

General Professional Practise Standards and Processes in ER (ER): Best Practise Update CPD

Who is this CPD aimed at?

New ER qualifications contain additional knowledge content in the area of professional practice that was not a requirement previously. As such, there are a large number of instructors who hold an earlier ER qualification who need to undertake assessed CPD in professional practice to help to 'bridge the gap' and demonstrate their knowledge/understanding of this important area.

From 30 September 2011 it will be a requirement that all instructors progressing to REPs Level 4 hold a REPs recognised Level 3 qualification in ER.

In 2010 new National Occupational Standards (NOS) in ER were developed and qualifications in ER all now map to the following ER Standards:

D463 Design, manage and adapt an exercise and physical activity programme with referred patients

D464 Instruct exercise and physical activities with referred patients

This CPD is therefore aimed at exercise professionals wishing to progress to Level 4 Specialist Exercise Instructor status who hold an ER qualification that mapped to the superseded ER NOS Unit D449 - Design, agree and adapt a physical activity programme with referred patients/clients.

Successful completion of this CPD is a requirement for these instructors to register with REPs at Level 4.

Instructors who hold an ER qualification mapping to the NOS unit D449 should complete this CPD prior to enrolling on a Level 4 Specialist Exercise Instructor course.

Instructors who hold a qualification mapping to the new ER NOS units D463 and D464 DO NOT NEED TO COMPLETE THIS CPD. However, should they wish to undertake this CPD to gain REPs CPD points, it will provide a useful tool to further assess understanding of these important professional practise elements. All Level 3 instructors wishing to progress to Level 4 are therefore encouraged to undertake this CPD.

N.B. As a guide, ER qualifications mapping to the new NOS units D463 and D464 were not available until end 2010/early 2011, however some training providers will have been legitimately delivering ER qualifications that mapped to the original NOS unit D449 after this point (due to the time it takes to re-develop training course resources/materials etc). If instructors are in any doubt as to which NOS their course mapped to they are advised to check with their training provider.

Aim of this CPD

This CPD provides Instructors with an older style ER qualification with some “top-up” training in specific areas of professional practise standards and processes. This evidence of understanding of professional practice knowledge is considered to be crucial in producing ‘fit for purpose’ ER Instructors and to ensuring this knowledge is achieved prior to progressing to one of the Level 4 Specialist Exercise Instructor disciplines.

N.B. The content of this CPD is now contained within new ER qualifications, which is the reason why it is not a compulsory requirement for instructors who have recently gained their Level 3 ER to complete this additional CPD.

REPs CPD points

Satisfactory completion of the on-line assessment gives 2 REPs CPD points. Details can be found in the member’s area of the REPs Website at www.exerciseregister.org

Learning Outcomes

On completion of this assessed CPD you will:

1. understand the meaning of professional practice in relation to the roles and responsibilities of the ER Instructor
2. understand how to evaluate the quality and reliability of evidence
3. be familiar with the structure of current healthcare systems and the commissioning process
4. understand the significance of health service documents and their impact on healthcare systems
5. understand the importance of effective inter-professional communication
6. understand how to write a letter to a healthcare professional communicating, appropriate information and using accurate language
7. understand professional role boundaries/scope of practise and how to refer back to healthcare professionals
8. understand the significance of health related behaviours and perceptions of the client
9. understand how psycho social economic status can be linked to health
10. understand the characteristics of individuals with an internal or external locus of control
11. understand the meaning of validity and reliability in relation to measurement of techniques and outcomes
12. understand the current position with regard to risk stratification of exercising patients

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1.0 Introduction

As the knowledge and skill base of exercise professionals continues to expand there is ever more contact with the medical and allied healthcare professions. As such, the Exercise Referral (ER) Instructor, must be able to communicate in a professional manner, taking account of normal best practise and principles of work within these fields. Additionally, while the exercise professional is not a doctor or a healthcare professional, those working with patients must have a level of awareness of terminology used within the medical environment and the processes that are required to ensure patient safety.

Letter writing, conducting exercise sessions in patients' homes, general communication, professional courtesy, understanding of one's professional boundaries and effective data collection all fall under the term "professional practise". In terms of their professional role within the ER process, it is not sufficient for exercise professionals to simply be competent at prescribing exercise programmes. Exercise professionals must also demonstrate competence in the practise, protocols and procedures in the settings within which they work (i.e. the fitness and medical/health environments).

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 the fitness sector on public health issues. The exercise professional should be proud of this achievement, which has been driven by everyone in the sector and seek to carry it forwards by striving for the highest professional standards through continuous development of their professional practise skills.

1.1 Professional Practise

'Professional practise' is the term that encapsulates the knowledge, skills, attitudes and best practise protocols and procedures which an exercise professional needs to possess in order to be able to plan, deliver, adapt, progress and supervise safe and effective exercise for the medical condition and tailor it to individual referred patients. For example, when working in ER the exercise professional should be familiar with:

- the national and local policy context within which ER operates.
- the clinical governance structures and commissioning arrangements of the NHS.
- key healthcare concepts such as
 - evidence-based practise,
 - clinical effectiveness,
 - cost effectiveness,
 - return on investment,
 - data protection,
 - patient confidentiality,
 - a client centred approach,
 - written communication and appropriate use of language
 - insurance,
 - CRB & other legal checks,
 - collaborative working,

To ensure the highest level of professional practise the exercise professional is obliged to remain up to date with all policy, research, best practise and standards developments in the field and should undertake regular CPD in the relevant areas.

1.1.1 Evaluating the quality and reliability of evidence

Best practise requires the use of evidence based programmes and procedures. The growth of the Internet and powerful search engines have greatly widened access to information. However, anyone can put information on the internet; some sites (such as the pro-anorexia sites) actively encourage and promote very unsafe practises, while others promote personal thoughts with no solid evidence base.

The exercise professional is responsible for ensuring the accuracy of the information they obtain from the internet and other sources and, therefore, must base their messages on recognised, reliable sources. In most cases peer reviewed research and evidence from academic or medical websites, or official Government policy papers or guidance, such as public health guidance from the National Institute for Health and Clinical Exercise (NICE), are the best sources of information. In addition, national charities or support groups* often have strong evidence-based information, resources and links to wider areas of learning.

Useful sites for obtaining Public Health policy and evidence are listed below:

- Department of Health: www.dh.gov.uk
- The Association of Public Health Observatories: www.apho.org.uk
- National Institute for Health and Clinical Exercise: www.nice.org.uk
- NHS Direct: www.nhsdirect.nhs.uk
- Cochrane Library: www.cochrane.org
- NHS Choices: www.nhs.uk (to access NHS Choices)
- British Nutrition Foundation: www.nutrition.org.uk
- BHF National Centre for Physical Activity and Health: www.bhfactive.org.uk
- World Health Organisation: www.who.int/
- Exercise is Medicine: www.exerciseismedicine.org
- National clinical condition-specific Governing Organisation and/or Charities and support groups (examples cited below*) are useful sites for obtaining evidence-based guidelines and expert consensus-based guidance relating to the clinical conditions specified in the Level 3 ER and Level 4 Specialist Exercise Instructor standards.

