DEVELOPING THE GP RESPONSE IN LONDON TO A NATIONAL CAMPAIGN TO INCREASE PHYSICAL ACTIVITY AMONG OVER 55s WITH LONG TERM CONDITIONS

REPORT

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Contents

A: BACKGROUND

Long Term Conditions (LTCs) are defined by the World Health Organisation (WHO) as health problems that require ongoing management over a period of years or decades. They include a wide range of health conditions and cover both non-communicable and communicable diseases, some mental health conditions and on-going disabling conditions. According to the Department of Health, there are currently 15.4 million people in England with a Long Term Condition. Due to an ageing population, it is anticipated that by 2025 the number of people with at least one LTC will rise by 3 million to 18 million.

The Department of Health estimates that the treatment and care of people with LTCs account for 70% of the total health and social care spend in England and amounts to £7 in every £10 spent. It is suggested that self management of LTCs will reduce GP visits by between 24% and 69% and hospitalisation by 50%. There is, therefore, an increasing impetus driven by the evidence for health care professionals to be able to empower power people with LTCs to take an active role in managing their conditions by providing them with the confidence, skills and information to enable them to take greater control over their health.

In addition, there is overwhelming evidence that exercise can bring tangible benefits to people with LTCs. Regular activity has been shown to have both preventative and therapeutic effects on many contemporary chronic conditions such as CVD, cancer, musculoskeletal disorders, obesity, diabetes and mental illness.

As a result, NHS London commissioned primary research to inform the development of a local response across London to a national campaign to increase physical activity among over 55s with LTCs.

B: THE RESEARCH BRIEF

1. Background

Promoting healthy lifestyles has been at the forefront of Department of Health and NHS thinking for some time now. Whilst much has been achieved through the provision of health, well-being and fitness programmes and by targeting action on health inequality, there still remains a great deal of variability across the country and within London it is thought that there is a good deal more that could be done.

In London itself, NHS activity to support and promote physical activity among people with long term conditions is variable. The National Health Checks programme is a preventative programme which is intended to help people stay healthy for longer. Offering tailored advice to motivate lifestyle change is a part of this programme and this includes the promotion of physical activity. However, the Health Checks programme has not to-date been run consistently across London although it has now become mandatory (2011).

Evidence has also shown that just as the amount of activity to support physical activity varies across London and, indeed, across boroughs, so does the models of these schemes. Presently they range from verbal advice to referral to specific exercise schemes such as exercise on prescription and walking for health.

As part of the drive to promote and support physical activity, NHS London in partnership with GaxoSmithKilne (GSK) are designing a national communications

campaign, 'Your Personal Best' that will aim to inspire and encourage people with long term conditions (PLTCs) to undertake more physical activity, breaking down the barriers and driving behavioural change, enabling them to achieve their 'personal best'. This campaign is set against the context of the London Olympic and Paralympic Games which are considered to be an unique opportunity to create a long-term legacy which includes making the UK a leading sporting nation and inspiring a new generation to take part in physical activity. Of especial concern is the opportunity to inspire those with LTCs to engage with this agenda.

Research commissioned by GlaxoSmithKline (GSK) found that, in line with previous research, GPs, nurses and pharmacists believe that those with LTCs would benefit both psychologically and physically from increased levels of physical activity. The research also indicated the importance of the role of the GP in promoting physical activity among the target population but suggests that there are enormous pressures on GP time (and this is particularly the case at the present time with the impending NHS structural changes) and as a result the impact of GP involvement in supporting physical activity is variable.

2. The Study

NHS London wished to implement a specifically local response to maximise the opportunities offered by the 'Your Personal Best' campaign and the 2012 Games to ensure a lasting legacy for GP involvement in promoting physical exercise for those with long term conditions.

NHS London believed that by adopting a social marketing approach, in line with the National Social Marketing Centre Benchmark criteria, it would enable them to meet their aim of:

- Understanding what NHS London can offer health professionals in exchange for supporting their patients, in terms of personal information and advice, to become more active and
- Understanding how NHS London can make it easier and quicker for them to do so effectively

Further to the GSK research and an audit of the Health Checks programme in London, it was believed that a further research study would enable NHS London to develop an effective campaign that would be aimed at GPs and practice staff in order to increase physical activity among the over 55s with long term conditions.

This study would form part of the late Scoping Stage of the NSMC's 'Total Process Planning Model'.

3. Specific Research Objectives

Specifically, the research commissioned would:

- Explore what support and systems need to be in place in the local health economy to support health professionals to promote and encourage, both proactively and appropriately, active lifestyles among those with long term conditions

In addition, it was anticipated it would provide

- An overview of pan London activity using new and existing data

- An understanding of what will move, motivate and enable GP practice staff to encourage and support their patients, both proactively and appropriately, to engage in realistic activity
- An understanding of the capacity needs of practice staff, so that self reliance and sustainability could be built in

The outputs from this research will be used to inform the pan London programme that will leverage the 2012 Olympic and Paralympic Games and the national campaign to emphasise and ensure a lasting legacy for improving physical activity among the target audience.

C: METHDOLOGY

The study took place between July-October 2011. It had been anticipated that the fieldwork would be completed earlier but unfortunately this was not possible. (See Methodological Notes below)

1. Methodological Approach

Further to the development of the initial proposal and in consultation with NHS London, it was decided that there should be two Phases of work which would be inter-related and would run concurrently. Firstly, an overview of pan London activity in order to provide a broad context for the study and, secondly, a qualitative study involving three London Boroughs. The rationale for this approach was as follows.

- Given the known broad range of approaches within London to the promotion of physical activity, it was felt that a discursive approach with those in pan-London key positions as well as with those at the Director and relevant commissioning levels in PCTs would add value to both previous research and to existing pan London audits such as the recent audit of the Health Checks Programme.

- A focus on three practices within three different and differing London Boroughs would enable a full in-depth exploration and examination of the issues involved in the promotion and support for physical activity. Recommendations could then be based on a solid research foundation thus enabling NHS London to activate the support and systems that need to be in place in the health economy to support health professionals in the promotion and encouragement of active lifestyles among those with long term conditions.

- The three London Boroughs chosen were Enfield, Newham and Kingston. They were selected so that the sample would include:

    - A variation in demographic make-up
    - An Olympic and non-Olympic Borough
    - An area in which general practice was perceived to be 'good engagers' and an area where this was perceived not to be the case
    - A range of responses to the Health Checks Programme

In addition, it was felt that a qualitative approach would be the most appropriate in that it provides the scope to engage in direct dialogue with respondents in order to unpack their views. Because of its flexible methods of investigation, qualitative methods are particularly adept at looking at the dynamics of how things operate and

can contribute to an understanding by identifying the factors that play a part in the successful or unsuccessful instigation and delivery of a service intervention.

Using qualitative methods to investigate the practices and procedures of a surgery and of all practice staff offered a number a number of advantages. In particular why promotion of healthy lifestyles and specifically physical exercise was so variable across London was likely to be multi-layered and complex and it was suggested that, for example, time pressures on GPs were likely to be only part of the issue.

Ideally qualitative interviews should be undertaken face-to-face. However, given the time constraints on the respondents alongside budgetary and travel constraints, some interviews were undertaken by telephone. Methodologically, this was not ideal but it was still possible to collect extremely useful and rich data.

Methods suitable for this project included both group-based approaches and individual interviews. The former – most commonly referred to as focus groups, although there are many methodological variants – bring together small numbers of people to discuss topics loosely identified in advance. Focus groups have the advantage of being cost effective (more people for your money) but also have a theoretical rationale. In focus groups people's views are often stimulated and brought into sharper focus by the opinions and experiences of others and there is an opportunity to hear and see how people interact on a given subject.

On the other hand, group-based methods give fairly limited scope to explore in-depth the 'stories' of individual respondents – their experiences and behaviour, views and perspectives and the links between these. This called for individual interviews in which topics were pursued in-depth with single respondents. In addition, confidentiality can also be an issue, particularly in health services research, where there can often be a fine dividing line between professional and personal opinions.

2. Process

Recruitment

Respondents who were interviewed in Phase 1 were initially written to either by email or by letter explaining the purpose of the study. In some cases, NHS London contacted the respondents in the first instance but, in others, the researcher took the lead. Initial contact was subsequently followed up by a telephone call to confirm arrangements.

However, in respect of the three Boroughs, NHS London contacted the Directors of Public Health initially.

Working with the Directors of Public Health, a further letter was written to three practices in each Borough. The practices were chosen by each Borough either by the Director of Public Health or by a designated individual within the PCT. The practices were chosen so that they would include:

- A range of practices in terms of size ie both single-handed practices as well as those with a number of partners
- A range of sizes in terms of patient lists
- A range of demographics of the local population

The letters that were sent to each practice outlining the study were jointly signed by NHS London and by a relevant person within each Borough. In one case, this was the

Director of Public Health, in the second this was the Assistant Director of Public Health and in the third, the letter was signed by the Interim Chair of the Commissioning Committee. A copy of the generic letter is attached in Appendix I.

It should be noted that given the pressure on time for the completion of this project, it was not possible to have as much input as initially hoped into the process of choosing of the practices. However, given that there was apparent consistency across the three Boroughs it was considered that there had not been a negative effect on the sampling. Nonetheless, one GP during an interview noted that the three practices chosen were all ones who were generally perceived to be ones that were 'engaged' and 'participatory' in that particular Borough.

Phase 1 - Overview of pan London activity

The first phase included two stages. Firstly an overview of existing research and data and, secondly, a series of qualitative interviews with designated individuals.

Stage 1

Initially and in order to develop an understanding of the background to the area and topic, the following was undertaken.

- An examination of the previous research undertaken by GSK
- An examination of the Health Checks Programme audit of 2009-2010 and 2010-2011
- An overview of relevant Department of Health and NICE Guidance[1]
- A brief study of the programme 'Let's Get Moving' that was designed to encourage local commissioning of physical activity interventions in primary care[2]

Alongside this, in-depth individual and group discussions were held with the following interviewees.

- 1 x mini group (face-to-face) discussion with
  - Deputy Director, Primary Care Commissioning, NHS London
  - Project Manager in Primary care Improvement Team, NHS London
  - Head of Primary Care Quality Improvement, NHS London
- 1 x group (face-to-face) with selected members of the GSK Long Term Conditions and Linked Steering Group (NHS London)
- 1 x discussion (face-to-face) with Senior Public Health Programme Manager, NHS London
- 1 x discussion (face-to-face) with Physical Activity Lead, Department of Health
- 1 x telephone discussion with the Long Term Conditions Lead, Department of Health

[1] Eg Department of Health. *Start Active, stay active; a report on physical activity from the four home countries' Chief Medical Officers*, Department of Health, July 2011; NICE, *Four Commonly Used Methods to Increase Physical Activity;* NICE, 2006. (Since then NICE have produced a series of Guidance on physical activity aimed at specific groups eg for children and young people/physical activity in the workplace etc. www.nice.org.uk)

[2] Eg Department of Health, *Let's Get Moving – A new physical activity care pathway for the NHS: Commissioning guidance* Department of Health, 2009; Boehleer C, Milton K, Bull F, Fox-Rushby J, The cost of changing physical activity behaviour: evidence from a 'physical activity pathway' in the primary care setting, *BMC Public Health*, 11:370, 2011. It is also understood that an evaluation of the programme has been undertaken by the Department of Health but has not yet been published.

- 1 x telephone discussion with the National Clinical Commissioning Network Lead
- 1 x telephone discussion with the NHS Health Check Administration Manager
- 1 x telephone discussion with the Chair of the Renal Association Exercise and Dialysis Forum

Stage 2

The second stage of Phase 1 was to conduct interviews with senior members of the PCT. They were selected on the advice of the Public Health Department in each Borough. All were either contacted initially by email or by telephone.

- Borough[3] 1
    - 1 x mini group face-to-face with
        - Assistant Director of Public Health
        - Head of GP Commissioning
- Borough 2
    - 1 x telephone interview with the Director of Public Health
    - 1 x face-to-face discussion with the Director of Primary Care Commissioning
    - 1 x mini group face-to-face with
        - 2 x Assistant Directors of Public Health
    - 1 x mini group face-to-face with
        - QIPP Programme Director for (X) Commissioning Group
        - Assistant Director of Out of Hospital Services
- Borough 3
    - 1 x face to face discussion with the Director of Public Health
    - 1 x telephone discussion with the Associate Director of Public Health
    - 1 x face to face discussion with the Physical Activity Lead
    - 1 x telephone discussion with the Public Health Programme Lead

Phase 2 – Research in Practices

During this Phase, qualitative research was undertaken in three practices chosen as detailed above. Following the initial letter to the practices, the researcher contacted each practice individually. In the majority of cases interviews were arranged with through the Practice Manager but on occasions, interviews were arranged with the GPs directly.

In four of the former cases, face-to-face discussions were held with the Practice Manager before interviews were arranged. This was felt to be both courteous and practical since it provided an opportunity for the research to be fully explained and to encourage practices to take part. These discussions did not take the form of an interview but, instead, were purely to detail the research process. It was not possible to go through this procedure with all 12 practices. As can be seen from the details of the sample below, in some practices, Practice Managers did take part in the interviews.

[3] In order to protect confidentiality, the three Boroughs have been referred to as Borough 1, 2 and 3. Please see also Notes (below)

Where interviews were arranged through the GP, it was unquestionably harder to recruit either GPs or other healthcare professionals within the practices. However, in general, interviews were made possible.

However, recruiting general practice staff is notoriously hard and there were a number of difficulties in this case. For example, in Borough 1, only two practices participated following three months of perseverance. This is discussed further in the Methodological Notes below. Finally, due to time constraints, it was also not possible to organise focus group discussions across practices with practice staff within each Borough, as was suggested in the original research proposal.

