

The Register of Exercise Professionals

A Paper Detailing the Professional Practice Standards and Processes in Exercise Referral and Special Populations Interventions.



Purpose of the Paper

Following the development of standards which form units of qualification at Level 4 for the Register of Exercise Professionals (REPs), the technical expert group of SkillsActive (the Sector Skills Council with responsibility for setting standards for REPs) determined that some additional generic knowledge statements concerning professional practice in exercise referral were required. These will be incorporated into the Level 3 unit of exercise referral (D449) as national occupational standards by March 2009.

For existing practitioners in exercise referral and for members of REPs working with referred populations some “top-up” or “refresher” training may be required and this paper explains in detail the new additional requirements of professional practice standards and processes. This paper has been commissioned by REPs and is free to its members who can complete some on-line questions based on the paper to show understanding and compliance with these new requirements.

Satisfactory completion of the on-line test gives 2 CPD credit points and details can be found through the members area of the REPs Website at www.exerciseregister.org

Introduction

As the skill base of exercise professionals continues to expand there is ever more contact with the medical and allied health professions. As such, the exercise professional, when working in the area of exercise referral (ER), must be able to communicate in a professional manner, considering normal best practice and principles or work within these fields. Additionally, while the exercise professional is not expected to become a *de facto* medic, it is entirely reasonable to expect a level of awareness of terminology used within the medical environment and the processes that are required to ensure patient/client safety.

Medical confidentiality comes under the Data Protection Act 1998 which will be covered in detail later. Letter writing, general communication, professional courtesy, understanding of one’s professional boundaries and effective data collection all fall under the term “professional practice”. It is no longer sufficient simply to be competent at the components of your profession (i.e. as an exercise professional); you must also demonstrate competence in the areas where your work takes you (i.e. the medical environment).

Much work has been carried out over the past few years to expand the profile and reputation of the fitness sector to a point where Government now seeks information from senior figures within our sector on issues regarding public health. The exercise professional should be proud of this achievement, which has been driven by everyone in the sector and seek to carry it forwards.

Section 1. Review of current health care systems in England Scotland Wales Northern Ireland

Practice based commissioning

As the health care model continues to evolve in the UK the exercise professional must be aware of the changing nature of potential referral pathways.

Many GP Practices have now joined to form larger organisations to meet the needs of a medical environment that is more closely aligning to the standard business model. These larger organisations (compiled of numerous individual GP Practices) are referred to as Practice Based Commissioning groups (PBC).

PBCs have significant financial and political presence within the health sector as they control large amounts of money and can dictate, within certain boundaries, where they spend it. In fact, the term Practice based Commissioning means exactly that, the Practices decide where to commission work from. For example, a large PBC may choose to commission all its ER programmes from a private provider from the leisure market or from the local Primary Care Trust (PCT). PCTs hold the overall budget from the Department of Health and are tasked with ensuring the health of their population, typically a county area. As such the PCT is responsible to Government for the expenditure of its budget.

A PBC unit will have a Chief Executive Officer and other management staff who may or may not be medically trained. In any case, the person in charge will have strong business skills and seek to ensure best value and best practice from any work they commission. PBCs are unlikely to commission from individuals insofar as ER is concerned but may choose to work with a larger organisation. Therefore, all exercise professionals working for an organisation wishing to be commissioned to deliver ER must be able to demonstrate a set of skills additional to those required simply for the delivery of the exercise component.

Best practice refers to actions that are understood to be the most effective within a given environment. Normally these would be backed up to some extent by an evidence base, prior learning and modification of processes, ongoing collection of data that is relevant to the intervention (i.e. height, weight BMI, waist circumference and possibly BP and medication use for an overweight/obesity management programme) and transparency of action. The last point means that others wishing to observe what you are doing, perhaps for reasons of audit or safety assessment, may easily do so.

Best value does not simply mean the cheapest; it must represent a careful assessment of the price determined against the outcome. For example, one provider may undercut another when bidding for the right to deliver the ER scheme, but upon closer examination they may not have the resources to safely and effectively deliver the scheme. In such a case the more expensive bid would be the best value.

PBC groups are required by law to deliver against national and regional targets. This may be overseen by the local PCT through collection and collation of data. National Indicator (NI) sets, Public Service Agreements (PSA), and Local Area Agreements (LAAs) determine what these things are together with directives from the Department of Health. For example, NI55 and NI56 require a reduction in obesity in children at reception year and year 6. All this information is available to view via your local PCT, Borough Council, County Council or DH websites (or a good internet search engine).

When considering an approach to a PBC group your organisation would ideally have the following in place:

- Detail of what you propose to do and why that benefits the PBC
- Costings in a recognised format (i.e. Excel)
- A letter of recognition/approval from the PCT
- Relevant insurance documents
- Relevant qualifications of staff
- CRB checks of staff if working with children or vulnerable adults
- A statement of compliance with the Data Protection Act
- A statement identifying what data you could collect and how you would ethically collect that data

As a result of the above and a positive outcome to the discussion your organisation may be expected to sign a Service Level Agreement (SLA). This would dictate exactly what was expected from each party, together with time scales and costs. Once signed an SLA constitutes a legal agreement. You and/or the organisation that you work for should expect to be held legally accountable if you fail to deliver against agreed goals.

Understanding annual reports from directors of public health

Annual reports from the Director of Public Health (DPH) identify the actions and desired actions of the local PCT and Councils in improving the population health. The DPH may be employed by the PCT or jointly with the Council and is responsible for delivering against national and regional health targets.

The annual report, which is available to anyone who asks, gives details of the local population, trends of ill health, determinants of ill health, wider epidemiology, and discusses in detail what the intended course of action is relative to various health variables.

