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STAKEHOLDER PERSPECTIVES ON REFERRAL PROCESSES TO LOCAL AUTHORITY HEALTHY LIFESTYLE PROGRAMMES: A MIXED METHODS STUDY

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Conferences

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Abstract

Background: The profound but often non-specific case for physical activity (PA) in population health and the wider economy provide strong rationale for promotion in primary care settings. However, there is limited acknowledgement towards the need for refined referral pathways to community-based PA programmes based on the perspectives of all relevant stakeholders involved in the overall referral process. Consequently, such programmes are underutilised in primary care, and struggle to deliver intended health outcomes at the community level. This study makes a novel contribution to existing research by using mixed methods to elicit the perspectives and experiences of multiple stakeholders involved in referral operations to healthy lifestyle programmes (HLP) in the East Riding of Yorkshire (ERoY), to highlight areas of improvement and inform more streamlined referral processes.

Methods: A convergent mixed methods design was adopted comprising of two distinct but equally important data collection phases. Phase I used semi-structured interviews with Primary Care Personnel (PCP; n = 28), which were analysed using inductive thematic analysis. Phase II adopted online surveys and semi-structured interviews to obtain data from Leisure Professionals (n = 48) and Leisure Customers (n = 20). Phase II data were analysed through a combination of descriptive statistics and inductive thematic analysis. Findings of research phases I and II were combined during the interpretation phase of this study, through the triangulation protocol.

Results: ***Key findings from Phase I*****:** Whilst many PCP saw value in PAP, they lacked the necessary skills and training to engage with it and were not well-informed about the HLP operating in local leisure centres. Due to systemic challenges on primary care and cumbersome referral processes, PCP struggled to make time for PAP or completion of HLP referrals. Assumptions about the barriers patient face to changing

problematic lifestyle behaviours represented another pertinent finding, which contributed to PCP limited capacity to support change. Suggestions for improvement included enhancing HLP awareness, improving feedback provision, and simplifying referral processes through interoperability. ***Key findings from Phase II****:* Referral documentation provided to Leisure Professionals from PCP was a major source of criticism. Feedback mechanisms were also largely criticised by Leisure Professionals and Leisure Customers, as they fail to capture and report novel lifestyle behaviour changes of HLP participants. It was a common perception that PCP and patients lacked adequate understanding of the HLPs, which was a key area suggested for development. Standardising how referrals are managed and what feedback is provided to PCP were other suggestions for improvement from Leisure Professionals. ***Key findings from Triangulation Protocol****:* Two overriding meta themes were identified: 'Poor Understanding' and 'Inadequacies of HLP Referral Processes'. Areas of agreement, partial agreement, silence, and dissonance were found within and across stakeholder groups.

Recommendations and Conclusion: Eight context-specific and needs-driven recommendations to support the advancement of HLP referral processes are presented. These are centered around improving understanding and addressing inadequacies of the referral pathway. The most pressing recommendations were: (1) to push for interoperability between primary care and leisure systems to address issues inherent in HLP referral processes; and (2) to increase workforce capacity to meet unprecedented demands associated with the COVID-19 pandemic. To put research findings to use in the 'real world', future research would benefit from the application of implementation science.

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Glossary of Terms

BCT	Behaviour Change Techniques
BHF NCPAH	British Heart Foundation National Centre for Physical Activity and Health
BMI	Body Mass Index
BT	Business Technician
CCG	Clinical Commissioning Group
CLW	Community Link Worker
CMO	Chief Medical Officer
COM-B	Capability-Opportunity-Motivation Behaviour model
DoHSC	Department of Health and Social Care
ERoY	East Riding of Yorkshire
ERL	East Riding Leisure
ERS	Exercise Referral Schemes
FC	Fitness Coordinator
FP	Fitness Professional
GDPR	General Data Protection Regulations
GP	General Practitioner
HLO	Healthy Lifestyle Officer
HLP	Healthy Lifestyle Programme
IMD	Index of Multiple Deprivation
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NP	Nurse Practitioner
ONS	Office for National Statistics
PA	Physical Activity
PAP	Physical Activity Promotion
PCP	Primary Care Personnel

PCS	Primary care sites
PHE	Public Health England
PIA	Physical Inactivity
PN	Practice Nurse
RCT	Randomised Control Trial
RCGP	Royal College of General Practitioners
RSA	Referral Scheme Administrator
SES	Socio-economic Status
TTM	Transtheoretical Model
UK	United Kingdom
VCSE	Voluntary, Community and Social Enterprise
WHO	World Health Organization

1 INTRODUCTION TO THE STUDY

1.1 Introduction

This introductory chapter intends to contextualise the research by providing a synopsis of the implications, contributors, and prevalence of the burgeoning public health problem worldwide: physical inactivity (PIA). It proceeds by outlining the political and pragmatic rationale for physical activity (PA), and physical activity promotion (PAP) in the context of primary care. Included within this chapter is an overview of the two principal approaches of PAP in primary care: counselling and advice, and referral to community-based PA interventions. Following this, the chapter explains the unique contribution this thesis intends to make to the literature, explicitly stating the overall thesis aim. The chapter concludes by providing a brief overview of the thesis organisation and structure.

1.2 Physical Inactivity

PIA, defined as "an insufficient PA level to meet present PA recommendations" (Tremblay et al., 2017, p. 9), is recognised as one of the biggest global public health challenges of the twenty first century with serious repercussions for public health (Blair, 2009; Booth, Roberts, & Laye, 2012; Kohl et al., 2012; WHO, 2018a). PIA differs to sedentary behaviour which is characterised by "an energy expenditure ≤1.5 metabolic equivalents, while in a sitting, reclining, or lying posture" (Tremblay et al., 2017, p. 9). Examples of sedentary behaviours include watching television or sitting at a desk (British Heart Foundation, 2017). Individuals can be both physically inactive and sedentary (i.e., failing to reach current PA recommendations and engaging in sedentary behaviours for extended periods), and physically active and sedentary (i.e., fulfilling current PA recommendations but being sedentary for

prolonged periods). Thus, sedentary behaviour is an independent risk factor to PIA, and poor health and well-being.

1.2.1 Physical Health Burdens of Physical Inactivity

There is an abundance of empirical data demonstrating the profound detriment of PIA on physical health. PIA constitutes the fourth leading cause of global mortality (WHO, 2010). In 2008, PIA was responsible for 6–10% of all global deaths from non-communicable diseases (Lee et al., 2012), that is, deaths by cardiovascular disease, chronic respiratory disease, cancers, and diabetes. The United Kingdom (UK) is positioned as the third highest (16.9%) amongst 36 European countries for all-cause mortality attributable to PIA (Lee et al., 2012) where PIA is responsible for one in six UK deaths (Public Health England; PHE, 2019).

PIA is one of four critical behavioural catalysts for the development of non-communicable diseases (others include tobacco use, unhealthy diet, and alcohol consumption). PIA is the primary modifiable behavioural risk factor of the development of thirty-five pathological and clinical chronic conditions, including metabolic syndrome, obesity, type two diabetes mellitus, non-alcoholic liver disease, cardiovascular disease, cognitive diseases, bone and connective tissue disorders, cancer, and diseases of the digestive tract, pulmonary, and kidney (Booth et al., 2012). In an attempt to calculate the burden of disease caused by PIA, Lee et al. (2012) determined country-specific population attributable fractions of PIA for each major non-communicable disease (i.e., a calculation designed to approximate the influence of a risk factor on disease occurrence). This study discovered PIA to be accountable for 10.5% of

the burden of disease from coronary heart disease, 13% of type two diabetes, 17.9% of breast cancer, and 18.7% of colon cancer in the UK. It was also estimated that 16.9% of all-cause mortality in the UK were attributable to PIA; a sizable contribution to the current non-communicable disease crisis (Arena et al., 2015). Moreover, epidemiological evidence has demonstrated that low levels of PA and high levels of sedentary behaviour increases the risk of cardiovascular disease and metabolic syndrome by 40% and 140% respectively (Engelen et al., 2017).

1.2.2 Psychological Health Burdens of Physical Inactivity

Aside from the physical burdens associated with PIA, there is an emerging body of literature suggesting PIA has favourable associations with psychological issues such as depressive symptoms (Cooney, Dwan, & Mead, 2014), dementia, and cognitive decline (Blondell, Hammersley-Mather, & Veerman, 2014). Section 1.3.1. provides greater detail with regards to how maintaining a physically active lifestyle is associated with many psychological benefits as the literature tends to be centered on the protective effect of PA rather than the unfavourable impact of PIA.

1.2.3 Economic Burden of Physical Inactivity

The health burdens inextricably linked to a lack of PA weighs heavily financially on healthcare systems worldwide. Ding et al. (2016) reported that the impact of PIA on five main non-communicable diseases and all causes of mortality costed the global economy in the excess of £67.5 billion (bn) in 2013 due to health-care expenses and productivity deficits. This is a

conservative estimate, since only five of the thirty-five chronic conditions associated with PIA (Booth et al., 2012) were included in the analysis. It is likely the true economic burden of PIA is higher at the global level. In the UK, figures from 2013 suggest that the PIA pandemic inflicted direct costs of £1849940 and indirect costs of £558020, yielding a total annual cost in the excess of £2.4 million (Ding et al., 2016). Once more, figures are conservative as indirect costs only took productivity losses due to premature mortality into consideration, disregarding other indirect costs such as absenteeism and presenteeism. In the UK, the National Health Service (NHS) suffers at the hand of PIA; withstanding expenses in the region of £1bn per year (Scarborough et al., 2011). Acknowledgement of costs to the wider UK society escalates this figure to around £7.4bn each year (PHE, 2014). In England alone, chronic health conditions often associated with PIA consume approximately 70% of acute and primary care health service budgets in England (NHS England, N/D). This is problematic as the NHS is in a state of crisis, bearing ever-increasing demands attributable to unhealthy lifestyle choices (Malhotra, 2016).

1.2.4 Contributors of Physical Inactivity

Despite the abundance of evidence linking PIA to severe health and economic penalties, PA levels remain alarmingly low, where evolution and cultural shifts are cited as common underlying causes. According to Thivel et al. (2018) we live in a paradoxical era where society has evolved in favour of evading or minimising physical exertion through a greater reliance of technology, yet there remains widespread attention and concern for healthy lifestyles. From an evolutionary perspective, it is argued that human species were programmed to be physically active because hunting, gathering food supplies, and building shelters was fundamental to our

survival (Booth, Chakravarthy, & Spangenburg, 2002; Hays, Thomas, Butt, & Maynard, 2010). However, in our modern era, the need to be physically active is non-essential to our survival due to technological advances, motorised transport mechanisms, and the engineering of work sites, schools, homes, and public spaces to minimise energy expenditure and prioritise convenience (Hays et al., 2010; Ng & Popkin, 2012). The WHO (2018a) argue that less labour-intensive jobs, more sedentary past-times, and an overreliance on mechanised means of transportation have contributed to declining PA levels. Ng and Popkin (2012) revealed how PA levels in the UK have deteriorated over a 34-year period across four main PA domains (i.e., occupation, home production, travel and active leisure) and sedentary time. From 1961-2005, they discovered a 20% decline in total PA amongst UK adults, and a 34.6% reduction in occupational PA. Based on these trends, these authors forecasted that by the year 2030, UK figures for total PA will reach a 35% decline when compared to the year 1961, and occupational PA will reduce by a staggering 60.1% (Ng & Popkin, 2012).

1.2.5 Prevalence of Physical Inactivity

Globally, 27.5% of adults are physically inactive, which typically augments with age, and is higher amongst females and high-income countries (Guthold, Stevens, Riley, & Bull, 2018). Furthermore, significant disparities in PA participation levels occur between gender and social position. Specifically, females (both adolescent and adults), older adults, marginalised and/or indigenous groups, those with disabilities and chronic diseases, those residing in rural communities, and those of a low socio-economic status (SES) have reduced access to safe, accessible, affordable, and suitable opportunities to be physically active (WHO, 2018b). One example of inequalities within PA engagement was highlighted in Sport England's most recent

Active Lives Adult Survey (using data from May 2019- May 2020) where individuals of a lower SES were found to be the most likely to be inactive (35%), and the least likely to be physically active (53% ; Sport England, 2020). This is considerable given that almost a third of the adult population in England fall within the broad definition of what constitutes lower SES (Sport England, 2020). Section 4.3.5.5 elaborates on the factors responsible for exaggerating inequalities amongst lower socio-economic groups in relation to unhealthy lifestyle behaviours more generally. Moreover, the Active Lives Adult Survey also persistently expose inequalities in sport and PA participation amongst different ethnic backgrounds. The latest survey reveals how 'Mixed' and 'White' adults continue to represent the most active ethnic groups, whereas 'South Asian' and 'Black' adults represent the least active ethnic groups (69% & 65% versus 57% & 53% respectively; Sport England, 2020). According to the Association for Public Service Excellence (2021) Black, Asian and Minority Ethnic communities are more likely to reside in areas of high deprivation, and experience additional barriers to PA participation due to cultural and language differences. These deep-rooted inequalities in sport and PA are at the core of Sports England's new 10 year strategy 'Uniting the Movement', which vouches to unlock of benefits of PA for everyone (Sport England, 2021).

To reverse the alarming trends of PIA across the globe, in 2013 each WHO Member State pledged to reduce their incidence of PIA by 10% by the year of 2025, relative to baseline statistics (WHO, 2013). In their updated "Global Action Plan on Physical Activity 2018–2030", this goal towards the relative reduction in the global prevalence of PIA has been extended to 15% to reflect the five year extension for action (WHO, 2018b). However, a colossal Lancet study based on 1.9 million participants across 168 countries examining global and regional

trends of PIA from 2001 to 2016 speculated that this target will not be met judging by current PIA trends, which have remained stable since 2001 (Guthold et al., 2018).

