

# Evaluation of the Physical Activity Care Pathway London Feasibility Pilot – Executive Summary

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Participation in regular physical activity is associated with the prevention of chronic disease and the promotion of health and well-being (Department of Health, 2004). Despite the positive benefits of physical activity, only 40% of men and approximately 30% of women are sufficiently active to benefit their health and the estimated costs of physical inactivity in England are £8.2 billion annually (Craig & Mindell, 2008; Department of Health, 2004; Foresight, 2007).

Promoting physical activity through primary care is recognised as an important approach to health promotion. Based on guidance from the National Institute for Health and Clinical Excellence, brief interventions which are tailored to provide advice and encouragement to support behaviour change are effective at increasing physical activity levels (NICE, 2006). Motivational interviewing has also been identified as an approach to facilitate behaviour change (Scales & Miller, 2003).

In 2007, the Department of Health developed a draft Physical Activity Care Pathway. The Physical Activity Care Pathway involves four key steps: assessment of patients' physical activity levels, brief intervention, signposting to local physical activity opportunities and follow-up consultations. This technical report presents the final results from the feasibility trial conducted by the BHFNC based at Loughborough University.

The trial was undertaken with 14 general practices recruited in two waves to allow for a rolling start to the project and also for lessons learnt from Wave One to inform and improve delivery and implementation in Wave Two. Patients were recruited either 'opportunistically' in routine practice or via disease registers. Patient eligibility was assessed using the following criteria: aged 16 – 74 years, absence of contra-indications, and appropriateness to discuss physical activity with the patient given the context of the consultation. Patients meeting these criteria were assessed for physical activity using the General Practice Physical Activity Questionnaire (GPPAQ; Department of Health, 2006). Patients who were not meeting the current physical activity recommendation, namely 30 minutes of moderate intensity physical activity on five or more days of the week (Department of Health, 2004), were invited to take part in the care pathway.

The brief intervention (BI) delivered by a primary care health professional involved assessing patients ratings of importance and confidence towards physical activity, goal setting, risk stratification and signposting to local physical activity opportunities. The BI was conducted using motivational interviewing principles and aimed to facilitate patients motivation to change their physical activity behaviour. Patients classified as 'high risk' were signposted only to supervised activity such as an exercise referral scheme. 'Low' and 'medium risk' patients could be signposted to less structured activities.

The Let's Get Moving patient resource pack was developed by the Department of Health with support from Natural England and used in the consultation to facilitate the brief intervention discussion. Follow-up consultations with patients were recommended at three and six months and included the re-assessment of self-report activity levels, goal setting, and providing general support to patients.

The evaluation objectives of this feasibility study included: assessing the relative success of different patient recruitment methods; the feasibility of delivery by different health professionals; identifying characteristics of patients recruited into the care pathway; economic analysis of the care pathway to the NHS; and collation of feedback from practitioners about their experiences of implementation.

This feasibility study included both quantitative and qualitative data collection. Practice data was collected on the administrative tasks involved in delivering the care pathway and de-identified patient level data were collected on recruitment and progression through the care pathway. These data were used to inform the economic analyses. Interviews and focus groups were undertaken with health professionals to capture their experiences and recommendations.

Since the experiences of the Wave One practices involved in this pilot study led to significant modifications of the care pathway protocols for Wave Two, only data collected from Wave Two were included in the main analyses. Wave Two involved six practices recruiting patients over a 12 week period. Three practices recruited patients 'opportunistically' and three practices recruited via hypertension disease registers.