It will also discuss ethics of intervention, such as targeting those on low incomes in areas identified by the Index of Multiple Deprivations (IMD) for specific interventions whilst not overlooking the wider population.

In some instances the DPH report will be a single document released annually whilst in other cases it will be released in a staged manner which will eventually compile a complete document. In certain cases your organisation may be able to have input to the finished document by submitting high quality information that is pertinent to the wider health agenda (i.e. regarding a well created ER scheme with evidence based outcomes).

It is expected that you make yourself aware of the contents of the DPH annual report in your area and that the ER scheme you are a part of maps to the identified needs of the local community to some extent.

Review of key health service documents

Perhaps the most important public health document of recent times relevant to ER is Choosing Health (2004). This document, from the Chief Medical Officer (CMO) identified key determinants of health and why individually and collectively we should choose health over ill health.

Backed up by sound evidence and linking to a host of other organisations, Choosing Health, amongst other things, identified the key role of appropriate physical activity and nutrition to general health and wellbeing. It also linked many of today's current morbidities (obesity, cardiovascular disease, type 2 diabetes and mental health) to our modern lifestyles of inactivity and poor food choice.

Evidence grids show how interventions typically found in ER schemes could have a positive impact on health either as an intervention or in a preventative manner. Of all the health documents that are presently available the exercise professional should be most familiar with this.

A National Service Framework (NSF) is a document that identifies best practice together with stated objectives by the DH pertaining to a number of conditions or population groups. For example, the NSF for Coronary Heart Disease considers a host of aspects pertaining to this condition and the needs for management in a variety of settings. There are numerous NSFs such as, Diabetes, Mental Health and Older People, with others coming out as they are ready (i.e. COPD later in 2008).

NSFs are targeted at the medical fraternity and allied health professionals with a more clinical or management bias. That said, the exercise professional working with a special population should be familiar with the NSF for that population where one exists. In the first instance one should search the DH website for NSFs and recent upgrades. The value of being aware and knowledgeable of the NSF is that you can model your intervention to produce outcomes identified within the NSF, therefore, you are more likely to be seen in a favourable and professional light by others.

Be aware that as NSFs are released and often have a long life (unlike peer reviewed papers for example), therefore it is your responsibility to ensure its contents are still valid.

NICE, the National Institute for Health and Clinical Excellence is technically an independent body that determines best practice and best value within the health sector. Originally the 'National Institute for Clinical Excellence' (hence NICE), it became the new expanded organisation with the amalgamation of the Health Development Agency.

Anyone can become a stakeholder in new NICE consultations, although it is typical for physicians or health professionals to be independent stakeholders and others to be part of groups registered. For example, the Health Improvement team of the local PCT is likely to be a stakeholder in the NICE document towards physical activity and the environment as they would expect to have input to the final decisions.

NICE receives some negative press on a regular basis as they are the organisation that bars the use of a particular drug on a cost basis. While this seems harsh to many, particularly those who are ill with the condition that might benefit from such a drug (and their families), the reality is that modern technology offers an ever expanding array of interventions and pharmacotherapy which continuously stretches the health budget.

NICE may also recommend non-medical interventions, for example, it has recommended that moderate level physical activity and psychosocial interventions (such as one might find in ER schemes) should be used as the primary interventions for mild to moderate depression and anxiety. The exercise professional

should be fully aware of NICE guidance pertaining to the patient/client group they work with where such guidance exists, and that they remain up to date with any amendments.

Other documents are continuously produced by the DH and other Government bodies. During 2007/8 there were a number of important documents regarding overweight and obesity in children and young people as well as the wider population. Exercise professionals engaged in ER are expected to remain aware of new documents through the use of search engines, on-line registrations and other appropriate resources.

Non-government organisations (NGOs) are also important in the wider health model, particularly charities and social care organisations. The exercise professional should be familiar with the NGOs most pertinent to the patient/client profile he/she works with. In some cases such organisations are considered leaders in new interventions and condition management.

Section 2. Inter-professional communication

Letter writing

Letter writing is a skill often overlooked; however, in worst case scenarios a written letter may be the document that defends you in a court of law or demonstrates your weaknesses.

GPs often complain about the standard of requests coming from exercise professionals. To many this may seem a minor concern but in reality it is a significant issue. A letter may be read as a legal document depending on its content, present an intelligent well considered proposal or suggest an ill-conceived attempt to step past professional boundaries.

Standard formatting should be used such as senders address, delivery address, date and signature block clearly identifying the sender. Thereafter, brief, concise and accurate description of what is proposed, by whom, for what purpose and the benefits of the proposed action. GPs receive many letters every day and too wordy documents are likely to be discarded immediately.

Identify the most appropriate person to send the letter to, in many cases this may be the Practice manager who is unlikely to be medically trained.

Language should be appropriate to the recipient, thus a letter to a medical professional should use appropriate medical language and terminology whilst a letter to a patient/client would most likely use lay language. Be sure to use spell checkers and use medical dictionaries where the spell checker does not give the correct option. Always look carefully at the option offered as it may cause offence. A good example is the word 'bariatric' which regards a form of anti-obesity surgery carried out by skilled professionals, the first replacement word offered is 'barbaric' which if used, is unlikely to progress one's discussions any further.

When writing to a medical professional an exercise professional would normally state their qualifications regarding the proposal (i.e. what makes them qualified to perform the action), any additional certification they have (i.e. CRB) and recognition of appropriate insurance. It is also very useful to formally recognise one's professional boundaries (i.e. the point which one would not pass e.g. diagnosing a condition) to reassure the medical professional.

The medical professional retains clinical liability for the patient/client during ER.

The above statement is isolated because of its importance. A medical professional must be entirely happy with your proposal and your competence otherwise they should and will decline your offer.