Other sources of regional or local information can be found on the regional Public Health Observatories and local NHS websites and in the local Director of Public Health annual reports.

* e.g. The British Association for Cardiovascular Prevention and Rehabilitation, The Arthritis Research Council, National Osteoporosis Society, Stroke Association, Parkinsons UK, Age Concern etc.

Most of the major medical journals are accessible on-line via PubMed. However, determining the quality and relevance of information requires specific skills. These specialist research methodology skills are taught on higher level sports and exercise science courses (for example, consideration of sample size, sample characteristics (i.e. gender, ethnicity, location, socio-economic profile), intervention characteristics and funding sources which 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). From a practical point of view, review papers are the most appropriate. Here experts review the evidence from major studies, often utilising statistical analysis, and then summarise their conclusions. Therefore, although it is important to read widely and build-up your analytical skills, for example by looking at review papers, it is recommended that you base your advice on national recommended guideline documents.

Evidence moves forward all the time and the exercise professional should be focused on the need to continuously develop their knowledge and practical skills through personal learning. REPs require a commitment to ongoing CPD which helps to ensure that fitness professionals are in-line with best practise requirements in their given area of expertise. The exercise professional should always strive to be fully aware of progress and best practise advances in their specific areas of work.

2.0 The structure of the health care system

The new coalition government set out its plans to reform the NHS over the next four years in its *Equity and Excellence: Liberating the NHS* (July 2010) paper. The aim is to devolve power from Whitehall to patients and professionals and move the focus of healthcare management to quality of care.

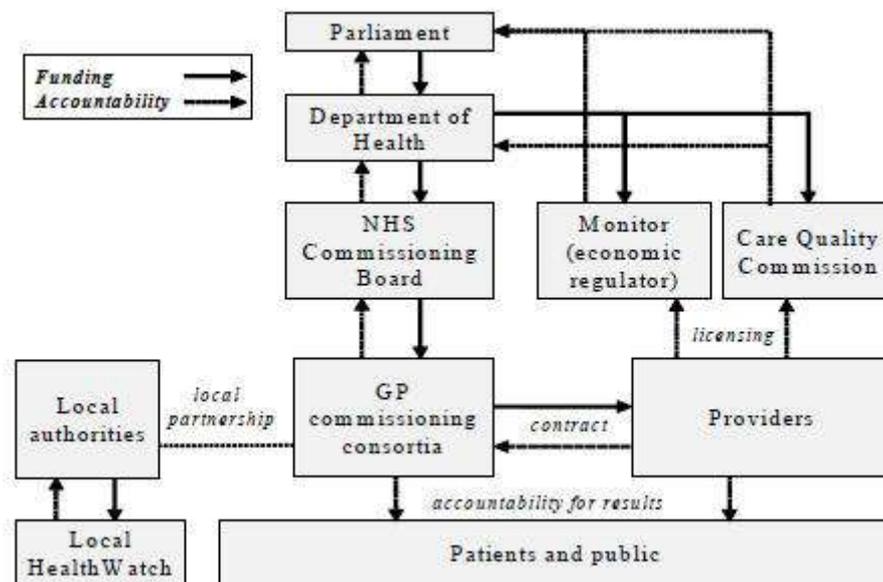
Significant changes to the current structure of the NHS have been proposed including the abolition of Strategic health authorities (SHAs) from 2012/13 – SHAs are the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level.

Furthermore, from 2013 Primary Care Trusts (PCTs), the NHS body currently responsible for commissioning healthcare services, and practice based commissioners will cease to exist and will be replaced by clinical commissioning groups (CCG), formed from GP practices, patients, carers, the public and a wide range of doctors, nurses and other health and care professionals.

The principal legislative reforms that will take place over the next four years will include:

- Enabling the creation of a **Public Health Service**, with a lead role on public health evidence and analysis;
- Transferring **local health improvement functions** to local authorities, with ring-fenced funding and accountability to the Secretary of State for Health;
- Placing the **Health and Social Care Information Centre**, currently a Special Health Authority, on a firmer statutory footing, with powers over other organisations in relation to information collection;
- Enshrining **improvement in healthcare outcomes** as the central purpose of the NHS;
- Making the **National Institute for Health and Clinical Excellence** a non-departmental public body, to define its role and functions, reform its processes, secure its independence, and extend its remit to social care;

- Establishing the independent **NHS Commissioning Board (NHSCB)**, accountable to the Secretary of State, paving the way for the abolition of SHAs. The NHSCB will initially be established as a Special Health Authority; the Bill will convert it into an independent non-departmental public body;
- Placing **clear limits on the role of the Secretary of State** in relation to the NHS Commissioning Board, and local NHS organisations, thereby strengthening the NHS Constitution;
- Giving **local authorities new functions** to increase the local democratic legitimacy in relation to the local strategies for NHS commissioning, and support integration and partnership working across social care, the NHS and public health;
- Establishing a statutory framework for a **comprehensive system of CCGs**, paving the way for the abolition of PCTs;
- Establishing **HealthWatch** as a statutory part of the Care Quality Commission to champion services users and carers across health and social care, and turning Local Involvement Networks into local HealthWatch;
- Reforming the **foundation trust** model, removing restrictions and enabling new governance arrangements, increasing transparency in their functions, repealing foundation trust de-authorisation and enabling the abolition of the NHS trust model;
- Strengthening the role of the **Care Quality Commission** as an effective quality inspectorate; and
- Developing **Monitor** into the economic regulator for health and social care, including provisions for special administration.
- Associated with these changes, reducing the number of **arm's-length bodies** in the health sector, and amending their roles and functions.



The new NHS structure

(From 'Equity and excellence: Liberating the NHS', presented to Parliament by the Secretary of State for Health by Command of Her Majesty, July 2010). N.B. The title of GP Commissioning Consortia has since been amended to Clinical Commissioning Group (CCG).

In order to shift decision-making as close as possible to individual patients, the Government will devolve power and responsibility for commissioning services to local CCGs.

A new NHS Commissioning Board will be set up to fund and oversee the CCGs. This will be a "lean and expert organisation, free from day-to-day political interference, with a commissioning model that draws from best international practice". However, it will be funded by and responsible to the Department of Health.

Following the establishment of the NHS Commissioning Board and a comprehensive network of CCGs, PCTs will no longer have NHS commissioning functions. To realise administrative cost savings, and achieve greater alignment with local government responsibilities for local health and wellbeing, the Government will transfer PCT health improvement functions to local authorities and abolish PCTs. Local Directors of Public Health will be jointly appointed by local authorities and the Public Health Service. Local Directors of Public Health will also have statutory duties in respect of the Public Health Service.

Local authorities' new functions

Each local authority will take on the function of joining up the commissioning of local NHS services, social care and health improvement.

