparative analysis of individual district areas has not been possible within the scope of our delivery.*

Data collection

Observing the data sets provided it is apparent that there is a proportion of data (12.4%) that is missing from the data sets collected. This could be due to several reasons and merits further investigation to understand why this is happening.

There is a significant drop in the percentage of completed data at 52 weeks compared to 12 weeks, with less than 10% being recorded. It is noted that collecting data at this stage is always challenging and we suggest considerations for collecting data at a shorter interval to support an increased rate of return and maintaining participant engagement.

There are variations in staffing and roles which may be having an impact on differences in data collection performance. From our review this was inconclusive and merits further investigation.

Participation rates

The data available highlights that 57.4% of people who are referred attend the first consultation. Consideration needs to be given to the reasoning behind why 42.6% of participants receive no induction to the scheme and the impact this might have on being able to provide a consistent service offer. Alternatively, to explore reasoning for the drop off in engagement.

Some suggestions to improve engagement, include reviewing information provided to participants at the referral point, improved assessment of readiness to change, and providing group introduction sessions where people can find out about the scheme before signing up.

There are differences in the number of people in each district area who have been inducted successfully completing 12 weeks - average of 49.7% (range 25.9-66.8%). It is not possible to determine the effectiveness any particular model of delivery from the data, but it highlights the potential for further forensic audits of each district.

In addition to the data picture, consideration for furthering the consistency in behaviour change support and widening the choice of activities is likely to have a positive impact on engagement and retention.

What to collect

There are several considerations relating to the type of data that could be collected for the scheme. The following data groups have been highlighted for consideration for future developments.

Demographic & Context

General demographic data will already be collected. We have included headings in this report as there was data not provided to protect anonymity. The following list can also support a person-centred approach, providing greater context for the design and development of a menu of opportunities and specific exercise prescription.

1. Age/DOB
2. Postcode
3. Ethnicity
4. Gender
5. Referrer details
6. Reason for referral (primary reason)
7. Secondary reason for referral
8. Reason for referral (as above) to provide context for the PA practitioner.
9. Side effects of medication to support considerations on timing and sequencing.
10. Activity history and preferences to understand potential readiness and support.

Outcome Measures & Tools

In addition to the above, the following outcome measures and tools are highlighted to support wider impact evidencing and storytelling from the scheme. These require consideration in light of evolving mission and vision statements i.e. any stated outcomes in the statements.

Physical activity levels

International Physical Activity Questionnaire (**IPAQ**) is a standardised tool used globally to measure physical activity levels in populations. The IPAQ was developed to create a unified and reliable instrument for assessing physical activity across diverse groups. This tool is recommended for cross scheme evaluations and would suit the Derbyshire model.

Another tool that is available is the General Practice Physical Activity Questionnaire (GPPAQ). A validated screening tool used in primary care settings in the UK to assess the physical activity levels of adults. Developed to help identify individuals who are physically inactive and may benefit from interventions to increase their activity levels.

> ***Please Note:*** *The selection of any tools should be considered in relation to the specific context in which they will be applied.*

Wellbeing scores

The following tools offer psychological measures to support evidencing quality of life adjusted years for participants.

- Wellbeing scale (WEMWBS - a common scale used).
- Quality of life scale (CASP-19)
- Social isolation/loneliness scale – wider assessment of PA impact.
- WELBY – increasing popularity based on easy conversation to QUALY score.

> **Please Note:** The selection of any tools should be considered in relation to the specific context in which they will be applied. Some tools include charges dependent upon usage.

Wider measures

The following elements could be considered to support greater insights for highlighting impact and return on investment for health partners.

- **GP visits:** upon induction, how many times has the client visited their GP in the past 3 months? To then be asked again at completion, then at each follow up. This data is highly important when looking at ROI.
- **Change in medication**: in week 1, collect the medication user is taking, then compare this to week 12, then follow ups to see if any change. Increasing physical activity may alleviate some of the symptoms of their health condition, therefore may influence medication status. Can support cost savings to the NHS.
- **Symptoms of health conditions** experienced (and how these may change after completing intervention) - symptoms may change over the course of the intervention, so it is important to recognise these and any possible changes due to increasing physical activity levels.

> **Please Note:** The collection of data may require sharing agreements to access patient records

Condition specific measures

The following elements could be considered to support greater insights relating to condition specific measures.