UK PIA statistics are amongst the highest globally (Savill, Murray, & Weiler, 2015). The latest Global Health Observatory data (2018) based on figures from 2016, indicates that 35.9% of the UK adult population do not meet current PA recommendations (40% of females, 31.5% of males). Recent data supplied by the Health Survey for England (NHS Digital, 2019) reported that 26% of males and 27% of females from a pooled sample of around 8200 adults are inactive (i.e., reporting below 30 minutes of moderate or vigorous PA per week). However, it is important to note that these figures were based on self-reported PA and a previous Health Survey for England adopting accelerometers to objectively measure PA (n = 4507) reported significantly lower statistics (4% of women and 6% of men achieving recommended PA guidelines in 2008; Health and Social Care Information Centre, 2009). This highlights a considerable disparity between subjectively measured and objectively measured PA levels and challenges the reliability of latest figures.

1.3 Physical Activity

The antidote of PIA is PA, which is commonly defined as any bodily movement produced through the contraction of skeletal muscles that requires energy expenditure greater than resting metabolic rate and raises heart rate (Caspersen, Powell, & Christenson, 1985; DoHSC, 2019). PA is a complex behaviour encompassing anything from unstructured activities as part of an individual's daily living (e.g., everyday walking, caring duties, or

domestic-related tasks) to structured activities (e.g., leisure activities or competing in sport). PA and exercise are two terms that are often used interchangeably, however exercise is "a subcategory of PA that is planned, structured, repetitive, and that favours physical fitness maintenance or development" (Caspersen et al., 1985, p. 128). PA is a primary modifiable determinant of health and can provide multiplicative health, social and economic benefits if undertaken frequently and of appropriate duration and intensity.

1.3.1 Physical Activity Recommendations

The Chief Medical Officer (CMO) issued the most recent UK PA guidelines, which propose that adults aged 16-64 should endeavour to be physically active on a daily basis and minimise sedentary behaviours (DoHSC, 2019). Specifically, adults should accumulate a minimum of 150 minutes of moderate intensity activity or 75 minutes of vigorous intensity activity and should incorporate muscle and bone strengthening activities on two days a week. Moderate intensity exercise refers to an aerobic activity where a conversation can be sustained such as brisk walking, whereas vigorous-intensity exercise refers to an aerobic activity where a conversation cannot be sustained such as sprinting (DoHSC, 2019; Norton, Norton, & Sadgrove, 2010). The same guidelines also give prominence to very vigorous intensity activities (e.g., running), however do not specify duration. Older adults (i.e., aged 65 and over) are encouraged to undertake the same amount of PA (i.e., 150 minutes minimum of moderate intensity or 75 minutes of vigorous intensity) however, there is more prominence given to maintenance and improvement of physical function through strength, balance and flexibility activities (DoHSC, 2019).

1.3.2 Physical Health Benefits of Physical Activity

Compelling epidemiological evidence demonstrates the profound benefits of PA for the primary prevention (i.e., minimising disease development) and secondary prevention (i.e., reducing morbidity through timely detection and treatment) of many chronic diseases. Kruk (2007) quantified the association between PA and the incidence of chronic disease and reported risk reductions of up to 75% for breast cancer, 49% for diseases of the heart and cardiovascular system, 35% for type 2 diabetes, and 22% for colorectal cancer. This is because PA is proven to contribute to the prevention of key chronic disease risk factors including hypertension, overweight, and obesity (WHO, 2018b). Furthermore, a landmark British Medical Journal article published by Naci and Ioannidis (2013) found that PA interventions had better mortality benefits then drug interventions among stroke patients, and had equivalent mortality benefits to drug interventions for the prevention and secondary treatment of numerous chronic diseases (i.e., prevention of coronary heart disease and treatment of heart failure and diabetes).

PA has also proven effective in reducing premature mortality. In a colossal meta-analysis studying the relationship between sedentary behaviour and PA using data from over one million adults, Ekelund et al. (2016) demonstrated how being physically active can eliminate the augmented mortality risks affiliated with prolonged sitting. Moreover, in the 2012 *Lancet* Series, Lee et al. (2012) speculated that a global 25% decline in PIA could prevent 1.3 million deaths worldwide, and complete elimination of PIA could boost global life expectancy by 0.68 years. Specifically, the UK could gain 1.07 years in life expectancy if PIA were eradicated (Lee et al., 2012).

1.3.3 Psychological Health Benefits of Physical Activity

Equally as important, yet more challenging to quantify, are the psychological benefits associated with taking part in PA. There is however, an emerging body of evidence demonstrating how common psychiatric disorders can be managed effectively with PA such as depression- predicted to affect 3.3 in every 100 individuals in England (McManus, Bebbington, Jenkins, & Brugha, 2016). A Cochrane review summarised evidence from 32 randomised control trials (RCTs) to determine the effectiveness of PA for the treatment of depression in adults (displaying mild to severe clinical symptoms), and asserted that PA reduces depressive symptoms in comparison to no treatment or control intervention (Rimer et al., 2012). However, findings must be interpreted cautiously as included trials were at high risk of selection bias (due to inadequate allocation concealment), performance and detection bias (due to not blinding outcome assessors), and attrition bias (due to inadequate reporting of outcome data). It has been speculated that physically active lifestyles could be attributed to 375,000 fewer diagnoses of depression every year (Sport England, 2021).

Systematic reviews have also found that PA is an effective adjunctive treatment alongside anti-depression medication for clinically diagnosed anxiety disorders (Jayakody, Gunadasa, & Hosker, 2013), another common mental health issue affecting around 5.9 in every 100 individuals in England (McManus et al., 2016). The negative symptoms of other severe mental illness such as schizophrenia have also been shown to improve with PA. A Cochrane review based on three RCTs concluded that PA was associated with improvements in mental health and well-being amongst schizophrenics (Gorczynski & Faulkner, 2010). Specifically, PA reduced negative symptoms of schizophrenia in comparison to standard care. Similarly, a

larger scale meta-analysis based on 39 RCTs examined the influence of PA interventions on several outcome measures (i.e., depressive symptoms, schizophrenia symptoms, anthropometric measures, aerobic capacity, and quality of life) in individuals with a psychiatric illness and found a large pooled effect of PA on depressive symptoms, schizophrenia symptoms and a moderate pooled effect of PA on quality of life (Rosenbaum, Tiedemann, Sherrington, Curtis, & Ward, 2014). However, consistent with other studies that collate the findings of RCTs (Rimer et al., 2012), common methodological issues are present (e.g., small same sizes, inadequate concealed allocation, binding of assessors, and reporting of outcome measures), and therefore caution must be exercised when interpreting these findings. Nevertheless, overall, the contribution of PA in relation to positive mental well-being outcomes is widely accepted.

There is emerging evidence demonstrating how diseases typically associated with an aging population can be offset through engagement in regular PA. A recent systematic review examining the relationship between PIA and several physical and mental health outcomes in older adults aged ≥60 years, identified compelling high-quality evidence that physically active older adults are at a reduced risk of cognitive decline, dementia, and Alzheimer's disease (Cunningham, O'Sullivan, Caserotti, & Tully, 2020). Similarly, the PA Guidelines Advisory Committee (2008) reported that physically active adults lower their risk of dementia and depression by between 20-30% compared to their inactive counterparts.

1.3.4 Social Benefits of Physical Activity

Equally as important, yet not thoroughly researched, are the social benefits associated with PA participation. Taking part in PA supports social inclusion, interaction, cohesion, trust, and capital by constructing common ground and a sense of belonging and connectedness, which in turn unites people together who are often from different backgrounds (PHE, 2020b; Sport England, 2021). Sport England's latest Active Lives Adult Survey found a positive association between levels of PA and social and community development, whereby those reaching the CMO's recommendations for PA reported higher trust scores in relation to their community compared to those who were inactive (mean score: 3.3 versus mean score: 3.4 respectively; Sport England, 2020). The same survey also found that those reaching PA guidelines were less likely to feel lonely compared to their inactive counterparts (6% versus 8% respectively; Sport England, 2020). A recent report published by the Association for Public Service Excellence (2021) suggested the social value generated from PA involvement within leisure centres between May-June 2019, equalled close to £262 million, and an additional £20bn of value was produced from stronger and safer communities.

1.3.5 Economic Benefits of Physical Activity

There are substantial economic benefits speculated from improvements to PA levels. A report commissioned by Sport England to calculate the social and economic value of community sport and PA revealed that every £1 spent on community sport and PA yielded a return on investment of almost £4 for individuals and society in 2017/18 (Davies, Christy, Ramchandani, & Taylor, 2021). It also boasted that the combined economic and social value of community sport and PA participation in England sits at £85.5bn, where for example,

savings were generated from enhanced levels of social trust, belonging and community engagement (£14.2bn), improved physical and mental health (£9.59bn), healthcare savings (£5.2bn), diabetes prevention (£3.6bn), improved life satisfaction (£42bn), and prevention of unnecessary GP visits (£450 million; Davies et al., 2021). However, given that not all social outcomes impacted by sport and PA participation were included in modelling, these figures are likely to underestimate the collective economic and social value of community sport and PA in England.

Although these economic benefits are hypothetical and conservative, these savings are of upmost importance given the financial state of the NHS and the alarming deficits that are mounting year after year (NHS improvement, 2016). To combat shortcomings, the NHS has been challenged to save an additional £22bn by 2020/21 as outlined in the NHS five year forward view (NHS England, 2014b). This document stresses that the sustainability and economic prosperity of the NHS is subject to drastic improvements in prevention and public health. One key area of concern within the five-year forward view is addressing the '*health and well-being gap',* (i.e., disparity in an individual's physical, mental, and social wellbeing and their perceptions of life satisfaction, worthwhileness, happiness, and anxiety; Office for National Statistics, 2019b) by acting on the wider influences of population health such as PA participation.

1.4 Physical Activity Promotion in Primary Care

The PIA epidemic coupled with the well-documented associated physical, psychological, and economic burdens provide a strong rationale for PAP, particularly in primary care settings to reduce the burden of PIA-related non-communicable diseases on the NHS. Primary care is considered "the cornerstone of the health services system in the UK" (Starfield, Shi, & Macinko, 2005, p. 457), functioning as the front door of the NHS. Primary care services, such as general practice, serve to provide comprehensive, long-term, person-centered care for a wide range of health needs, whilst coordinating care elsewhere when appropriate, such as facilitating entry to community-based services (e.g., district nursing, sexual health services, and health promotion services), secondary care services (i.e., specific expertise services usually delivered in a hospital clinic), or tertiary care services (i.e., highly specialised expertise services provided in a specialist setting; Starfield et al., 2005).

Numerous global experts and organisations endorse the promotion of healthy lifestyle behaviours and PA in primary care settings, and celebrate PA as a "wonder drug" (McNally, 2015, p. 12) and a "miracle cure" (DoHSC, 2019, p. 3). Interventions to increase PA levels in at-risk populations are renowned as one of the best buys in Public Health (Morris, 1994), which explains why in 2012, 39 national guidelines and policies featured PAP (Weiler, Feldschreiber, & Stamatakis, 2012). For example, the American Medical Association and the American College of Sports Medicine (2007) established a global health initiative; *Exercise Is Medicine*, which endeavours to improve health and well-being through encouraging health professionals to incorporate PA assessment and prescription into all patient interactions, regardless of existing chronic conditions. Likewise, the WHO (2010) advocate PAP as a public health

priority and support the provision of PA advice and prescription in primary care. Many UK influential bodies also back PAP. The DoH publication "Choosing health: making healthy choices easier" (2004) champions the UK healthcare system as an ideal venue for lifestyle and PA promotion, supporting ERSs are one method to halt PIA. NIHCE have published a series of Public Health Guidance surrounding PA, specifically advocating three approaches to foster an active society: community-based walking and cycling programmes (2012), brief advice in primary care, otherwise known as PA counselling (NIHCE, 2013), and ERSs (2014b). More recently, PHE (2016) asserted that health professionals must be aware of the PA needs of their community, and should be knowledgeable of resources and services available to support PA (e.g., local PA interventions and primary care-based interventions). The national PA framework, "Everybody active, every day" (PHE, 2014) emphasises the value of PAP both within and beyond the health sector, arguing that all public-facing professionals across domains of education, sports and leisure, and health and social care can help push PA messages through the "making every contact count" initiative (NHS England, 2014a).

There is also a strong practical rationale for PAP within the primary care domain. Primary care organisations are ideally placed to advocate PA as a preventive and curative medicine due to their vast contact with the public, especially those who are inactive, have health issues, or are considered 'at risk' of developing such issues (PHE, 2020b). In England, more than 340 million consultations are undertaken in general practice every year, which denotes a colossal 90% of all NHS patient interactions (Hippisley-Cox & Vinogradova, 2009). The average person will consult with their GP around seven times per year, a figure that doubles for patients over the age of 80, whom on average consult with their GP around 14 times annually (Royal College of General Practitioners; RCGP, 2013). While GPs are considered the

more trusted profession in the world (Ipsos, 2021) and a credible source of information for health advice (Leemrijse, de Bakker, Ooms, & Veenhof, 2015; Leijon, Bendtsen, Nilsen, Festin, & Stahle, 2009), there has been a recent push for primary care to refrain from the traditional GP-centric model to one that endorses shared collaboration amongst all primary care staff (Thompson & Walter, 2016). Changes to the General Medical Services contract in 2004 facilitated this by encouraging extended relationships with the general practice team by making it mandatory for patients to register with a practice, rather than an individual GP (Goodwin, Dixon, Poole, & Raleigh, 2011). Subsequently, primary care professionals have increasingly partaken in PAP. Moreover, the recent support for social prescribing models at the policy level (NHS England, 2014b; NHS England, 2016), and the subsequent commissioning of *Community Link Workers* (CLWs) as an interface between clinical settings (e.g., primary care) and the voluntary, community and social enterprise (VCSE) sector, means non-clinical professionals are also involved in PAP as part of the wider social prescribing and public health agenda. Collectively, both clinical and non-clinical individuals operating in primary care (hereafter referred to as primary care personnel; PCP) hold a privileged position in the assessment and promotion of PA during patient interactions (Bélanger et al., 2015; Sallis, 2015), should actively seek to identify those not reaching UK PA guidelines (National Institute for Health and Care Excellence; NIHCE, 2013), and should refrain from underestimating their wider influence in developing a societal culture that endorses PA (Brooks, Ahmad, & Easton, 2016).