Local authorities will therefore be responsible for:

- Promoting **integration and partnership working** between the NHS, social care, public health and other local services and strategies;
- Leading **joint strategic needs assessments**, and promoting collaboration on local commissioning plans, including by supporting joint commissioning arrangements where each party so wishes; and
- Building partnership for **service changes and priorities**. There will be an escalation process to the NHS Commissioning Board and the Secretary of State, which retain accountability for NHS commissioning decisions.

It is clear that the current healthcare model is to undergo significant change over the next four years and as it continues to evolve it is important that ER instructors are aware of the potential impact it may have on ER schemes.

2.1 The commissioning process

Commissioning is the process of assessing the needs of a local population and putting in place services to meet those needs. It is a complex process with responsibilities ranging from assessing population needs, prioritising outcomes, procuring products and services, and managing service providers. Increasingly it is expanding to include the way decisions are made about directing investment as well as direct service commissioning.

At a national level, the new NHS Commissioning Board (NHSCB) will lead the commissioning system, to support continuous improvement, value for money and safeguard the core values of the NHS. It will account for the overall NHS budget and directly commission around £20 billion of services (primary care, prison healthcare and some specialised services). It will be responsible for the authorisation of clinical commissioning groups (CCG), formed from GP practices, patients, carers, the public and a wide range of doctors, nurses and other health and care professionals. The NHSCB will have a leadership role in promoting patient involvement and choice, and addressing inequalities in access to healthcare.

The local CCG will commission the great majority of NHS services for their patients.

CCGs must commission all urgent and emergency care within their boundaries, and are also responsible for any unregistered patients who live in their area. CCGs will have flexibility to work in partnership when commissioning services, for example with other groups, local authorities and the NHS Commissioning Board. However, as public bodies, they will be unable to delegate their statutory responsibility for commissioning decisions to private companies or contractors.

Quality premiums will still be paid to CCGs who achieve high quality outcomes but restrictions will be put in place to restrict how the CCGs can use the premium.

Again at a local level, new health and wellbeing boards will be the key forum for public accountability of any public service directly related to health and wellbeing. The core purpose of the new boards is to improve local health and social care, and reduce health inequalities. They are to join up commissioning across health, public health, social care and wider services that the board agree are directly related to the health and wellbeing of a community. Improved alignment of commissioning strategies should ensure better health and wellbeing outcomes for the whole population, better quality of care for all their users, and better value for the taxpayer.

The Government has also set out an ambitious and central role for Joint Strategic Needs Assessments (JSNA). The process aims to provide a comprehensive analysis of local current and future needs for adults and children to inform commissioning. This will include a wide range of quantitative and qualitative data, including user and community views, and is intended to lead to better health and wellbeing outcomes and help address persistent health inequalities. Building on the needs and assets identified through the JSNA, the health and wellbeing board will be required to produce the new 'Joint Health and Wellbeing Strategy' (JHWS) that will drive all health and wellbeing strategic commissioning in a locality.

The proposals place a new shared statutory obligation on CCGs and the local authority to produce JSNA and JHWS (through the health and wellbeing board) and to commission with regard to them. The NHS Commissioning Board will also be expected to have regard for both JSNA and JHWS.

Improving the commissioning of ER schemes is at the heart of improving the quality and effectiveness of such interventions. World class commissioning is a statement of intent to invest public funds **“to secure the maximum improvement in health and well-being outcomes from the available resources”**. The principles of world class commissioning will underpin the commissioning process at a local level.

The emphasis of world class commissioning is to achieve better outcomes through:

- **Better health and well-being for all**
 - People live healthier and longer lives.
 - Health inequalities are dramatically reduced.

- **Better care for all**
 - Services are evidence-based, and of the best quality.
 - People have choice and control over the services that they use, so they become more personalised.

- **Better value for all**

- Investment decisions are made in an informed and considered way, ensuring that improvements are delivered within available resources.
- Local health boards work with others to optimise effective care.

The eleven world class commissioning organisational competencies require commissioners to:

- Locally lead the NHS.
- Work with community partners.
- Engage with the public and patients.
- Collaborate with clinicians.
- Manage knowledge and assess needs.
- Prioritise investment.
- Stimulate the market.
- Promote improvement and innovation.
- Secure procurement skills.
- Manage the local health system.
- Make sound financial investments.

The Department of Health four step planning and commissioning model (developed for weight management services) and the world class commissioning competencies can be used in the context of improving the outcomes of ER schemes.

The four step commissioning model puts people at the centre of the intervention and provides commissioners with a process to ensure that commissioning contributes to meeting the organisation competencies for world class commissioning. The four key steps of the commissioning cycle include:





In 2009 the Department of Health produced the document 'Let's Get Moving - A new physical activity care pathway for the NHS: Commissioning guidance' which sets out an evidence-based behaviour charter model called 'Let's Get Moving' to encourage local commissioning of physical activity interventions in primary care. It is hoped that the national roll-out of Let's Get Moving will help to embed the promotion of physical activity as an essential component of high-quality primary care.

On being commissioned to deliver a service such as ER, a provider organisation may be expected to sign a Service Level Agreement (SLA). This would state exactly what was expected from each party, together with time scales and costs. Once signed an SLA constitutes a legal agreement. The exercise professional and/or the organisation that they work for should expect to be held legally accountable if they fail to deliver against agreed goals set out within the SLA.

2.2 Understanding annual reports from directors of public health

Directors of Public Health (DPH) are now employed by local authorities and jointly appointed with the new 'wellness service'. Public Health England, will lead on driving health improvement locally and is responsible for delivering against national and regional health targets.

Annual reports that are currently produced by DPH identify the actions and desired actions of the NHS and local authority in improving the population's health.

The DPH annual report, which is a public document, 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 a range of health variables.

It will also discuss the 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's 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 evidence-based outcomes from local ER scheme may input to these annual reports where they have relevance to the wider health agenda.

It is expected that ER Instructors make themselves aware of the contents of the DPH's annual report in their area and that the ER scheme they are involved with mirrors the identified needs of the local population.

2.3 Review of key health service documents

Physical activity is integral to national public health policy.

The Secretary of State for Health has made it clear that physical activity plays a key part in the NHS delivering its quality and efficiency commitments, building on progress in implementing the commitments set out in Lord Darzi's Department of Health 2008 report 'High Quality Care for All NHS Next Stage Review Final Report'.

An important public health document (known as a white paper) of recent times relevant to ER is Choosing Health: making health choices easier (2004). This document, from the Department of Health 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 choices.

Evidence within Choosing Health shows how interventions typically found in ER schemes could have a positive impact on health either as an intervention or in a preventative manner.

In 2005 the Department of Health followed up with 'The Choosing activity: a physical activity action plan' which set out Government's plans to encourage and co-ordinate the action of a range of departments and organisations to promote increased participation in physical activity across England. It summarised how the commitments on physical activity presented in the public health white paper Choosing Health: making healthier choices easier would be delivered.