In total, 21 GPs were interviewed, 11 nurses and/or healthcare assistants, three Health Trainers and two Practice Managers. Importantly, all interviews in this Phase were face-to-face. The interviews broke down across the three practices in the three Boroughs as follows:

- Borough 1
    - 1 x interview with GP – single handed practice
    - 1 x group with
        - 5 x GPs (including 3 GP registrars)
        - 1 x Locum GP
        - 2 x Practice Nurses
    - 1 x group with
        - 3 Health Trainers
- Borough 2
    - 1 x mini group with
        - 1 x GP
        - 1 x Healthcare Assistant
    - 1 x group with
        - 1 x Practice Nurse
        - 1 x Healthcare Assistant
    - 1 x group with
        - 1 x GP
        - 1 x Healthcare Assistant
        - 1 x Practice Manager
    - 1 x group with
        - 7 x GPs
        - 1 x Practice Manager
    - 1 x interview with GP
- Borough 3
    - 3 x GPs
    - 1 x Locum GP
    - 1 x Healthcare Assistant
    - 2 x mini groups with
        - 1 x Healthcare Assistant
        - 1 x Practice Nurse

Interviews and Analysis

Qualitative data collection is flexible, open-ended and responsive to what respondents have to say. Thus, questions are not formulated in advance and coverage of an issue will often vary a great deal between people because of the differing perspectives and experiences they bring to bear. Nonetheless, it is usual to sketch out a rough ground plan to be covered.

Topic guides were developed in discussion with both NHS London which provided a framework for each session and for subsequent analysis of the data. The guides were only a framework for discussion and interviews remained flexible allowing for spontaneity and full exploration of the issues. A copy of the Guides used in Phase 1 and Phase 2 of the research can be seen in Appendix II and Appendix III respectively.

Interviews lasted between one hour and one and a half hours and, apart from the telephone interviews, were held in respondents' place of work. All interviews were carried out by Kate Melvin and were digitally recorded with the respondents' permission. One respondent, however, refused to be recorded and accurate notes were taken instead. All data has been treated in the strictest confidence by the researcher who abides by the Ethical Guidelines of the Social Research Association.

All interviews were transcribed verbatim by a professional transcription service. The subsequent analysis, in the sense of identifying key themes and piecing together their relationships, was ongoing throughout the project, including data collection. There was a stage, however, at the end of the fieldwork, once transcripts had been prepared when a systematic working through of the data took place and a final analysis built that was supported by the evidence to hand.

There are many ways of dealing with the practical handling of qualitative data but system and transparency are always critical objectives. Essentially the analysis of the transcripts followed the established procedure of the National Centre for Social Research's Framework of Analysis developed in the 1980s[4]. This is an iterative process but is based on three clear stages:

- Data management – reviewing, labelling, sorting and synthesising the data
- Descriptive accounts – identifying key themes, mapping the range of themes and developing classifications
- Explanatory accounts – building of expectations behind the patterns and themes emanating from the data

Thus, the process was as follows:

- Listening to tapes and reading through transcripts
- Marking and coding transcripts to themes and issues and storing these to facilitate inspection and for use in support of analysis
- Development of emerging analyses
- Refinement of analysis through a debrief presentation to the client

Outputs

A verbal de-brief of the findings was presented to NHS London in October 2011 and this was followed by a presentation of the study at the Long Term Conditions: Social

[4] . Ritchie, J, Lewis J, (eds) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, Sage, 2003

Marketing Stakeholder Workshop facilitated by the National Social Marketing Centre.

This report details those findings.

3. Methodological Notes

Respondents within the first Phase of the research were particularly willing and enthusiastic to take part in this study, not least due to an expressed concern that physical activity was an area which should have a far greater focus. Indeed, it became necessary to be very focused during the recruitment of this Phase to ensure that the research objectives remained central.

However, during the second Phase, as noted above, it was particularly difficult to recruit. There were a number of reasons for this - for instance GPs are particularly busy at present with greater work commitments alongside the pending NHS structural reforms and the research also was taking place during the summer period when many GPs were on leave. More importantly, there appeared to be a particular reluctance to engage in discussions about physical activity and this is discussed in the following report. Nonetheless, the research revealed rich and interesting data not simply in spite of this but also because of this. Indeed, this study was able to collect a wealth of data on the topic in question and, in the process of collection, on other areas as well. This report, to some extent therefore, does not do justice to the data collected.

The following report is divided into five sections as follows.

- Executive Summary
- Introduction
- The Current Scenario
- The Context of the Surgery
- Moving Forward

Please note the views of the commissioners have not been separated from the views of GPs but it is made clear where their views differ. All the views expressed in this report are those of the interviewees who participated.

In this report all attempts have been made not to identify any individual, Borough or practice. For this reason, quotations are annotated simply by:

- Phase 1:- this includes all those interviewed in Phase 1
- GP – Phase 2:- this includes all GPs (including Locums[5]) interviewed in Phase 2
- Practice Staff – Phase 2:- this includes all Practice Managers, Practice Nurses, Healthcare Assistants and Health Trainers interviewed in Phase 2

Finally, this research could not have taken place without the time and support provided by those interviewed. Respondents were not incentivised for their participation and it is both acknowledged and appreciated that a good number of participants took part in the research in their own spare time.

[5] It was thought a possibility that Locum GPs may well have a different perspective from salaried GPs or partners in a practice. There was no evidence in the research that this was the case.

D: EXECUTIVE SUMMARY

General Issues

- It was clear in exploring and examining the issues involved in the promotion of physical activity that it was an especially broad and complex area. This study can only reflect a part of the picture and it was evident that a good deal of work is being done in this area which this research was not able to and did not cover. Hence, this study should be seen very much as an exploratory stage in the process of the 'integration' and further promotion of physical activity into healthcare.

- It was of interest that the views of those in Phase 1 among Directors of Public Health and commissioners did not differ substantially from those of GPs, nurses and healthcare assistants. Where they did, it tended to be a matter of emphasis and not of content. However, it did appear that there was, at times, a disconnect between those who spoke at a national rather than a local level and, in particular, there were perceptions in Phase 1 regarding GP behaviour which were not corroborated by the evidence from GPs themselves.

- GPs, unlike those either based in PCTs or at a national level, were not simply reluctant to be interviewed but it was also difficult at times to engage them fully in conversation. In part, this was due to a certain cynicism on the part of some about the opportunistic nature of the research given the Olympic context. More importantly, it also appeared to be because some GPs clearly felt that there was little to discuss since, in their view, they 'referred' people to exercise or 'talked about it' to patients in any case.

- 'Physical activity' was also an area that was seemingly lacking in clear definitions and parameters at a number of different levels. The topic seemed inexorably broad and full of complexities and contradictions. On the one hand for example, it was clear that it was simply not possible to talk about physical activity in any generic sense. On the other, it was notable that, during interviews, when respondents talked about 'physical activity', it was not always clear whether they were or they should be talking about activity generally or exercise for those with long term conditions specifically.

- In addition, it seemed unclear as to exactly what 'promoting' or 'supporting' physical activity actually meant. It was not straightforward either as to whether a distinction should be made between physical activity as a preventative measure or as a curative measure and the extent to which it should be 'medicalised'. This latter point was important in that it also fed into not just whether GPs felt comfortable with the 'preventative' agenda but also that patients may expect and be more content with a prescription and a referral than just mere general advice.

- Importantly, too, respondents seemed to see physical activity, conceptually, as an integral part of health care for all patients but, in practice, it was not. It was this dichotomy that seemed to underlie many discussions. For instance, although many respondents tended spontaneously to talk about physical activity generally and not specific to long term conditions, it was ironic that for most GPs it was clear that their only experience in talking about it was in relation to long term conditions.

- Additionally, respondents, especially those working in general practice clearly tended to associate physical activity with those who were deemed as being 'overweight'. Spontaneously, the issue of weight would be raised and it was unusual

for these interviewees to talk about it in the context of patients for whom weight was not an issue.

- The dichotomy was also exemplified by a debate running across discussions as to whether it should be seen as part of health promotion generally or whether it should be treated separately, similar to alcohol or smoking. Some argued that it should remain part of 'lifestyle' since by being an 'add-on' it would not become integral to all care. Certainly, it was questioned during the research why the focus of the study was only on the over 55s. Others believed that it should be treated separately so that it would become a focus for healthcare professionals.

- Among healthcare professionals interviewed in this project, it was clear that it was simply not the case that the majority of GPs or other healthcare professionals did not promote or encourage physical activity. Instead, respondents were divided by the extent to which the topic was reportedly discussed in their consultations. At one level, it clearly depended on whether physical activity was a particular interest of a GP. At another level, it was possible to segment respondents into those who were 'proactive' and those who were far more 'reactive' and who merely either responded to patient demands for exercise or who felt that it was a high priority for that particular case – for example in cardiac rehabilitation.

- A further segmentation was between those who talked about referrals to a particular activity or programme and those who appeared to see it more 'holistically' believing that it should be part of life more generally, thus encouraging patients to build up their activity in their day-to-day lives. Some alluded to a danger for future provision of assuming that physical activity meant 'sport'.

- Indeed it was clear that the majority of those interviewed 'believed' in physical exercise but it seemed evident that this should be distinguished from the integration of it into their daily consultations. Many, however, argued time was a huge barrier in a ten minute consultation particularly with patients with long term conditions since managing their condition would be the priority. In addition, their own perceived lack of knowledge alongside their own lack of exercise (acknowledged or otherwise) were also frequently mentioned as barriers to encouraging and motivating patients.

- The evidence also showed that there was a seeming lack of co-ordination in the system at a number of different levels. For example, knowledge of referral programmes between providers and general practice and within general practice as well. At another level, too there appeared to be a lack of co-ordination between primary and secondary care and between general practice and health trainers in terms of who was referring whom to what.

- However, it seemed the problem was not simply a lack of co-ordination but equally a lack of follow-through. For example, patients were referred to programmes but this did not tend to be followed up and GPs or other health care professionals rarely received feedback. Feedback was seen by many as being important as a motivator in the promotion of physical activity for both patients as well as GPs.

- Indeed, it seemed apparent that many GPs, in spite of clearly believing that physical activity was part of their remit and role, also thought that by simply referring their 'job was done'. Others equally did not believe that it was their responsibility to hold all the local knowledge about activities.

- It was noteworthy that many GPs were more eager to discuss why patients did not take up either referrals for physical activity or to be generally more active rather than what they, as healthcare professionals could do.

- Nonetheless it remained debatable whether there would be a receptive mind set if these barriers were removed and almost all argued that the issue should be far higher on everybody's agenda.

- At a national level as well, it appeared that there was a vacuum in terms who 'owned' the agenda for physical activity at a local and at a more strategic level. A number debated whether 'physical activity' should be under the remit of Public Health or Clinical Commissioning Groups.

- In Phase 1, it was pointed out on a number of occasions that there had never been a co-ordinated and national campaign for physical activity although there had been numerous attempts over the years to encourage greater promotion of physical activity in primary care.

- During discussions, respondents pointed to programmes that had been 'successful' in the past. In one Borough, the PCT had initiated their own programme of activity and, in the surgeries where it was known, it was seen as a 'success' in terms of ease of referral and choice of activities. Similarly, in the minority of cases where respondents were using the national Let's Get Moving programme, there was evidence again that it was well thought of. In one of the other Boroughs, however, there was a perception that facilities were simply inadequate. Often, too, where facilities did exist they were costly and usually patients had to be available outside working hours to access the programmes. In addition, there was a fear on the part of some that new programmes were often cut due to the present financial stringency. But it is noteworthy that attitudes towards provision did not appear to be affected by the amount of available provision in any one Borough.

- More specifically, there was a debate echoed in a number of discussions as to whether it was a question of enough programmes or simply the right programme for the specific long term condition. But more commonplace was an acknowledgement on the part of many health professionals that they simply did not know what existed in their area. The general consensus was that GPs and practices needed to be told repeatedly about new programmes.

- Most thought that a variety of media, especially emails, sent both directly to GPs and/or via the practice manager were a good form of contact but there was an almost unanimous call for face-to-face contact in order to motivate GPs to promote and encourage physical activity.

- Spontaneously respondents called for educational talks firstly to 'educate' healthcare staff about exercise and its benefits, citing case studies for example and secondly to provide information about activities generally as well as locally. Whereas some believed that physical exercise specialists or even consultants should deliver these talks, others felt that GPs would respond more positively to a colleague.

- Some felt that the introduction of CCGs, would be an ideal time to put it once again on the agenda but the majority believed that this was unlikely, given the financial constraints and presently there was too much upheaval within the NHS.

- Others felt that by inserting it into more care pathways and on disease templates similar to smoking and drinking, it would ensure that it would become higher on the

agenda. It was argued, too, that the future emphasis should be on the development of the integration of physical activity into self-management care plans for long-term conditions and with the present rethinking of the management of long term conditions, it was imperative that it should no longer remain an outsider in healthcare. Those who supported the argument for incentivisation believed, for example, that if it were incentivised, it would firstly bring attention to the issue and then it would become 'normalised' as had happened with other aspects of care.

- But many believed that alongside this and educational talks the answer lay more at a more local level for example in GPs taking more exercise, attending classes or going on walks with patients. Indeed, it was commonplace for respondents to emphasise that this agenda was not necessarily about reinventing the wheel in terms of new services. Instead it seemed it would be more appropriate to work towards a clearer understanding of what was meant by 'physical activity' by whom and for whom and how an uptake of physical activity might benefit both patients and GPs.