The promotion of PA in primary care settings can be divided into two dominant categories: first, provider-based PA counselling and advice, and secondly, signposting or referring to community-based PA interventions.

1.4.1 Physical Activity Counselling and Advice

Many interchangeable terms are used to describe PA counselling and advice (e.g., behavioural counselling, brief advice, and brief negotiation), nonetheless, it relates to recommendations of increasing habitual PA for the purpose of gaining health benefits. This form of PAP is appropriate when an individual is receptive to and capable of executing PA recommendations into action independently, and they do not have health risk factors, or other psychosocial or medical needs that require tailored PA programming (Craig, Dinan, Smith, Taylor, & Webborn, 2001). Thus, when PA advice and counselling is provided, clinical and legal responsibilities lie with the health professional, though the patient is responsible for their actions during the implementation of these recommendations into practice (Craig et al., 2001). The Transtheoretical Model (TTM; Prochaska & DiClemente, 1983), and the Capability-Opportunity-Motivation Behaviour model (COM-B; Michie, Van Stralen, & West, 2011) are amongst the most popular theoretical underpinning models of PA counselling and advice. More detail on these behaviour change models is provided in section 3.3.2.1.2.

5As (an acronym for Assess, Advise, Agree, Assist, and Arrange) is the most popular framework of PA counselling and advice. Although originally developed for smoking cessation (Glynn & Manley, 1995), it is widely regarded as a unifying framework for behavioural counselling in primary care (Khan, Weiler, & Blair, 2011). Specifically, 5As guides health professionals to ASSESS a primary care patient's current PA levels (Estabrooks, Glasgow, & Dzewaltowski, 2003) using a validated screening tool such as the General Practice Physical Activity Questionnaire (GPPAQ; DoHSC, 2009) which categorises patients as active,

moderately active, moderately inactive, or inactive. Next, health professionals should ADVISE a patient on how much, what type, and what intensity of PA is appropriate (Shuval et al., 2017). Estabrooks et al. (2003) suggests that PA advice should link to a patient's current health status, whilst highlighting the beneficial effects PA may elicit. Following this, health professional and patient should mutually AGREE a tailored action plan that acknowledges potential barriers that may hinder their ability to reach their PA goal (Estabrooks et al., 2003; Shuval et al., 2017). In the ASSIST phase, a patient should be encouraged to formulate specific strategies to overcome their perceived barriers to attainment (Estabrooks et al., 2003). Finally, health professionals should ARRANGE a follow-up appointment to support a patient to adhere to their PA action plan (Shuval et al., 2017). Shorter variations of this framework (i.e., ASK, ADVISE, ASSIST) have been recommended when delivering brief interventions (i.e., short conversations of around 30 seconds) with adults in primary care (Thompson, Aveyard, Jebb, Blackshaw, & Coulton, 2017).

PA counselling and advice using a framework such as the 5As benefits from brief, patient-centric, scheduled interactions delivered by a credible health professional, however, the reality of delivery in primary care is much more complex. Research has identified the minimal training in UK medical schools devoted to non-pharmacological approaches to healthcare such as PAP (Osborne et al., 2017; Vuori, 2016; Weiler, Chew, Coombs, Hamer, & Stamatakis, 2012; NHS England, 2019), which has led to an incompetency in PA counselling and exercise prescription (Dunlop & Murray, 2013). Following demands for mandatory training on lifestyle medicine (Malhotra, 2016), there has been a recent move towards a whole-system educational approach to PAP, which endeavours to target undergraduate education, postgraduate education and continuing professional development such as PHE's and Sport England's "Moving

Healthcare Professionals programme" (Brannan, Bernardotto, Clarke, & Varney, 2019). Nevertheless, it may take a substantial amount of time for this teaching and learning to manifest in routine clinical practice and in the interim, questions remain around whether health professionals have sufficient training to deliver PA counselling interventions. This helps to explain why referrals to community-based PA interventions for expertise and supervised exercise programming has proved to be an increasingly popular approach to PAP.

1.4.2 Community-Based Physical Activity Interventions

The second main approach to PAP in primary care is through signposting or referring to community-based PA interventions delivered in a range of settings such as community centres, leisure centres, and workplaces (Heath et al., 2012). These interventions encompass broad services such as walking programmes, as well as condition-specific services such as cardiac rehabilitation programmes, weight management schemes, falls prevention schemes, and Exercise Referral Schemes (ERS; Dugdill, Crone, & Murphy, 2009). This form of PAP is appropriate when an individual requires support with motivation, programming, supervision, and monitoring in relation to changing their behavioural patterns, and these interventions are directed at particular health outcomes (Craig et al., 2001).

Since the inception of ERS in the 1990s, they have remained one of the most widespread community-based PA interventions in England (Fox, Biddle, Edmunds, Bowler, & Killoran, 1997; Sowden, Breeze, Barber, & Raine, 2008). It has been speculated that less than 200 ERS existed in 1994 (Fox et al., 1997), which proliferated to 600 by 2011 (Pavey, Taylor,

et al., 2011). The term “exercise referral” has many synonyms, including but not limited to exercise on prescription, PA on prescription, PA referral schemes, exercise is medicine, green prescriptions, and social prescriptions, which are used interchangeably amongst researchers (Arsenijevic & Groot, 2017; Thomson, Camic, & Chatterjee, 2015). Nonetheless, the term exercise referral scheme, abbreviated to ERS, is adopted throughout this thesis.

ERS are multi-component, collaborative interventions, usually commissioned by local authorities in the UK that serve to tackle inequalities in health care, prevent disease, promote good health and well-being, and improve quality of life at the community level (Craig et al., 2001; Heath et al., 2012). Their intention is to increase PA behavioural patterns into the daily routines of inactive or sedentary adults who have pre-existing health conditions or risk factors (Heath et al., 2012). ERS involve a primary care or allied health professional identifying and directing ‘at-risk’ population groups via a referral process to a third-party service (usually managed by appropriately qualified Exercise Professionals in a sport or leisure centre), where a PA program tailored to the patient and their medical needs is devised and delivered, typically lasting from 10-16 weeks (Arsenijevic & Groot, 2017; Pavey, Taylor, et al., 2011). Through an ERS referral, the responsibility for the design and delivery of exercise programming alongside safe and effective patient management transfers to Exercise and Leisure Professionals. However, healthcare professionals retain overall clinical responsibility for the referred patient and thus, remain an integral component of the referral system. Individuals with conditions that have been shown to improve with PA are typically eligible for referral. Examples include metabolic diseases (e.g. obesity or high blood cholesterol), cardiovascular diseases (e.g. Ischemic heart disease or stroke), mental health problems (e.g. mild anxiety or depression) and orthopaedic problems (e.g. osteoporosis; Arsenijevic & Groot, 2017).

Despite serving as one of England's most widespread community-based PA interventions, most ERS were developed in the absence of clear structure, referral guidance or quality control indications (Hillsdon, 1998). This has caused vast heterogeneity amongst ERS and operational variations in respect of length, setting and delivery format. In attempt to raise the standards and quality of ERS, the National Quality Assurance Framework for exercise referral systems was published in 2001, which extracted best practice from existing ERS models and identified key quality standards (Craig et al., 2001). Nevertheless, nine years after this publication, it was suggested that only 46% of ERS in England, Scotland, and Northern Ireland (n = 102) followed this framework to inform scheme development and delivery (British Heart Foundation National Centre for Physical Activity and Health; BHF NCPAH, 2010). To complement the National Quality Assurance Framework for ERS, the BHF NCPAH (2010) created an 'exercise referral toolkit', which sought to guide the design, implementation and evaluation of UK schemes. Despite these publications, constraints on capacity and resource have determined the extent to which ERS are complying with quality standards and guidance (Pavey, Anokye, et al., 2011). Consequently, the effectiveness of ERS remains subject to much debate (NIHCE, 2014b) and their reputation of being "wild and woolly" endures (Henderson, Evans, Allen-Collinson, & Siriwardena, 2017), which has implications for their utilisation in primary care.

1.4.3 Effectiveness of Physical Activity Promotion in primary care

Despite an overall consensus amongst studies in favour of primary care-initiated PA interventions, there is contention surrounding the most effective PAP strategies. A

contemporary systematic review and meta-analysis focusing exclusively on PAP delivered by primary care providers without connections to additional support components (e.g., ERS) is an exemption to this consensus, and concluded that PAP has limited effect on patient PA behaviour (Van der Wardt, Di Lorito, & Viniol, 2021). These authors calculated the overall effect size of different PA interventions at 6 and 12 month follow up, where in both cases, the overall effect size was small (0.04 versus 0.20 respectively). A second conclusion of this study pooling evidence from 24 interventions with diverse consultation approaches (e.g., single PA counselling sessions; PA counselling sessions with follow-up visits or telephone call), theoretical underpinnings (e.g., motivational interviewing) and support mechanisms (e.g., tailored reports and goal setting), was that there was no superior counselling strategy for PAP (Van der Wardt et al., 2021). In contrast, Orrow, Kinmonth, Sanderson, and Sutton's systematic review and meta-analysis (2012) examining whether PAP in primary care settings elicits sustained effects on PA levels amongst sedentary adults found that PAP does have sustained positive effects on PA behaviour, where levels of self-reported PA significantly increased at 12 months. However, this studies pooled analysis of fifteen RCTs did not find any evidence to recommend ERS interventions over the provision of brief advice or counselling (Orrow et al., 2012). Although only three ERS trials were included, these findings were in accord with another systematic review and meta-analysis specifically examining ERS (Pavey, Taylor, et al., 2011). This study based on eight RCTs (*n = 5190*) discovered that whilst ERS demonstrated a 16% increase in the relative risk of achieving recommended PA levels, and a -0.82% reduction in depressive symptoms when compared to usual care (e.g., brief PA advice), there was insufficient evidence to support their use over alternative PA interventions (e.g., walking programmes) or behaviour change programmes. Campbell et al. (2015) evaluated both the clinical and cost effectiveness of ERS in comparison to usual care (e.g., PA advice giving) by pooling evidence from eight studies involving almost 5200 participants. In terms of clinical

effectiveness, this study found a 12% increase in the relative risk of achieving recommended PA levels at 6–12-month follow-up amongst ERS participants compared to those who received usual care. However, in relation to cost effectiveness, findings indicated that ERS produced marginal health gains (0.003 quality-adjusted life-years) at a supplementary cost of £225 versus usual care. This study also highlighted many uncertainties regarding the clinical effectiveness of ERS. For instance, it remains unknown whether small increases in self-reported PA result in clinically significant improvements in health (Campbell et al., 2015).

Recently, there has been more attention towards other ERS outcomes beyond self-reported PA in attempt to establish the true effectiveness of these interventions. Wade, Mann, Copeland, and Steele (2020) sought to determine whether changes in health and well-being outcomes upon completion of ERS were meaningful. This study retrospectively analysed data from the UK-wide National Referral Database, encompassing data from 23,731 participants from thirteen individual ERS. Whilst this study discovered statistically significant changes from pre to post ERS intervention in most health and well-being outcomes (i.e., body mass index; BMI, systolic blood pressure, mental well-being, quality of life, & self-efficacy), only two of these outcomes were considered to be clinically meaningful (i.e., systolic blood pressure & mental well-being). This study calls for more closer and critical consideration towards the implementation of ERS to understand how to maximise their potential.

1.5 Summary

In light of the burden of unhealthy lifestyle behaviours such as PIA, there is increased attention towards public health interventions designed to encourage healthy lifestyle behaviours as a means of reducing mortality and morbidity such as community-based PA interventions. In the context of this PhD project, this is reflected in the community-based Healthy Lifestyle Programmes (HLPs) available in ERoY, which aim to promote positive lifestyle behaviour change through increasing PA.

1.6 Background and Purpose of the Research

The opportunity to undertake this PhD project presented itself in September 2016. The East Riding of Yorkshire (ERoY) Council leisure services approached Dr Caroline Douglas and Dr Samantha Nabb at the University of Hull with a research proposition aimed towards streamlining patient referral onto their specialist PA-based behaviour change programmes (collectively referred to as the Healthy Lifestyle Programmes; HLPs).

The primary aim of this PhD project is to elicit the perspectives and experiences of multiple stakeholders involved in the HLP referral processes operating in ERoY to highlight areas of improvement and inform systemic change to streamline and enhance this process. In order to achieve this aim, this PhD project has four primary objectives:

1. To explore PCP perspectives and experiences of the HLP referral process, and highlight areas of improvement.

2. To explore Leisure Professional's perspectives and experiences of the HLP referral process, and highlight areas of improvement.
3. To explore leisure customer's perspectives and experiences of the HLP referral process, and highlight areas of improvement.
4. To propose recommendations and pragmatic solutions to streamline HLP referral processes through an amalgamation of key findings.

1.7 Thesis Overview and Organisation

This thesis is arranged into thirteen distinct chapters. The proceeding twelve chapters are detailed briefly in turn below.

Chapter 2 represents the first reflexive narrative, concerned with researcher-participant lived interactions. It encompasses the relational dimensions of this PhD research and is a transparent account of the primary researchers' (AW) interactions with each cohort of participants (i.e., PCP, Leisure Professionals and Leisure Customers), drawing on research diary entries and field notes. Its ultimate purpose is to set the stage of the primary researchers lived and observed experiences with study participants as an 'outsider', and to highlight unspoken systemic issues of HLP referral processes as experienced first-hand by the researcher, thereby helping to justify the necessity of systemic change in favour of a more streamline referral process.

Chapter 3, the literature review, begins by highlighting the strong disconnect between Public Health policies concerning PAP in primary care and the reality of PAP in these settings. This is followed by a discussion of the factors contributing to the lack of PAP in the primary care context, which are organised around PCP, the patient, and the PA programme. Next, the chapter proceeds to highlight several limitations of the current evidence base, before stating how this PhD endeavours to make a unique contrition to existing literature. The overall aim and primary objectives of this thesis are stated in the concluding section of chapter 3.