More recently, the following national strategies have acted to raise the profile of physical activity as a key tool in public health policy:

- Department of Health 'Be active, be healthy: A plan for getting the nation moving' (2009);
This plan emphasises the physical activity legacy of the 2012 Olympic and Paralympic Games and its contribution to the target for 2 million adults to be more active in the run up to the 2012 Games. Be Active, Be Healthy supersedes the Choosing Health: Choosing Activity Delivery Plan and provides details of an improved delivery infrastructure, new national programmes and highlights the importance of local delivery to meet community needs. The plan is set around four guiding principles:
 - Informing choice and promoting activity
 - Creating an "active" environment
 - Supporting those most at risk
 - Strengthening delivery

- 'Healthy weight, healthy lives: A cross-government strategy for England (2008)'
This cross-government strategy is the first step in a sustained programme to support people to maintain a healthy weight.
- Before, during and after: making the most of the London 2012 Games a cross-government strategy setting out actions to achieve the target of helping two million people to become more active by the time of the 2012 Olympic Games and Paralympic Games.

Another initiative of relevance is the 'Public Health Responsibility Deal', launched on 15 March 2011. The Responsibility Deal is government driven and has been established to tap into the potential for businesses and other organisations to improve public health and tackle health inequalities through their influence over food, alcohol, physical activity and health in the workplace. The Deal's strength comes from organisations of different types across varying sectors working together to improve people's health. The Deal focuses on 'five core commitments', 'collective and individual pledges' and 'supporting pledges' made by those who have signed-up to the Deal.

The FIVE core commitments of the Responsibility Deal:

1. *We recognise that we have a vital role to play in improving people's health.*
2. *We will encourage and enable people to adopt a healthier diet.*
3. *We will foster a culture of responsible drinking, which will help people to drink within guidelines.*
4. *We will encourage and assist people to become more physically active.*
5. *We will actively support our workforce to lead healthier lives.*

Government priorities do change from time to time and reports will be published which reflect these changes, so it is important for instructor's to keep abreast with new reports.

National Service Frameworks

A National Service Framework (NSF) is a document that identifies best practise 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. New ones are published from time to time.

NSFs are targeted at doctors and allied health professionals with a more clinical or management bias. That said, the exercise professional working with a specific population should be familiar with the NSF for that population where one exists. NSFs and recent upgrades can be found on

the Department of Health website. 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, but particularly by service commissioners.

National Institute for Health and Clinical Excellence

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. It also acts to determine best practice and best value within the health sector.

Anyone with a legitimate interest can contribute to NICE consultations. Such 'stakeholders' will normally be a recognised professional or other group although individuals may also contribute. For example, the Health Improvement Team of the local PCT is likely to contribute to a NICE consultation on physical activity and the environment as they would expect to have input to the implementation of NICE's recommendations.

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 effectiveness 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 medicine offers an ever expanding array of interventions which continue to make demands on the financial resources of the NHS.

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.

In 2006 NICE produced the guidance document 'Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling'.

This guidance was aimed at professionals in the NHS, local authorities and the voluntary sector. It focused on four methods of getting adults to be physically active:

- Brief interventions – advice delivered by GPs and other non-hospital-based health professionals.
- Exercise referral schemes – referral to a tailored physical activity programme.
- Pedometers – use of a device to measure how far you have walked.
- Walking and cycling schemes.

The exercise professional should be fully aware of NICE guidance pertaining to the patients they work with and they should remain up to date with any changes or new guidance as it arises.

Other documents are continuously produced by the Department of Health and other Government bodies. Exercise professionals engaged in ER are expected to remain aware of new policy/guidance 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 patients he/she works with. In some cases such

organisations are considered leaders in new interventions and condition management and publications they produce should be referred to alongside government policy/guidance.

3.0 Inter-professional communication

The most effective interventions use multi-disciplinary practise as a central concept of condition management. As long term supervised exercise is increasingly recognised as part of the patient care pathway it is rare that the exercise professional will work without any recourse to either managers or other professionals. Being part of a multidisciplinary team must be a key aim for the ER instructor.

ER Instructors should ensure that they have the skills and the confidence to communicate effectively and work professionally with people who have other expertise.

Within the multi-disciplinary team the exercise professional should be confident to offer recommendations regarding their area of expertise and experience. Equally, they should seek, and 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/knowledge transfer, wider skills base, reduced likelihood of something pertinent being missed and opportunities to discuss issues that are not clear or straightforward.

ER Instructors should ensure they have access to other professionals to discuss, in confidence, the most appropriate course of action (e.g. additional condition-specific adaptations or tailoring and motivational strategies) for a particular patient.

3.1 Complying with local health and safety protocols and procedures

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 exercise professional 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. The exercise professional should be able to focus on the core aspects of the programme. In lone (i.e. independent) working the exercise professional must ensure, as far as is reasonably practicable, that the environment is safe.

Personal safety is an issue for both male and female exercise professionals in both on-site and off-site interventions. Pre-prepared plans for requesting assistance should be in place, time lines for where and 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/local authority) on lone/independent) working are available and the exercise professional is strongly recommended to consider attending one of these.

Perhaps the most significant risk is the threat of a claim of inappropriate behaviour. In a lone /independent working environment where there is only the exercise professional and the patient, simply the claim of inappropriate behaviour (even if unsubstantiated) may be sufficient

to significantly damage the reputation of the exercise professional. Professional practise requires only appropriate physical contact between the exercise professional and patient for which permission must always be asked. There must be clearly defined rules of physical contact which are discussed prior to proceeding with the intervention programme, and opportunities to discuss and feedback, without fear of ridicule, anything that has made either party feel uneasy. There should also be a mechanism to discontinue the professional relationship if it appears that there is a potential threat in continuing it. Members of REPs are bound by their Code of Ethical Practise which includes standards of conduct and behaviour (the code of ethics is available at www.exerciseregister.org). Ensuring that the specifics and limitations of this code are fully understood by the referring professionals is important for clarity of roles and responsibilities.

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

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 increases.

3.2 Written communication

Letter writing (and other related written tasks such as record keeping, progress reports etc) is a skill often overlooked; however, in worst case scenarios a written letter may be the document upon which a civil case against you stands or falls. 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.

- **Presentation:**
Standard formatting should be used such as sender's address, delivery address, date and signature, 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.
- **Letters:**
Letters should be addressed to the patients GP or to the health professional who made the initial referral (with a copy to the GP). The contents of such a letter are essentially clinical and therefore confidential 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 would most likely use lay language. However, it is now common practise for a copy of letters between doctors and other health professionals to also be sent to the patient. It is advisable to follow this practise firstly because it ensures that the patient knows exactly what is being written so there are no hidden agendas and secondly, the patient can go to the doctor with the copy and ask 'did you get this letter from my ER instructor?' This helps to keep things running smoothly. Inevitably the letter will have some technical language in which either the exercise professional or the GP can explain to the patient.

Be sure to use spell checkers and use medical dictionaries where the spell checker does not give the correct option. Make sure that the terms you use are accurate. For example you should refer to Type 1 or Type 2 diabetes not 'diabetes'. A common mistake is to muddle up symptoms and signs. A symptom is what the patient complains of. A sign is what is observed or elicited. So a patient may complain of pain in the shoulder when lifting a dumb bell. That is a symptom. You observe that they cannot abduct the arm beyond 90 degrees. This is a sign.