E: INTRODUCTION

There was a consensus that the promotion of 'physical activity' had not been taken up as a national and mainstream agenda. Some respondents felt that this was a fundamental reason firstly why take-up of exercise especially for patients with long term conditions had been variable and slow but also why it was still considered to be a side issue. A number argued that essentially there had been inadequate commitment from the top:

> *'If the Department were really committed, the communications team would do a far better job…where is the commitment? Why haven't they got a national information programme…I still remember the AIDs slogan…If they are really going to take it seriously, like smoking, you have got to do it seriously and believe in it'*
> (Phase 1)

> *'I am not convinced of the commitment because these people at NHS London or in the Department of Health, they are on short jobs and they want to make a difference when they are there but then they will be gone after a while and then they are not bothered. So it is difficult to make anything integral so that it remains there all the time and maintains the funding'*
> (GP – Phase 2)

Further, there appeared to be an element of cynicism regarding the forthcoming campaign of which this study formed a part. It was not just the Olympic incentive that made it seem to some as being rather opportunistic but equally there was a concern expressed that any initiative that was put in place would be short lived.

> *'The thing is isn't it, it is all about the Olympics but I don't want to do this for the Olympics, I want to do it for my patients on a long term basis'*
> (GP – Phase 2)

> *'What NHS London shouldn't do is start something unless they can sustain it…they might spend a lot of money on a short term basis in January and then by February or March, whatever it is, is scrapped'*
> (GP –Phase 2)

Essentially, it was felt by a number of interviewees that it was not just a matter of appropriate Guidance for example but there had to be co-ordination to tackle the issue as a whole so that it was no longer a postcode lottery:

> *'It needs to be more across the board so you don't have a postcode lottery. If you happen to live near one practice that is really keen on physical activity, that is great but if you live near a practice that is not fussed then you don't get that same access'*
> (Phase 1)

A number drew attention to areas around the country where there had been programmes or initiatives that had been perceived to be highly successful but in the words of one senior clinician there had been:

> *'Tons of attempts and plenty of false dawns. Up and down the country there are many pockets of beacon examples of this but apart from anything else the numbers are small…all of the clinics are great but they can only take four or five people a month and we are talking about hundreds and thousands of people who are inactive…*

(Phase 1)

'Here it happens in pockets I think rather than across the patch…and it doesn't' seem joined up in any way…but I think that is common across the country'
(Phase 1)

A number, too, commented on the apparent disconnect between the various levels of the NHS which in turn was seen to prohibit a more co-ordinated approach.

'Public Health are trying hard to work with GPs but it is very difficult and I don't think they are particularly in tune with GPs or wanting to respond to them but I don't think GPs are that responsive either'
(GP – Phase 2)

'The governments, successive governments have talked about promoting, whenever they get the platform, they talk about exercise and health improvement. But they are not able to deliver on the local level where it actually matters to the patient and in fact there is a total disconnect'
(GP – Phase 2)

Alongside this call for a national thrust, there was at the same time a demand for a local agenda as well.

'You have to get that message over time and time again. But increasingly my experience is the more local the thing is the more likely it is to make a difference for people'
(Phase 1)

'The way this Borough works is that it is very much localism. So if there are resources, give them to us and we will make sure they are used in the most effective way based on our local knowledge…GPs will be happy working with people they know and are local and have the interest of their local population at heart'
(Phase 1)

However, it was generally acknowledged that essentially the uptake of physical exercise was a very much a learning process that was still underway. A good number spontaneously likened it in this respect to smoking arguing that lessons could be learnt.

'I think it is early days so I think people have set things up and we are learning from what is working. I also think there are lessons from the process with smoking and we should all learn from those as well'
(Phase 1)

F: THE CURRENT SCENARIO

Discussions regarding the present level of take-up of physical activity focused initially upon both the variability in the take up of physical activity in London and whether respondents perceived the present availability of activities adequate. Connected to this too was the effect that the Health Check Programme had had on the take up and promotion of physical exercise and also the extent to which the General Practice Physical Activity Questionnaire (GPPAQ) was being used.

1. Health Checks

Following the on-going audit that has been carried out by NHS London there was an awareness that, until recently, there had been a good deal of variation and lack of consistency in the uptake and delivery of the Health Check Programme in London. Even across the three Boroughs involved in this study, it was evident that there was a huge variability in how the Programme was being delivered[6]. Firstly, it was clear that not all surgeries were running it. In one Borough, for example, due to the cost it was only being run in part of the Borough and in one surgery in another Borough it was reported that they were no longer carrying them out for the same reason. Where the Programme was being run, it appeared that it was largely being done systematically in a practice although, in one example, interviewees said it was being run opportunistically depending on who came to see a doctor.

A number of practices, too, argued that they had been, in effect, being carrying them out anyway before the introduction of the programme and in one case it had been, in their view, to the detriment of their normal practice.

> *'We were doing it anyway….we are now possibly doing fewer blood pressure checks randomly as it is not part of the programme…so before I would do it every three years, now they have said five years. We had a very high level of blood pressure coverage before all this started'*
> (GP Phase 2)

Respondents who were running the Programme reported that it had not only identified those with long term conditions but equally it had provided an opportunity to talk about physical exercise. In general, Health Checks were carried out either by the Practice Nurse or by the Healthcare Assistant in a practice. During interviews, both of these two groups of interviewees said that they did try to discuss exercise and recommend activities during the Health Check. Some clearly discussed physical activity on a consistent basis and it had prompted others to recommend actual exercise programmes to patients which was something they had not been doing previously.

> *'I see people with chronic diseases so we do talk about it, if they need to lose weight for example and things like that. Obviously, we recommend exercise if they are not doing it and what can be done…Sometimes they ask you'*
> (Practice Staff – Phase 2)

> *'Before we were just talking about exercise when we saw patients and now it is quite a new thing to do with vascular checks and now we are referring patients to actual programmes…I didn't know about them before'*

[6] It should be noted that different areas called the Health Checks Programme by different names. In one Borough for example, it was called the MOT and in some interviews with practice staff it often took quite some time to clarify whether they were focusing on the Health Checks Programme or on routine checks for patients with long-term conditions.

(Practice Staff – Phase 2)

However, there were also a number in this group of interviewees who felt that they were not able to advise if there was a medical problem

> *'If they have got things wrong with their heart or whatever, I would send them back to the Dr as it is not for me to say go for a run…if they were just overweight I would them send to the* (XXX) Programme…'
> (Practice Staff – Phase 2)

It was apparent, too, that this group were generally not asked to talk about exercise and often reported they did not unless the patient themselves brought it up.

> *'They* (GPs) *never ask me to talk to them about exercise…it if comes up and the only time it does is with a new patient check, I try to incorporate it…'*
> (Practice Staff – Phase 2)

But a more interesting perspective came from a PCT. They believed that the difficulty was if a patient, for example, was diagnosed to have high blood pressure or were likely to be diabetic, the medical condition was treated before lifestyle was discussed or looked at.

> *'In fact what should happen is that the person should be encouraged to change their lifestyle and then if that doesn't work then they are treated…So they treat the patient and they spend a long time and in the end it* (the exercise) *gets forgotten, the referral doesn't happen and it takes months for anything to happen…'*
> (Phase 1)

It was also pointed out that firstly, given the age criteria of the Programme, it may well miss those in the most need but more importantly there was a whole swathe of the population who would not attend any Health Check appointment.

> *'But the Health Checks have been a whole population programme and not been let's target those most in need. So potentially it could just have brought more of the worried well through the door and could be increasing recording and not capturing…again it is the ones that are most marginalised that don't actually come forward…'*
> (Phase 1)

> *'I personally think that sometimes people who are the most healthy are more likely to come for them and the least healthy are less likely to come for help and advice'*
> (GP – Phase 2)

In addition, there tended to be no money for recalling patients nor was there reported to be any for following-up patients.

2. General Practice Physical Activity Questionnaire

Investigating the GPPAQ had not been a part of the initial brief for this study. However, it was an issue that had been brought up by respondents in Phase 1 and subsequently was added to the topic guide for those interviews still remaining in Phase 2.

From discussions, it was evident that the majority of those questioned in Phase 2 had not heard of it and it was not being systematically used across practices in any one Borough.

However, in one PCT, it was believed that GPPAQ was being used in practices and also as part of the Health Check Programme in order to assess the level of physical activity so that an appropriate recommendation could be made. Nonetheless, in the three practices consulted in that Borough, the evidence did not seem to bear this out. One GP in this area complained:

> '*It is very complicated – I don't want to be filling in lots and lots of details. I am quite happy to fill in weight, blood pressure, BMI but I don't want to do waist measurement because I don't think it is useful*'
> (GP – Phase 2)

In this same Borough, a practice nurse reported that she had used it but had now stopped since she felt that it did not provide her with any useful information since in her view it had not made any difference as patients tended to know if they were active or not.

> *'We do something much more basic now…it is just a moderately active, inactive, it is nowhere near that scale anymore…I think generally people know when they are being inactive'*
> (Practice Staff – Phase 2)

In another Borough, one GP said he did 'have it on his computer' and believed that it was beneficial in that it pointed out what he should be doing about physical activity. However, he did not take it necessarily any further following filling it in and tended to use it purely as an information source. One commentator in Phase 1 did subsequently remark that they felt that it was an issue that GPs may not know how to take the GPPAQ forward. Training had additionally not been provided for GPs to articulate any information that was going to be motivating for the patient.

> *'It should be embedded in EMIS and the other GP software systems. We have got Read Codes ready to receive the GPPAQ information but the trouble is nobody uses it and nobody knows what to do with it'*
> (Phase 1)

3. Variability in Take-Up of Physical Activity

A number of respondents in Phase 1 suggested that for any substantive change in the take-up of physical activity there were three interlocking components. Firstly, why, in the eyes of respondents, patients might not take up any referrals offered, secondly, whether there were adequate structures and thirdly the barriers and difficulties confronting GPs and other healthcare professionals in practices. In this section, the first two components are discussed.

a) The Take-Up of Programmes

It was of particular note that healthcare professionals largely tended to attribute the lack of both the take-up of physical exercise programmes and the building upon day-to-day activities to patients themselves and to the provision itself rather than to anything they might do or not do in consultations with patients.

> *'We can advise but that is all we can do and most do not take it on board'*

(Practice staff – Phase 2)

'I can imagine that the vast majority of people after a year of having the GP speaking to them about exercise, I would say only 1% might still be exercising after a year…. Actually if we did it for a whole year, they might just find another GP!'
(GP – Phase 2)

Across the board, healthcare professionals stressed that if the patient did not want to attend or follow up a referral there was simply nothing they could do. Ownership and motivation were simply essential. A number argued too that inserting physical activity alongside smoking and alcohol intake into disease templates or care pathways also would probably make little difference.[7]

'We can ask the patient to go but if the patient hasn't got the wish to go, that process is going to stop there….they don't take their medication regularly. Do you think they are going to take the exercise referral and go to the gym? The patient does not take ownership of their condition and they have to do that'
(Practice Staff – Phase 2)

'The point is you can take the horse to the water but you can't make him drink it. That is all. There is a limitation to what you can do'
(GP – Phase 2)

'It is similar to smoking. We ask about it all the time as if they do now want to stop smoking it is completely pointless booking them in with the smoking nurse…It is exactly the same with exercise. We cannot force them'
(GP – Phase 2)

To some extent, but not to the same degree, those in Phase 1 supported this view:

'It is a bit like smoking cessation. Until you have that motivation to exercise and realise the benefits of it…it is very much patient driven. You can do as much as you like…you can put it on a template, you can make QOF payments but the patient still needs to do it. It is not easy'
(Phase 1)

'I think it is hard. They (GPs) *can't force the patients so it is hard to know what to do. The patients have to want to do it'*
(Phase 1)

Whereas it was generally agreed across discussions that a 'health scare' was a good motivator, some also argued that incentives to patients could make a difference. In particular, were respondents' experiences of exercise on prescription. Patients would reportedly attend when it was free but once the prescription finished so would the attendance of many of the participants.

'We had this (XXX) *scheme and they had a big pile of forms we had to sign to confirm the chronic condition. And I seem to remember it was free and the forms were going like hot cakes…it was a big incentive, a huge incentive for patients and then when it wasn't free, the people stopped going'*
(GP – Phase 2)

[7] This is discussed in more detail in Section H

'Exercise on prescription was very popular and people went for a particular period and when they were asked to pay they stopped, the majority of them…A few continued'
(GP – Phase 2)

But it appeared there was also a body of experience that argued that even when it was free it was hard to make patients change their habits.

'A lot of patients their priority is not to change. And it is also normal for them and normal for their family and normal for their neighbours to not exercise. Nothing makes a difference'
(GP- Phase 2)

However, across the board there was general agreement that cost was critical and many believed that for high take-up schemes needed to be free. In addition, many of the schemes tended to be run in the day time thus excluding anybody working. Alongside cost, easy accessibility was seen as being important particularly for those who were less mobile as well as for those who had young children

Some respondents in Phase 1 supported the premise that socio-economic reasons also played a large part, arguing that those that attended schemes tended to be the ones that were already supportive of exercise and keeping fit.

'I would say the middle classes do more exercise - it is definitely a socio-economic thing'
(Phase 1)

Demographics were also thought to play a part. In areas, for example, where there was a high ethnic minority population, cultural issues were seen to be a potential barrier and the importance of ensuring that provision was adaptable for all communities was emphasised.

Finally, respondents in both Phases felt that a serious consideration for patients was safety and the environment.

'I mean it is about having a safe environment for the kids as well. Would you let your kids go to that park after school? I know I wouldn't and most of my patients wouldn't go themselves after work let alone their kids'
(GP – Phase 2)

b) Types of Provision

There was unquestionably a strong body of opinion that felt there needed to be a more strategic approach to provision. The central debate was whether there were appropriate facilities for specific conditions or whether this was the best way in any case to approach the problem. It was suggested by some that it was not possible to satisfy all patients with varying conditions but care pathways needed to be looked at so there were facilities available for specific illnesses.