- **Risk of falls; Short Falls Efficacy Scale International** (Short FES-I) - important for those who are referred with a condition linked to falls/older adults. For those who might be referred due to risk of falls, another survey could be Balance Vigilance Scale.
- **Social value:** exploring this will help develop the argument for future funding for such interventions improving social outcomes.
- **Specific outcomes in relation to referral reason**: for example, referred due to high blood pressure, measuring BP is a must. Referred for an MSK condition, then measuring levels of pain and range of movement are essential.

Other measures in relation to fidelity

Completing standardised fidelity checks to ensure what is being delivered is what was planned for delivery (Rowley, 2020; Shore, et al. 2019) – planning observation of sessions to ensure that professionals are delivering activity sessions as prescribed.

The above provides a selection of data that can be captured to monitor and evaluate exercise by referral schemes. Some should be collected pre and post 12 weeks to track improvements. We would recommend that existing data collection systems are improved, consideration is given to the key outcomes that merit measuring before selecting adding to existing measurement requirements, and a minimum data set agreed.

3.8 Equity in model delivery

As part of our review, we considered insights available for varying costing models and their impact of cost on equality in the delivery of the service.

It was recognised from consultations carried out, that it is important to ensure locality areas have the ability to shape offers to the needs of local residents, and to work within the remit of available assets, including the workforce. However, these create a difference in the value of the offers provided.

Some research had already been conducted by the public health team which stated there was a lack of research to provide conclusive proof of the impact of cost on participation in the short and long term.

Literature generally highlights that there is a lower rate of participation in exercise by referral by people from lower socioeconomic groups. It should be considered that the cost of participation in the scheme is only one of the financial barriers that comes into play, as there are other costs such as:

- Transport.
- Childcare.
- Activity clothing.
- Loss of opportunity to earn income (especially on zero-hour contracts)
- Other wider social and psychological barriers (confidence, capability, peer support).

Further literature searches undertaken by Move Consulting had similar challenges in finding relevant studies or reporting of cost issue within existing research. However, cost is widely agreed as a barrier to participation.

Insight from the Physical Activity for Health Pathways project has uncovered different approaches being taken to mitigate cost as a barrier. These include:

- Incorporating free access opportunities – generally activity types are delivered by wider voluntary sector and community-based organisations. There are also some examples of low attendance classes being offered as an incentive too.

- **Education on benefits and opportunities** – providing messaging and information on the benefits of activity for general health and specific conditions. This can help to increase perceived value. In addition, raising awareness for low and no cost or no equipment options.
- **Try before you buy** - ensuring that there is an initial free period for individuals to try activities before they commit. Also, highlighting the ability to bring a friend to trial options with you.
- **Target group subsidy –** offering reduced cost access for target groups e.g. people receiving Tax Credits or Retired.
- **Donation models -** where participants can offer a donation to participate, are offered a discretionary fee based on their needs or pay-it-forward, covering the fee for other participants if they are able. (Variation on donation giving)
- **Levering Care Budgets** - Consideration of how people may be able to use personal care packages to include activity options (see Using your personal budgets and personal health budgets to get active - Get Yourself Active)

3.9 Existing delivery agents

In relation to the findings from our consultations with system partners across Derbyshire, it is apparent that there is an appetite for greater collaborative working to achieve a more consistent and connected delivery model. This holds the capacity to provide a universal service offer to residents across Derbyshire. Currently there are several delivery agents across the county:

- **Exercise by Referral Programme:** predominantly a gym or exercise class offer, delivered in a leisure setting with specialist support provided by exercise by referral instructors. Beyond the programme access to facilities is incentivised through a time limited subsidised offer.
- **Live Life Better Derbyshire:** provides lifestyle advice and support to residents across Derbyshire. This includes both online and face to face activity classes and signposting to wider community classes.
- **Walk Derbyshire:** provides information and support to encourage local communities to get out and walk more, including regular led walks.
- **Jog Derbyshire:** provides a network of social jogging groups led by qualified volunteers.
- **Local Authority Provision/Leisure Trust:** there is a mix of local authority and commissioned services across the county that includes leisure centre-based activities and outdoor spaces such as parks.
- **Community groups & clubs:** includes activities delivered by wider community-based sport clubs and wider voluntary sector.
- **Green Social Prescribing:** supports people to engage in nature-based activities such as walking and cycling, gardening, food growing projects and conservation tasks.

It is clear from this list that there is a wide range of provision across the areas and by linking exercise by referral to this provision a wider offer could be realised.

3.10 District area survey & Consultations

District area leads survey

A survey of the 8 district areas across Derbyshire (excluding Derby City) was completed as part of the review. This helped to explore operational delivery at place. During the review window, responses from 6 of the district areas were returned.