- Professional title:
When writing to a medical professional an exercise professional would normally state their position e.g. Senior ER Fitness Instructor in the Westside ER Scheme. Degrees should be included and ensure that your ER qualification(s) are highlighted as fitness sector qualifications are unlikely to mean much to health professionals. It will be assumed that you have the appropriate additional qualifications and had the appropriate safeguarding checks and have the requisite personal liability insurance.
- Stay within your professional boundaries:
Avoid the temptation to offer a diagnosis; Exercise Instructors are not trained diagnosticians!

The medical professional retains clinical liability for the patient 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 decline to refer a patient to you or take note of any advice you may offer. While most doctors do not have a detailed knowledge of exercise programmes you should inform him/her in general terms of the programme which is being undertaken, For example, 'Your patient will be doing aerobic work starting at a low intensity which will increase as he/she gets fitter. There will also be some training to improve muscle strength and endurance as well as flexibility and motor function such as balance and coordination. Your patient will be carefully monitored throughout each training session.'

Letters come under the Data Protection Act 1998 and you therefore require a patient's consent to write one. It is sufficient to say, 'I would like to write to your doctor. Is that OK with you?' Failure to comply with the Data Protection Act may constitute a criminal offence and attract significant legal penalties. Any letter about a patient should be stored in accordance with the Data Protection Act. In simple terms that means that is accessible only to those authorised to access it and nobody else.

Make sure that a letter does not contain any observations which cannot be supported by evidence or are judgemental or demeaning. Thus you must not write, 'This lady is very fat and just needs to stop pigging out'. It has to be, 'This lady has a BMI of 32 which places her in the clinically obese range. She would therefore benefit from advice about healthy eating.'

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.

3.3 Confidentiality

Confidentiality in a medical or paramedical environment is essential.

It is unwise to underestimate the potential legal ramifications of failure to comply with confidentiality laws. Both criminal and civil proceedings can be brought against a person failing to comply with the Data Protection Act. There are serious penalties for failing to comply with it

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 for which it was collected
- must be destroyed once it has no further value for that purpose

Further to this, verbal communication is also covered by the Act. So exercise professionals must be conscious of what they say, to whom and who may overhear it. This applies equally to one's partner as to colleagues and other staff.

Aside from the legal aspects, confidentiality is central to ensuring that a patient 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.

While confidentiality for patients is an ethical duty the legal aspects are enshrined in the Data Protection Act 1998. In working with patients the following points are at the core of confidentiality:

- Control of access to a patient's referral form and notes
- Their exercise 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'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 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 is fail safe

As with anybody else working with patients, exercise professionals are bound by the conditions of the 1998 Act and it is a criminal offence to step out side them.

3.4 Respect of professional boundaries

The term 'professional boundaries' refers to the scope with which a person can act given their 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 are trained to perform. While it is generally safe and appropriate to perform this task exercise professionals would step beyond their professional boundary if they were to say to a patient with contraindicated blood pressure, "you have high blood pressure". That is a statement a fitness professional is not qualified to make. 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 can take another measure when the patient is more relaxed and/or less anxious. (It is well known that blood pressure often rises when it is taken by a professional person – so called 'white coat hypertension') and/or they can refer the patient 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 outside their professional boundaries. Exceptions exist of course. Physiotherapists for example frequently prescribe specific exercises as part of rehabilitation from illness, injury or surgical intervention. The Medical Defence Unions advise that doctors should be asked "is there any medical reason why your patient should not undertake this form of exercise?" having described in general terms what that programme will be. However, we need to avoid confusion here. If the patient has actually been referred for exercise then the doctor has already answered that question.

It is imperative that exercise professionals are able to identify their own professional standards and boundaries for their multidisciplinary colleagues and stick rigorously to these. These standards and indicators are set out clearly in the NQAF (2001). Only through continued compliance with such conduct will exercise professions continue to increase their reputation as a significant part of the national health agenda.

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

REPs recognises the achievement of qualifications and CPD for exercise professionals whilst SkillsActive develops the National Occupational Standards (NOS) which form the basis of qualifications. The General Medical Council and Medical Defence Unions recognise REPs as the UK body for the registration of exercise qualifications and as such allow medical professionals to refer low risk patients with certain medical conditions to exercise professionals who are registered with REPs with the Level 3 ER category of registration.

Accurate awareness of one's professional boundaries will enhance 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 are likely to provide comprehensive management of a patient's condition.

3.5 How to refer back

In certain circumstances it may be that a patient'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's decision to stop taking their medication, perhaps because they believe that they no longer need it, the exercise professional should strongly urge the patient not to change anything unless under direct instructions from their GP or other healthcare professional. At the same time clear notes should be taken outlining the course of action taken. This should be signed by a manager. The referring party (i.e. GP) should be informed of this action by the patient at the earliest opportunity. This should be followed up by a letter from the exercise professional to the doctor. The exercise professional's responsibility is to tell the doctor that as the patient has decided not to take their medication he/she feels it is no longer safe to continue with the exercise programme without the doctor's advice.

For a more straight forward referral back to the 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 send this to the original referrer. A copy of this letter or email should be kept in the patient's records.

The patient should be made aware that this is happening, together with the reason why it is happening and what action, if any, they need to take. Any further intervention by the fitness professional must not take place until the referring health professional gives permission for this.

3.6 Legalities

There is a raft of legislation in the United Kingdom, which governs duty of care, employment, working practises and professional practise.

The Home Countries may have their own legislation in some areas; 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 patients, clients, fitness and health professionals and employers alike. It is a serious offence to infringe these Acts. Such infringement can attract serious penalties. Ignorance of the law is no defence against breaking the law.

Some documents that people believe remove responsibility generally do not. For example, a waiver signed by a patient does not waive responsibility of a duty of care by the exercise professional.

Where documents exist that set out best practise the Courts will normally judge an individual's practise by these as well as hearing advice from experts in the relevant field. In the realm of ER the NHS document *ER Systems: A National Quality Assurance Framework (2001)** is such a document, backed up by the ER NOS D463 and D464 (and/or other relevant Physical Activity

and Health NOS e.g. Unit D518 Design, agree and adapt a physical activity programme for adults with Cardiac Disease) and the British Heart Foundation ER Tool Kit (2010).

* N.B. A new 'Professional and Operational Standards for Exercise Referral' document is being developed to take account of NHS and fitness sector professional education changes. This will act as an update to the existing National ER Standards document.

3.7 Ethics

Ethics is about how we behave, setting out what is right and wrong, what is acceptable and what is not. Ethical standards have developed over many centuries. They are built on the moral, religious and philosophical thinking of many generations with each succeeding generation developing and applying this thinking to their own times. Thus what are acceptable changes differ from time to time but there are four key principles which apply across the board of human behaviour and are highly relevant to working with patients. These **four** key principles are:

- **Autonomy**, that is a person's right to make their own decisions about what happens to them and what is done to them. A doctor may strongly advise a person to have an operation but the decision rests with the person. They may decide that they do not want the operation and they cannot be forced to have it against their wishes. Similarly, a person cannot be forced to undertake an exercise programme and they have an absolute right to decline to do what an exercise professional advises.