Letters must not contain personal information as recognised under the Data Protection Act 1998 unless you have the written approval of the person to whom the information pertains. Failure to comply with the Date Protection Act may constitute a criminal offence and attract significant legal penalties. Any letter that does contain personal information should be stored in accordance with the Data Protection Act, in simple terms, accessible to all those authorised to access it and nobody else.

Letters that form part of an agreement should be kept for no less than 5 years in a safe environment. Letters that contain very important information should be protected from inappropriate access and fire.

Confidentiality

Discussed to some degree in letter writing, confidentiality in a medical or pseudo medical environment is essential.

It is unwise to underestimate the potential legal ramifications of failure to comply with confidentiality laws. Both state and private proceedings can be brought against a person failing to comply with the Data Protection Act, significantly punitive punishments and very large fines can be delivered to a person found guilty of a breach.

While individuals should familiarise themselves with the Data Protection Act, in summary it states that personal information:

- May only be collected with the permission of the person to whom the information pertains
- May only be transferred between individuals/organisations where the person to whom the data pertains has given their express permission
- May only be transferred in a secure manner such as encrypted and password protected e-mail, secure area fax, personal delivery
- Must be stored in a secure format such as secure access server, locked filing systems
- May only be used for the purpose that it was collected for, such as monitoring progress of a particular condition
- Must be destroyed once it has no further value for that purpose

Further to this, verbal communication is also covered by the act and as such exercise professionals must be conscious of what they say, to whom and who may overhear,

Aside from the legal aspects, confidentiality is central to ensuring that a patient/client feels confident to share all the information with you that you will need to devise and deliver an effective intervention. Once a confidence is broken it is unlikely ever to be fully regained.

Respect of professional boundaries

The term 'professional boundaries' refers to the scope with which one can act given their individual set of qualifications, experience, certification, insurance and other variables that may change over time.

A good example is the taking of blood pressure, an action that many exercise professionals perform. While it is generally safe and appropriate to perform this task an exercise professional would step past their professional boundary if they were to say "you have high blood pressure" to the patient/client. To do so is a medical determination, made over a number of controlled assessments by a person trained to do so. What the exercise professional may say is "your blood pressure is too high for me to work with you today" and then state that they might take another measure after the patient/client has calmed down if anxious or refer the patient/client back to the referring medical professional.

Many medical professionals are not qualified to recommend a specific course of exercise other than to be more physically active. Therefore, to ask if a particular exercise is safe may be asking the medical professional to comment past their professional boundaries demonstrating one's lack of knowledge. Exceptions exist of course; physiotherapists for example frequently prescribe specific exercises.

It is imperative that exercise professionals identify their own professional boundaries and stick rigorously to these. Only through continued compliance with such standards will the exercise profession continue to increase its reputation as a significant part of the national health agenda. Exercise professionals should clearly state that they recognise their professional boundaries when communicating with medical professionals.

Qualifications exist to recognise an individual's achievement in learning and application of a set of new skills. Exercise professionals should ensure that they have the right qualifications to ensure they are legally able, and technically competent to deliver a safe and effective intervention to their patient/client. Working with a patient/client where one does not have the pre-requisite qualifications, for whatever reason, steps clearly past professional boundaries, exposing the patient/client to risk of harm and the exercise professional at risk of prosecution.

The Register of Exercise Professionals (REPs) recognises the achievement of qualifications for exercise professionals whilst SkillsActive develops the national standards which form the basis of qualifications. The General Medical Council and Medical Defence Union recognises REPs as the UK body for the registration of exercise qualifications and as such allows medical professionals to refer to people who are suitably registered. Members of REPs working with referred populations should have the status of Level 3

advanced instructor plus a unit of exercise referral based on the national standard of D449 (details available at www.exerciseregister.org).

Accurate awareness of one's professional boundaries will enhance a reputation and allow others to engage in confidence with an ER scheme. Indeed, the ER model expects and requires a range of disciplines to work together as it is recognised that no one profession or skill set is likely to fully remedy an individual patient/client's condition.

How to refer back

In certain circumstances it may be that a patient/client's condition worsens, or they become non-compliant with their medication. In such cases the ER professional is bound to refer back to the original referring professional.

In the case of becoming aware of a patient/client's decision to cease taking their medication, perhaps because they believe that they no longer need it, the exercise professional should strongly urge the patient/client not to change anything unless under direct instructions from their GP or other medical professional. At the same time clear notes should be taken outlining the course of action taken which should be signed by a manager. The referring party (i.e. GP) should be informed of this action by the patient/client by phone at the earliest opportunity; this should be followed up by letter. Confirmation that this information has reached the referring party should be sought and retained.

For a more straight forward referral back to original referrer, such as a worsening of the condition where one might have expected an improvement, the exercise professional should write their concerns in a confidential letter (or secure e-mail) and return this to the original referrer. This should be delivered in the appropriate manner with clear recording of time lines.

The patient/client should be made aware that this is happening, together with the reason why this is happening and what action, if any, they need to take. This should be a discussion based process rather than prescriptive so far as possible.

It is the responsibility of the exercise professional to ensure that the referring medical professional takes back control of the patient/client.

Depending on the circumstances the patient/client may return to the ER schemes and indeed successfully complete the scheme.

Legalities

In all cases the law of the land (i.e. UK law) presides unless otherwise stated and agreed.

The home Countries may have specific laws pertaining to specific actions; it is the responsibility of the exercise professional to be familiar with these.

Acts such as the Data Protection Act 1998 and the Health and Safety at Work Act 1974 exist to protect all. It is typically a serious offence to infringe these acts, one which may attract a custodial sentence or unlimited fines.

Ignorance of the law is not a recognised defence in the UK.