The survey responses highlighted the themes below:

Recruitment

The central portal (LLBD) was noted as the main source of referrals, but a few others were mentioned e.g. a cardiac rehab BACPR transfer form.

All areas were seeking to meet the criteria for inclusion. The only challenges noted were where there were no qualified staff. Where there were gaps noted these included not receiving referrals from NHS health checks, linked to CVD, or ability to provide support for people living with cancer, and pulmonary and cardiac support not being offered in all venues in the locality. Some noted that they were supporting people with other health conditions but did not state what these were. It is likely they could be neurological conditions. One area was delivering a separate falls programme in 7 outreach venues.

Triage

Once areas receive referrals through the central portal, all provided a first consultation incorporating a needs assessment before a specific exercise plan is made with the client.

There was some ambiguity in responses relating to triage processes. Further review of the understanding of the triage process and scope between EbR and LLBD may benefit ensuring clarity between staff.

Behaviour change

The provision of a structured offer of behaviour change support was not determined from the responses and it is assumed variations in approach are present, if not happening at all.

Only one respondent noted the techniques being used within the process. With most areas stating the frequency of touch points through the scheme, as opposed to specific support. (start, mid-point and end). While this frequency is in line with NICE policy it is not consistently being delivered. One area only stated at the first consultation, one first consultation and mid-point only and two did not state any behaviour change being applied.

Further clarity and training for types and levels of behaviour change support provided is suggested to create greater consistency in delivery and support of outcomes.

> **Please Note:** We did note resources undergoing development by LLBD to support behaviour change for participants (workbook / goal setting manual). This could be considered for wider use and circulation.

Structured opportunities

Where stated, there appears to be a difference in the range of leisure centre-based activities being delivered, with gym, 1-2-1 swim and group-based circuits being the most consistent. Some areas have expanded the offer to allow participants access to a wider range of types of classes. Only one mentioned a walking session once per month.

We recommend that discussions are held with areas to see how access to a broader leisure centre can be arranged during the 12 weeks. Providers should be encouraged to work with wider providers to enable greater signposting to other activities both during and beyond the 12-week programme.

Workforce (Staffing, Delivery & Qualifications)

Staffing

Across the local system, there are a range of staffing structures and delivery models operating. In some areas there are full time staff managing exercise referral and in others this function is part of wider duties – we assume models have developed based on current funding models and meeting local delivery needs.

We noted references to both administrative roles and direct delivery through the survey responses. For administration, there are some additional duties referenced for hybrid roles which focus on marketing and data management. One area reported having a dedicated administrator in post to support participant bookings and data management for the scheme.

Delivery

The survey highlighted some variations in local delivery models and approaches. One area indicated a focused one-to-one model for EbR referrals, with wider signposting to support. Most provide access to group-based classes with one-to-one consultations included. There appears to be further variation in the diversity of the offer from the previous review completed in 2023, but a direct comparison is not possible at this time due to the number of survey responses.

Consideration may be given to more efficient delivery models with group-based classes over one-to-one sessions, this would also have the advantage of providing peer support for participants.

Qualifications

Focused on direct delivery, areas highlighted working to meet the qualification criteria set for the scheme (Exercise Referral Instructor led). A range of additional qualifications were also noted in survey responses, but we are unable to determine the effectiveness of specific variations in available delivery models.

Given potential changes to national policy (See 2.1 National Areas of Interest), we would advise completing a full-scale workforce skills/needs assessment. This could support future innovations, helping to address potential capacity challenges highlighted through the review.

Exit routes

Most of the respondents offer a discounted membership scheme, from 3 months up to one year. Pay as you go is also offered as well as signposting to wider classes including walking groups. Consideration should be given to building wider opportunities, alongside continued support for participants to sustain behaviour change. For example: continued communications and behaviour change nudges.

District area consultations

Following the survey, online consultation with the 8 district area leads highlighted further considerations for the future design of Exercise by Referral.

- Processes - there was a need expressed to ensure processes were streamlined to make referral easier – including education for referrers to give them the confidence in signposting patients – not just to Exercise by Referral.

  It was noted that this would need consideration to ensure overlap and links with other referral programmes including LLBD, social prescribing, place-based work.
- Staffing & skills - capacity and turnover of skilled staff is presenting challenges. This permeates with national workforce development challenges too, where policy makes reaching identified deployment criteria expensive and time consuming. Local issues were suggested potentially being exasperated by the current funding timescales.