Chapter 4 offers the reader a contextual background of ERoY, and the council's provision to promote health and well-being. It unfolds by offering a detailed overview of ERoY in terms of its geography and populace. Next, attention is turned towards health inequalities across the region, and the prevalence of disease and unhealthy lifestyle behaviours. The local authorities commissioned initiatives delivered within leisure centres to support health and well-being, known as the "Healthy Lifestyle Programmes" are then discussed, followed by eligibility and exclusion criteria for referral.

Chapter 5 provides the rationale and justification for the qualitative methodology chosen to elicit the perspectives and experiences of PCP involved in patient referral to the HLP (Phase I of this research project). It precedes by recapping the aims of the research before providing specific details concerning participant eligibility, sampling, and recruitment. Next, this chapter describes the philosophical assumptions underpinning this study and the chosen methods (i.e., individual semi-structured interviews). The nuances of data collection and

analysis are thoroughly explored. This chapter concludes with an examination of key ethical considerations relevant to the first phase of this research.

Chapter 6 presents interview findings from Phase I of this PhD project, involving twenty-eight PCP involved in patient referral to the HLPs. These interviews served to comprehend the referral process from their perspectives and experiences, and their barriers and facilitators of referral. Participant characteristics are detailed and then the chapter proceeds to illustrate interview findings identified through inductive thematic analysis. Interview findings are organised into overarching themes, higher-order themes, lower-order themes, and subthemes. These are discussed in conjunction with compelling participants quotes.

Chapter 7 justifies the emerging use of mixed methods adopted in the second phase of this research project, intended to elicit the perspectives and experiences of Leisure Professionals and Leisure Customers in relation to HLP referral processes. Phase II aims, eligibility criteria, sampling and recruitment procedures are detailed. Next, the chapter makes the case that the combination of qualitative and quantitative methods helps to produce more complete knowledge, and facilitates more solid conclusions through converging and corroborating research findings. Following this, nuances of data collection tools are explained (i.e., bespoke online surveys and interview schedules for each of the three cohorts), and details of data analyses are provided. Key ethical issues relevant to the conductance of the second phase of this project are explained in the final section of chapter 7, alongside justification for presenting survey and interview findings of Leisure Professionals, (i.e., Referral Scheme

Administrators; RSAs & Fitness Professionals; FPs), separate to those of leisure customers in the succeeding chapters.

Chapter 8 presents findings of Leisure Professionals from the second phase of this research project, where data is presented as two separate strands for clarity (i.e., survey data and interview findings of RSAs & FPs). First, the chapter reports the findings of RSAs online survey data (n = 16) analysed through descriptive statistics and inductive thematic analysis. It precedes by presenting thematically analysed interview findings based on a self-selected sample of eleven RSAs. Interview findings are organised into overarching themes, higher-order themes, lower-order themes, and subthemes (where appropriate), and combined with compelling participant quotes. Next, the chapter advances to illustrate the findings of FPs online survey data (n = 32) and interview findings (n = 14), which were analysed in the same way as described above. Collectively, this insight provides the reader with an understanding of the referral process from the perspective of Leisure Professionals involved in the processing and management of HLP referrals.

Chapter 9 presents survey data and interview findings collected from Leisure Customers during the second phase of this research project. This chapter begins by reporting the findings of online survey data based on a sample of twenty Leisure Customers, which were analysed through a combination of descriptive statistics and inductive thematic analysis. The chapter precedes to depict findings of follow-up interviews with a self-selected sample of twelve Leisure Customers, where the process of thematic analysis identified a multitude of higher-order themes, and lower-order themes encapsulating the perspectives and experiences

of Leisure Customers who had been referred onto a HLP. Themes are discussed in conjunction with salient raw data extracts to retain the voice of this sample.

Chapter 10 synthesises the qualitative and quantitative research strands of this PhD outlined in chapters six (Phase I; PCP interviews), eight (Phase II; Leisure Professionals online surveys and interviews), and nine (Phase II; Leisure Customers online surveys and interviews). The Triangulation Protocol guided the process of integration, which facilitated the identification of two overarching meta themes and several meta subthemes. These are discussed in relation to each individual cohort, and their significance or novelty in light of previous relevant literature and theory. This consolidation of findings from all stakeholders involved in the referral process (i.e., PCP, Leisure Professionals, and Leisure Customers), through the identification of overarching meta themes, enabled higher level interpretation of individual research components, thus providing a complete picture of HLP referral processes. This chapter concludes with an explicit overview of the strengths and limitations of this thesis.

Chapter 11 provides a series of context-specific and needs-driven recommendations to simplify HLP referral processes which are discussed in relation to the two overriding meta themes discussed in chapter 10, and are informed by the perspectives of all local stakeholders who contributed to this research project. Recommendations are also discussed in light of the COVID-19 pandemic. This Chapter closes by recapping the overall aim of this research project, how each of the thesis objectives were met, and the key findings of individual research components before presenting the most pressing recommendation, anticipated to be of greatest benefit to HLP referral processes.

Chapter 12 represents the second reflexive narrative, concerned with the primary researcher's changing positionality from an 'outsider' (i.e., an academic researcher) looking in to HLP referral processes, to an 'insider' of the primary care community during the latter stages of this PhD project. Its purpose is to maintain transparency around how these professional experiences altered the researcher's lens, exposed delicate nuances, and inevitably shifted the researcher's interpretations of the data, and thinking around improvements to HLP referral processes.

2 OUTSIDER REFLEXIVE NARATIVES

2.1 Introduction to Reflexivity

Reflexivity recognises that ‘no research is free of the biases, assumptions, and personality of the researcher’ (Sword, 1999, p. 277), which is especially true for qualitative researchers who serve as the instrument of inquiry (Yin, 2015). Thus, a researcher’s positionality (often discussed in relation to their ‘insider’ or ‘outsider’ relationship to the population involved in the inquiry; Coghlan & Brydon-Miller, 2014), and perspectives may have implications for a research project. The practice of reflexivity, whereby a researcher continuously observes their thought processes, challenges their assumptions, and explicitly recognises the extent to which their positionality impacts on the research, is celebrated as a fundamental bastion of quality control in qualitative research (Berger, 2015). It involves the conscious and deliberate reflection and self-scrutinisation of their lens through which they observe and make sense of the phenomena under investigation (Alvesson & Skoldberg, 2000). Reflexivity also recognises the value of a researcher’s relationship with others. Specifically, interpersonal reflexivity is concerned with the relational dimensions of research, where emphasis is placed on researcher-participant lived interactions and their conversational dimensions (Walsh, 2003).

2.2 Purpose and Organisation

The practice of reflexivity throughout the undertaking of this thesis assisted in a nuanced ‘behind the scenes’ understanding of primary care operations and the Healthy Lifestyle Programme (HLP) referral processes, which prompted the writing and inclusion of reflexive narratives. These narratives are presented in two distinct parts to provide a 360-degree

overview of my journey, where I started as an 'outsider' (detailed in the present Chapter), and transitioned to an 'insider' positionality (detailed in Chapter 12), where the blurring of these boundaries helped to better illuminate the challenges of lifestyle promotion delivery in primary care settings. The present chapter, focused on accounts of interpersonal reflexivity, encompasses my experiences with study participants (i.e., HLP referrers, service providers, and service users), where I perceived myself to be in the position of an 'outsider' studying the unfamiliar. This detachment, I believe, enabled me to remain neutral and objective. The scrutiny of researcher-participant dynamics through interpersonal reflexivity were facilitated in several ways. First, research diary entries encompassing accounts of initial impressions, emotions and experiences were recorded shortly after each interaction with study participants. Second, field notes were compiled during each interview to capture relational dynamics that played out between the researcher and each study participant alongside anything else thought to be interesting or pertinent.

What will follow is a brief introduction to the structure of the current reflexive narrative. It begins by revealing roadblocks in the initial phases of this research project in relation to the recruitment of PCP. Next, two distinct engagements within the primary care sector are divulged to purposefully highlight variations in experience, and bring to light observed flaws of HLP referral processes. Following this, attention is turned towards accounts of interactions with Leisure Customers, where their stories at the point of referral often mirrored the researcher's subjective experiences in general practice, revealing faults in referral processes. Finally, the chapter reflects on engagements with those employed by the leisure sector, which provides a sharp contrast to encounters in primary care. It serves as a microcosm of my unique lived

experiences and interactions with study participants and offers a deeper appreciation of the HLP referral process, and its unspoken flaws to underscore the necessity for systemic change.

2.3 The Battle Commences

"*Your email obviously didn't make that much of an impact because I don't remember it*" the Practice Manager scoffed as he cut our conversation short. I politely thanked him for his time, put down the phone, and stared into space. My eyes filled with tears of frustration. My enthusiasm deflated. My efforts condescended. I questioned what more I could do. That was my twenty- seventh phone call to surgery gatekeepers and for me, it symbolised the pinnacle of rejection. I was following-up on recruitment correspondence to surgery gatekeepers, who controlled access to my target PCP audience. If I was not stopped in my tracks by receptionists aggressively guarding the time of Practice Managers, I was immobilised by Practice Managers fiercely protecting their practice staff or simply ignoring my communications. Sometimes, they challenged why this research project did not offer any service support cost to protect PCP's time for participation. Other times, they argued their staff did not have the time to participate. It had been a relentless battle where more often than not, I wondered if this research project had any chance of survival.

Naively, I once considered the ethical application process onerous. I had felt prepared, excited, and confident to undertake successful access negotiations with surgery gatekeepers. I believed I had accrued a wealth of experience conducting individual interviews during my MSc studies. I had confidence in my ability, trusted in my data collection material, and had the

support of Public Health and the local authority Clinical Commissioning Group (CCG) who commissioned this project. Following institutional ethical approval from the Department of Sport, Health and Exercise Science Ethics Committee at the University of Hull, I applied for a research passport for rights of access to conduct research on general practice premises. As part of the application process, I acquired an occupational health screening honorary contract, and provided evidence of my immunisation record, address, identity, study materials and support from two references. I also submitted a CV to demonstrate competency in undertaking research. It seemed long-winded but it afforded me time to liaise with key individuals representing ERoY Public Health and ERoY CCG to discuss the project, scrutinise data collection materials, and consider potential strategies for recruitment. I had also undertaken two pilot interviews with GPs, and it was during one of these pilots I was advised the best recruitment strategy would be to approach Practice Managers. Yet I was also forewarned, "*You will get a very, very poor response*". I did not think this would be the case due to the weight the commissioners carried, however, I obtained a supportive statement from the Director of Public Health East Riding for use on recruitment resources as a precautionary measure. Six months after institutional ethical approval, a research passport was granted, and I was finally permitted to begin access negotiations with gatekeepers of general practice sites.

Fast forward a further six months and I found myself slumped in front of my PhD supervisors, perplexed that PCP recruitment was still very much in its infancy. It had been a hard lesson to learn, and I felt my confidence dwindling. I began to question if I was too inexperienced. The false sense of self-assurance that I had starting this project was short lived. I had bitten off more than I could chew in taking on a PhD. But where had I gone so wrong? I was persistent in my efforts with surgery gatekeepers to facilitate circulation of recruitment

material amongst their workforce. I had consulted with East Riding leisure (ERL) sites to obtain contact information for PCP actively involved in the referral process. I had encouraged all my study participants during my first wave of recruitment to provide details of other prospective participants who may be interested in contributing to understanding. I was determined not to surrender but felt I had exhausted every avenue possible. It was time to revise our recruitment strategy again, which felt more like a strategic plan of attack on a battlefield. We demanded support from the research commissioners, specifically requesting direct contact details of GPs due to the sheer difficulty of surpassing surgery gatekeepers. Frustratingly, our bid was declined. However, it was agreed that a recruitment email direct to GPs could be sent on our behalf via the CCG internal mailing system, and a bulletin could also be featured on the NHS East Riding Hot Topics platform. Hallelujah! We had infiltrated the enemy line, but it had been a slow and exhausting step forward. A small battle won, but not the war we had anticipated fighting.