## Key Results:

- This study has provided a very good insight into the feasibility of implementation of the care pathway and suggestions have been proposed for modifications to the care pathway protocols.
- 526 patients were assessed for eligibility for the care pathway; 148 from disease register practices and 378 from 'opportunistic' practices, representing recruitment rates of 16% and 6% respectively.
- The GPPAQ was completed with 449 patients: 14% of patients were classified as 'active', 13% were 'moderately active', 24% were 'moderately inactive' and 50% were 'inactive'.
- 83% (n=367) of patients screened using GPPAQ were interested in the care pathway and the brief intervention consultation.
- Of the 367 patients who were interested in a brief intervention, data were recorded for 315 patients (14% loss of data).
- 96% of patients (n=301) who received the brief intervention were identified as 'ready to change' and received the full BI consultation, including signposting.
- Risk stratification classified 74% of patients as 'low risk' and 24% as 'medium risk'. Only 4 patients (1%) were classified as 'high risk'.
- Of the 300 patients who received signposting, the most frequently signposted activities were 'local authority leisure services' (n=118) and 'self-directed outdoor activities' (n=89). The least frequently signposted activities were 'exercise referral and condition specific classes' (n=4).
- 101 patients attended a follow-up consultation, which took place, on average, 15 weeks (range 4 – 23 weeks) after the brief intervention.
- Total associated costs to the NHS for all components of the care pathway (excluding the cost for training and supporting health professionals) ranged from £620 (Bromley-by-Bow) to £3,388 (Churchill). When the costs of the training and ongoing practice support are included the overall costs range from £2,445 to £6,933.
- Mean cost per patient to deliver all components of the care pathway (excluding the cost for training and supporting health professionals) range

from £48 to £308. Mean cost per patient to deliver the care pathway, including the cost for training and supporting health professionals, range from £124 to £630.

- Feedback from practitioners indicated that the design of the care pathway and the specific focus on how to promote physical activity, helped practitioners raise the topic and emphasise the importance of physical activity to patients.
- The patient-centred method of the brief intervention, with the use of motivational interviewing techniques, was viewed as beneficial and was considered to be helpful in increasing the likelihood of patients changing their physical activity behaviour.
- Feedback from practitioners revealed that many aspects of the care pathway approach to the promotion of physical activity were liked, considered to be feasible, and were perceived to be well received by patients.
- Although this study was not designed to demonstrate the effectiveness of the care pathway to deliver short or long term behaviour change, health practitioners perceived a range of patient benefits including weight loss, “breathing better”, reduced blood pressure and improved mental health and well-being.

### **Recommendations:**

- It is recommended that an effectiveness trial is undertaken to determine the impact of the revised care pathway protocols on patients’ physical activity behaviour.
- An effectiveness trial should incorporate a full economic analysis including a systematic assessment of the health outcomes of the Physical Activity Care Pathway.
- To maximise involvement and availability for patients, training of all staff in the practice should be considered thus allowing multiple staff members to be available to undertake screening, brief interventions and follow-up consultations.

- Two days of training appears necessary to develop the knowledge, skills and confidence to enable practitioners to deliver the care pathway. In addition, practitioners valued the on-going support which was provided throughout the project. Wider implementation will require sufficient resources to adequately train and support health practitioners.
- Patient recruitment to the care pathway should be extended to include other disease registers, and could also be: incorporated into disease management clinics; integrated into 'preventative clinics' (e.g., men's health and women's health clinics); delivered via group consultations on physical activity (similar to smoking cessation).
- Increased publicity of the Physical Activity Care Pathway, for example in the practice and the local community, was suggested as a potentially useful additional component to increase patient interest and uptake.
- The care pathway EMIS templates should be embedded into existing templates to maximise ease and usage.
- An agreed standard risk stratification criteria should be developed.
- Clear guidance is required on how the Physical Activity Care Pathway should be embedded into standard practice, particularly in terms of the implications the PACP may have on existing systems and infrastructure, for example exercise referral schemes.
- Health practitioners suggested that the care pathway protocols should be revised to include just one follow-up appointment at six months to align with other re-call protocols.
- Publishing the Let's Get Moving resource in a variety of languages would facilitate delivery of the brief interventions in languages other than English and would also make the resource accessible for non-English speaking populations.
- Financial backing, for example via QOF, may be needed for practitioners to embed the Physical Activity Care Pathway into standard practice.