However, the exercise professional also has rights. Where a person persistently refuses to act on the reasonable advice of an exercise professional, the exercise professional may quite ethically withdraw from the professional relationship.

The central issues of consent and confidentiality are governed by the principle of autonomy.

The exception to autonomy is where a person is deemed incompetent to make informed decisions for themselves (not something likely to be encountered within the exercise professional's work). The law makes special provision for these people who are said to 'lack capacity'.

- **The duty to provide benefit** (i.e. be effective). This is obvious and simply states that in our professional work we have a duty to benefit our clients and patients. The other side of the coin is that if we are advising without a strong evidence base that it will provide benefit, we should not be advising it.
- **The duty not to cause harm** (i.e. to be safe). This is also obvious but it makes us ask the question 'is there a chance that what I am advising the patient to do may harm them?' We all recognise that asking a client or a patient to lift an inappropriately heavy weight may well injure them so we don't do that.

These two principles: the duty to provide benefit and refrain from causing harm, extend widely into how we behave and carry out our professional work. They mean that we will:

- be punctual and courteous
- keep accurate records
- work within our professional boundaries;

- keep up to date,
 - put the patient's welfare before our own
 - be non-judgemental about such issues as education, social background, health status, ethnicity and sexuality.
- **Justice.** This means that personally we will :
 - treat people as having equal value
 - endeavour to allocate our time and expertise fairly.

It has much more difficult applications in the public arena in the distribution of resources which can be illustrated by two examples.

- (i) After reviewing the evidence, NICE concludes that a certain drug should be funded by the NHS. In making this decision it is seeking to 'be just or fair' that preventing public money being spent on another drug which is not as effective as it is claimed to be and thereby making that money available for effective treatments.
- (ii) Similarly if exercise became a normal part of healthcare, money would be saved and there would be a much more 'just or fair' use of limited public resources.

In research there is a requirement for ethical approval by the appropriate ethical committee before the research can be undertaken. The committee's job is to ensure that the principles of ethics are adhered to in the study. For example if the study involves comparing one drug with another one the patients must be informed about what the drugs do, their side effects and the fact that they will not know which drug they are taking. They must be free to decline to take part in the study and opt out at any stage. Where an exercise professional wishes to embark on any form of study involving patients ethical committee approval must be obtained – but be warned that may take many months!

4.0 Consulting skills – adopting a client-centred approach

As well as having the technical knowledge required to be a safe and effective ER instructor it is crucial that the exercise professional can also consult in a manner that enables a successful outcome to be achieved for the patient.

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. These principles can be adapted for engaging patients.

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/ condition
- awareness of psychological state of change
- interest

- empathy
- professionalism
- awareness of professional boundaries

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

Consulting is a two way process where the end result is acceptable to both parties involved 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 design and delivery of an appropriate, safe and effective intervention.

4.1 Unravelling jargon

Different professions often say the same thing in different ways using what seem to be complicated terms. The medical professional may use complex terminology accurately to explain a condition whereas a patient will use 'lay language', however, doctors increasingly explain medical matters in ways which can be understood by lay people.

Similarly terms used within the fitness industry may also be difficult for patients to understand. For example many people who have never been into a gym before will have little idea what aerobic exercise is or know what a 'lat pull down' is. Thus it is important to put both medical and exercise terminology in ways which can be understood without giving inaccurate information. This may be particularly difficult for an exercise professional to do with medical terminology. The Internet is a useful source of 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 may not:

- recommend changes to prescription medicine
- agree with a patient who asks if they should change their medication
- offer advice on the condition and its likely prognosis
- disagree with a medical professional's opinion

4.2 Appreciation of client perceptions

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.

Different patients will interpret the same situation in different ways; indeed, the same patient may well interpret the same situation in different ways at different times depending on their emotional status or external cues such as influential others (e.g. family, healthcare/exercise professionals) etc.

Evidence suggests that in a medical or paramedical environment, 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 patient may give an answer to placate or impress the exercise professional, who would then proceed with that 'knowledge', creating an end result with which the patient does not engage.

Where possible the exercise professional should consider the perceptions of the patient by considering what may impact upon them. This is not easy but is necessary to fully appreciate the needs of the patient. For example, an exercise professional who has never been obese may find it challenging to consider the perceptions of an obese patient 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. Nevertheless, it is likely that the exercise professional has had a similar experience at some stage of their life where he/she felt vulnerable and threatened. While this experience may be useful in empathising with the patient, it is very unhelpful to use phrases such as 'I know how you feel', or 'I was in a similar situation once.' Rather the exercise professional has to enable the patient to identify their feelings and perceptions, face them and find ways of dealing with them.

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

4.3 Respecting health behaviours

Health behaviours are behaviours that may have an impact upon someone's health and are often divided into sub-components such as:

- dietary choice
- taking part in screening programmes
- visiting a doctor/healthcare professional
- levels of physical activity/inactivity
- risk-taking sexual behaviour
- patterns of tobacco, alcohol or substance control

Health behaviours are a complex mix of:

- personal beliefs,
- peer pressure,
- socio-demographic background,
- influence of significant/influential others,
- advertising
- previous experiences

The exercise professional should present themselves as a professional individual who can offer advice or, where necessary, signposting to other specialists, but must never pass judgement or offer unwanted advice. However, where there are serious and often long-standing issues which influence lifestyle, exercise professionals are not usually trained to deal with them and should not try to do so. For example, obesity and over eating may be associated with sexual abuse during childhood. This presents a huge barrier to changing eating habits. Once an exercise professional suspects that there is a deep underlying issue, no attempt should be made to unearth it, but the patient should be advised to consult their doctor.

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

4.4 Psycho socio economic status

Across the UK there are a wide range of socio-economic groups, coupled with the psychological impact such variations have on people. The Index of Multiple Deprivation (IMD) identifies by local authority electoral 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
- wealth
- job profile,
- local area information which will be available from the PCT and/or local authority websites.

This can be a useful tool when identifying the likely socio-economic status of your patient.

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.

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 when giving recommendations.

For example, access to safe areas for physical activity may not be available, or be perceived as unavailable to a patient from a deprived socio-economic environment where the perception of crime is high. Higher quality food may be less available in a deprived socio-demographic neighbourhood or beyond the income of the patient. In this social group, therefore, it may be very difficult for patients to establish healthy eating patterns and specialised help will need to show how it is possible to eat healthy on a low income. 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 ER provider may assist with the cost of accessing a programme.

The exercise professional should consider **all** aspects that may impact upon the health and well being of the patient 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 local neighbourhood centres.

4.5 Understanding illness behaviour – how patients handle illness

Illness behaviours are those that the patient engages in once they are, or believe that they are ill. This is driven by many different factors.

- Some people may choose to ignore an illness as a coping strategy where another will seek advice from all quarters. Sometimes 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 back to the original referring medical specialist if the patient intends to change medication by buying OTC drugs.