2.4 Uncharted Territory

"*Wow, I made it*" I whispered under my breath as I perched in the GP surgery waiting area. I had arranged an interview with a GP who sat on the CCG board and proclaimed a keen interest in prevention of lifestyle-related diseases during initial email conversations. I waited amongst other patients, paying attention to my surroundings to observe if the leisure programmes were advertised on surgery noticeboards. Nothing. The waiting room was deathly silent except for the tapping of the receptionist on her keyboard and infrequent sighs from patients becoming noticeably impatient. I sat and took a deep breath as I tried to contain my excitement. Due to the difficulty of recruitment, especially GPs, securing this interview felt

like I had won a small fortune on the lottery. "*Amy Wilkinson*" a deep voice called, "*if you'd like to follow me*". With that, a silhouette turned and began walking away. This was not how I anticipated these initial face-to-face interactions. How could I introduce myself, shake hands, build the rapport I knew was crucial to engagement and in-depth interaction? I scurried along after the voice, with futile attempts to make small talk along what seemed like a never-ending dreary corridor. Once in the GPs office, a big desk separated us, the GP faced directly in front of me on an executive leather chair, whilst I sat on a basic conference chair. This was firmly GP territory, and it unsettled me. I felt very much in the position of a patient, an outsider presenting with my questions, and relying on the GP's 'expert knowledge' to enlighten me on the answers (in this case HLP referral processes). Despite this particular GPs keen enthusiasm for non-medical interventions to support lifestyle behaviour change, the power imbalances were overwhelmingly apparent and unsettling. If I, an experienced qualitative researcher with a pre-arranged meeting and a set agenda felt this apprehensive, I wondered what messages were being inadvertently communicated to patients who presented with lifestyle-related issues. I did not feel the environment was conducive to feelings of support, encouragement, or equality. The cracks in HLP referral processes were beginning to show…

Some punishing eight months after my first interview, I found myself once again in the waiting room of another GP surgery, but this time to interview a CLW. The remit of a CLW is to provide personalised support to individuals presenting with non-medical issues (e.g., lifestyle issues, social issues, financial issues, housing issues), through introducing or reconnecting them to appropriate sources of community and statutory support following a comprehensive assessment of their needs, preferences, goals, and values. This can help to build community and personal resilience, and lessen health and well-being inequalities by addressing

non-medical determinants of health. I was politely collected from the waiting room by this CLW and led into a quiet consultation room. First, I was struck by the room organisation, which created a welcoming atmosphere. Chairs were positioned at a 45-degree angle and there were no large physical obstructions between us. Throughout this interview, many references were made to behaviour change techniques (BCT) such as the use of motivational interviewing and ensuring that patients were equally involved in decision-making around their health and social care. Aside from the HLP, this CLW was incredibly knowledgeable about other services and resources to support health and well-being from VSCE organisations. This novel approach to patient care was client-centered, owing to the allowance of one-hour long consultations. This allowed CLWs to collaborate with patients as opposed to trying to "fix everything" for them. Unlike my experiences with GPs, I felt very much at ease during this interview and did not sense power inequalities. Following the interview, I envisioned being in the position of a patient in respect to lifestyle issues and PA referrals once more. With the affordance of extended consultations to uncover patient needs, preferences, concerns, and goals whilst actively discussing various avenues of support, I pondered what impact this might have on a patient's experience of referral to the HLPs. It was clear at this point; it was necessary to complement this study with another, examining the patient's perspective of their referral journey. I was keen to hear first-hand about a patient's initial referral experiences in primary care in terms of how the topic of lifestyle change and the HLPs were raised, what choices they were given, how they felt, and what they thought could have been done differently. PCP had offered their interpretations of patient referral experiences in terms of barriers to referral, but I believed it was vital to give voice to the patients themselves. This missing link was fundamental to understanding the nuances of HLP referral processes.

2.5 Lured into the Unknown

"He didn't tell me anything about the LiveWell programme…All he told me is I would get a phone call from the Withernsea leisure centre". I tried my best to keep a poker face yet found myself becoming increasingly frustrated that leisure customers were not as insightful as I had first anticipated. I was interviewing an elderly gentleman who had participated on one of the HLPs: the LiveWell scheme. He explained how his surgeon refused to operate on his knee due to his obesity and the associated risks of performing surgery. He was instructed to see his GP and actively ask for a referral for exercise to help him reduce his body weight prior to being reconsidered for surgery. However, this participant was unable to recall any information provided by his GP in terms of the LiveWell programme, which he described left him feeling "*nervous"*. In fact, he was barely able to recall anything about his experiences of referral in primary care. My initial thoughts were perhaps he could not remember because considerable time had lapsed since his referral, especially since the LiveWell programme is a 12-month scheme. However, it quickly became apparent that this was not the case.

The overwhelming majority of customers were unelaborate and minimalistic in their accounts of their interactions with PCP prior to being referred onto a HLP. It is important to note that none of these customers had been referred by a CLW, which I believe would have been an interesting comparison of experience. However, CLW roles were in their infancy in primary care at the time of this research. One completer of the ERS who suffered with arthritis of the hips explained how "*the advice [from the GP] was when you can't walk, come back and see us again",* indicative of a reactive (and rather callous) approach to healthcare rather than preventive. This individual eventually requested a HLP referral from his GP after learning

about the ERS through his retirement group. In fact, many customers adopted an active role in their referral to the HLPs as opposed to being actively encouraged by a PCP, yet were often not provided with further information, guidance, encouragement, or resources. Just as I had experienced during my GP interviews, customers described impersonal encounters at the time of their referral, which for them triggered apprehension about embarking on a HLP. It became apparent they were passively shuffled through the system without any further understanding of the HLPs or support, which often caused anxiety and uncertainty about their upcoming initial leisure appointment. Such feelings often mirrored my experiences in the GPs consultation room. It was evident the atmosphere created in primary care, coupled with the lack of supplementary guidance or support, represented a major fault in HLP referral processes.

One customer outlined: "*The person you see at the leisure [centre] is more important than the doctor*". highlighting for me, the difference in approaches between leisure and health professionals. Contrary to their experiences in primary care, upon meeting FPs, referred Leisure Customers stated they were fully informed about the HLPs and made to feel at ease. They elaborately told of much warmer experiences at the leisure centre, applauding FPs for being supportive, encouraging, attentive to individual needs, and holistic in their approach. For example, one customer celebrated how his trainer uncovered his struggles with depression and signposted to the emotional well-being service. Most customers were much more forthcoming and elaborate in their descriptions of experiences at the leisure centres in comparison to in primary care.

2.6 The Truce

As I prepared once more for battle with gatekeepers- this time those controlling access to Leisure Professionals- I felt a little wiser, cautious, and mature. However, I was caught completely off guard yet again, but this time for all the right reasons. On this occasion, gatekeepers to my participants were Fitness Co-ordinators (FCs) who were responsible for managing the day-to-day operation of individual ERL centres and the supervision of front-line leisure staff.

Following a FC led tour of one leisure centre situated in a coastal town of the ERoY, it became clear why customer descriptions of their experiences at the leisure centres were more heartfelt than their experiences in primary care. As we walked around the facility, I noticed my recruitment posters, distributed to leisure gatekeepers only a few days prior, had already been placed on multiple notice boards. This contrasts sharply with my experiences with surgery gatekeepers who were often a hinderance to the distribution of recruitment material. I supposed this was a consequence of the extended working collaborations between the University of Hull and the ERoY council. The FC guiding the tour enthusiastically showed me apparatus such as Boditrax (a precision body composition analyser) and the leisure centres latest Les Mills equipment. He also politely introduced me to passing employees. What struck me the most was how friendly and welcoming everyone was, from the receptionists to the cleaners, to the café staff, to passing leisure users. The atmosphere was incredibly hospitable and positive. There was a sense of equality amongst everyone, which was in contrast to the noticeable power imbalances often apparent in GP surgeries. This tour allowed me to appreciate a patient's

transition from primary care to the leisure centres following a HLP referral as to some extent it replicated a patient's first leisure visit.

Following the tour, I was invited to a team meeting so I could discuss the research project with the leisure centres team of FPs. This FC had already contributed to the research and was keen to encourage and support his team to do the same. After I gave my spiel to the staff, the FC permitted each member of his team to take time out from their shift to participate, if they so wished. He covered several HLPs appointments with referred patients to facilitate this. I was taken aback, especially given the rejection I had experienced during my battle with surgery gatekeepers. Instead, leisure gatekeepers went above and beyond to ensure that their staff were fully supported to contribute to this research. It was difficult to stay composed because inside I was bursting with gratitude. When the whole team at this particular leisure centre volunteered to be study participants, I could hardly contain my excitement!

I never thought I would take so much pride and joy in having a crammed diary. Leisure Professionals had relished the opportunity to be heard and to shape the referral process, and I cherished the struggle for diary space. They were eager to share suggestions to improve this process- occasionally it was a challenge to draw conversations to a close during interviews. However, what moved me the most was how helplessly passionate and enthusiastic they were about their work, and the health of their clients. You could see it in their glistening eyes as they celebrated client successes. They believed in their clients. It was genuinely inspiring and so plain to see why the customers I interviewed kept citing their experiences on the programme rather than their experiences of referral in primary care. In my earlier interviews some PCP had

declared their enthusiasm for lifestyle promotion and prevention, but it was never this emphatic or as convincing as that of FPs. Sitting in front of them, I could almost feel palpable energy. It is an experience you cannot fully appreciate from reading an interview transcript, no matter how insightful the content. My feelings of equality and gratitude mirrored that of customers who were responding to being in an environment where they felt listened to, supported, and inspired to make a change.

2.7 Conclusion

In summary, this reflexive preamble serves as a microcosm of the researcher-participant interactions within the primary care and leisure sector, which brings to light several unspoken systemic issues of HLP referral processes, and reinforces the necessity for systemic change. This unique behind the scenes understanding of referral processes enabled the 'outsider' primary researcher to simulate the patient journey, transitioning from the uninspiring GP surgery to the hospitable leisure centre. It exposed some of the issues in GP consultation rooms, where a combination of time constraints and an unwelcoming atmosphere failed to create a context conducive to positive lifestyle behaviour change. Whilst my first-hand experiences with CLWs were much warmer and client-centered, none of the customer sample had been referred via this means because CLWs are non-medical PCP and therefore can only advocate leisure HLP provision rather than initiating a referral. Instead, many customers had adopted an active role in their HLP referral by approaching medical PCP. Nevertheless, the lack of further support or provision of information left them feeling uneasy during this transition period towards the leisure centre. Those initial worries and apprehensions were quickly put to rest upon meeting with Leisure Professionals, which echoed my experiences with this cohort.

However, it highlights a key defect in HLP referral processes, which could have significant implications for whether or not a referred patient takes up a referral. As explained in section 2.2, there are two distinct reflexive narratives within this thesis to provide a 360-degree overview of my journey. These are split to demonstrate my changing positionality from an 'outsider' (detailed in the present Chapter) to an 'insider,' and thus is picked up again in chapter 12.

3 A REVIEW OF THE LITERATURE

3.1 Introduction

This chapter intends to review the evidence base relevant to this thesis, which is positioned in the context of PAP and referral operations to PA-based behaviour change interventions. It unfolds by highlighting the contradiction between public health policy and reality in relation to the promotion of PA in primary care settings. Next, the chapter proceeds with a discussion of the factors contributing to the lack of PAP in the primary care context. Next, consideration is given to the limitations of prior literature, which whilst providing important insights into the complexity of PAP in primary care, is limited to advice giving and counselling, an unequal focus on GP perspectives, and a disregard towards the views and experiences of other stakeholders involved in referral operations, specifically PA service providers (e.g., Leisure Professionals) and service users (e.g., ERS participants). In recognition of these limitations, this chapter builds a compelling case for the unique contribution this PhD research makes to existing research. Finally, the chapter concludes by explicitly stating the research aim and objectives.

3.2 The Contradiction Between Public Health Policy and Reality

As introduced in chapter 1, PAP is high on the public health agenda and features heavily throughout national public health policies and guidelines (American Medical Association & American College of Sports Medicine, 2007; DoHSC, 2004; NIHCE, 2012; NIHCE, 2013; NIHCE, 2014b; PHE, 2014; WHO, 2010). Despite the common assumption that primary care is an ideal arena to promote PA, the reality is different, so much so that it has been labelled a '*utopian quest'* (Lion et al., 2019, p. 1). International research indicates that only 20-28% of

patients who would benefit from increasing their PA levels are offered advice (Glasgow, Eakin, Fisher, Bacak, & Brownson, 2001), considered for a lifestyle referral (Bouma et al., 2017), or referred to a local leisure centre or organised activity (Leemrijse et al., 2015). There is dispute over England's rates of PAP in primary care. A recent questionnaire-based survey based on a sample of 1013 GPs in England found that 72% of GPs fail to discuss PA with their patients (Chatterjee, Chapman, Brannan, & Varney, 2017). Whilst this statistic is similar to international rates of PAP, Harrison, McNair and Dugdill (2005) argue that PA referral rates are significantly poorer. These researchers conducted a longitudinal analysis of 6610 referrals to a district-wide ERS in the north-west of England over a five-year period (January 1998-December 2002), and estimated that of the 70% of sedentary adult population; only 4% were referred. It is important to recognise that data were collected over 20 years ago, and therefore results may represent a time where PAP was not as much as a public health priority as it is today.

Referral rates serve only as a prompt for further investigation and in general are not a valuable marker of referral quality and performance (Foot, Naylor, & Imison, 2010). Instead, the quality of patient referral should be judged in relation to the key components of high quality referral: necessity, destination, and process (Foot et al., 2010). Necessity refers to the timely referral of patients when necessary. Destination focuses on whether referrals are made to the most appropriate location in the first instance (Foot et al., 2010). Finally, process is concerned with how well the referral method is orchestrated. For instance, whether referral letters encompass all required information and whether all stakeholders involved are equal in their understanding of the purpose and expectation of referral. This guidance is centered on the interface between primary and secondary care (i.e. medical care provided by a specialist) not

referrals to community settings, which is unsurprising given that 90% of general practice referrals direct patients to care provided in the NHS (Marshall, Gregory, & Bullard, 2018). It is assumed that these three key components of high-quality referral are generalisable to most referral processes, including PA referrals.

3.3 Factors Influencing Physical Activity Promotion in Primary Care

The low levels of PAP in primary care has spurred interest into the factors that affect a PCP's decision to engage and promote it. A *primary care personnel* (PCP) is defined as "anyone working in primary care whose remit includes offering lifestyle advice" where examples include "GPs, Health Trainers, Health Visitors, Mental Health Professionals, Pharmacists, Physiotherapists and Practice Nurses" (PNs; NIHCE, 2013, p. 7). According to Moore et al. (2011) these professionals are in prime position to provide valuable insights into common challenges of PAP, and which patients are most and least receptive to PA referrals. Existing research on the factors influencing PAP in primary care settings is extensive, yet typically places emphasis on barriers to PAP, and less generally, facilitators to PAP. It is necessary here to clarify the meaning of barriers and facilitators. A barrier is defined as something that hinders or inhibits the promotion of PA; a facilitator is something that encourages the promotion of PA. In the literature, the contributing factors influencing PAP typically fall into three distinct categories, those relating to PCP, the patient, and the PA programme. This chapter proceeds to explore each of these categories.

3.3.1 Factors Relating to Primary Care Personnel

A large body of research identifies barriers and facilitators affecting PAP in primary care, which relate specifically to the referring PCP. Typically, these include a lack of consultation time, limited knowledge and understanding, attitudes, and health behaviours.