Some documents that people believe remove responsibility generally do not. For example, a waiver signed by a patient/client does not waive responsibility of a duty of care by the exercise professional as it is unlawful to do so.

Where documents exist that set out best practice the law will often be determined by these, together with external factors. In the realm of ER the document *Exercise Referral: A National Quality Assurance Framework* (2001) is such a document, backed up by the National Occupational Standard (NOS) D449, and the Level 4 NOS relevant to the condition of the patient/client.

Ethics

Ethics are determined to ensure that one is treated in a way that is humane and appropriate to the desired outcome. Ethical considerations would exclude safety, appropriateness, other potential actions

and the difference between them, the consequence of intervening, the consequence of not intervening, UK laws, precedence.

For example, it is not ethical to withhold treatment where treatment exists and is approved for use. Another example is that it is not ethical to withhold treatment from one group in order to assess the impact of treatment on another group if the withholding of the treatment will cause deterioration of the condition.

In research there is a requirement for ethical approval prior to beginning the research. However, for most exercise professionals this is not needed as the work is typically not part of a research project. Nevertheless, ethics may dictate that you give the potential for a wide range of patient/clients and not limit your intervention based on gender (except where medically appropriate), age, potential to pay etc.

Ethics may also cover confidentiality, beliefs and actions after the intervention.

Ethical panels exist within the medical and academic fraternities and exercise professional are directed to these areas if the need arises. Be aware that ethical approval for human intervention studies can be very protracted (i.e. up to or even more than 12 months)

Section 3. Client centred approach

Consulting skills

It is not sufficient to simply have the technical knowledge of an exercise referral intervention, although this is an important requirement, the exercise professional must be able to consult in a manner that enables a successful outcome.

Sales organisations have realised for years that there is a specific skill required to get a person to engage in a new product or behaviour. You may have noticed a high level of apparent interest in what you do or an apparent empathy with your situation from a person trying to sell you something.

In the main it is reasonable to suggest that people are wary of change. A person coming into an ER scheme for the first time may be highly anxious; not only is there change from established behaviours, but the environment is often perceived as hostile.

Consulting skills combine a range of concepts including

- Motivational interviewing
- Knowledge of the patient/client condition
- Awareness of psychological state of change
- Empathy
- Professionalism
- Awareness of professional boundaries

After a successful consultation the exercise professional will know more about the patient/client's preferences likes and dislikes, while the patient/client will know more of what the ER process entails and feel confident in the skills and communication of the exercise professional.

Consulting is a two way process where the end result is acceptable to both and achieves the desired outcome.

People consult with each other all the time. However, in the ER model this is a process of communication that is recorded and then impacts on the creation and delivery of an appropriate and safe intervention.

Appreciation of client perceptions

Different patient/clients will interpret the same situation in different ways; indeed, the same patient/client may well interpret the same situation in different ways at different times as a result of learning or external cues.

Evidence suggests that in a medical or pseudo medical environment, or one that is perceived as such (such as ER), the answer someone gives to a question is the answer they believe the questioner wants, not necessarily the one they believe to be true. Consequently, a client may give an answer to placate or

impress the exercise professional, who would then proceed with that 'knowledge', creating an end result which the patient/client does not engage with.

Perceptions are driven by a range of processes such as age, gender, religious beliefs, ethnicity, previous experience, fatigue, influential others etc. Perceptions are not necessarily stable, although religious and ethnically based ones are more likely to be so.

Where possible the exercise professional should consider the perceptions of the patient/client by considering what may impact upon them, this is not easy but is a required action to fully appreciate the needs of the patient/client. For example, an exercise professional who has never been obese may find this challenging to consider the perceptions of an obese patient/client who walks into a gym for the first time. What may be a place of sanctuary and comfort to the exercise professional is likely to be a place of threat and discomfort to the patient/client. Nevertheless, it is likely that the exercise professional has felt that experience at some stage of their life and may be able to recall how they reacted.

The use of open questions, coupled with a demonstrable level of empathy will allow the patient/client to express their perceptions of the environment or exercise programme, which in turn will allow for necessary adaptations to be made.

Respecting health behaviours

People develop their behaviours from a range of precursors such as genetic predisposition and previous experiences. Some behaviour may be as a consequence of highly personal events and the exercise professional should never directly challenge a specific behaviour.

Health behaviours are behaviours that may have an impact upon someone's health and are often divided into sub-components such as dietary choice, entry into screening programmes (i.e. visits to GPs), levels of physical activity or more frequently inactivity, sexual behaviour (i.e. risk taking) and patterns of tobacco or substance control.

Health behaviours are a complex mix of personal beliefs, peer pressure, socio-demographic background, influence of significant others, advertising and previous experiences.

The exercise professional should present themselves as a professional individual who can offer advice or signposting to other specialists, but who would not pass judgement or offer unwanted advice.

The exercise professional should be aware that certain behaviours mask other issues and that unsolicited delving into the precursors of behaviour may result in information of a distressing or illegal nature being given. In most cases the exercise professional should note health behaviours, be clear that they are there to assist if required but will not impose any change and have access to other professionals should the need or request for assistance develop.

Often, as a consequence of personal experience through the ER programme a patient/client will gain first hand experience of improved health and seek further improvements through a change in other health behaviours.

Psycho socio economic status

Across the UK there is a wide range of socio-economic divide, coupled with the psychological impact such variations have. The Index of Multiple Deprivations (IMD) identifies by ward, a range of socio-economic indicators such as local employment, average salary, number of dependants, health outcomes, housing, schooling, access to food outlets etc. This can be a useful tool when identifying the likely socio-economic status of your patient/client. Additionally, there are other markers of wealth and job profile (A, B, C, C1, D, and E) and local area information available from the PCT and Council websites.