'It would be more effective to target exercise to specific cohorts of patients to tailor that exercise to their needs as part of a specific care package rather than just have a general referral scheme to a local leisure centre'
(Phase 1)

'*Because of disease co-morbidities, the idea is that if you have a specialist programme where people are trained and understand either respiratory problems or chronic kidney disease then that is where these programmes work really well…'*
(Phase1)

Further, it was evident from a number of interviewees that one of the problems with general provision was that the patient may not get admitted on to exercise programmes due to their condition.

'With people who have got COPD or something you can start getting into situations where people at the normal leisure centre are hesitant to take people like that into normal gym programmes'
(Phase 1)

'Exercise has to be tailored to each individual because certain conditions can't do certain things so you have to be careful where you refer them'
(Practice Staff – Phase 2)

Clearly there seemed to be the general view that given there was not one size that fitted all it was important to have a range of options and that would include more specialist provision as well

'You couldn't put some patient groups in a generic type class but you can at the beginning stages of a disease and it is about being far more strategic'
(Phase 1)

But within a more formalised and structured approach, it seemed that there was a need for greater flexibility of thought around the issue. As one GP commented:

'I think we have got to get away from the fact that a specific place like a gym will be what some people are looking for but it may not be what most people are looking for'
(GP – Phase 2)

Common among respondents was a view that it was important that there was a shift away from the view that 'activity' equalled going to a gym or doing 'sport'. Although, as will be seen in the next section, healthcare professionals did suggest to patients that it could be just as effective to raise their level of physical activity by building on their day-to-day activities, it seemed apparent that 'doing' exercise was usually interpreted as attendance at a formalised programme of some sort.

'You don't have to join a gym to keep fit and you don't have to spend money to get fit and exercise…but the gym could be a start and then they could change their behaviour – it is just getting over that barrier of exercise is lifting weights or running on a machine'
(GP – Phase 2)

'One of the challenges that physical activity schemes have got to get over is that it is about going to the gym so that physical activity becomes a specialist thing that you can only do with the right equipment and lycra and you have to look good…we very much need to think that sport is a minor subset of physical activity'
(Phase 1)

But on the part of the patient, for example, it was suggested that many may feel cheated if they walked away from the surgery without a referral or prescription of some sort.

> *'It* (exercise on prescription) *was very popular with patients. There was not a great evidence base but patients loved it. They also walked away with something but it is short term. They also might feel fobbed off if they are not prescribed anything…'*
> (Phase 1)

> *'You are more likely to get a response if you apply it* (referrals) *to patients with niche conditions, COPD is a good example, because then the patient knows they are being actually referred for a very good reason'*
> (Phase 1)

c) Availability of Provision

The three Boroughs sampled in this study appeared to vary enormously in terms of exercise provision available. In one Borough, for example, many of the GPs believed that there was very little provision. It was here too that there were Health Trainers but in one group discussion it was quite clear that many of the GPs attending did not know who they were or the nature of their role. For their part, the Health Trainers reported that they had contacted every practice in the area, sent referral forms, contact details as well as flyers. In contrast, in another Borough, healthcare professionals understood that there was a variety of provision that included a specific activity programme, walking programme, diet and fitness clubs, an expert patients' programme and so on.

Nonetheless, in all three Boroughs and within PCTs, there was a strongly held view that GPs would probably not be aware of provision in their area.

> *'I don't know if the GPs would know about any of the schemes. I doubt it…I suppose they might be aware of the Health Checks we do but not any of the schemes'*
> (Practice Staff – Phase 2)

> *'There are huge amounts of provision here in* (XXX) *and I would highly doubt that many of our GPs know'*
> (Phase 1)

Others in Phase 1 argued that it normally takes a substantial amount of time for GPs to realise what is available.

> *'It takes practices, and I learned this from experience, three years to know a programme and to actually start referring whatever we do'*
> (Phase 1)

> *'I do find our biggest barrier is how we get our messages to GPs about programmes. We will be in a meeting and they will say they have no idea that the* (XXX) *Programme existed. It has been running for literally ages…'*
> (Phase 1)

Linked to this was a further concern aired by many interviewees that schemes and provision often changed and this not only made it harder to embed but also created difficulties for surgeries. Although, ironically one PCT representative said they were

stopped at times purely because they had not been used, most believed it was due to general funding stringency.

> *'So we can start a programme for six months to a year. The programme has no referrals and straightaway it is stopped. So we discontinue it and we start another one….but if you have a programme for a long-time, practices will start to remember it'*
> (Phase 1)

> *'There was one just called Exercise and Referral but that got taken away…it is difficult for us to get excited about what is going on because a lot of the time it can be scrapped…'*
> (GP – Phase 2)

Against this background, respondents debated whether there was enough provision overall. Opinion was once again divided. On the one hand, there was a group from both Phases that believed there was simply not enough provision

> *'If they say every person with a long-term condition has to be referred to a physical exercise scheme then what do they mean? They have to look at the logistics of that…who is going to provide it all? It isn't there now'*
> (GP – Phase 2)

> *'We will refer if we have the facilities but we don't'*
> (GP – Phase 2)

On the other was an equally held view that it was not a question of more services but about improving what was already in existence.

> *'I think rather than trying to invent new things, the Government should be buying into what is already there and maybe give us free membership to things like Weight Watchers or Slimming World rather than trying to get a new scheme'*
> (GP – Phase 2)

> *'I think it is a case of working potentially with more the existing groups out there and seeing what they want and what is the local solution for them rather than trying prescribe something nationally down onto them'*
> (Phase 1)

Given that many surgeries were not necessarily on top of what was available in their area, it was important, for the majority, to have regular up-dates of information[8] which should be sent both to the Practice Manager as well as to GPs. This was requested in the form of a whole range of media – emails, letters, information sheets (but one side only), websites, videos running in GP reception areas and less often, leaflets. Some also called for a service directory which could be up-dated on a quarterly basis. The ideal, however, in the eyes of many would be for the information to be disseminated at meetings, for example, at a cluster level meeting or more broadly in an area setting.

As important as information, though, was ease of referral. It is noteworthy however, that this appeared to be more of an issue for those in Phase 1 than it was for GPs.

[8] It had been suggested by NHS London that 'trusting' the information might be an issue for practices. This did not seem to be a factor for any respondents interviewed. Far more pertinent for them was both the cost and the availability.

Although a minority of GPs mentioned they did not want to be filling informs in great detail it certainly did not seem to be a critical factor in terms of whether they referred or not.

> *'Ease of referral is absolutely crucial. There can't be endless forms – just simple referral '*
> (Phase 1)

> *'It makes it so much easier if it is straightforward…I haven't got any time really otherwise but you'd still do it'*
> (Practice Staff – Phase 2)

d) Let's Get Moving

Discussion of the national programme, 'Let's Get Moving' was not a main consideration in the research brief. However, the programme did arise in conversation spontaneously most commonly in Phase 1. There was only evidence of the programme being used in one Borough but there was some confusion, in another, whether the exercise referral scheme they were using was Let's Get Moving. The vast majority of respondents in Phase 2 had not heard of it.

Where it was being used, there seemed to be positive feedback with healthcare professionals strongly supporting the idea that it was more of a signposting service rather than a referral programme.

> *'They take a broad range of patients…they do take people with long term conditions and obviously that is what they specialise in but we can refer anyone. The patients will go and have a consultation with them and they suggest because of the condition where would be the safest place for them to go'*
> (Practice Staff – Phase 2)

In one practice the Let's Get Moving team came into the practice once a month and this too was appreciated alongside the fact that there was not a long waiting list.

In a similar vein, in another site, where there was a similar exercise referral programme, as mentioned above, practices were largely appreciative apart from the fact that although it was offered at a low cost, it was not free.

G: THE CONTEXT OF THE SURGERY

In this section, the extent to which GPs and other healthcare professionals supported the promotion of physical activity and the difficulties in doing so is discussed. It is broken down into three interlocking parts: problems in definition and the narrative of 'physical exercise'; perceptions of the role and behaviour of GPs and other healthcare professionals; and barriers confronting General Practice.

1. Definitions and Parameters – the Narrative of Physical Exercise

During the interviews, it soon became evident that there was a distinct lack of clarity about what was precisely meant by 'physical activity'. A good number of GPs asked for clarification in terms of what was meant by activity not simply whether it was a designated exercise programme or whether it simply meant building on day to day activities but who the target audience were, what were the appropriate targets and for which categories and so on.

In one noteworthy example during discussions on definitions, one GP in a single handed practice commented that he interpreted 'referrals' to physical activity as referring to the physiotherapist or to other therapies.

> *'It's not called physical activity…it is called rehabilitation after cardiac surgery. Other long term conditions, they go under the category of physiotherapy, specialised therapies. They are just not called exercises but therapies and come under the category of the therapy subject'*
> (GP – Phase 2)

For most, however, there were two immediate issues. Firstly, it was felt instinctively that it was just not possible to define physical activity in any generic sense for those with long term conditions since different patients would demand different types of treatment.

> *'Well you can't talk about them as one. If you are going to talk about long-term conditions such as neurological or epilepsy you can't tell them to go off swimming but you might tell your osteoarthritis person who has hypertension to go off swimming'*
> (GP –Phase 2)

Secondly and almost simultaneously, many also instinctively shifted the conversation to arguing that long term conditions should not be singled out and that physical exercise should be promoted and encouraged with everybody who walked into the surgery rather than as an adjunct to treatment. It was additionally questioned why the study was concentrating on the over 55s since it was important for all ages.

> *'We need to do something for the population as a whole…and the greatest impact where you start to get more people out exercising must be from the broader population. What is the point of just isolating those with long-term conditions?'*
> (Phase 1)

> *'I think we should be focussing on everybody from a young age…the encouragement of it should be across the board for everything and everybody'*
> (GP – Phase 1)

'There is clearly a need for exercise not only for the chronic diseases…and we should be talking about everybody clearly and I wouldn't have an age restriction…it is important to catch everyone. I mean why not families? Why not children? But if you can get that 30-50 age group exercising regularly and looking at their lifestyle it would be far more beneficial in the long-tem than targeting the 55+ '
(GP – Phase 2)

It was also interesting to note one comment from a Health Trainer who said recently they had been seeing patients who had self-referred from a younger age group

'The problem I have with this is that you are concentrating on the over 50s again and there is a big gap that is being left out and these people need help. We are getting a lot of people under 50 who are coming to see us who want help with physical activity'
(Practice Staff – Phase 2)

On the other hand, it seemed apparent from discussions that, for many but not all, their only experience of talking about physical activity with patients was with those with long term conditions.

'Ultimately it should be for everybody and we should have the whole population doing it…but where people start is where you have the biggest impact on the disease areas like diabetes, obesity, COPD and so on…and it comes to mind'
(Phase 1)

'I suppose people with long term conditions, we are more conscious of giving them advice and generally, more healthy people, not so much'
(GP – Phase 2)

Moreover, many respondents, especially GPs, did not just discuss it in terms of those with chronic conditions but quite spontaneously and immediately linked it specifically with weight and obesity[9]. This was not lost on a number of those interviewed.

'It is associated with obesity and you normally have weight management plans where you get referral in…In most places now it is coming as branch of obesity which doesn't give it justice really'
(Phase 1)

'They (GPs) *never ask me to talk about exercise to patients. The only time it ever comes up really is in a new patient check and they need to lose weight so I try to talk about it then but it is always with weight'*
(Practice Staff – Phase 2)

In one respect, this was thought legitimate in that if a patient was overweight, it was hard to ignore and thus it would spring to mind immediately.

'If someone comes in and is overweight, the first thing I am going to say is right, you've got to look at the input and the output of your calories. Output is exercise, input is what you put in your mouth'
(GP – Phase 2)

[9] It should be noted that in some areas weight management forms part of a Local Enhanced Service.

'I see chronic illness and people that are sent to me are more likely to express their concern about their weight so that is the first thing so think about is weight normally'
(Practice Staff – Phase 2)

The Health Trainers interviewed in this study were particularly vocal on this point.

'For me I only have ever had two people who have been referred for exercise who are not overweight. And I have only have really spoken to my GPs that I work with on weight management things and not about physical activity. I don't think they talk about it unless it is about weight. GPs need to understand that it isn't just about weight'
(Practice Staff – Phase 2)

Nonetheless, the majority agreed that it was critical that exercise should be defined as being integral to health care generally. Many thought that GPs very much saw it merely as an 'add on' whether it was discussed in consultations in connection with long term conditions or with everybody.

'I think they (GPs) *see it as an add on – it shouldn't be'*
(Practice Staff – Phase 2)

'It has never been seen that way but it should become part of the package, that exercise should be done by people. I mean there is enough evidence to say that it is beneficial and it works. It should become more of a care pathway rather than an add on'
(Phase 1)

And even with long-term conditions where it seemed to be an integral part of the advice given such as diabetes care, cardiac rehabilitation and possibly renal care, it was still considered by a few interviewees to be an afterthought.

'The only point where you have got it as an integral part of patient education is diabetes where you do talk about diet. But I suspect probably they don't talk about exercise as second nature as they do with diet'
(Phase 1)

On another paradigm again, opinion was divided on whether physical activity should be conceptualised as part of lifestyle and more generally in health promotion or singled out on its own. The danger, as some saw it, was that if singled out separately from other lifestyle interventions, it would remain an add-on. If, on the other hand, it was part of health promotion, there was a greater chance of it becoming integral to care but at the same time it may continue to remain a low priority.

'Other things like smoking and diet are also equally important. I mean you can't ignore those things and just concentrate on exercises alone – it has to be a holistic approach. There is no point you doing exercise every day, and then eating cream cakes and smoking 20 cigarettes and drinking three pints of beer'
(Practice Staff – Phase 2)

'It has got to be integral to health and everything else and we know the benefits if we had people eating healthily, exercising…it is the whole package, the whole lifestyle and I don't why they have just picked on exercise – I suppose the Olympics'
(GP – Phase 2)

Linked to this was a discussion echoed across interviews about whether physical activity was being talked about as a preventative measure or as a cure. This, in turn, linked into the debate about the 'medicalisation' of the agenda. Some in Phase 1 believed that GPs would only respond if it were 'medicalised' since they worked on a diagnosis and cure basis.