3.3.1.1 Lack of Consultation Time

A lack of consultation time represents the most frequently reported barrier to PAP amongst PCP in UK (Buckley, Finnie, Murphy, & Watson, 2020; Din, Moore, Murphy, Wilkinson, & Williams, 2015; Douglas, Torrance, van Teijlingen, Meloni, & Kerr, 2006; Goodman, Davies, Dinan, See Tai, & Iliffe, 2011; Graham, Dugdill, & Cable, 2005; Lawlor, Keen, & Neal, 1999; McKenna, Naylor, & McDowell, 1998; Winzenberg, Reid, & Shaw, 2009), European (Bohman, Mattsson, & Borglin, 2015; Geense, van de Glind, Visscher, & van Achterberg, 2013; Leemrijse et al., 2015), and US (Omura et al., 2018) literature sources.

Hébert, Caughy, and Shuval's (2012) systematic review based on a combination of qualitative and quantitative studies (N = 19) revealed that a lack of time represented the most commonly cited barrier to PA counselling (cited within 14 papers) amongst primary care providers. Of these fourteen studies, seven were based in the UK (Douglas, Torrance, et al., 2006; Goodman et al., 2011; Graham et al., 2005; Lawlor et al., 1999; McDowell, McKenna, & Naylor, 1997; McKenna et al., 1998; Steptoe, Doherty, Kendrick, Rink, & Hilton, 1999), and all but one (Graham et al., 2005) were purely quantitative in design. Furthermore, the samples of these UK-based studies were homogenous, comprising mainly of GPs (Douglas,

Torrance, et al., 2006; Graham et al., 2005; Lawlor et al., 1999; McKenna et al., 1998; Steptoe et al., 1999). One of these studies indicated that as many as 92.5% of GPs struggle to engage with PAP due to limited consultation time (Lawlor et al., 1999). In contrast, another reported that a lack of time affected only 23% of Health Professionals (i.e. GPs & PNs; Graham et al., 2005). These statistical variations may be explained by the samples. For instance, all respondents in Graham et al.'s study (2005) were reported to be physically active, and therefore it could be suggested they placed more importance and prioritisation on PAP. Indeed, there is evidence to suggest that Health Professionals who undertake regular exercise are up to four times more likely to regularly promote PA to their patients compared to those who do not (McKenna et al., 1998).

Nevertheless, high statistics have been reported in research not included in Hébert et als systematic review. For example, a survey-based study focused on the perspectives of 391 District and PNs in the UK found that 88% of PNs experience time constraints in relation to PAP (Goodman et al., 2011). More recently, a mixed methods study involving 56 UK GPs discovered that a lack of consultation time was the most commonly reported barrier to PA counselling and referral within general practice (cited by 61% of the sample; Buckley et al., 2020). US studies have also revealed how over 60% of PCP believe they do not have adequate time to engage in PA counselling with patients presenting with cardiovascular disease risk factors (Omura et al., 2018). Furthermore, 69% of Nurse Practitioners (NPs) believed that exercise counselling engagement hinged on consultation length (Tompkins, Belza, & Brown, 2009). A contemporary systematic review continues to support the notion that limited counselling time remains the most reported barrier to PAP (Albert, Crowe, Malau-Aduli, & Malau-Aduli, 2020). This systematic review, based on thirty-four studies conducted within the

last decade, encompassed the views of a vast range of healthcare professionals within and beyond primary care (e.g., GPs, Physiotherapists, Exercise Physiologists, Dietitians, Diabetes Health Educators, Pharmacists, Surgeons, and Occupational Therapists). This suggests that time constraints in relation to PAP are not a unique barrier within primary care, and instead, impacts many professionals of the healthcare system.

Studies adopting more exploratory methodologies have attempted to shed light upon the reasons underpinning time constraints in relation to PAP. Research conducted outside the UK has suggested the assessment of PIA is a time-consuming and complex task (Winzenberg et al., 2009), and systems or processes adopted to issue PA referrals are unnecessarily complicated (Bohman et al., 2015). This is especially problematic when patients have increasingly complex health conditions, which denotes the majority of consultation time and leaves minimal time for the assessment, counselling, or prescription of PA (Patel, Schofield, Kolt, & Keogh, 2011; Winzenberg et al., 2009). Similar notions are evident in UK-based research. Graham et al.'s (2005) qualitative arm of their mixed methods study discovered that UK GPs (n = 9) and PNs (n = 2) have limited capacity to initiate PA discussions due to their obligation to attend to a patient's initial reason for contact. Indeed, in primary care, acute and chronic illnesses often take precedence over anticipatory practices such as PAP (Campkin & Doyle-Baker, 2015), which explains why preventive efforts have been poor relative to the scale of the PIA epidemic (Matheson et al., 2011).

Unprecedented demands imposed on general practice also contribute to the strain on consultation time, which in turn, negatively affects PAP. Key policy level documents in the

UK (British Medical Association, 2017b; NHS England, 2014b; NHS England, 2016) have highlighted the strain of recruitment and retention in the primary care workforce. The North East and Yorkshire region in particular falls victim to the lowest vacancy fill rates in England (Rolewicz & Palmer, 2020). This is further compounded by the fact that some professions in the primary care workforce such as doctors have seen their earnings decrease by around 20% over the last 10 years (Curran, 2018) in spite of increasing inflation rates (ONS; Office for National Statistics, 2020a). This may help to explain why the GP workforce in England dropped by 1.6% from 2017-2018 (Buchan, Charlesworth, Gershlick, & Seccombe, 2019), despite government ambitions to recruit an additional 5,000 GPs by 2020 (NHS England, 2014b).

In addition to workforce tensions, there have been reports of significant increases in the quantity of primary care consultations as well as increasing complexity of patient care, resulting in calls for consultation length to be extended to at least 15 minutes with flexibility according to patient need (British Medical Association, 2015; RCGP, 2013; RCGP, 2019). In their analysis of 30 million patient consultations across a three-year period (2010/11- 2014/15), the Kings Fund concluded that face-to-face consultations had risen by 13 per cent, and telephone consultations by 60 per cent (Baird, Charles, Honeyman, Maguire, & Das, 2016). Hobbs et al. (2016) reported that in the last decade, GPs in England have experienced a 100% increase in telephone consultations, and a 12% rise in face-to-face consultations, and inferred "English primary care could be reaching saturation point" (p. 2323). Singlehandedly, GPs already undertake around 340 million consultations annually (British Medical Association, 2017a), thus if trends continue, strain on the primary care workforce will be further exaggerated. The irony is, referral of more patients to PA interventions has the potential to reduce burden

on the NHS, and yet the reality is often impractical because increasing pressures on general practice are not accompanied by proportionate growths in workforce capacity (Baird et al., 2016).

3.3.1.2 Limited Knowledge or Understanding

The literature proposes that PCP lack knowledge and understanding in relation to PA (Chatterjee et al., 2017; Douglas, Torrance, et al., 2006; Persson, Brorsson, Ekvall Hansson, Troein, & Strandberg, 2013), and local PA opportunities (Buckley et al., 2020; Geense et al., 2013; Graham et al., 2005; Henderson et al., 2017; Leemrijse et al., 2015; Tompkins et al., 2009; Wormald & Ingle, 2004; Wormald, Waters, Sleap, & Ingle, 2006). In the UK, it has been suggested that only 20% of GPs are familiar with current CMO PA guidelines (Chatterjee et al., 2017), whereas only 7% of PNs, and 9% of Health Visitors (Douglas, van Teijlingen, et al., 2006) are informed. Thus, PCP lack the knowledge required to assess and influence PA behaviours in primary care patients (Weiler, Feldschreiber, et al., 2012). Foot et al. (2010) argue that referrals should be made once the needs of an individual patient are perceived to lie beyond a health practitioner's particular expertise and capability. Given this paucity of knowledge in relation to influencing PA behaviours, referrals to an ERS and other PA interventions provide a useful outlet for PCP. Nevertheless, the National Quality Assurance Framework for exercise referral systems states that all initiators of referrals must comprehend and discuss the potential risks and benefits associated with PA with respect to a patient's health status, family history, and medications (Craig et al., 2001). Therefore, it is imperative that PCP have a sufficient level of PA understanding to comply with recommendations of this framework, especially if they choose to make referrals to ERS.

UK studies focusing on the patient's perspective have argued that patients are not provided with sufficient explanations in relation to PA interventions due to limited PCP awareness and understanding (Wormald & Ingle, 2004; Wormald et al., 2006). International studies have also found limited PCP awareness and understanding to be a hindrance to PAP (Persson et al., 2013; Tompkins et al., 2009). Campkin and Doyle-Baker (2015) suggest that when Health Professionals lack adequate understanding of a particular health care discipline or community resource, they are uneasy utilising these assets. This may help to explain the underutilisation of PAP internationally (Bouma et al., 2017; Glasgow et al., 2001; Leemrijse et al., 2015), and in England (Harrison et al., 2005). The notion that health professionals lack adequate knowledge and understanding is further reiterated in literature appreciating the perspectives of UK Exercise Professionals. For example, Exercise Professionals in Henderson et als study (2017) criticised health professionals referring to ERS for inaccurately completing referral forms and failing to disclose their patient's health contraindications, which they attributed to their lack of understanding. There are medico-legal implications of inadequate ERS referral forms as FPs are discouraged from accepting liability for a referred patient until all relevant information has been disclosed (Craig et al., 2001).

This limited awareness and knowledge is reflected of the paucity of training on non-pharmacological approaches to healthcare in the medical school curricula or in the continuing education of physicians, despite doctors wanting more guidance (Osborne et al., 2017; Vuori, 2016). Multiple surveys conducted in the UK have reported an absence of training and education with respect to PAP from the perspectives of multiple health professionals including

GPs (55% of a sample of 1013; Chatterjee et al., 2017), PNs (46% of a sample of 212; Douglas, Torrance, et al., 2006) and Health Visitors (52% of a sample of 169; Douglas, Torrance, et al., 2006). A questionnaire based survey examining 31 UK medical schools discovered that on average, only 4.2 hours are devoted to teaching PA science and promotion over the course of a five year degree (Weiler, Chew, Coombs, Hamer, & Stamatakis, 2012). In addition, only 56 per cent of UK medical schools educate their students on the CMO PA guidelines (Weiler, Chew, et al., 2012). On a similar note, typically only 8 hours are dedicated to nutrition training and developing an understanding of healthy weight achievement and maintenance (NHS England, 2019). In comparison, over 100 hours are dedicated to pharmacological studies (O'Shaughnessy, Haq, Maxwell, & Llewelyn, 2010), leading to a default reductionist and reactive approach in the delivery of healthcare rather than a preventive, proactive position (Matheson et al., 2011). Consequently, PCP are principally medically orientated because education pertaining to non-pharmacological approaches is insufficient (Persson et al., 2013). What is more, the medical curriculum places more attention on other unhealthy lifestyle behaviours such as smoking compared to PA (Hauer, Carney, Chang, & Satterfield, 2012), further contributing to incompetency in exercise prescription which has been recognised by UK university deans (Dunlop & Murray, 2013). This knowledge gap continues to widen because research concerning the role of PA for health is published in sources that are not often pursued by practicing GPs (Vuori, 2016). Thus, it is unsurprising that health professionals fail to disclose all relevant information when referring to lifestyle programmes because relevance requires a level of professional judgement underpinned by sound knowledge (Craig et al., 2001).

To address this widespread lack of awareness and understanding, an open-access letter sent on behalf of groups affiliated with Public Health (e.g. Doctors, Nutritionists, Sport

Scientists) demanded mandatory training on lifestyle medicine for both medical students and practicing Health Professionals (Malhotra, 2016). This group hoped to witness the rise and increased utilisation of lifestyle intervention referrals rather than the reliance on drug prescription as a means of achieving a financially sustainable NHS (Malhotra, 2016). Many researchers concur that PAP in the healthcare system must be viewed and dealt with in an invariable manner like pharmaceuticals (House of Commons Health Select Committee, 2015; Vuori, Lavie, & Blair, 2013), and the new generation of medical professionals must refrain from prescribing pharmaceuticals as a first response to diseases of PIA. This reliance on the conventional biomedical model of healthcare and prescription of pharmaceuticals is 'flawed' according to Sallis (2015), as it only strengthens a patients reliance on the medical system rather than encouraging them to take responsibility for their own health. Some researchers deem the lack of PAP to insufficiently active patients unethical and negligent (Matheson et al., 2011; Sallis, 2015). To address the widespread lack of awareness and understanding not only requires fundamental and perpetual education and training, but also requires the methods to prescribe and deliver it (House of Commons Health Select Committee, 2015; Vuori et al., 2013). By 2030, the RCGP hope to witness the abandonment of the traditional 20th century biomedical model of healthcare in favour of a more holistic model. They envision a healthcare system that is respectful of physical health in the context of each individuals broader life circumstances, and one which strives to empower individuals to live as healthy as possible (RCGP, 2019).

Encouragingly, there have been recent efforts towards enhancing awareness and understanding of PA amongst the medical community. Many online resources and e-learning modules for health professionals have emerged in recent years to help them encourage their patients to become more active. Such resources include the Moving Medicine toolkit (Faculty

of Sport and Exercise Medicine UK, 2021), and Health Education England's PA and Health programme on their e-Learning platform (2021). Moreover, PHE and Sport England are in the early stages of implementing and evaluating a whole-system educational approach to PAP, targeting undergraduate education, postgraduate education, and continuing professional development (Brannan, Bernardotto, Clarke, & Varney, 2019). This approach, named the "Moving Healthcare Professionals programme" strives to embed PA counselling into undergraduate and postgraduate clinical training to ensure the next generation of healthcare professionals possess the expertise and confidence to support their patients to be physically active. However, it is important to recognise that even if mandatory lifestyle medicine training were implemented in the UK medical curriculum today, it would take a reasonable amount of time for it to manifest into routine practice.