Most patients cope with illness very well. Anxiety and fear are normal when we get sick. However, where these become severe they 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 (which may not be as expected), and utilise the skills of others in a multi-disciplinary team approach.

4.5.1 Sickness Role

In simple terms the sickness role is the behaviour that a person exhibits because they believe that is how other people expect them to behave. For example a person with influenza may present themselves as very tired and feeling generally poorly more or less than the actual symptoms they feel.

Sometimes an illness becomes an attention seeking device and generates an abnormal level of dependency. This is particularly hard to manage and indeed an exercise professional may collude with it by encouraging dependency on them. However, the exercise professional's objective is always to help the patient take responsibility for themselves and their lifestyle.

4.6 Locus of control

Locus of control attempts to understand whether or not a person feels that they are in control of a situation and therefore have some influence on the outcome.

For example, one obese person may believe that they can control their obesity by 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. Clearly the one has a good chance of losing weight while the other is unlikely to be successful.

There is substantial literature on locus of control in the health psychology journals. A lot of work has been done in managing the locus of control in smoking, alcoholism, obesity, mental health and substance abuse which provide useful models for exercise professionals.

Locus of control theory separates individuals into internals who believe they themselves to have an influence on their circumstances and experiences, and externals who believe other factors, outside of themselves are the key influences on 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 resist external pressures more effectively (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 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 cannot influence a situation, often because of previous failure. Externals are also less likely to engage in actions they perceive to carry a risk of failure and will require more motivation.

The exercise professional should learn to recognise characteristics of internal and external locus of control.

4.7 Developing a client needs analysis

ER is not a generic 'one size fits all' programme. Indeed, patients with the same condition are likely to have very different needs in addition to the ones which normally accompany the condition. It is important to try and identify these. They may change over time depending on the stage of the condition and a patient's confidence in managing it. Identifying these needs requires a sense of security and trust in the exercise professional, which is generated by a feeling of empathy rather than by an instructional or confrontational approach.

Information should be recorded confidentially for later analysis.

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 judgement about what is being said. Equally, they should be certain that they understand what the patient means by reflecting back to the patient with such phrases as "so what you're saying is..." "am I right in thinking that...?"

Do not make assumptions. For example, the patient 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 what assistance is needed and how it should be delivered before a programme is started (i.e. ask the patient).

A patient may chose to withhold information or simply forget to mention something and only offer it up once a relationship of trust has been established. Therefore, the exercise professional should be prepared to accept new information and adapt the programme as

necessary. The patient 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 information on the referral form the exercise professional may need to go back to earlier discussions with the patient or, at times, consult with the referring healthcare professional.

4.8 Motivation, counselling and support techniques

There are several different counselling techniques of which motivational interviewing and cognitive behaviour therapy (CBT) are two examples. Exercise professionals **should not** engage in this type of work unless they are qualified to do so. Furthermore, there is often limited one-to-one time available to employ these techniques to any real effect.

Exercise professionals **should attempt** to create an environment where the patient feels empowered to move forwards. They should be active listeners, providing non-judgemental answers, reflecting back the patient's thoughts and feelings to demonstrate understanding of the patient's situation.

Other counsellors may be used to deliver specific programmes such as smoking cessation or additional assistance with mild depression. These can be accessed via the local NHS or mental health service.

Support techniques which can have a significant impact on people's lives may include the creation of social networking opportunities that do not include structured exercise. This could simply be allocated time for social events such as 'tea and chat' or an allotted time for discussion.

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 positive effect on the patient'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 satisfy themselves about the safety, appropriateness and professional standing of any person/organisation involved in motivation or counselling services. The local NHS may hold a register of recognised groups such as MIND that offer professional support in a safe environment.

4.9 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, sexuality or age.

Equality means that there is equal access to services. This includes the assessment of:

- cost
- travel
- accessibility of venue e.g. frailty
- awareness of programmes

- the use of translation services to ensure the most appropriate groups are informed about local health enhancing services etc

It is not sufficient to simply state that a service is open to all members of the community when barriers such as cost prevent some people from accessing it.

Tracking referral data to identify which groups access a service must be done with care, but such practise can identify important findings such as that those least likely to access a service are those who are most likely to benefit. Equally, recognition that different conditions are more prevalent in certain ethnic groups will enable a more accurate and effective campaign to attract those most at need.

5.0 Measurement techniques for motivation, outcome evaluation, exercise prescription and physical activity

It is important to balance the needs of the patient and the value of various tests. Too few tests and it will not be possible to assess outcome accurately; too many and the patient will feel that the process is being done 'to them' rather than that they are a part of the process.

Tests may be motivational so long as the patient understands the time line for improvement (e.g. a fat percentage is not likely to improve for weeks or months). 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 to work in a more focused manner, or de-motivating as it suggests they are a failure.

The other concern with repeated testing is whether it causes the patient only to 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 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 tests measure an aspect that may in turn be impacted by many other things. For example, a weight increase or worsening bioelectrical impedance result of an overweight/obese female patient may be due to increased fat mass or fluid retention associated with the menstrual cycle. 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. Nevertheless when serial measurements are being made every attempt should be made to ensure that the **testing conditions** are the **same each time**.

The principle of good measurements/testing is **to guide exercise prescription** so that it is appropriate to the patient's physical and psychological potential and that it enables appropriate adaptation of programmes over time. Tests should be:

- appropriate to the patient's needs,
- performed as a two way process *with* the patient rather than done to them,
- confidential and private,
- conducted in a manner likely to promote continued improvements.

On rare occasions the patient may not want to know the results. In such a case the information should be recorded and stored safely so that the patient may view them at a later date if they wish to.

While quantitative measurement is important there are other ways of assessing progress qualitatively. Examples of these are quality of life questionnaires and anecdotal evidence.

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

Much time is often devoted to testing physical fitness 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 de-motivating if performed poorly. To meet best practise guidelines the test or assessment tool must be:

- validated
- reliable

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 pedantic it is important to consider the value of the test in terms of the significance a patient gives to it. The sit and reach test is one of the classic tests offered in a gym environment. Consider what useful information this gives in relation to the needs of the patient 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 bounce forwards a little and place stress on the lower back. The risks and benefits of carrying out such a test for the patient must be carefully evaluated.

Many tests exist that have had their validity tested extensively with the group of subjects for whom they were designed, for example, the Cooper test for aerobic endurance, the use of goniometry for joint angle potential (ROM), 1RM for maximal strength. Wherever possible the exercise professional should use a test with published, recognised, validity that is appropriate to the patient group. If there is no appropriate validated test for a given patient, instructors should discuss how best to proceed with a senior colleague/other appropriate member of the multi-disciplinary team.

Reliability is another important concept in testing. **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 topical is obesity assessment. Many different bioelectrical impedance instruments 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 conditions. 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.

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. However, it has to be recognised that with most measurements there is always some variation in the results even when all the other variables are constant. For example some equipment used for the bioelectrical impedance measurement of body composition has a 3% error range. So it may give a reading of body fat percentage as 15% but the actual percentage may be 12 or 18. This relatively small variation is not important because what we are looking for in taking regular measurements are the trends – are they going in the right direction.