Evidence demonstrates that health has strong links to socio-economic status; life expectancy, birth weight, likelihood of smoking and obesity levels are all linked to socio-economic status. Therefore, it is reasonable to set up an ER scheme in an area of lower socio-economic status to provide a service where the need is likely to be greatest.

Additionally, some aspects of mental health, specifically mild to moderate depression and to a lesser extent anxiety have links to socio-economic status. An exercise professional should consider both internal and external influences on their patient/client when giving recommendations. For example,

access to safe areas for physical activity may not be available, or be perceived as unavailable to a patient/client from a lower socio-economic environment where the perception of crime is high. Higher quality food may be less available in a lower socio-demographic neighbourhood (known as food deserts) or beyond the income of the patient/client, in such cases recommendations of this kind may be counter-productive.

Travel costs to the ER centre, access costs, and child care costs will all impact upon the likelihood of initial uptake and continued attendance. In some instances there may be a range of discounted options available or the PCT may assist with the cost of running a programme.

The exercise professional should consider all aspects that may impact upon the health of the patient/client and offer professional assistance or cost reduction when necessary. However, evidence suggests that some level of financial buy in improves retention; equally, perceptions of charitable giving may be unwelcome, the exercise professional needs to consider all aspects carefully and is well advised to seek advice from local professionals in neighbourhood centres.

Understanding illness behaviour

Illness behaviours are those that the patient/client engages in once they are, or believe that they are ill.

What drives illness behaviour is as complex as health behaviours and may well vary over time. Often the illness behaviour will be the driver as to the amount of prescription and treatment the patient/client has had, far more so than the physiology of the condition itself.

Some people may choose to ignore an illness as a coping strategy where another will seek advice from all quarters. Often the behaviour will be disproportionate to the illness and may exacerbate the original condition.

Fear avoidance belief considers how a person may avoid an activity for fear of harming themselves further (i.e. not climbing stairs because their back will hurt) where in fact an increase in cardiovascular and strength work (i.e. climbing stairs) may make their backs better.

Hypochondria and frequent changing of GPs may also be symptomatic of illness behaviour and the exercise professional should be aware of the need to seek additional assistance to manage certain aspects of such behaviour.

Other common aspects of illness behaviour are increased use of alternative medicines and over the counter treatments (OTC). The exercise professional must be careful not to be drawn into commenting on or recommending OTC medicines, or indeed any medication, and should always refer the patient/client back to the original referring medical specialist if they intend to change medication.

Essentially illness behaviours fall into the psychological domain and are best managed by an appropriately trained specialist in this field. The exercise professional should continue to use their ER skills in the management of the principle conditions, paying regard to the responses of the patient/client (which may not be as expected), and utilise the skills of others in a multi-disciplinary team approach.

Locus of control

Locus of control attempts to understand whether one feels that they are in control of a situation (i.e. they can have some influence on the outcome) or whether chance or other uncontrollable factor influences the outcome.

For example, one obese person may believe that they can control their obesity through reducing their calorie intake and increasing their physical activity, whereas another may believe their condition is entirely genetic and whatever they do will be ineffective.

There is a range of literature discussion health psychology, where locus of control sits, and the exercise professional is directed to consider this through peer reviewed material. Some measures of locus of control exist, especially around health related locus of control in specific domains (i.e. obesity and mental health).

Locus of control theory separates individuals into internals, those who believe they impact upon a thing, and externals, those who believe other factors influence outcome.

Typically, an internal will work harder and longer to achieve their desired goal, often without too much external cueing. Internals are also able to better resist external pressures (i.e. peer pressure) once they have decided upon a course of action. Externals, however, are likely to rapidly lose belief in a positive outcome and may adapt/modify their required outcome to a more obtainable goal. Externals may also develop a condition referred to as learned helplessness, where they 'learn' to believe they are helpless to impact upon a situation, typically through repeated failure experiences. Externals are also less likely to engage in actions they perceive to carry risk (of failure) and will require significantly more external reward structures to proceed.

The exercise professional should learn to recognise characteristics of internal and external locus of control and review testing systems. It is also wise to discuss this concept with the mental health specialist at the PCT or local health care provider to assess what level this is considered relevant in the roll of ER.

Sickness role

In simple terms the sickness role is the behaviour that a person presents that they perceive, and think others believe, should be a consequence of their condition. For example a person with influenza (flu) may present themselves as being fatigued, have difficulty in breathing and feeling generally poorly more or less than the actual symptoms they feel.

Being sick may cause one to become more the centre of attention than they otherwise would be and as such be perceived as a positive experience. In other cases people have been prosecuted for continuing their sickness role past the point of physical recovery and claiming Government sickness benefits.

The exercise professional should interpret the level to which the patient/client is sick using the ER form and previous experience. It is important not to directly challenge a person's perception of their illness as this is likely to cause a defensive response and reduce further communication.

Developing a client needs analysis

ER is not a generic 'one size fits all' programme. Indeed, patient/clients with the same condition profile (e.g. obese, type 2 diabetes) are likely to have very different needs.

The purpose of a needs analysis is perfectly encapsulated in the term itself, to create an analysis of the needs that the patient/client has. This may change over time as the condition improves or degenerates, as other external factors influence the patient/client or as they become more comfortable with their own ability to manage their condition.

The needs analysis must be carried out in a manner that elicits the maximum information from the patient/client. Feelings of safety (from ridicule or unwanted information being passed on) and professional belief in the exercise professional coupled with a feeling of empathy will enable a full disclosure more readily than a didactic approach.

Information should be recorded for later analysis but the patient/client must be clear that this is held in confidence. The exercise professional should so far as possible use discursive language and mannerisms, therefore, note taking, while important should not be allowed to create a teacher/pupil relationship or otherwise weaken the inclusive relationship.