  The reintroduction of funding of qualifications would be valued to address gaps in provision. There was a call for a more standardised/consistent approach across areas such as joint training/orientation while retaining local flexibility.
- Audience needs – linked to the above and previous points around workforce auditing, it was noted that the scheme was attracting participants with more complexed needs such as neurological conditions.
- Scope expansion – there was a general agreement for an ambition to broaden out the scope of the schemes to incorporate wider community-based opportunities, either delivered by volunteers or leisure centre staff. Some noted a need to consider consistency of delivery and perceived safety concerns in certain environments.
- Co-design of interventions – there was a noted need for greater engagement with residents to co-design interventions.
- Monitoring & data collection - there was a need for better monitoring/data collection processes. suggestions to drive improvements include, improved orientation training, feedback of information so it can be seen how it is being used to drive improvement, understand key outcomes achieved and successes from scheme delivery.

4.0 Recommendations

From the completed review, two main groups of recommendations are presented for consideration. The first, titled Adapt, focuses on opportunities to further strengthen the existing delivery model. The second, titled Adopt, proposes the integration of services to create a single operating model, further formalising the combination of exercise-based referral (EbR) opportunities with community-based activity options.

4.1 Adapt: strengthening the exercise by referral scheme and system

The review highlights opportunities to strengthen the existing operating model. Based on the themes explored in the full report, the following 11 recommendations are proposed:

4.1.1 Review the vision and mission language for Exercise by Referral and wider physical activity programmes operating across the county, with key system partners.

4.1.2 Review and agree principles of working connecting to the delivery of the identified vision with key system partners, holding each other to account in the delivery of services.

4.1.3 Create an internal facing campaign making the vision and mission language accessible to all, ensuring all system partners who have contributed to the vision can identify and utilise it.

4.1.4 Explore a peer led review of processes with referrers to evolve a model of medical guidance for referral. Investigate opportunities to expand self-directed activity opportunities.

4.1.5 Complete district level health needs assessment (population) and pair this with a workforce needs assessment to support service and workforce development requirements.

4.1.6 Review existing external communications and marketing across all system partners, ensuring that the sentiment of the identified vision and mission is reflected in a relatable way to residents.

4.1.7 Review the referral pathway for EbR alignment to LLBD programme to create symmetry with the level of service provided to EbR referrals. Create a pathway to connect referees with place-based experts to identify physical activity options.

4.1.8 Evolve data collection requirements and approaches. This includes exploring opportunities to make processes easier to implement along with measures by:

- Exploring re-sequencing/shortening data capture points across the scheme.
- Offering peer group data training and orientation for key staff. E.g. referrers.
- Clarifying definitions to help data recording quality. E.g. Completion criteria
- Including a wellbeing measure for health economics measurement
- Exploring opportunities for increasing capacity for data administration.
- Considering how automated processes/participant led collection can be used.
- Ensuring that data reports are fed back to the collectors.

4.1.9 Expand the activity opportunities incorporated as part of the EbR scheme. Specifically, explore activity options based in the wider community.

4.1.10 Explore multi-disciplinary group models to potentially alleviate capacity challenges and create greater diversity. Such as using instructors with varying levels of qualification working collaboratively to support service users and exercise referral instructors designing programmes which are delivered by other staff.

Please Note: *The criteria to support the complex needs of specific audience groups to be explored and agreed at place.*

4.1.11 Co-develop a consistent service level delivery model with all stakeholders that incorporates a consistent specific intervention to support behaviour change. To achieve this, you could:

a. Audit all existing delivery models to highlight how behaviour change is being applied.
b. Identify key touch points and intervention details, consider development of resources for participants and delivery staff to utilise.
c. Develop training and orientation for delivery with all staff.
d. Build in support for consistent delivery.

4.2 Adopt: creating a physical activity pathway for Derbyshire

Building on the above recommendations and considering the existing assets available across the county, the review highlights the potential to further integrate services locally to establish a clear and consistent level of service for all.

Based on the themes explored in the full report, the following 9 recommendations are proposed:

4.2.1 Create a single system wide pathway of delivery which integrates exercise by referral as a 'level of support' for the identified audience as well as including a wider menu of opportunities.

From the review undertaken, exploring delivery models, operating systems and available resources between the physical activity elements of the Live Life Better Derbyshire (LLBD) programme and EbR would be recommended.

4.2.2 Consider refreshing the 'brand' for Exercise by Referral through its incorporation into the LLBD programme to create a Physical Activity Referral Scheme for the county.