6.0 Risk stratification

Risk Stratification is part of an ongoing Risk Assessment and Management Strategy (RAMS)

Increasingly attention is being brought to the importance of ensuring that a clear, published RAMS is in place in all patient and general exercise services in order to ensure medico-legal integrity of the service for all patients and professionals involved.

Risk stratification is a process by which the exercise professional evaluates the medical history of a client to determine the level of risk of a health/disease event occurring either acutely or predicted for the future. Typically a rating of low, medium or high risk of such an event is established. However, this is not a static rating and the exercise professional should note changes in health and fitness condition that can either increase or decrease an individual's level of risk. For example an individual who has medical treatment (e.g. medicine or surgery) that significantly reduces symptoms and associated problems may also reduce their level of risk.

Risk Stratification is not a single rating

Risk stratification is rarely a single measure or rating as a number of different medical aspects can be risk stratified. Individuals, especially over the age of 50 years, could have a number of individual conditions that each need to be risk stratified. Furthermore there are two general aspects of risk stratification that need to be determined for each condition:

1. What is the risk of an “acute” event occurring from physical exertion (here and now!)
2. What is the risk of an individual developing a specific condition over-time (chronically) for the future?

For the exercise professional the greatest concern is naturally the immediate risk of an event being caused “acutely” by participation in exercise.

Take for example an individual who is obese, has high blood pressure and is diabetic. This individual will be rated as a “high risk” of acquiring cardiovascular disease or a stroke in the “future” but if they have no present cardiac or circulatory pathology they could be rated as low risk of an “acute” event on exertion. This shows that the risk stratification of a person is multi-factorial. Consider again this person who is obese, with high blood pressure and diabetes and then consider the following:

- Depending on the stability of the blood sugar control, this person would need to be evaluated on whether they are at a low, medium or high risk of an acute hypo- or hyperglycaemic event during exercise

- If the person has no cardiac or coronary heart dysfunction, then they will be at a “low” risk of a cardiac event during low to moderate intensity exercise
- Being inactive is linked to a high risk of an acute event during heavy exertion and even more so if there is underlying cardio-circulatory pathology
- If the person has existing cardiac or coronary artery or circulatory disease then a separate process of risk stratification would need to be determined for the risk of a cardiac event during low moderate or vigorous activity

Another example might be an older person with balance and strength problems and osteoporosis. They will be considered high risk of both falling and fracturing. They may however have no other health conditions so would be at low risk for example of a cardiac event during exertion. However, the incidence of many acute and chronic health conditions tend to accelerate after the age of 70 years, so age must be considered within risk stratification.

The Risk Stratification process, and the overall RAMS, involves the ongoing assessment, monitoring, quality assurance and strategic management of risk in relation to:

- The patient(health and functional status)
- The environment (access, transitions, transport etc where appropriate)
- The professional (expertise and experience matched to clinical need)
- The evidence(currency of exercise prescriptions) and best practise guidance
- The operational and evaluation systems in place.

Part of this process must be to ensure that the RAMS and the respective roles and responsibilities of all involved is made public to the PCT /GP Consortia, the local multi-disciplinary teams, the ER Service staff and the patients.

The aim of Risk Stratification

When it comes to exercise, many health professionals may tend to consider risk stratification in a negative sense, raising fears about patient/client participation with the outcome of excluding participation. This process should however focus on the more positive aspects from the perspective of doing everything possible to include patients/clients to participate. The risk stratification is there to help the exercise professional appropriately modify the type of exercise situation (class, group, or individual session); the amount and qualified level of supervision or monitoring required; and putting in-place appropriate pre-activity screening procedures and safety procedures and equipment in the event that a problem arises. Assuming appropriate exercise screening, adaptation and monitoring takes place by an appropriately qualified exercise professional then in most cases, patients/clients have more to gain (physically, psychologically, socially) than to lose by participating, which is the underpinning philosophy of ER Schemes.

The role of the exercise professional in relation to the role of the referring medical practitioner

The medical professional (Doctor, Nurse or allied health professional) makes an ER on two assumptions: 1. they are acting in the best interest of the patient and 2. the person to whom they are referring is appropriately qualified to receive that patient with a given condition(s). The exercise professional should however, not assume that this is a clear pathway to start a patient/client exercising until you have taken all the necessary steps for screening and risk stratifying the patient. There is nothing wrong in making a decision that at present, the patient you have in front of you may be beyond your present level of competency. BUT, your

responsibility does not stop here; you should take up the responsibility to seek out someone who can help with this patient, as opposed to excluding participation outright.

As an appropriately qualified exercise professional, it is your responsibility to gather the correct information in order to appropriately risk stratify a patient/client. You are the specialist in exercise, you know your own exercise settings and there is nothing wrong in checking and double checking that you have all the correct information to risk stratify as best as possible before engaging a client in exercise. Experience, appropriate training and continuing professional development is required in order to keep abreast of the latest information so that you can carry out the risk stratification process to the highest standard.

Recognised Risk Stratification Protocols

There has never been a nationally agreed definition and understanding of risk stratification in the context of ER in the UK.

A range of approaches are being utilised by ER schemes: Some schemes are following the pyramid presented in the NQAF which aligns the patient's health characteristics with the required level of exercise professional expertise according to the national occupational standards; some schemes are using the ACSM risk stratification categories; others schemes are using guidelines developed at a local level in consultation with medical professionals and clinical exercise physiologists; and finally, some schemes are unsystematically using a combination of one or more of the above approaches.

A single approach to risk stratification does not exist, however it is apparent that there is a significant need for a risk stratification tool which would enable exercise professionals to standardise their approach to risk stratifying referred patients.

A project is currently underway to establish a national protocol for risk stratification that can be applied to ER, however, in the absence of any national guidance presently, exercise professionals are advised to continue to use the pyramid model presented in the National Quality Assurance Framework for ER Systems (NQAF, 2001) which includes a model for matching patient characteristics, including risk, with instructor competence and experience. In addition an alternative risk tool developed by Irwin and Morgan which uses a traffic light system to identify risk could be utilised.

(Adapted from the BHF National Centre for Physical Activity and Health ER Toolkit, 2010)

Although in the UK, risk stratification protocols do exist for each of the clinical conditions positioned at Level 4, these are condition-specific and have been developed by the medical experts involved in these specialities e.g. Cardiac Rehab, Falls Stroke. A validated tool to stratify both more complex patients (multi-pathology, poly-pharmacy etc) and also, low risk patients, is much needed by the health and exercise sector.

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.

Furthermore, UK standards on risk stratification will be contained within the 'Professional and Operational Standards for Exercise Referral' document that, once published, will act as an update to the existing National ER Standards document, the NQAF. The new standards are being produced by the Joint Consultative Forum of Medical Royal Colleges, The Faculties of

Health & Sport and Exercise Medicine, The Chartered Society of Physiotherapy and the Fitness Sector of the United Kingdom.