> *'I think there is a tension…if we medicalise it too much, we actually prevent common sense from taking place and prevent GPs from ever doing anything. If we don't medicalise it all, you get a whole group of patients who are left stranded and inactive'*
> (Phase 1)

> *'And for GPs the easiest way to get them is the curative bit and then the preventative second. So we can just win them on the curative and in any case the preventative effect is very long term'*
> (Phase 1)

Others, too, raised a concern that GPs did not really understand the preventative agenda.

> *'But when it comes to raising the issue of prevention it is seen very much big-brother like. Or it is perceived to have been'*
> (Phase 1)

> *'I think the battle is they do not understand prevention and they are not convinced by it…they more like to treat rather than prevent'*
> (Phase 1)

2. Perceptions of the Role and Behaviour of GPs

a) Perceptions of Role

It was unquestionable that for the vast majority interviewed in Phase 2 there was an agreement that discussing physical activity was the role of the GP. Given that conceptually most stated that keeping fit and healthy was an integral part of healthcare, it would seem perverse for it not to be seen as part of their role.

> *'I think it is my responsibility to point out to people that they should be exercising more and eating the right diet'*
> (GP – Phase 2)

A substantial number also commented that it was actually the responsibility of the practice as a whole.

> *'Well as primary carers we should all be doing it at every opportunity, everybody in the practice because if patients say, the doctor's told me that, it is better if it is coming from all of us, every health care worker'*
> (Practice Staff – Phase 2)

> *'It has to be everybody's job in the practice. We all need to work together'*
> (GP – Phase 2)

There was also a further section of GPs who believed their job was firstly to tell the patients and, secondly, to ensure that the patients were passed to the person most appropriately qualified in their own surgery

> *'My feeling is it is the job of a Healthcare Assistant to talk about exercise who is appropriately trained…but it is the role of the GP to tell the patient what is wrong and how to fix it and then it is down to the patient'*
> (GP – Phase 2)

In stark contrast to this, were the views of those in Phase 1 from all three Boroughs. They believed that GPs did not consider it to be their job and that it would not be top priority or even in their mind-set.

> *'I think the key issue for GPs is that they see it as somebody else's domain and not really something for them. We have an understanding of the importance of physical activity but it is not within the mindset of GPs in the same way'*
> (Phase 1)

> *'I think some GPs probably don't refer because they just don't believe in physical activity. It is easier for them and less time consuming to write a prescription or to say, here is a bit of information, off you go….'*
> (Phase 1)

To some extent, too, this view was echoed by some practice staff:

> *'I am not sure that for most GPs it is really integral to their thoughts'*
> (Practice Staff – Phase 2)

> *'It is rare that they* (the GPs) *refer someone to me for physical exercise or even suggest I talk about it. It is usually something I might mention'*
> (Practice Staff – Phase 2)

Nevertheless, for the GPs it was the nature and extent of the role, beyond merely raising the subject, that seemed to be in question. Whereas some argued the GP surgery should not be the focus or the centre of the expertise, others went on to stress that it was their job simply to refer on to an outside agency:

> *'Weight management or increased exercise is not something, unless you've got a GP who actually wants to lead the whole practice out on cycle rides, that I think we are set up to do…but it is not that we don't believe in it. There are other people who are experts who can do it better'*
> (GP – Phase 2)

> *'Is it my role? Yes, it is a health issue. You can certainly flag it up but I don't think it is the GPs job to sit down and discuss it or work out a plan. You need someone who is equipped to do it…so we can make them aware of the facilities and facilitate but we can't carry all the weight here'*
> (GP – Phase 2)

One GP appeared to echo the voices of many when they pointed out that their role was actually quite clear cut.

> *'It is clear to me. I have no issue to directing the patient to where they can access the information but I do not think it is my responsibility for holding it. If*

we were responsible for the information, then we should be getting jobs with the Council. I should not be the gatekeeper'
(GP – Phase 2)

Similarly, other GPs reported that they believed that their role was to advice their patients to look on the website or to contact the Civic Centre and local libraries.

b) Perceptions of Behaviour

The evidence showed that it was clearly not a case of whether or not GPs mentioned or discussed physical exercise with their patients, it was the extent to which they did so. Indeed, the overwhelming majority said they did talk about it with patients particularly those with long term conditions (as noted above) but it was clear on probing that behaviour varied enormously. Moreover, the evident sense of reluctance about being interviewed could have been in some part precisely because they believed it was an area of care in which they already engaged.

At one end of the spectrum were those who appeared to be relatively reactive to the problem presenting in the surgery.

'When a patient comes to us and says they want to lose weight and they are interested in exercise, we will get them to see one of our healthcare assistants but it is something they initiate not me'
(GP – Phase 2)

'I will talk about it if a patient asks me. But generally it is opportunistic as it is rare that a patient will come in and say, I want to discuss physical activity so it just depends'
(GP – Phase 2)

And, once more, it tended to be those in Phase 1 who believed that many GPs fell into this category.

'At the moment it is a treatment and they focus on the referral, a reaction to the problem and I don't think many GPs will have a nice chat to someone and say let's talk about exercise'
(Phase 1)

'I think it is part of the white noise in the consultation. It is a bit like healthy eating with five fruit and veg and those sorts of things. It is something they say when they have to but with very little commitment'
(Phase 1)

But at the other end of the spectrum there were GPs who were evidently proactive in terms of raising the issue, discussing it and either referring on or, instead, talking about how they might build on every day activities.

'If you say exercise some of the people think they may have to go to the gym so I normally talk about activity and then that opens a whole spectrum of things, to talking about walking, gardening, swimming and so on.
(GP – Phase 2)

'For us it is top priority. Before they get into the stage of disease or any illness, the exercise is paramount that we always stress in the first contact. In this practice everyone does it – us, the doctors and it is very much encouraged.

(Practice Staff – Phase 2)

From the discussions it seemed that GPs who had a particular interest in physical activity or who prioritised it would ensure they spent time talking about it.

> *'The personal preference for exercise differs some think it is important and others don't…so some of us spend five minutes and some of us spend five seconds to tick that box'*
> (GP – Phase 2)

> *'I have a Masters in Sports Medicine so I tend to make a point of always bringing it up and I tend to promote it to a lot of my patients quite often as a first port of call'*
> (GP – Phase 2)

This was corroborated both by nurses and especially by Health Trainers.

> *'It really depends how interested they are but I have one GP who is very keen and he refers everyone to me as he knows I have the time to put in a proper plan, a six month one to really get the patient to make it part of their life'*
> (Practice Staff – Phase 2)

But what seemed to be crucial and evident in the vast majority of interviews was a sense that there was little co-ordination between the key stakeholders. Although a number spontaneously commented that it was vital to work together as a team in a general practice and to 'sing from the same song sheet', it was clear that this was not always the case.

In one surgery in the sample, the GPs believed that there was an organised approach both to referrals for exercise and to those patients who need other physical activity support in that it was a team effort with the nursing staff. However, in the eyes of the nursing staff that were interviewed, this was clearly not the case. Firstly, they were not aware of a 'list' of activities and secondly it was not usual for a GP to mention exercise to them. It was also noteworthy that the Health Trainers interviewed also had experience of this.

> *'Recently a GP referred a patient to me twice in six months, they had just forgotten and I don't think they really think about it'*
> (Practice Staff – Phase 2)

More pertinently, it appeared that the behaviour of the majority of GPs, as evidenced in their discussions as well as with those who worked alongside them, meant that once the lifestyle box was ticked or the referral made their responsibility had ended.

> *'To be quite honest, I fill in that referral form and I really don't know where it ends up – you fill in the form and you hope they get the exercise'*
> (GP – Phase 2)

> *'I think lots of colleagues refer and advise but actually in their busy day just do it and then it is done and that is it'*
> (GP – Phase 2)

There was equally a feeling from nursing staff that felt that they were at times, rather put upon.

'I think when (GPs) *refer, then they don't have to think about it…'*
(Practice Staff – Phase 2)

'We are very busy and I know it is probably not on the top of their agenda but it is something they think, oh go and see the nurse. Then we do it and they just simply delegate it out'
(Practice Staff – Phase 2)

And it also appeared that secondary care did the same as well at times.

'I mean I had a letter from a teaching hospital about a patient saying, please refer to your local community gym programme. Well, we don't even have one'
(GP – Phase 2)

Some GPs recognised this issue as did voices from Phase 1.

'What you need is a captain of the ship to redirect a co-ordinated team. It doesn't matter whether that is the GP or the nurse but you need somebody to implement the process, to refer on, to talk to the patient'
(GP – Phase 2)

'The other thing is that they want to fire and forget so you need one person to sort it out really. Otherwise, it is almost, I have done my bit as a GP and made the referral and that is it'
(Phase 1)

Finally, in one site in this study, the Public Health Department had set up a telephone line in the Department to act as a referral point as well as a help-line for lifestyle related issues such as physical activity, diet, alcohol and so on.

'We have called it a lifestyles phone number. It was trying to find a central point of contact where our people won't necessarily know every detail but they will have a script and people will get put to the right places rather than just lost in the ether'
(Phase 1)

3. Specific Barriers

a) Time and Associated Issues

Similar to the GSK research, it was clear that one of the major barriers to the promotion and encouragement of physical activity was time. It was certainly the issue that was usually brought up first during interviews. Many drew attention to the fact that patients with long term conditions often presented with a range of problems that needed attention and crucially the condition itself needed constant management.

'We are asked to do more and more and more…sometimes unfortunately we have to concentrate on one, two or three things in that ten minute consultation. We are seeing them for so many different things in the consultation, it is difficult. It does not make it less important but it is difficult'
(GP – Phase 2)

'If they come in with a shopping list of you know five complaints, you may not have time to get round to all of those things and to talk about lifestyle as well…'
(GP – Phase 2)

'People come in with two or three different problems always and we haven't got the time because whatever you say, this will come back to back with the blood pressure or high cholesterol so we just normally spend all our time doing follow-ups'
(Practice Staff – Phase 2)

It was pointed out that spending time on lifestyle issues, particularly exercise, would mean that it would be at the expense of something else that might be as if not more important and equally every patient needed tailored individual advice.

'It normally is at the expense of something else. And I go off and talk about exercise and then they will say well, I have got this other thing as well and they have another problem and I have spent all the ten minutes on exercise'
(GP – Phase 2)

'There is no one solution that fits all patients. You have to talk about it slowly and individualise the advice and that takes time. Then there is not time to talk about anything you need to like the management of their condition'
(GP – Phase 2)

A number of nursing staff related that a further and connected problem due to the shortage of time was that, when under pressure, they were unable bring to mind the facilities that were available. In one interview, for example, a practice nurse said initially she did not know of any available provision but, by the time the interview was almost completed, she had managed to relay a long list.

'I can never think of groups when asked but I do know about lots. When a patient comes in you don't have that much time and you just can't think. You deal with the problem in hand'
(Practice Staff – Phase 2)

'It is very hard to think about it when the patient is in front of you. And then you have to sell it and you haven't got much time to think about it and what you need to say and what to tell them to do'
(Practice Staff – Phase 2)

Another complication aired by both GPs and practice staff was that patients often had immediate physical or mental health issues which would need to be dealt with before they were able to tackle any exercise. For instance, possibly psychological services or physiotherapy. This once more, was time consuming in the allocated ten minutes.

'Because unless people can get some treatment for their poor knees or their back ankles and their bad back and get that sorted out, blah, blah, blah that to them is their mental block to actually then doing exercise for the rest of their health issues. They won't think of exercise until all that is done'
(GP – Phase 2)

'If they can't walk down the stairs and walk down the street without being in pain they are not going to want to sit on a bike in a gym or go to a swimming class'
(Practice Staff – Phase 2)

In this regard, there was a minority voice that felt concerned that recommending the wrong exercise may lead to legal proceedings. One commentator from Phase 1 felt this recourse to legal action just might be the answer!

> *'I mean it is this medical legal rubbish isn't it? That is what I would see as the reflex as to why people wouldn't feel confident about talking about and recommending exercise'*
> (GP – Phase 2)

> *'Yes, but wouldn't it be good if a patient sued a doctor for not giving them advice about physical activity!'*
> (Phase 1)

b) Images and Perceptions

Although the time factor was more than often the immediate response as to why physical activity was not actively promoted and encouraged, it was evident on probing that it ran alongside three further and critical issues.

In the first place, a number of GPs seemed very conscious of the fact that they, themselves did little or no exercise and felt that it was hard for them to talk about it if this were the case.

> *'I mean if you are telling them to give up smoking and you reek of tobacco it is not really powerful is it? If you can say, that this is the sort of exercise that I do and this where I go and this is what I pay and this is how I feel about it, it has to be better'*
> (GP – Phase 2)

> *'Well look at me…do you think patients would take me seriously if I recommended lots of exercise?'*
> (GP – Phase 2)

A number of those in Phase 1 also saw this factor as a potential barrier.

> *'But some GPs they are not very good advocates themselves…they are quite portly and unhealthy themselves!'*
> (Phase 1)

> *'I think it would be good if GPs committed themselves to being active and their staff as the best way to become advocates is if they see it for themselves. If you look at some of GPs then clearly physical activity is not high on their agenda'*
> (Phase 1)

For those working alongside GPs such as Health Trainers it was also seen as an important and compounding factor not least so that the patient could identify with the purveyor of advice and information.