4.2.3 Review all physical activity options/opportunities and delivery workforce across system partners to create menus of opportunity that are proportionate to service user needs.[1]

4.2.4 Consider developing a multi-disciplinary team approach to workforce resourcing to support a more accessible recruitment drive to increase capacity in programme delivery.

[1] Consider emerging insights from the national Physical Activity for Health Pathways project delivered by Move Consulting.

4.2.5 Explore new operating models and agreements to support existing staff to continue to deliver on physical activity by referral interventions.

4.2.6 Continue to utilise the Thesus system to monitor programme engagement, consider the existing data set to ensure that required information is feasible for a wider range of partners to input, and what tools may be required to support this.

4.2.7 Create a training offer for system partners to enhance data collection processes, focusing on the value of collating clean data for each service user correctly.

4.2.8 Produce biannual system focused reports to highlight the impacts of collaborating on data collection, sharing insights on programme performance and impact. Compliment this by using stories from service users that can be used as case studies.

4.2.9 Expand workforce capacity for the 'triaging process' to maintain the level of service provided to service users.

4.2.10 Utilise place-based experts to support in identifying physical activity options.

4.3 Steps towards implementation

As fundamental steps towards the implementation of any developments in the existing model of practice, whether to Adapt or Adopt, we recommended the following:

1. Pilot the Integrated Model
    a. Trial an integrated EbR and LLBD model in a small cohort to test operational alignment and service outcomes.
2. Training and Capacity Planning
    a. Assess workforce capacity and implement additional training to prepare for the transition.
    b. Develop a tiered delivery model to ensure the workforce can meet diverse needs effectively.
3. Technology and Data Integration
    a. Streamline and standardise the referral system and datasets to support a unified operational framework.
    b. Explore the implementation of shared platforms like Thesus and digital tools like the Activity Passport.

5.0 Conclusion

Whether through recommendations under the Adapt or Adopt headings—or a combination of both—our review has identified a common narrative from system partners, whether delivering exercise-based referral (EbR) services or working outside of them. This narrative emphasises the need for a more cohesive, effective, and user-friendly service that supports Derbyshire residents in leading healthier lives.

By aligning systems, leveraging expertise, and incorporating innovative tools, there is an opportunity to develop and deliver a new physical activity pathway and service offer for residents.

To clarify, the proposed model would evaluate whether specific elements of the pathway should be accessible via referral, while other elements could be offered through alternative mechanisms, e.g. self-referral/ self-directed activity, signposting and recommendation. Essentially, this operating model aims to enable individuals to access a single pathway tailored to meet their circumstances and needs.

What remains paramount is that any system developed ensures people can access the appropriate level of support to meet their unique needs. Finally, transitioning towards a model that integrates physical activity into a broader public health framework aligns with national trends and current thinking on public health strategies.

Note: references for this document are available on request

6.0 Annexes

Annex 1 National guidance documents

National Quality Assurance Framework (out of publication) - this was the original policy guidance developed in 2001, and while NICE guidance has been developed much of the policy technically still applies. It was noted that many schemes found meeting the criteria challenging and hence the Exercise Referral Toolkit was developed to support implementation.

NICE public health guidelines (PH54) - Physical activity: exercise referral schemes NICE guidelines on the delivery of exercise referral and roles in delivery.

Consensus statement - Benefits outweigh the risks: a consensus statement on the risks of physical activity for people living with long-term conditions | British Journal of Sports Medicine Evidence review on risk of adverse episodes during activity for people living with health conditions.

National Exercise Referral Toolkit - https://ncsem-em.org.uk/wp-content/uploads/2020/10/section-1-background-technical-report.pdf Developed in 2010 to support implementation of exercise referral across the country. While not official policy it provides support and advice on the design, implementation and evaluation of schemes.

Physical activity referral standards - Physical activity referral standards - Publications - Public Health Scotland – sits within wider guidance of a tiered model of the delivery of physical activity (tier 2) and seeks to provide a process to drive improvement in the physical activity referral sector. The standards provide advice for commissioners and delivery agencies and have 6 recommendations covering partnership working between health and physical activity sectors local delivery models.

Quest standards - Quest - Exercise Referral Standard – was developed in Suffolk to provide a set of locally tailored operating standards to ensure schemes were operating in line with the 2014 NICE guidelines for both exercise referral and behaviour change and that pathways were in place for exercise referral aligned to evidence-based principles and best practice guidelines; as well as local health and wellbeing priorities. This has subsequently been promoted by Quest across the country. The assessment criteria cover scheme safety, scheme delivery, information sharing and monitoring and evaluation. While not national policy it provides a useful framework for assessing quality of schemes.