3.3.1.3 PCP Attitudes

The attitudes of health professionals have a tremendous influence on engagement with PAP in primary care. Previous research identifies a range of attitudes amongst PCP in relation to PAP. Pethkar, Naik and Sonawane define attitudes as "a latent, non-observable, complex but relatively stable behavioural disposition reflecting both direction and intensity of feeling toward a particular object*"* (2010, p. 32). A large body of research has highlighted that some PCP hold a negative attitude towards PAP and feel more comfortable confining to a strictly clinical remit (Din et al., 2015; Graham et al., 2005; Persson et al., 2013). In particular, many UK PCP consider PAP to lie outside their expertise and remit, and less important when compared to other health promotion activities such as smoking cessation (Din et al., 2015; Graham et al., 2005). The lower perceived worth and prioritisation of PAP in comparison to

other health promotion activities may be attributable to the long-standing lack of reimbursement (Sallis, 2015). The NHS Quality and Outcomes Framework (QOF) is a national strategy that governs the provision and quality of care in general practice in England by defining strategic priorities and providing rewards for achieving set targets. Since 2004, the QOF has incentivised PCP to consult with patients about smoking, yet has not featured any PA-related indicators (Savill et al., 2015). Hence, PAP has been undervalued, neglected, and relegated to subordinate priority in primary care consultations (Heron, Tully, McKinley, & Cupples, 2014; Savill et al., 2015; Weiler, Feldschreiber, et al., 2012), which has led many researchers to call for more incentivisation through the QOF (Buckley et al., 2020; Savill et al., 2015), or through comparable government support and funding (Graham et al., 2005) to enhance PAP. Moreover, some PCP believe they are objects of marketing campaigns that encourage the prescription of drugs (Rubio-Valera et al., 2014). This sophisticated motivation for pharmaceutical solutions may be supporting the prescription of drugs rather than encouraging non-medical means of treatment, thereby strengthening reliance on the medical system (Sallis, 2015). However, the climate could be set to change in light of the newly published Enhanced Service Specification for Weight Management 2021/22, which through the QOF will offer GP practices £11.50 per referral of obese patients to weight management services (NHS England, 2021). This incentivisation through the QOF may be a vital step forward in changing PCP attitudes towards lifestyle promotion and PAP, especially since PIA is a primary contributor to obesity.

There is contradictory evidence to suggest that some PCP are supportive of PAP (Bélanger et al., 2015; Douglas, Torrance, et al., 2006; Tompkins et al., 2009). In relation to health promotion activities more generally in primary care, Geense et al. (2013) conducted

interviews with Dutch GPs (*n* = 16) and PNs (*n* = 9) and reported a mix of conflicting attitudes regarding their perceived roles and responsibilities. This study identified six GP discrete attitudes: the 'ignorer', 'adviser', 'confirmer', 'evangelist', 'interferer' and 'nurturer', all of which demonstrates differing attitudes towards, and engagement in health promotion. However, the relevance of these findings may be narrow given that 'health promotion activities' in this study encompassed smoking, alcohol, obesity, dietary, and PA. Other international studies have found that the large majority of GPs (Bélanger et al., 2015) and NPs (Tompkins et al., 2009) trust that PAP is a vital part of their role and has equal status to pharmaceuticals. This falls parallel with UK studies, which have found that over 92% of GPs and 99% of PNs regard PAP as a central feature of their work (Douglas, Torrance, et al., 2006). Nevertheless, scarce response rates (Bélanger et al., 2015; Douglas, Torrance, et al., 2006), questionable methods without substantial validation (Tompkins et al., 2009), and publication in low impact journals (Bélanger et al., 2015; Tompkins et al., 2009) raises questions about the trustworthiness and transferability of these findings.

3.3.1.4 PCP Health Behaviours

The personal health behaviours of PCP are another factor thought to influence PAP. Literature suggests that PCP who exhibit healthy behaviours are more likely to promote PA amongst their patients (Hébert et al., 2012; Huijg et al., 2015; McDowell et al., 1997) and report fewer barriers to PAP engagement (Zhu, Norman, & While, 2011), whereas PCP exhibiting unhealthy behaviours experience more barriers (Geense et al., 2013). McDowell et al. (2015) analysed questionnaire data based on 272 UK PN and highlighted how physically active Nurses regard barriers, such as a shortage of resources, protocols, and success as less inhibiting to PAP

in comparison to their non-active colleagues. Geense et al. (2013) contested that GPs exhibiting unhealthy lifestyle behaviours find it more challenging to advise patients on their PA and other lifestyle behaviours due to the risk of appearing hypocritical. Indeed, patients do make subjective appraisals on their GP based on their physical presence, perceived health status, and disclosure of personal lifestyle behaviours (Newton et al., 2015), and therefore patient social judgements may determine the credibility of advice offered by health professionals, and ascertain the extent to which they adhere to this advice.

3.3.2 Factors Relating to the Patient

The literature has highlighted many factors that influence PAP in primary care, which relate specifically to the patient. Research from the patient's and exercise professional's perspective is presented where available and appropriate. Psychological factors such as a lack of motivation, reduced confidence, and negative attitudes represent a wide-ranging spectrum of barriers influencing a patient's PA behaviours and their acceptance of PAP provided to them in primary care. Another broad cluster of barriers to PAP relate to the accessibility of PA opportunities, initiatives, and programmes due to financial constraints and transportation issues. Finally, a patient's health status and a lack of time have been found to influence PAP.

3.3.2.1 Psychological Factors

3.3.2.1.1 A Lack of Motivation

Motivation, defined as the psychological forces that drive a person towards a particular goal (Sheldon, Arndt, & Houser-Marko, 2003), has been highlighted as a key factor influencing

PAP in primary care. Specifically, a perceived lack of patient motivation is identified as a leading barrier to PAP, whereas high patient motivation is considered a prominent facilitator (Geense et al., 2013; Graham et al., 2005; Huijg et al., 2015; Leemrijse et al., 2015; Omura et al., 2018; Tompkins et al., 2009). Geense et al. (2013) discovered that out of forty-one barriers influencing health promotion activities in primary care, a perceived lack of patient motivation was the chief hindrance (cited by 19 out of 34 Dutch GPs and PNs). Other international quantitative studies have found patient motivation to be a prominent factor influencing PAP amongst 34% of American PCP (Omura et al., 2018), 87% of American NPs (Tompkins et al., 2009), and 44% of Dutch GPs (Leemrijse et al., 2015). A mixed methods study examining the factors influencing ERS referrals reported that 69% of GPs and PNs prioritised smoking cessation referrals over PA referrals due to an underlying assumption that changing smoking behaviours requires less patient motivation and long-term perseverance in comparison to changing PA behaviours (Graham et al., 2005).

It has been suggested that PCP make subjective judgements on a patient's motivation and confidence, and only target individuals they perceive to be motivated to change PA behaviours (Carstairs, Rogowsky, Cunningham, Sullivan, & Ozakinci, 2020; Din et al., 2015). According to Din et al. (2015), health professional appraisals of patient motivation are sometimes derived from their physical appearance, health conditions, age, and gender. Given that motivation is a malleable, fluctuating product of social interaction, rather than a stable trait (Miller & Rollnick, 2002; Rollnick, Miller, & Butler, 2008), subjective appraisals of a patient's motivation can be often misconstrued, causing the avoidance of PAP (Moore et al., 2011). The Enhanced Service Specification for Weight Management, which from 2021 will incentivise health professionals through the QOF to tackle the prevalence of obesity, recommends that

"[GP] practices should make an individual assessment of patient readiness to engage with weight management services" (NHS England, 2021, p. 8). Unfortunately, it does not stipulate how readiness for change should be assessed, nor does it recommend any specific tools to guide conversations around assessing motivation. Without this guidance, health professionals may continue to make subjective appraisals about their patient's motivation and confidence.

There have been exceptions where research has found limited patient motivation does not influenced PAP. Douglas, van Teijlingen, et al. (2006) present contradictory evidence in their mixed methods study involving Health Visitors (n = 169) and PNs (n = 212) in Scotland. This study used a questionnaire survey and in-depth interviews to comprehend perspectives and practices of routinely advising patients about PA and discovered that whilst a patient's level of motivation did not hinder PAP, it determined the extent to which patients complied with guidance. According to Bélanger et al. (2015) some PCP accept that imperfect receptivity, compliance, and adherence is an inherent reality for any treatment option, and is not distinct to PAP. As such, the development of resiliency against a lack of patient motivation is key to facilitating engagement with PAP (Bélanger et al., 2015).

Albeit a small proportion, some studies have appreciated the patient's perspective of being referred onto behaviour change programmes, where motivation has emerged as a key factor influencing uptake and adherence. This provides some validation to claims made by PCP in prior research. A contemporary UK qualitative study conducted by Birtwistle et al. (2018) sought to comprehend the factors influencing a patient's decision to take up an ERS referral by

utilising the socio-ecological model as a framework to identify and differentiate between intrapersonal, interpersonal, and organisational level factors. Motivation was found to be a crucial intrapersonal factor affecting ERS uptake, which the authors divided into three subthemes revealing the complexities of this psychological construct: 'health factors' (motivation to engage with ERS to improve their physical and/or mental health), 'for others' (motivation to engage with ERS influenced by family, peers, and health professionals), and 'competing priorities' (motivation to engage with ERS affected by external commitments).

Similarly, other UK-based studies have highlighted the relevance of health factors in relation to uptake of PA-based programmes (Graham, 2006; Moore, Raisanen, Moore, Din, & Murphy, 2013; Wormald et al., 2006), and the relevance of significant others (Graham, 2006; Moore et al., 2013). Moore et al. (2013) highlighted differentiations between the primary health motivations for younger and older patients, where independence and ability to perform everyday activities were important motivators amongst patients of a retirement age, and occupational functioning served as a pivotal motivator amongst patients of a working age. Graham (2006) uncovered complexity to health-related motivational factors where ERS participants described their present health status, age-related factors, and investments for their future health. Many researchers have also demonstrated the malleable nature of patient motivation, describing a transition from being extrinsically driven at the start of participating on an ERS to intrinsically driven throughout the programme (Eynon, O'Donnell, & Williams, 2018; Hardcastle & Taylor, 2001).

There are contrasting viewpoints within literature appreciating the patients' perspective in relation to the success of Health Professionals in eliciting and strengthening a patient's motivation to pursue lifestyle behaviour change. The way in which discussions around PA are raised by health professionals have a considerable impact on a patient's receptivity and acceptance of the topic (Carstairs et al., 2020), and their motivation towards behaviour change (Rollnick et al., 2008). Several researchers have highlighted how some patients feel a strong sense of accountability to their health professionals, and on the back of an ERS recommendation, feel obliged to follow through with a referral (Graham, 2006; Hardcastle & Taylor, 2001). Carstairs et al. (2020) has indicated that patients view health professionals as a key motivator and facilitator towards increasing their PA levels. A questionnaire-based study comparing North and South GP surgeries in England (York & Maidenhead) found that 46% of general practice patients (N = 94) welcome PA advice, support, and guidance from a PCP (Morton, Thompson, Wheeler, Easton, & Majeed, 2016). This finding corroborates the work of a recent qualitative study based on a sample of fourteen primary care patients in Scotland, where the majority of patients were accepting of PA discussions with their health professional as it nudged them to consider and take action towards making positive lifestyle changes (Carstairs et al., 2020). Thus, there have been calls for Health Professionals to take advantage of their unique position, and upskill in motivational communication skills to foster autonomous motivation and facilitate behaviour change (Birtwistle et al., 2018; Craig et al., 2001).

Some literature has examined the ability of Health Professionals and Exercise Professionals in the cultivation of motivation for lifestyle behaviour change. Deutschman and Keeler (2007) argue that GPs endeavour to motivate patients by relying on medical facts to provoke fear which results in them 'avoidance coping'. This approach, also known as the

'righting reflux' or the 'expert trap', is in direct opposition to motivational interviewing, which is person-centered, encourages individuals to elicit their own motivation for change, and values the contribution of the client's resources in the change process (Miller & Rollnick, 2013). Interestingly, a questionnaire-based survey including 376 GPs revealed that almost a third of GPs perceived that patients were unlikely to be motivated to follow their provision of advice on PA, indicating a lack of confidence in their ability to cultivate motivation (Graham, 2006). There is a larger evidence base suggesting that Exercise Professionals serve as a key source of motivation and support throughout a patient's journey to PA behaviour change on an ERS (Hardcastle & Taylor, 2001; Wormald & Ingle, 2004; Wormald et al., 2006). According to Deutschman and Keeler (2007), Exercise Professionals are more successful in guiding someone to change their lifestyle behaviours compared to health professionals because they are non-judgemental, focus on building rapport, and achieving small wins to help reframe an individual's way of thinking so they are able to accept responsibility for their health.

There is much attention towards understanding the influence of peer support on motivation. *Peer support,* by definition, is "the provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population, to address a health-related issue of a potentially or actually stressed focal person" (Dennis, 2003, p. 329). Peer support capitalises on social networks to help strengthen PA behaviour and can take multiple forms such as small groups, one-to-ones (either face-to-face or via telephone), web-based chat rooms, or buddy systems (Heath et al., 2012). Embuldeniya et al. (2013) synthesised the qualitative literature concerning the perceived impact of peer support for individuals with chronic disease. This study found that mentors are able to

sympathise and relate with mentees due to their first-hand experiences of changing lifestyle behaviours. This shared identity between a mentor and mentee reduces feelings of isolation, and creates a context conducive to empowerment, hope, and belonging. Moreover, information and guidance provided through peer support is perceived to be more impactful and credible than information-provision alone, as it is grounded in personal experience (Embuldeniya et al., 2013). In relation to ERS, researchers have proposed that existing participants stand as realistic role models for new ERS participants, which can help to strengthen feelings of competence (Moore et al., 2011), whilst group exercise environments with participants at different programmatic stages can also incentivise adherence (Graham, 2006). The value of 'buddy systems' as a mechanism of social support in the early stages of community-based PA opportunities has also been highlighted by both patients and Health Professionals in a recent UK qualitative study (Carstairs et al., 2020). This is also supported by the National Quality Assurance Framework for exercise referral systems, where guideline 2 recommends that ERS participants should be provided with opportunities to engage with social support networks to encourage the maintenance of PA behaviours (Craig et al., 2001). Similarly, establishing 'community role models' is a key recommendation of PHE guidance concerning addressing inequalities in PA. Consequently, the literature has seen the emergence of ERS with mechanisms to enhance and promote social support and social participation in attempt to overcome common patient barriers to PA adherence (Martín-Borràs et al., 2018).