> *'I do think though if a GP is actively seeking exercising then they will promote healthy lifestyles in that surgery. Practise what they preach'*
> (Practice Staff – Phase 2)

> *'You have to be aware when you are passing information to patients, you can't be judgemental and you know I think if I was 22 stone and sat here I wouldn't dream of giving advice or information – it would be totally hypocritical'*

(Practice Staff – Phase 2)

It was explained that one of the difficulties was thought to be that if you were not comfortable either about your own weight or lack of exercise it would be hard to talk about it to others. This tended to be brought up by those in Phase 1.

> *'Many of the GPs will be overweight and obese themselves. It is a very, very contentious issue if you don't feel comfortable raising it. With weight and physical activity people are still not yet comfortable and if you don't go cycling or whatever, your personal perceptions can intervene. It is about the patient and what questions might come back'*
> (Phase 1)

> *'So we need to support practices on how to manage that situation, how to ask those questions in a non-intrusive way and encourage and suggest. At the moment I don't think they are skilled in holding those sorts of conversations…I expect they will tell you that patients want pills but actually they don't feel comfortable talking about these things particularly if their own lifestyle is not that healthy'*
> (Phase 1)

Ideally, if they did exercise themselves, they would know what the barriers were, what they felt about the experience and the benefits. One GP during an interview said that he hard recently started to do exercise and now felt he was able to talk about it with a good deal more confidence

> *'Me, personally, as a doctor who has just started exercising, I can see the difference. I can now talk to my patients and tell them I feel better, your psychology improves, you lose weight and then you are motivated to look at other aspects of your life'*
> (GP – Phase 1)

> *'If you plan a service in a way you want GPs to be involved and then include the patients you could get the whole lot of GPs go through the process that the patient group go through to have their own experience so that know exactly what the benefits are to themselves and then they are able to encourage patients'*
> (GP – Phase 2)

c) Feedback

The importance of providing feedback to GPs once they had made a referral to an exercise programme or indeed following giving advice, was underlined by most respondents in Phase 2. One commentator in Phase 1, however, suspected that GPs would not look at feedback forms or information but the evidence did not seem to bear this out. Many GPs, for example, bemoaned the fact that they rarely received feedback from referral schemes and where it was received it was unquestionably appreciated particularly in the Borough where the PCT had initiated their own activity programme. There, their premise assumed there would be a programme in place that worked from concept to delivery.

> *'It has been really encouraging in terms of our feedback…it is a two way thing both for the GP and for the patient. They will see that it has worked for the patient and it will encourage them to think again about the next one. It has definitely I think made a difference to our referral rates'*

(Phase 1)

'I haven't had feedback yet but I am told we will be getting it and it will be really good to have it to be honest. We have had it from the patients but it would be great to know if it is the right programme for them and for their health and to see the mental effects too'
(Practice Staff – Phase 2)

At one level it was clearly useful from the health perspective so that GPs and other practice staff could see any immediate health benefits which would in turn affect both future medication and treatment. This applied not just to exercise programmes per se but equally to Health Trainers and physiotherapists. It also enabled GPs to provide more individual advice.

'There is some merit in knowing how each patient is progressing and we can motivate them more rather than motivating everyone at the same level. We should be able to refer patients and the physical trainers should communicate directly with us to advise which patient is doing how much and so on…we could even give them prizes'
(GP – Phase 2)

'I never got, when we did have access to a referral scheme, any feedback form telling us how many sessions they had had and I wanted to know if the patient had activated the referral, if they attended the sessions and then you can establish if it was beneficial to the patient as a whole'
(GP – Phase 1)

At another, there was evidence that it encouraged more referrals since it not only encouraged patients it equally motivated the GPs.

'GPs who use our service have found patients coming back and saying, it is pretty good and then if they have feedback from the Health Trainer then they think that's brilliant and they refer someone else'
(Practice Staff – Phase 2)

'It is very important. If you have advised or motivated a certain individual and they say, I have done this, you say, well done, you have done this and got this far. It helps their motivation and then it encourages you to go on to the next person'
(Phase 1)

Conversely, it was seemingly the lack of feedback that was very much a de-motivating factor either in perception or in reality.

'I think loads of people get advice but you've got no way of knowing or monitoring it or measuring it. The thing is that people lose heart if they don't see any improvement and if we don't know, then we can't encourage them'
(GP – Phase 2)

' The thing is I need to know if they have increased their walking or something…it is non-stop here and you do lose motivation to go on plugging it and then you don't know what to say the next time you see them'
(Practise Staff – Phase 2)

Further, it was pointed out that patients could be referred to a venue or activity that was no longer in operation and that was thought to have a particularly negative effect on those that experienced this.

Finally, there was a view heard in Phase 1 that argued that by completing the loop and delivering feedback it would help make physical activity more integral to their daily care.

> *'GPs rarely get feedback so it is normally referrals out and nothing comes back. Historically, I think that is changing as we go forward but without that loop, it is not and will not be embedded into their psyche'*
> (Phase 1)

d) Knowledge

A lack of knowledge about physical activity seemed to be a critical issue for many of those interviewed. During discussions, it often became clear once definitions and parameters had been clarified that it was an issue in varying degrees for most, even for those with Masters in Sports Medicine.

> *'All I know that when I hadn't done my Masters people would come in and I wouldn't know what to say to them. I am sure lots of GPs are like that. It is easier now but even now I have to think carefully about my response'*
> (GP – Phase 2)

Some argued that the difficulty was that everyone knew 'something about it' and that knowledge was assumed but not developed in any depth thus rendering any helpful and meaningful conversations with patients that much harder. It could also be particularly difficult for nursing staff who often were the ones dealing with it. A number of this latter group of respondents asked for protocols and guidelines to help them. One nurse explained that she was a loss when a patient asked which exercise, how much or for how long.

> *'All GPs know there is benefit of physical activity but I don't think they understand the depth of the benefit. I don't think GPs know about the massive health benefit in prevention for example. Training is essential as we simply don't have the knowledge"*
> (GP –Phase 2)

> *'I just want personally a better understanding of it because I am not sure what I am doing. I mean I am not too what ages should be doing what or what I say when they ask me how high my heart rate must be before they stop. I have had no training and guidelines would be useful'*
> (Practice Staff - Phase 2)

This was equally an area that was a focus for discussion in Phase 1 as well.

> *'I wonder whether a lot of GPs get very fed up with the idea of exercise because they don't know and don't have the resources of advice and education behind them so they don't know what to say to patients'*
> (Phase 1)

> *'Largely, I think their knowledge is intuitive, they don't understand the evidence base and they don't get knowledge from training'*
> (Phase 1)

Others pointed out that when there was a new referral scheme, they were unsure of the evidence behind it and thus, were reluctant to recommend it. And one GP remarked they were uncertain of the benefits of a GP repeatedly advising a patient:

> *'Yes it is simple, exercise is going to do you good for your long term condition but in terms of the evidence for how they provide it, that can be lacking sometimes so you are not too sure'*
> (GP – Phase 2)

> *'The question is, what is the evidence that a GP talking to their patients about exercise is really going to increase their exercise in the long term. How effective is it really and truly?'*
> (GP – Phase 2)

Finally one GP remarked that one of the difficulties was, in their view, that the cost benefits were also uncertain.

> *'You can't say if that person does walk three miles a day that will save you x pounds on prescriptions or anything. You don't know the timeframe in which the savings will occur or arise. Then is it about treatment or about prevention? There is that often quoted statement the physical activity is the best buy in public health. Financially, I don't know how it stacks up'*
> (Phase 1)

4. Potential Solutions

a) Education

It was particularly noteworthy that, across the board, both GPs and practice staff called for educational meetings to be facilitated by somebody who was an 'expert'. Opinions on who this should be varied between consultants, Health Trainers, physical exercise specialists or other GPs. Some felt, however, that GPs would not be knowledgeable enough but others believed it would useful since they would be 'role models' for others. A minority put forward the idea that it could be a role for a 'GP with a Special Interest' which one GP had previously explored in another Borough but had had little success in gaining support.

But it was clear that most felt that a professional coming in to talk to GPs would both be effective in terms of raising their knowledge but equally in terms of motivating them. The need to have experience of working on the ground was generally thought to be critical.

> *'Yeah, somebody who can explain it but not somebody who knows because they have learnt it but who has actually seen the benefits – maybe a consultant… what you need is someone to come in physically and say to them* (GPs) *this works and they have the proof…They will want to if saves them money though'*
> (Practice Staff – Phase 2)

> *'My gut feeling is that you need to get GPs interested, don't you. So you need to make this a service where the GsP are going to sit up and think, ok this is different, this is not just referring people, how can I be educated about exercise. And actually have a question and answer session. Because you don't know what the problems are until you face them and the questions and then you can all share and learn'*

(GP – Phase 2)

There was also a suggestion that the meetings could be on rotational basis with information in advance so members of a practice could choose which sessions to attend. Although it seemed that many would be happy to attend a meeting with other practices, it should be kept local.

It was suggested that the content of these meetings could include:

- Evidence and benefits of exercise for specific long term conditions particularly in terms what has worked for particular patients ie results of those people who entered a scheme eg patients who no longer have to take painkillers for their osteo-arthritic knees/or who take less days of work/or their diabetic control has improved without changing medication and so on
- What is evidenced based, what 'works' and what 'counts' as exercise
- What they should be recommending to whom
- The potential role of the Practice Nurse/Healthcare Assistant and that of the GP
- Potential cost benefits emphasising savings

Even though leaflets were not thought of as being particularly useful by most, it was felt by a minority that there might be a place for them in educating both GPs and patients. Conceptualised as 'flash cards', they could list key messages to remind GPs of how to approach the subject or important facts. Similarly, they might serve as useful reminders to patients as well.

c) Physical Activity Clinic

A further idea put forward was that of a physical activity clinic similar to smoking cessation clinics. Here, the main benefits were again that it would be easy to refer and that they would receive feedback about their patients. In addition, it would advantageous to have a named person and thus a 'face to refer to'.

> *'It would be possible to have a name. It is always useful to have a name and a face to pass on to patients'*
> (Practice Staff – Phase 2)

> *'We would be able to refer our patients and there would be feedback as to who is doing well and who is not and the physical trainers should communicate directly with us to advise us about our patients'*
> (GP – Phase 2)

If there were an exercise therapist, as another GP mooted, patients would get their own personalised plan following an appointment which could then be followed up. Such a therapist also might be able to deal with issues that had previously prevented them from doing exercise such as any musculoskeletal problems for example.

Alternatively, the clinic or therapist could be rotational as well, visiting groups of patients either in surgeries or in libraries or other civic centres. Some suggested that there should be a gym or space in a local surgery for the activities.

> *'A lifestyle consultant in effect and somebody who could talk to them, redirect people to the right place, tell them what is available…we do have people who come here like the hearing aid person…'*
> (GP – Phase 2)

Some interviewers in Phase 1 likened it again to smoking cessation suggesting that practice staff should be trained up regardless of how large the gap in their knowledge was since they would need to be become 'expert'.

> *'It started in pharmacies and they got trained up – they went through a Level 1 and a Level 2 training so they were equipped with the right information and knowledge to deliver that service. I think you have to do the same with this and to make sure that they are all up to a certain level of understanding and are able to advice patients…'*
> (Phase 1)

d) Motivational Interviewing

During debates about the difficulties of talking to patients about exercise, the subject of 'motivational interviewing' training arose spontaneously and regularly not least because it was part of the process of 'Let's Get Moving' and was also integral to a referral programme in one of the Boroughs.

Across both Phase 1 and Phase 2, motivational training found relatively little support. In some cases there was mere derision.

> *'Our staff here have had training in their roles and qualifications and we go through with them how to approach these patients and the sorts of things to talk about and to recommend. So we do invest time but not specifically motivational training and you know what? If you said to me, would you like to go for motivational training? I would say, just don't waste my time'*
> (GP – Phase 2)

> *'We had people from the* (XXX) *programme come along and we did it and they waffled for an hour and it was a real waste of time…it could have been fitted in five minutes and not everybody needed to be there'*
> (GP – Phase 2)

Some in particular questioned the evidence base for it.

> *'I think the evidence base for motivational interviewing is just rubbish. I think there is a definite lack of evidence about it…'*
> (Phase 1)

Other respondents, especially nursing staff but also some GPs, felt that they did not need it since it was rather pointless given their perceptions of patients.

> *'We don't need it…we just want the information because you can say until you are blue in the face to somebody and they say, yes they will go to the gym, and then they walk out of here and they just think, I am not listening to them. There is no point'*
> (Practice Staff – Phase 2)

> *'I think you will find that most patients, if they want to talk about it they will and if not they will shut you off, there and then…So I can't imagine it would help. The trouble with it is that it won't take into account different personalities and assumes that everyone is going to be motivated in the same way'*
> (Practice Staff – Phase 2)

However, there were a few GPs and healthcare staff who felt it was or could be hugely beneficial but more common was either a view that they simply did not know about it or that they thought they had had it anyway but could not remember.

> *'The best output has always been shown to be motivational interviewing, you know, getting the patient to own the fact that they need and they want to do physical activity. The outputs are not as good as if they're told to do it'*
> (GP – Phase 2)

> *'I don't really know about it but it sounds good to know how to get it across, how important it is. If they come up with, I don't have time, I don't want to, I can't afford to, how do you come back with a reply? I am sure that there are a lot of GPs who have questions like that they don't know how to answer'*
> (Practice Staff – Phase 2)

> *'I don't know what staff motivational interviewing is or what it involves, what it deals with so I have simply no idea'*
> (GP – Phase 2)

Those in Phase 1 also appeared to have little experience of it . Again, in discussions, it attracted interest but one of the immediate issues raised was the necessity of being able to justify it financially, a view resonant with GPs.