Wider NICE considerations

The following lists some of the key guidelines that align to EbR.

- Advice on physical activity and reducing inactivity that fits easily into people's everyday life (such as walking), and is tailored to people's needs, preferences capabilities and circumstances.
- Supervised, individually tailored and prescribed, progressive exercise training including both aerobic and resistance training.

- Use behaviour-change techniques to inform provision: to raise awareness of the benefits of and types of lifestyle changes. Explore and reinforce participants' reasons for wanting to change and their confidence about making changes, set goals and action plan.
- Advice on medications use in relation to physical activity e.g. short acting nitrates or insulin.
- Advice on monitoring activity levels.
- Disease specific 'prescriptions' e.g. modifications, number of sessions, or particular types of activity such as strength and balance for those at risk of falls.

Annex 2 Criteria review

Derbyshire scheme	Guidance	Recommendations
Aged 19+	Aligns with PH54 although original NQAF was 16+	Could potentially open up to 16+
Resident/registered with GP in Derbyshire	N/A	Could also offer to people working in area
Be inactive or sedentary, i.e. those doing less than 150 mins per week but primarily targeting those doing less than 30 minutes physical activity per week	Aligns with PH54 the definition aligns to Sport England categories of activity	
Inclusion criteria • Diabetes type I & II • Hypertension systolic <180 and diastolic <100 mmHg) • Hyperlipidaemia • Musculoskeletal conditions: joint replacement, simple non-mechanical • low back pain, rheumatoid arthritis, osteoarthritis, osteoporosis • Stroke/TIA • Stable mental health condition and accessing mental health services (DCHFT, IAPT, Rethink etc.) • Undergone an NHS Health Check and identified with a CVD risk of >20% • Post COVID syndrome (Referrals will be only accepted from Derbyshire Post COVID assessment service, dchst.longcovid@nhs.net)	PH54 states that 'exercise referral schemes should apply to people who are sedentary or inactive but otherwise apparently healthy.' The focus is rightly for people with health conditions. We would expect the conditions selected for inclusion to be reflective of the health needs of the population, alongside the capacity /qualifications of the workforce. Review highlights that while all are delivering agreed requirements optional conditions are dependent on the qualifications of staff.	While reviews of qualifications are planned (CIMSPA) underway (Skills Active) there has never been a scope of practice published, this alongside the consensus statement makes identification of scope of inclusion criteria challenging and is something we will be requesting to be reviewed as part of the national work. We would therefore suggest that the main criteria are continued until national reviews have been undertaken, unless local priorities have changed.

Exclusion criteria Uncontrolled/poorly controlled Diabetes • Uncontrolled/poorly controlled hypertension (resting systolic blood pressure ≥ 180 mmHg; DBP ≥100mmHg) • Musculoskeletal disorders exacerbated by exercise • Stroke/TIA - Recent (<3 months ago) • Unstable mental health condition/ Not accessing mental health services • A BMI measurement indicating that an individual is overweight or obese as a single reason for referral • Anyone who has completed the programme previously unless under exceptional circumstances • Cancer diagnosis > 5 years • Unstable angina • Resting blood pressure of 180/100 • Ventricular aortic aneurysm • A significant drop in blood pressure on exertion • Uncontrolled tachycardia - 100 beats per minute at rest • Unstable/acute heart failure • Uncontrolled arrhythmia • Febrile illness	The exclusion criteria match with either contraindications, or those potentially requiring a higher level of qualification. More clarity could perhaps be provided on which MSK conditions would be exacerbated – as practice may have moved on after the publication of the original criteria Consideration should be given to why people who have had cancer diagnosis more than 5 years ago are excluded as there a long-term side effects of treatment that may last over 5 years – especially if no support has been provided in early year of treatment.	
Staff competencies Exercise referral REPS level 3 Cardiac rehab REPS level 4 BACPR Pulmonary rehab – REPS level 4 Chronic respiratory disease- level 4 Chronic respiratory disease 4 stroke - Exercise and Fitness Training after Stroke Instructor (EfS) Later Life Training cancer – REPS level 4 certificate in cancer rehab other – appropriate qualification to deliver specific sessions	Other qualifications now available include Mental health Postural stability/ falls/back pain Neurological; conditions Diabetes and obesity	Consideration given to the health needs of the population and qualifications held by instructors alongside capacity to see if other conditions could be included