Listening without placing one's own perceptions against what is being heard is a skill learned over time. The exercise professional should be clear not to pass judgements about what is being said. Equally, they should be certain that they understand what the patient/client means; reflective practice ("so what you're saying is" "am I right in thinking that") will assist in this.

Do not make assumptions, for example, the patient/client with a disability may appear to need assistance to stand from a seated position, yet when such assistance is given it may actually cause offence. Be clear to set what assistance is needed and how it should be delivered in advance of any programme delivery.

A patient/client may choose to withhold information in the first needs analysis and only offer it up once they have decided that the relationship warrants a further sharing of information. Therefore, the exercise professional should be prepared to accept new information and adapt the programme as necessary. The patient/client should feel that they are able to share new information with their exercise professional, in confidence, at any time.

Where a needs analysis clashes with the referral form information the exercise professional should clarify the true version. This may require confirmation of understanding from an earlier discussion or a discussion with the referring professional.

Unravelling jargon

Many different versions of a simple statement can be offered using language particular to different professionals. The medical professional may use complex terminology to accurately explain a condition where a simpler version would suffice for the patient/client, others will explain in lay language from the outset.

Equally, terms used within the fitness industry may mean nothing to those who have no previous experience within this environment.

The exercise professional should strive to use accurate language in a manner most suiting the patient/client. It is appropriate to offer lay examples of medical terminology so long as the exercise professional is entirely sure they can perform such a translation accurately.

There are numerous web sites that can accommodate this, in all cases though it is important to identify the source of the information. NHS Direct has an excellent library as does the NHS Choices site, both are peer reviewed and screened for inaccurate information.

The exercise professional must be clear that they may not recommend changes to prescription medicine, agree with a patient/client who asks if they should change their medication, offer advice on the pathology or progress of a medical condition or disagree with a medical professional's given opinion.

Various types of motivation, counselling and support techniques

There are a number of techniques that have some level of evidence towards them being a positive influence in disease management.

Motivational Interviewing (MI) is a specific skill that requires a certificated training programme to deliver properly. This uses certain skills to enable a patient/client to take themselves to a place where they want to pursue a course of action for their own reasons rather than because they have been told to. Often, the only thing that is barring them from moving forwards is the appropriate levels of motivation. Again, the skill is in accurate listening, non-judgemental answers, reflective practices and the creation of an environment where the patient/client feels empowered to move forwards.

Cognitive Behavioural Therapy (CBT) is a more involved process that is normally delivered by a psychologist or mental health professional with appropriate training. CBT involves modifying the cognitions (or thoughts) of a person so that previously learned behaviours are changed. While CBT may be used in ER the exercise professional would not deliver this (unless specifically trained and certified).

Other counsellors may be used to deliver specific programmes such as smoking cessation or additional assistance with mild depression; these can typically be sourced via the local PCT or mental health collaborative.

Support techniques may include the creation of social networking structures. Social meetings that do not include exercise and/or structured classes that are followed by an allotted time for discussion can have a significant impact on the lives of many people. There has been a steady rise in the numbers of people living on their own, often exposure to a new group, which is welcoming and presents a friendly safe environment will have a cascade effect on the patient/client's self esteem.

A range of other techniques are available and the exercise professional must consider each on its merits. The exercise professional is responsible for any forward referral he or she makes, as such, they should rigorously ensure the safety, appropriateness and professional standing of any person/organisation involved in motivation or counselling services. The PCT may hold a register of recognised groups such as MIND that offer professional support in a safe environment.

Equality and ethnicity

Equality and respect/awareness of the differences within various ethnic groups is central in all forms of health care. Equally, in many cases the law requires that no person be excluded on the grounds of race, religion, gender or age.

Equality means that there is equal access to services, this includes the assessment of cost, travel, awareness of programmes and the use of translation services to ensure the most appropriate groups can learn of interventions. It is not sufficient to simply state that a service is open to all if its location or cost precludes certain groups.

While tracking for purposes of identifying which groups use a service must be used with care, such a practice can often identify that those most likely to benefit from a programme do not attend in sufficient numbers.

Recognition of different practices within different ethnic groups will reduce the potential to cause offence. Equally, recognition that different conditions are more prevalent in certain groups will enable a more accurate and effective campaign to attract those most at need.

Section 4. Professional behaviour

Ethics and confidentiality

Ethics considers whether a thing or action is correct or acceptable considering moral, social, religious and legal values. In some cases, research for example, ethical approval is given from a university while in other cases a PCT or hospital board may give ethical approval. In most cases of ER this is not required where one is using standard recognised practice and not removing any rights from a person.

Confidentiality is covered within the Data Protection Act 1998 and earlier within this module. Considerations within ER are:

- Control of access to a patient/client's referral form
- Their training programme (if it has reference to their condition/s)
- Transfer of personal information from one place to another
- Storage of personal information
- Use of information for purposes other than that for which it was obtained
- Retention of personal information after it has served its purpose
- Unauthorised sharing of a patient/client's information in any manner

All these can be managed by following professional guidelines such as:

- Use secure storage systems, physical and electronic
- Send information via secure routes or anonymise data (i.e. use patient/client codes instead of names with a separate list identifying codes and names)
- Be aware of people trying to access data fraudulently
- Have a system that fails safe

The exercise professional is bound by the laws of confidentiality, it may be a significant criminal offence to deliberately use or allow confidential data to be used in a manner not specifically authorised.

Working independently or as part of a multi disciplinary team

It is rare that the exercise professional will work without any recourse to either managers or other professionals. In fact, the most effective interventions use multi-disciplinary practice as a central concept of condition management.