> *'I think the few who have done it are great believers in it but they would also say it is impossible to imagine going again on a training that is two afternoons, that is just too much and impossible to do'*
> (Phase 1)

> *'Most motivational interviewing is much longer than a normal interview so it cannot be done in a normal consultation so it will be a massive workload for a GP as you are taking them away from their normal day job and that costs'*
> (GP – Phase 2)

H. RAISING THE PROFILE

Undoubtedly there was an overall awareness that this was a huge and complex agenda and one that could not be tackled in the short term. The majority stressed that it needed to become embedded in health care and many discussions focused on how this could best be done so that the agenda of physical exercise could be raised at a national level. Many respondents also pointed out that the approach and commissioning agenda for long term conditions was changing and this was evident during discussions in both Phases across the three Boroughs. However, underpinning these discussions were the uncertainties presently in the health service one of which was a fundamental concern as to whether this agenda was or should be the responsibility of Clinical Commissioning Groups or Public Health. With Public Health moving into Local Authorities, there was a feeling among some that that was its natural home since, after all, it belonged within the realm of the 'wider determinants' of health.

> *'As public health goes into the local authority then the game changes….I think there are grey areas on both sides…Are these sorts of budgets going to be with the Local Authority under a public health guise or will they be the responsibility of GPs?'*
> (Phase 1)

> *'They need to take a longer proactive view around health, starting from schools and primary education, rather than trying to be reactive and just treating it…it should be removed from the clinical – I think it should be Public Health'*
> (GP – Phase 2)

Nonetheless, for the majority of respondents, it was certainly an area which should be, at least in part be the responsibility of the NHS. Broadly, there were three aspects to the debates as how the agenda might be moved forward. Firstly, the perceived impact of Clinical Commissioning Groups, secondly, the need to ensure that physical exercise became a feature of both care pathways and disease templates and, thirdly, whether incentivsation was an appropriate way forward.

1. Clinical Commissioning Groups

There was certainly some optimism among respondents about the potential commitment of Clinical Commissioning Groups to the prevention agenda in general and physical activity in particular. Both those in Phase 1 and Phase 2, for example, believed that the Groups would be supportive of the agenda but that it would depend on a number of factors. In the first place, it was thought it had to be seen against the background of the government and local agendas and commissioning intentions.

> *'It depends on the Government agenda. They are saying they want to strengthen public health but if their agenda goes somewhere else then with the best will in the world it won't make a difference'*
> (Phase 1)

> *'I don't think it will fall off the agenda but it depends how many things are dumped on the commissioning groups and what kind of emphasis is put on it in the contracts'*
> (GP – Phase 2)

It was also thought that the make-up of the Groups and personal interest would be critical thus potentially reinforcing the post code lottery

'It will probably continue to be very variable across the country – commissioning is going to be done in pockets isn't it. But if GPs are interested in it they will push for it. It will be their budget but intentions may change once they are responsible'
(Phase 1)

'It will depend on who is running the commissioning groups and who is sitting on the boards and what they are interested in. The ones that shout louder will be the ones that make the decisions'
(GP – Phase 2)

But for the most part, interviewees were despondent. The majority believed that it would either remain on the back burner or drop off the agenda entirely not least because of the financial crisis and the stringency of commissioning decisions which tended to operate on a year on year basis.

'With Public Health moving into Local Authorities, waiting times, A&E performance, something like physical activity which is not high up on the agenda already will just fall off in the next couple of years. It is just that there are so many competing agendas'
(Phase 1)

'I think it will fall low down…you have got spending money on treatments, acute care and all the topical things in the news and spending money on cancers etc. It is not a sexy topic or a headline clincher'
(GP – Phase 2)

In this regard, commissioners in two Boroughs argued that there was probably a large population that remained untapped further adding to the potential cost.

'And you have to think what is the cost of it all if we start identifying more and more people. Obviously that is what we have to do but what is the cost of doing that?'
(Phase 1)

The lack of detailed evidence in terms of the effectiveness of specific interventions as well as of cost effectiveness would, many believe, contribute to this scenario.

'People are looking at things that have got a very, very hard outcome. Like actually reducing length of stay or does it benefit a clinic in cost terms, is it cheaper than the consultant…patient care is taking a back seat now and it is all about money'
(Phase 1)

'*The problem is that it is long-term. You can't measure the effects in six months or one year…I don't know how long after you commence activities when they kick in. There is a lag period and it also depends on the level of activity that you do…It is just not that straight forward or monitorable*'
(Phase 1)

2. Care Pathways

One possible solution that was briefly debated during the study was whether inserting physical activity into care pathways or in disease templates would be an effective way forward.

There were a number of supporters, particularly in Phase 1, on the basis that inserting into care pathways was one way of ensuring that it would become integral to patient care.

> *'It should be part of therapy rather than just another option and part of the whole care package. If it is a core part of services and not an attached on part of how we manage patients or manage care pathways, then it is more like to become embedded'*
> (Phase 1)

> *'It has to be part of the care pathway, the package and not an add-on so it shifts from something which is a nice extra to being something which is part of the care…Physical activity, it is so huge and it should be in every care pathway I can possibly think of'*
> (Phase 1)

But there was less unanimity over whether it should be inserted into disease templates so that it might be, for instance, seen alongside alcohol or smoking. Whereas some believed that it was the only way to raise its profile among GPs, others felt that again it would depend on the individual clinician and it might not actually affect the levels of physical activity or patient compliance.

> *'I think to make it integral, the only way to do it is by putting it into these templates that we have to complete and I think most GPs respond well to that'*
> (GP – Phase 2)

> *'It does come down to the individual clinician though and how much importance he attaches to it. I suppose too it is a good way of measuring if it is ticked but if you don't tick it, it doesn't mean you haven't done it. Either way, it also doesn't mean the patient is going to do anything. '*
> (GP – Phase 2)

In contrast to this, was the view that it was not about changing the care pathways or inserting it into disease templates but, rather, looking at care management from a different perspective.

> *'You have to look at it from a different viewpoint, from the other end of the telescope and that end is the patient point of view. You have got to ask the individuals and you have got to look at what their needs are. What do they want to do with their life and if you want to achieve then you need to be able to make those right decisions otherwise you are not going to '*
> (Phase 1)

3. Incentivisation

Although there was evidence of patient incentivisation for physical activity, there was no evidence in any of the Boroughs of GP incentivisation. On being questioned whether this would be a way both to raise the profile of physical and to increase the uptake there was a wide range of responses. Some were instinctively welcoming of the idea since it would be awarded more attention.

'I think it would be a good thing because otherwise it is left to our goodwill to do.-.it would mean that you did the job properly as it might have to be documented and followed up'
(GP – Phase 2)

'I am not a fan of it as it means you have to prioritise it over everything else. But it is the age we live in and if you wanted to promote it, it is a good way of getting a bigger pool of GPs interested in it'
(GP – Phase 2)

Others, especially nursing staff, felt that it was the only mechanism to which GPs responded.

'I mean GPs won't really do much if funding isn't available and if they are not getting paid for it and that will really get them going'
(Practice Staff – Phase 2)

'They have got to have an incentive and it is money, it is always money'
(Practice Staff – Phase 2)

Clearly, however, incentivisation was an area where there was almost unanimous agreement that it would need very careful thought. In the first place, a distinction needed to be made between what was 'core' practice and what was 'additional' and this appeared complicated by the extent to which GPs saw it as their responsibility. Some believed that they should not be incentivised for something that was their 'job'.

'If you are talking about promoting healthy exercise and healthy living in people with long-term conditions, you should be doing that automatically as part of your care but if you are talking about motivational interviewing or something different then that's fine'
(GP – Phase 2)

'I think they will do it without money – it is personal interest and you get practices interested and it is about showing what the alternatives are for GPs that count. It is more about a cultural shift for the GP to talk about it rather than an overnight financial solution. It also part of their day to day job'
(Phase 1)

It also tended to imply they were not doing the job properly in the first place.

'I feel reluctant to say that we have got to have some sort of carrot waved. It is suggesting that we are not making the recommendations at the moment. We are'
(GP – Phase 2)

'I don't think it is appropriate. It is not necessary as I see that as part and parcel of our work anyway'
(GP – Phase 2)

A more practical issue brought up was that it might mean that something else would have to be dropped or the focus would be in appropriate.

'The problem is we are so, so busy and then we would start to prioritise and to drop it…'
(GP – Phase 2)

'The problem would be of course that you would focus too much on that and not on the wider picture and the whole thing becomes skewed'
(GP – Phase 2)

Far more complex was the precise nature of the incentivisation noted by both GPs and commissioners alike. For example, whether it should be for targeting a specific group of patients, discussion of activities, making the referral, follow-up or so on.

'And the GPs we have been talking to say, yes incentives are nice but they actually want to be good doctors first and the incentives will help…but how do you enforce it and how do you manage it? You can measure it for smoking. And you will probably end up with those patients who would have done it already and you won't be targeting the ones that probably do need it'
(Phase 1)

'How are you going to measure the thing? How are you going to pay?' Are you going to pay for the referrals we do or are you going to pay the number of attendances by the patient, or are you going to measure the BMI, waist circumference? What?'
(GP – Phase 2)

In addition, a number of GPs felt that there would be instinctive opposition to any contractual levers. A LES appeared to have disadvantages as did QOF in spite of its assumed intentions

'I think the LES' people can opt in and out of those but if you did it through QOF and you did it through every disease pathway you are more likely to get less malpractice aren't you'
(GP – Phase 2)

'They have been incentivising GPs through doing QOF payments and then they have been slowly taking the QOF payments away expecting you to be integrating it into your care. But it depends on the GP as when there are so many other things to concentrate on, and if you are not going to paid for it, you stop doing it'
(GP – Phase 2)

Finally, some discussions were held about the advantages of incentivising via peer review. Both those in Phase 1 and Phase 2 believed this might be a viable option but once more care would have to taken in the design.

APPENDIX I

Letter to GP Practices

13 September 2011

Dear

Re: Research into the promotion of physical activity in Primary Care

We are writing to you to invite you and your practice to participate in a qualitative research study that has been commissioned by NHS London.

The purpose of the study is to explore and examine what support and systems need to be in place to assist health professionals to promote and encourage active lifestyles amongst people with long term conditions. We are inviting nine practices, across three London boroughs (Enfield, Newham and Kingston), to take part in the project with the intention that the findings will be able to feed into a national campaign that is due to be launched to the public in early 2012.

An independent research consultant commissioned by NHS London, Kate Melvin, has been asked to carry out the research and may be contacting you within the next few days in order to discuss with you the possibilities for arranging meetings with members of your practice. Ideally, if it were possible, it would be useful to speak to different members of your practice including GPs, Practice Nurses and other members of staff who may be involved with the treatment of those with long term conditions.

We do appreciate how busy practices are, particularly at this time of year but, as with all qualitative research, it is important to obtain the full range of perspectives and views so that there is a coherent understanding of the complexities of issues that presently confront practices.

Interviews and meetings will last no longer than one hour and the information collected will be held in the **strictest confidence.** In reporting the findings of the study, no names will be given and every effort will be made to ensure people or practices cannot be identified by any other references. In accordance with standard practice, the meetings will be tape-recorded so that all views and opinions are accurately captured. The tapes will be kept secure and accessed **only** by the researcher. After the project is complete, all records will be destroyed.

If you have any questions in the meantime, please do not hesitate to contact Helen Harrison at NHS London, email: helen.harrison@london.nhs.uk or Kate Melvin directly who can be reached on 07748 762 986 or email address is katemelvin@rescon.fsnet.co.uk.

We are very grateful for your time and support in this project.

Yours sincerely

APPENDIX II

DISCUSSION GUIDE
GP RESPONSE – LONG TERM CONDITIONS
PHASE 1

Introduction to Respondents

A brief summary of the aims and purpose of the project will be given.

It will be pointed out that this very much a guide in the sense that it sets out key issues to be raised and some possible lines of questioning. The order in which issues are raised will tend to vary and questions will seldom be asked in the way they appear on the guide. The guide will be adapted according to each individual site.

It will be explained that the interview will be a fairly informal session that is anticipated to not last more than an hour. In order to obtain an accurate record, permission will be requested to tape-record the interview. The tape and the resultant transcript will be accessible only to the study team and every effort will be made to make sure that their views cannot be linked with their name when the research is reported.

A: General

- Details of respondent's role and responsibilities
- Personal 'Involvement' (or interest) in long-term conditions

B: Long-Term Conditions - General

- What are the general levels of long-term conditions among the over 55s in the local area?
    - Which?
    - Why?
    - Have the levels changed at all?
        - For which conditions?
        - Over what time period?
- To what extent are they aware whether long-term conditions are recorded accurately by GPs?
    - Why are they not recorded accurately?
    - Does it make a difference as to which long-term conditions?
    - What are the issues involved?
    - What are the difficulties?
    - What are the implications?
- To what extent, are Health Checks or other similar programmes (eg risk stratifications) being carried out in the area?
    - What are the factors involved?
- Who is carrying out Health Checks?

- GPs?
- Pharmacists
- Outreach workers?

- To what extent has the Health Check Programme made a difference to the recording of long term conditions for the over 55s in their area?

  - How? In what way?
  - If not, why not?

- Have the results of the Health Checks informed any modification to the Health Checks programme?

C: Commissioning Issues for Long-term Conditions

- Very generally, how has commissioning for Health and Well Being changed over the last year or so within your PCT?

- And what about commissioning for long-term conditions?

- What has this meant for the treatment of long-term conditions for the over 55s?

  - Is it different from any other adults with long term conditions

- With the recent structural and changes within the NHS, how will this change further?

  - In what way?
  - Greater/less involvement of Public Health?

- And financial changes?

- To what extent, in their view, are the new local CCGs supportive of the health and well being agenda?

  - In particular, in the treatment of long-term conditions

- Will the new commissioning structures be potentially beneficial to the treatment of long-term conditions?

  - How and in what way?
  - What will be the main enablers and barriers?