While day to day intervention (i.e. a single ER session) may only require the exercise professional, there should always be access to other skills or guidance. In independent working, perhaps as a personal trainer with ER qualifications there should still be some line of access to other professionals to discuss, in confidence, the most appropriate course of action for a particular patient/client.

Specific issues pertinent to independent working are health and safety, personal safety and potential for a claim of negligence or inappropriate behaviour to be made against you.

Health and safety is everyone's responsibility, however, when specifically directing a person to do something the ER instructor has a responsibility that the action is safe and that the area in which the

action is to take place is safe. In a gym or other facility it is a legal requirement that a risk assessment has been carried out, as such the exercise professional can focus on the core aspects of the programme. In lone working the exercise professional must ensure, as far as is reasonably practicable, that the environment is safe.

Personal safety is an issue for males and females. Pre-prepared plans for requesting assistance should be in place, time lines for when you should be available again on the phone or at a certain place and personal referrals will reduce the risk. Special courses (often run by the PCT) on lone working are available and the exercise professional may wish to consider these.

Perhaps the most significant risk is the threat of a claim of inappropriate behaviour. In a lone working environment where there is only the exercise professional and the patient/client, simply the claim of inappropriate behaviour (even if unsubstantiated) may be sufficient to significantly damage the reputation of the exercise professional. Professional practice requires minimum contact between the exercise professional and patient/client, clearly defined rules of contact discussed prior to proceeding with the intervention programme, opportunities to discuss and feedback, without fear of ridicule, anything that has made either party feel uneasy and a mechanism to stop the professional relationship if it appears that there is a potential threat in continuing. Members of REPs are bound by their Code of Ethical Practice which includes standards of conduct and behaviour. Details are available at www.exerciseregister.org.

The exercise professional should, at the earliest opportunity, raise his or her concerns of regarding a professional relationship to a trusted colleague and make notes of times, dates and specifics of the cause of concern.

Within the multi-disciplinary team the exercise professional should be confident to offer recommendations regarding their area of expertise and experience. Equally, they should be ready to accept and work with the advice from other professionals in a respectful way. The beneficial components of multi-disciplinary working are numerous, including wider knowledge base, wider skills base, reduced likelihood of something pertinent being missed and opportunities to discuss issues that are not clear or straightforward.

Exercise referral is a proponent of multi-disciplinary working and the exercise professional should ensure that they have the skills and the confidence to communicate effectively and work professionally with a range of other skills.

Issues of confidentiality are important in multi-disciplinary working as not all the members of the team may be authorised to access all of the information, and as the number of information transmissions increase the potential for a lapse in information security increase.

Managing referrals within a business profit environment (community service versus profit motive)

There is often a paradox between what the health model wants and what the business model wants. ER first and foremost considers the patient/client at the centre of the process (a client centred model). However, the realities of the modern health system require monetary considerations to be made throughout all processes.

In some cases external funding (such as Big Lottery grants or charitable funds) may pay for the ER scheme to run. This process is typically time limited though and can impact upon people who rely on the programme for their income.

Larger leisure providers and some private organisations necessarily need to generate a profit overall. In some cases they may choose to run ER as a 'loss leader', taking a financial loss with the future prospect of more new members who are likely to stay as members for longer than others from normal recruitment processes. There may also be a philanthropic motive of the senior managers within the provider or consideration of an active ER scheme as promoting the provider as a caring part of the wider community.

In most cases however, there needs to be a business case to run an ER scheme. The nature of disease demographics dictates that many people coming through ER may be from lower socio-demographic backgrounds. Therefore, costs must be kept to a minimum if the scheme is not to exclude a whole section of the community (see Equality and Ethnicity).

Economies of scale dictate that if numbers increase the cost per unit typically decreases. While this sounds very mechanistic it is true of most things. Thus, ER programmes running continuous programmes

with high use of groups rather than individual interventions will have lower costs per patient/client going through the programme.

Patient/client type will also affect cost. Those taking patient/clients with more significant conditions (i.e. cardiac rehabilitation) are likely to cost more than those taking less complex conditions. There are also training issues to consider when identifying the patient/client groups you will accept. This is not discriminatory so long as you can demonstrate that you are accepting patient/clients on the basis of local area need, skill sets of ER staff and appropriateness of the venue.

Efficiency is central in any cost model, therefore, the use of clear systems, accurate recording methods, co-ordinated staff leave and use of the most appropriate ER staff will assist significantly.

The delivery of a well planned ER scheme following good business methods will allow for more patient/clients to be seen in a timely manner. Thus in some ways the business and health needs overlap.

Professional Practice

Professional practice is the term that encapsulates the range of considerations and actions the exercise professional engages in to demonstrate a level of professional appropriate to the environment in which they work. For example, when working in ER the exercise professional should consider such concepts as best practice (both as an exercise professional and from the PCT or GP perspective), data protection and confidentiality, a client centred approach, letter writing and appropriate use of language in regard of the intended recipient, insurance, CRB and other legal checks and collaborative working.

Throughout this document specific areas are discussed in more detail. The exercise professional is obliged to ensure they remain up to date with all developments in professional practice.

Understanding the evidence base (what evidence is strong, weak and in need of developing)

Best practice requires the use of evidence based programmes and procedures where the evidence exists. The growth of the internet and powerful search engines has widened access to information exponentially. However, anyone can place information on the internet; some sites (such as the pro-anorexia sites) actively encourage and promote very unsafe practices, while others promote personal thoughts with no evidential background.

The exercise professional is responsible for ensuring the accuracy of the information they obtain from evidence sites. In most cases peer reviewed evidence from academic or medical sites or Government produced information from the Department of Health is the best source of information. National charities or support groups often have strong evidence based information and links to wider areas of learning. Useful sites for obtaining evidence are (all prefixed www):

- dh.gov.uk
- nice.org.uk
- nhsdirect.nhs.uk
- cochrane.org
- nhs.uk (to access NHS Choices)
- bnf.org

Most of the major medical journals are accessible on-line but there is a skill in determining what information is relevant. Consideration of sample size, make up of the sample (i.e. ethnicity, location, socio-economic profile) may all have had an impact on the outcome. Simple things like recognising if the data relates to humans or animal modelling can be missed if not looked for.

Other sources of information are the regional Public Health Observatories (found through a search engine), the PCT, the DPH annual report.

Evidence moves forwards all the time and the exercise professional should be focused on the need to continuously develop their knowledge through personal learning. REPs requires a certain level of CPD and this has significantly increased the profile of the exercise profession, nevertheless, this should be seen as a minimum requirement and the exercise professional should always seek to be fully aware of progress in their specific areas of work.

Validity and reliability of measurement techniques and outcomes (pedometers, questionnaires, fitness tests)

Much time is often devoted to testing within the gym environment and people place significant emphasis on the outcomes over time. However, testing for the sake of testing is time consuming and may be demotivational if performed poorly.

Validity considers whether the test is a valid assessment of the desired component. For example, does a sit to stand test identify quadriceps strength, whole lower body strength, arm strength (in pushing oneself out of the chair) co-ordination, fear of falling or understanding of the instruction? While this may sound a little pedantic it is important to consider the value of the test in terms of the pressure the patient/client puts against it. One of the classic tests in a gym environment is the sit and reach. Consider what useful information this gives in relation to the need of the patient/client to get down on the floor and up again, bend from the back with almost straight legs, and with the best will in the world still bounce forwards a little and place stress on the lower back.

Many tests exist that have had their validity tested extensively, for example, the Cooper test for aerobic endurance, the use of goniometry for joint angle potential (ROM), 1RM for maximal strength. Where possible the exercise professional should use a test with documented validity that is appropriate to the patient/client. However, there is a lesser level known as face validity, where the test seems to measure what one believes it measures. In some cases it may be useful to create a test to measure progress. A good measure of face validity is to perform the test and ask a trusted knowledgeable colleague to say what the test is measuring. If they say you are measuring what you intend to measure the test has face validity, if not it doesn't.

Another important concept in testing is reliability, is the test reliable? This is important as many decisions are made based on test outcomes, if the information is unreliable the intervention may be inappropriate. One area where this is topically pertinent is obesity assessment. Many different bioelectrical impedance scanners exist with differing levels of reliability. The shorter the measuring range (i.e. through the arms and upper torso only with the hand held devices) the more the computer programme has to extrapolate to obtain an answer. Whole body systems are typically more reliable in that they ensure the same value under the same circumstance. This is very important because low reliability may lead to false increases or decreases in value which may have a significant impact on the self esteem of the patient/client.

Equipment used in ER should be calibrated on an annual cycle (unless the recommended guidelines are for shorter periods) to have their reliability established. It may be a false economy to buy cheaper testing equipment as the reliability is often poor and it ends up being of little or no use.

A good way to test the reliability of a system is to repeatedly measure an individual who has not changed (i.e. every 15 minutes) to see if the results are the same, in some cases (e.g. on low cost equipment) the results differ every time.

Use of measurement techniques for motivation, outcome evaluation, exercise prescription, physical activity guidance

There is a need to balance the needs of the patient/client and the value of various tests. Too few and it will not be possible to accurately assess outcome, too many and the patient/client will feel that the process is being done to them rather than being a part of the process.

Test may be motivational so long as the patient/client understands the time line for improvement. Also, the likelihood of plateaus should be raised in the initial stages so they are not misinterpreted as periods of failure. Clearly a test that shows a decline may be motivating insofar as it encourages the patient/client to work in a more focused manner, or demotivating as it suggests they are a failure.

The other concern with repeated testing is whether it causes the patient/client to only consider the extrinsic reward components of a good test result. This can be managed by simply using the test outcome to identify personal improvements while asking the patient/client to assess how they feel and what improvements it has made to their daily life.

Evaluating the outcome of an assessment requires skill in interpretation and then delivery. Some test measure a thing that may in turn be impacted by many other things. For example, weight increase or worsening bioelectrical impedance result of an overweight/obese female patient/client may be due to increased fat mass or a change in retained internal water. The skill is in interpreting which is the more likely. In fact the best way to smooth out variations is to look for trends over time rather than individual assessment results.

The principle use of good measurements is to guide exercise prescription so that it is appropriate to the patient/clients physical and psychological potential and that it enables appropriate adaptation over time. Tests should be appropriate to the patient/clients needs, performed as a two way process with the patient/client rather than to them, confidential and private, and in a manner likely to promote continued improvements. In some cases the patient/client may not want to know the results, in such a case the information should be recorded and stored safely so that the patient/client may view them at a latter date if they wish.

Guidance for PA should be linked to the current levels determined by the test results and would ideally be structured to give a progression line towards and potentially past current recommended guidelines.

Section 5. Risk stratification

Principles of risk stratification

There is currently ongoing research into the most appropriate risk model for ER. The NQAF (2001) has some risk modelling and the exercise professional should familiarise themselves with this.

Other organisations of solid reputation, such as the American College of Sports Medicine (ACSM) have models that have been extensively tested over time although these tend to focus on cardiac risk.

Occasionally there may be some local risk models created by the PCT or specific organisations, although these often require a level of clinical expertise to interpret accurately.

The exercise professional is directed to look for future releases from SkillsActive and REPs regarding risk modelling. The principles are for exercise professionals to determine what is appropriate and available for:

- *Common systems for risk stratification*
- *How to choose which risk stratification system is correct for each type of client*

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