- And referrals to physical activity?

D: Incentivisation for Physical Activity

- Which nationally proscribed levers, incentives or initiatives do they believe have been effective in the promotion of physical activity for long- term conditions?

  - QOF?
  - National Indicators?

- QUIP initiative?

- What local levers and incentives have been used to promote physical activities for long-term conditions?
  - Local Enhanced Services?
  - Local QOF?
  - PbC incentive schemes?
  - Other local schemes?

- And in local contracts?
  - APMS/PMS contracts?
  - Contracts with community provider services?
  - Contracts with the VCS?
  - Contracts with acute service providers?

- And any other local guidance schemes?

- How will this scenario change, in their view, over the next year or so?
  - In what way?
  - Eg the balance between incentives and contracts in terms of promotion of health and well being and in particular physical activity?

- Have there been any incentivisation schemes within your PCT for referrals to physical exercise?

- Should it be incentivized?
  - If yes, why?
  - If no, why not?

- In their view, what would be the most effective way of incentivizing the promotion of physical activity for patients of the age of 55 with long-term conditions?
  - Eg publishing information about referrals locally
  - Incentivising the practice as a whole

E: Referrals to Physical Activity - General

- In terms of referring patients to physical activity, to what extent does it make a difference <u>how</u> the long-term condition is identified?

- To their knowledge, to what extent have Health Checks made a difference to levels of referrals to physical activity?
  - Is there any way of checking? Recording?

- In their view, to what extent are established protocols for long-term conditions effective in promoting referrals of those with long-term conditions to physical activity?

- Which protocols? Why? In what way?
- Are there issues about outcomes?

- And what about more general guidance for long-term conditions?

- Why, in their view, does the level of referrals to physical activity vary so across London?

    - Eg dependent on condition
    - Age/gender/socio-economic status/ethnicity etc
    - Political priorities of the Borough
    - And amount of groups (self-organised)

- And within your PCT?

F: Referrals to Physical Activity Exercise – GPs

General

- Which long-term conditions are treated at a PCT level and which at a practice level?

    - In their view how does this affect referrals to physical activity?

- In their view, is it the role of GPs to refer physical activity?

    - Why?
    - Who else could have the responsibility?

- To what extent do they think that GPs consider it to be their role?

    - Why?
    - Why not?
    - What about role of Practice Nurse
        - Or pharmacist?

- To what extent are they aware of GP activity in terms of referrals of physical exercise?

    - Is it variable among:
        - Practices
        - Nurses
        - GPs
        - Areas etc
    - Why?

- To what extent do they think HCPs refer to exercise that builds on day to day activities as opposed to more formalized structures?

- Is staff motivational training provided at all?

    - If not, should it be?

Types of Activities and Access

- To what extent do they think there is an issue with language and definitions?
    - Eg the difference between active lifestyle and physical activity
    - Specific activities vs general physical activity advice
- To what extent are they themselves aware of types of provision of physical activity locally?
    - And GPs?
    - Practice staff?
    - And community staff?
- Are they aware of how services and provision are promoted?
    - How would GPs and community staff gain awareness?
    - How should they be promoted?
    - Through which media?
- How could GPs access the information more effectively?
    - Should GPs be the recipient of the information or should it be the practice nurse?
    - Or pharmacist?
    - Who else?
- To what extent, do they think HCPs 'trust' the information?
    - How do they know it is accurate
    - Or beneficial?
- In their view, do they consider there are adequate forms of provision available?
    - Of all types of provision?
        - If not, which? What?
    - If not, why not?
- In their view is the type of provision appropriate?
    - Should it be general
    - Or should it be more targeted
- Have services been diminished due to funding cuts?
    - Which?
    - What have been the effects of this?
- In terms of referrals, do you know what works and what doesn't?
- Is feedback collected from GPs/HCPs about the services?

Barriers and Facilitators

- In their view, in terms of GPs what are the main barriers in the referral of patients with long-term conditions to physical activity programmes?
    - Issues about referral templates for different long-term conditions

- Lack of awareness
- Lack of adequate incentives
- Lack of time
- Lack of support for the agenda – why?
- Perceptions of physical activity
  - Among GPs
  - Among Community Health teams
  - Among practice staff
  - Among patients
    - Which? Why?
- Perceptions of patient responsibility to be more active?
  - Among patients
  - Among GPs
- Issues in staff motivation
  - GPs
  - Other health care professionals
  - What are the issues?
  - Do they need training? Why? What?
- Perceptions of people with long-term conditions
  - Which long-term conditions?
- Lack of physical exercise champions?
- Whether goals are realistic?
  - Who sets them?
  - Who should set them?

- At what stage of the process/pathway do the barriers play their part?
  - In the initial stages of the condition?
  - When complications arise I the conditions and/or more specialist advice is needed
  - In the referral process?
  - In the implementation of the services?
  - And so on

- In their view, do organizational structures affect the referral to physical activity in any way?
  - Eg how the practice may be organized in terms of staff roles and responsibilities
  - Integration between practice staff and community staff/third sector provision

- What in their view has caused any particular difficulties in your PCT (as opposed to more generally across London)?

- What are the main facilitators?

- Do they think that GPs would see the same barriers or different ones?
  - And Practice Staff?
  - And Community Health staff?

- (***If relevant)*** In their view why has progress in <u>their</u> PCT been so variable?
  - Among GPs themselves

- What are the main factors?

G: Conclusions

- Where and with whom do they consider the responsibility and implementation of the physical activity agenda should lie now and in the future?

- What factors (incentives, approaches etc) would increase the implementation and take-up of physical exercise programmes?

  - In their area?
  - More broadly, in London

- In their view, what would be the most effective way to ensure the sustainability of this agenda following 2012?

- What support could be or should be provided to practices/networks or individuals?

  - Why?
  - How?

- What support could be or should be provided by GPs in order to alleviate the barriers for patients with long term conditions?

  - Why?
  - How?

- And what about support provided by other health care professionals?

- In your view, how much of a priority should this agenda be?

  - Why?

Interviewees will be thanked for their time

APPENDIX III

TOPIC GUIDE
GP RESPONSE – LONG TERM CONDITIONS
GUIDE FOR GPs

Introduction to Respondents

A brief summary of the aims and purpose of the project will be given.

It will be pointed out that this very much a guide in the sense that it sets out key issues to be raised and some possible lines of questioning. The order in which issues are raised will tend to vary and questions will seldom be asked in the way they appear on the guide. The guide will be adapted according to each individual site.

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A: General

- Details of respondent's role and responsibilities
- Personal 'Involvement' (or interest) in long-term conditions

B: Long-Term Conditions - General

- To what extent do they think that long term conditions are recorded accurately by GPs?
    - Why are they not recorded accurately?
    - Does it make a difference as to which long-term conditions?
    - What are the issues involved?
    - What are the difficulties?
    - What are the implications?
- Are they carrying out Health Checks?
- To what extent do they think the Health Checks Programme makes a difference to the recording of long term conditions for the over 55s in their area?
    - How? In what way?
    - If not, why not?

D: Incentivisation for Physical Activity

- Do they think that any nationally proscribed levers, incentives or initiatives have been effective in the promotion of physical activity for long- term conditions?

- QOF?
- National Indicators?
- QUIP initiative?

- Have there been levers and incentives that have been used locally to promote physical activities for long-term conditions?

  - Local Enhanced Services?
  - Local QOF?
  - PbC incentive schemes?
  - Other local schemes?

- And in local contracts?

  - APMS/PMS contracts?
  - Contracts with community provider services?
  - Contracts with the VCS?
  - Contracts with acute service providers?

- Have there been any other incentivisation schemes within your PCT for referrals to physical exercise?

  - Eg publication of local GPs referral rates etc

- How will this scenario change, in their view, over the next year or so?

  - In what way?
  - Eg the balance between incentives and contracts in terms of promotion of health and well being and in particular physical activity?

- Should referrals to physical exercise be incentivized?

  - If yes, why?
  - If no, why not?

- In their view, what would be the most effective way of incentivizing the promotion of physical activity for patients of the age of 55 with long-term conditions?

  - Eg publishing information about referrals locally
  - Incentivising the practice as a whole

E: Referrals to Physical Activity - General

- In terms of referring patients to physical activity, to what extent does it make a difference how the long-term condition is identified?

- In their view, to what extent are established protocols for long-term conditions effective in promoting referrals of those with long-term conditions to physical activity?

  - Which protocols? Why? In what way?
  - Are there issues about outcomes?

- And what about more general guidance for long-term conditions?

- What, in their view, are the factors that create the variation in referrals to physical activity across London?

    - Eg dependent on condition
    - Age/gender/socio-economic status/ethnicity etc
    - Political priorities of the Borough
    - And amount of groups (self-organised)

F: Referrals to Physical Activity Exercise – GPs

General

- To what extent do consider it to be the role of yourself and other GPs to refer patients to physical activity?

    - Why?
    - Why not?
    - What about role of Practice Nurse
        - Or pharmacist?

- Are you aware of the levels of referrals to physical activity in your practice?

    - And in other practices locally?

- If it is variable, why might this be the case?

    - Eg who refers
    - Different long-term conditions etc

- What do they see as the benefits for them of improving physical activity among the over 55s with long term conditions?

- To what extent do you refer to exercise that builds on day to day activities as opposed to more formalized structures?

    - Why? Why not?

- Are you aware if staff motivational training is provided in your area?

    - If not, should it be?
    - Would your practice staff attend?
        - Why? Why not?

Types of Activities and Access

- To what extent do they think there is an issue with language and definitions?

    - Eg the difference between active lifestyle and physical activity
    - Specific activities vs general physical activity advice

- To what extent are they themselves aware of types of provision of physical activity locally?
    - And other practice staff?
    - And community staff?
- How are physical activity programmes advertised or promoted in their area?
    - How would GPs and community staff gain awareness?
    - How should they be promoted?
    - Through which media?
- Do they consider it to be easily accessible?
- ***(If relevant)*** How could it be made more accessible?
    - Should GPs be the recipient of the information or should it be the practice nurse?
    - Or pharmacist?
    - Who else?
- To what extent, do you 'trust' the information?
    - How do they know it is accurate?
    - Or beneficial?
- In their view, do they consider there are <u>adequate</u> forms of provision available?
    - Of all types of provision?
        - If not, which? What?
    - If not, why not?
- In their view is the <u>type</u> of provision appropriate?
    - Should it be general
    - Or should it be more targeted
    - Or simply as part of the care pathway and not an 'add-on'
- Have services been diminished due to funding cuts?
    - Which?
    - What have been the effects of this?
- With regard to different programmes, do you know what 'works' and what doesn't?
    - In terms of length of attending programme
    - In terms of meeting 'targets'
- And formalized programmes vs merely building on everyday lifestyle?
- Is feedback collected from GPs/HCPs about the services?

<u>Barriers and Facilitators</u>

- In their view, what are the main barriers confronting you in the referral of patients with long-term conditions to physical activity or physical activity programmes?
    - Issues about referral templates for different long-term conditions
    - Lack of awareness
    - Lack of adequate incentives
    - Lack of time
    - Lack of support for the agenda – why?
    - Perceptions of physical activity
        - Among GPs
        - Among Community Health teams
        - Among practice staff
        - Among patients
            - Which? Why?
    - Perceptions of patient responsibility to be more active?
        - Among patients
        - Among GPs
    - Barriers for patients
        - How could these be ameliorated?
        - By whom?
    - Issues in staff motivation
        - GPs
        - Other health care professionals
        - What are the issues?
        - Do they need training? Why? What?
    - Perceptions of people with long-term conditions
        - Which long-term conditions?
    - Lack of physical exercise champions?
    - Feedback?
        - What sort of feedback to GPs want?
    - Whether goals are realistic?
        - Who sets them?
        - Who should set them?

- At what stage of the process/pathway do the barriers play their part?
    - In the initial stages of the condition?
    - When complications arise in the conditions and/or more specialist advice is needed
    - In the referral process?
    - In the implementation of the services?
    - And so on

- In their view, do organizational structures affect the referral to physical activity in any way?
    - Eg how the practice may be organized in terms of staff roles and responsibilities
    - Integration between practice staff and community staff/third sector provision

- What in their view has caused any particular difficulties in your practice?

- What are the main facilitators?
    - Permission from them?
- Do they think that other HCPs would see the same barriers or different ones?
    - eg Practice Staff?
    - And Community Health staff?

C: Commissioning Issues for Long-term Conditions

- Very generally, in their view how has commissioning for Health and Well Being changed over the last year or so within your PCT?
- In their view, what have changes in commissioning for Health and Well Being meant for the treatment of long-term conditions for the over 55s?
- How will this change further with the development of Clinical Commissioning Groups?
    - In what way?
- And financial changes?
- To what extent, in their view, do they think the CCG is supportive of the health and well being agenda?
    - In particular, in the treatment of long-term conditions
- Will the new commissioning structures be potentially beneficial to the treatment of long-term conditions?
    - How and in what way?
    - What will be the main enablers and barriers?
- And referrals to physical activity?

G: Conclusions

- Where and with whom do they consider the responsibility and implementation of the physical activity agenda should lie now and in the future?
- What factors (incentives, approaches etc) would increase the implementation and take-up of physical exercise programmes?
    - In their area?
    - More broadly, in London
- What factors would ensure GPs promoted physical exercise as an 'add on' to people's every day lives?
- What support could be or should be provided to practices/networks or individuals?

- Why?
- How?
- By whom?

- What support could be or should be provided by GPs in order to alleviate the barriers for patients with long term conditions?

    - Why?
    - How?

- And what about support provided by other health care professionals?

- In your view, how much of a priority should this agenda be?

    - Why?

- In their view, what would be the most effective way to ensure the sustainability of this agenda following 2012?

Interviewees will be thanked for their time

Kate Melvin
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