3.3.2.1.2 Behaviour change theories

There are an overabundance of theories attempting to explain the determinants of health and human behaviour, where often theories include psychological concepts pertaining to

motivation (i.e., cognitive processes that energise and direct behaviour) and self-confidence/self-efficacy (i.e., belief in one's ability to perform a specific behaviour and persist in that action in the face of adversity or challenge). It is not the purpose of this thesis to synthesise behaviour change theories, however it is important to briefly review the two most common theoretical models of health behaviour underpinning behaviour change interventions- the Transtheoretical Model (TTM; Prochaska & DiClemente, 1983) and the Capability-Opportunity-Motivation Behaviour model (COM-B; Michie, Van Stralen, et al., 2011). The TTM and COM-B both intend to translate research findings into behaviour change interventions rather than merely serving as explanatory frameworks for the determinants of behaviour change (Nilsen, 2020).

3.3.2.1.2.1 The Transtheoretical Model (TTM)

The single most popular theory widely applied to health behaviour education and promotion is the TTM, developed by Prochaska and DiClemente in 1983. The TTM is a biopsychosocial model that draws upon 128 explanatory constructs from 33 theories of behaviour including the self-efficacy theory (Bandura, 1982; Bandura, 1997), and the model of decision making (Janis & Mann, 1977). The TTM describes health behaviour change as a conduit through five discrete stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. Self-efficacy, motivation, and decisional balance are conceptualised as key drivers of movement from contemplation to active stages of the TTM (Prochaska & DiClemente, 1983). Pre-contemplation is characterised by a lack of intention to change problematic behaviours because the cons of behaviour change are far greater than the pros (Petrocelli, 2002). Individuals in this stage may have failed in previous behaviour change

attempts or may be oblivious to the negative consequences of such behaviours (Prochaska & Velicer, 1997). In the contemplation stage, individuals begin to consider change, typically in the next six months (Prochaska & Velicer, 1997). The decisional balance shifts in this phase as the pros and cons of change carry equal weight, which may cause some ambivalence towards behaviour change. In the preparation stage there is an intention to take action towards behaviour change in the immediate future (usually in the next month) because the pros of change outweigh the cons (Calfas et al., 2002). Individuals in the preparation stage may devise an action plan or have taken baby steps towards change (Calfas et al., 2002). Action is the fourth stage whereby individuals have made some observable modification to their behaviours (Prochaska & Velicer, 1997). Vigilance against relapse is crucial in this stage of the TTM to prevent individuals from reverting to previous behaviours. The maintenance stage represents the fifth phase where these observable behaviour modifications are sustained for at least six months (Prochaska & Velicer, 1997). Relapse is less attractive in this phase as individuals become increasingly confident in the sustainability of new behaviours.

Although the TTM is considered the most widely applied theory to health education and promotion, it was originally derived from a study of addictive behaviours involving 872 individuals (Prochaska & DiClemente, 1983). Unlike single addictive behaviours such as smoking, PA is multi-dimensional and complex. Therefore, many researchers are critical of the TTMs application to PA interventions (Hutchison, Breckon, & Johnston, 2009; Mastellos, Gunn, Felix, Car, & Majeed, 2014). A Cochrane review argued there is limited evidence to support the use of the TTM in combination with PA interventions (Mastellos et al., 2014). It has been contested that the TTM overlooks the true complexity of PA behaviour change as it focuses only on the individual and neglects other influencing factors such as environmental,

social (e.g. age, gender, and SES), and political influences (Buchan, Ollis, Thomas, & Baker, 2012).

3.3.2.1.2.2 Capability-Opportunity-Motivation Behaviour (COM-B) model

The COM-B is a relatively new behaviour change model developed by Michie, Van Stralen and West (2011) which is increasingly popular in academic, policy (NIHCE, 2014a), and intervention fields due to its simplicity, comprehensiveness, and practical nature (Michie, Atkins, & Gainforth, 2016). COMB-B argues that behaviour is influenced by three key interacting determinants: capability (i.e., internal psychological and physical factors contributing to an individual's ability to perform a behaviour), opportunity (i.e., external physical and social factors facilitating or prompting a behaviour), and motivation (i.e., subconscious, and conscious brain processes that energize and direct behaviour). In order to execute a particular behaviour (B), an individual must perceive that they have the necessary knowledge, skills, and abilities (C), the physical and/or social opportunities (O), and a desire to engage with that behaviour more than rival behaviours (M; Social Change UK, 2019). To facilitate effective and sustained behaviour change, interventions must target one of more of COM-B components (Social Change UK, 2019).

3.3.2.1.2.2.1 The Behaviour Change Wheel (BCW) framework

The BCW framework was adapted from the COM-B model, and was born from a systematic literature review synthesising 19 behaviour change intervention frameworks to form a conceptually coherent framework (Michie, Atkins, & West, 2014; Michie, Van Stralen, et al.,

2011). The BCW serves as a theoretically underpinned guide to help intervention designers identify and target, in a systematic and transparent way, what changes need to occur in order for a desired behaviour to be achieved. Thus, it facilitates a shift from the behavioural analysis of an issue (COM-B) to the application and integration of evidence-based interventions to bring about change and close the gap between what is known and what is practiced, also referred to as implementation science (Michie et al., 2014).

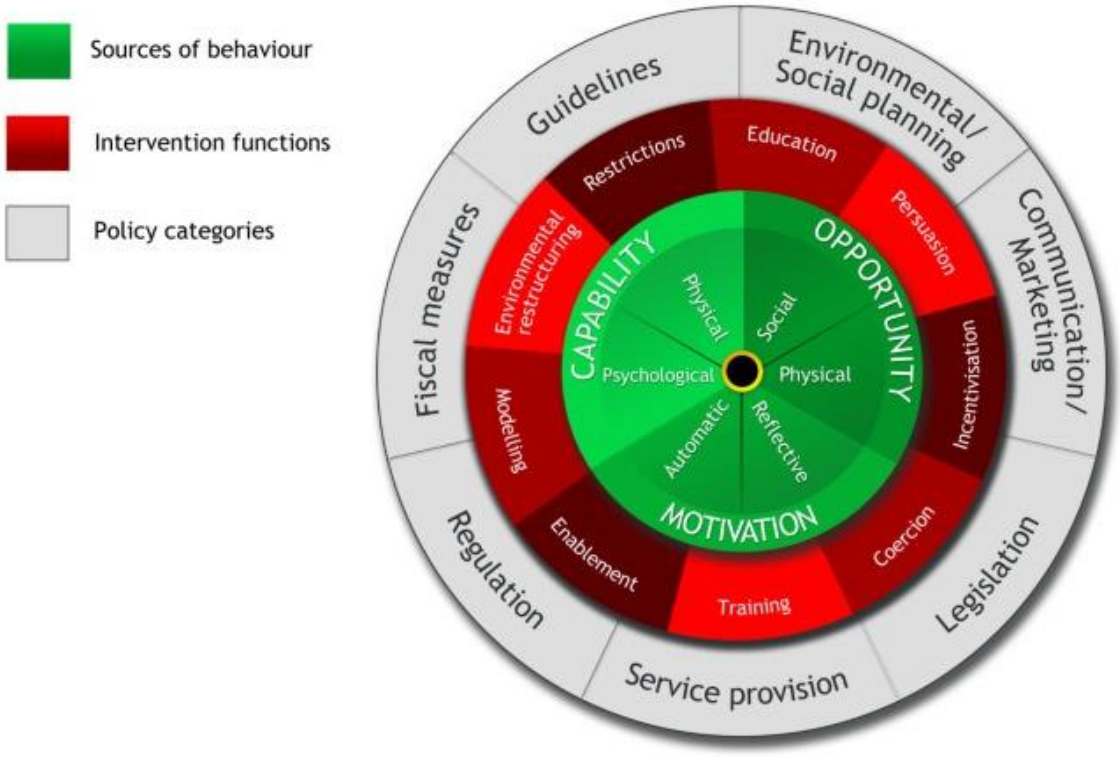

Figure 3.1. The behaviour change wheel

Note: from *the behaviour change wheel: a new method for characterising and designing behaviour change interventions* by Michie, Van Stralen and West (2011). Retrieved from https://implementationscience.biomedcentral.com/articles/10.1186/1748-5908-6-42?report=reader

As shown in Figure 3.1., the COM-B model sits at the core of the BCW, encapsulated by nine ‘intervention functions’ that aim to address defects in capability, opportunity, and motivation, and seven ‘policy categories’ which serves to guide the development of effective behaviour change interventions. Once the specific intervention functions and policy categories have been chosen, the next step in intervention design is to canvass all potential behaviour change techniques (BCT) that are likely to be effective in bringing about change, before adopting a rational system to select the most appropriate amongst them. To do this, one must take several factors into consideration: the target behaviour, the target audience, and the context in which the intervention operates (Michie, Van Stralen, et al., 2011). The APEASE (Affordability, Practicality, Effectiveness and cost-effectiveness, Acceptability, Side-effects/safety, and Equity) criteria can guide this process of determining which intervention functions, policy categories, and BCTs are likely to be of greatest impact at the individual, practitioner, and organisational level in any given context (Michie et al., 2014).

3.3.2.1.2.2.2 The East Framework

A second framework often used in conjunction with the COM-B model and equally valued for its role in implementation science is EAST, which can facilitate in the development of behavioural solutions and interventions using learning from behaviour science (Hallsworth et al., 2016). Developed by the Behavioural Insights Team in 2012, the EAST framework is comprised of four ideals, which postulate that a policy must be Easy, Attractive, Social, and Timely to encourage or nudge desired behaviours (Algate, Gallagher, Nguyen, Ruda, & Sanders, 2012). Making it Easy is about reducing hassle so change seem simple and effortless. This may be achieved through simplifying decisions by harnessing the power of defaults to reduce any hassle or stress. Making it ‘Attractive’ is about ensuring something is visible,

accessible, and perceived to be of benefit. The provision of incentives and rewards or emphasising potential losses of not taking immediate action are techniques that may increase the 'Attractiveness' of a desired behaviour. Making it social is about harnessing the power of social networks and social norms to encourage a particular behaviour (Hallsworth et al., 2016). Finally, making something timely refers to prompting individuals when they are most receptive. Major life events, such as having a myocardial infarction, are often a disruption to existing behavioural patterns and therefore a prime opportunity to encourage behaviour change (Algate et al., 2012). Put succinctly, a behavior is more probable if it is made easy, attractive, social, and timely.

3.3.2.1.2.3 Behaviour change techniques

There is considerable attention towards the active ingredients of behaviour change, otherwise known as BCT. The year 2008 witnessed the publication of the first taxonomy of BCT (N = 26; Abraham & Michie, 2008). A few years later, there were efforts to group BCT into domain-specific taxonomies. In relation to PA and healthy eating, Michie, Ashford et al. (2011) developed a descriptive 40-item CALO-RE taxonomy to standardise definitions of BCT, thereby permitting understanding of how for PA and dietary interventions work in relation to BCT components. More recently, a cross-domain, hierarchically structured BCT taxonomy has been developed, consisting of ninety-three internationally agreed and validated BCT (Michie et al., 2013).

Motivational interviewing is one BCT featured in the CALO-RE taxonomy, and has been found to be associated with the maintenance of PA and healthy eating behaviours at ≥12 months in a recent systematic review and meta-regression analyses based on overweight and obese adults (Samdal, Eide, Barth, Williams, & Meland, 2017). Motivational interviewing is defined as "a client-centered, directive therapeutic style to enhance readiness for change by helping clients explore and resolve ambivalence" (Hettema, Steele, & Miller, 2005, p. 91). It is based on the premise that change is more likely to occur if individuals produce their own reasons for change. As such, its practices help to create a context conducive to change by exploring an individual's own argument for change, and resolving any ambivalence to increase intrinsic and autonomous motivation, and confidence (Breckon, 2014; Miller & Rollnick, 2013). The ultimate goal of motivational interviewing is to elicit and strengthen change talk (Breckon, 2014). Although it was first developed as a brief intervention for problematic alcoholic consumption, it has since evolved as a communication style when addressing any behavioural problem to build both motivation and confidence. However, there is some ambiguity around the effectiveness of motivational interviewing in eliciting behaviour change within the time constraints of primary care consultations (Morton et al., 2015).

3.3.2.1.3 Reduced Confidence

Much of the literature focused on ERS has discovered that individuals eligible for such schemes lack in self- esteem, and have limited confidence in their exercise ability, particularly within a gym environment. In 2004, Wormald and Ingle conducted focus groups with thirty primary care patients to elicit their perspectives of an ERS operating in North Yorkshire. With the aim of improving service provision, these authors questioned patients on their ERS

experiences and found that ERS populations were apprehensive about exercising in the gym. These findings concur with UK ERS participants of Graham's doctoral thesis (2006) whom disclosed concerns about self-presentation whilst exercising in a gym environment amongst other gym users who they perceived were younger and physically fitter. Similarly, a qualitative study exploring the perspectives of 38 Exercise Professionals discovered perceptions that ERS participants have anxieties towards starting their programme which stem from the presence of 'fitter' gym users, fears of entering an unfamiliar social environment, and limited confidence in their exercise abilities (Moore et al., 2011). More recently, a UK-based qualitative study focused on the perspectives of nine ERS adherers discovered that their confidence concerning exercise abilities was low at the start of an ERS, yet increased throughout scheme duration, which was a critical factor associated with adherence and the formation of an exercise identity (Eynon et al., 2018).

3.3.2.1.4 Negative Attitudes

There is evidence suggesting patients hold entrenched negative attitudes towards lifestyle behaviour change and instead embrace 'quick fix' medical interventions with immediate benefits (Matheson et al., 2011). A large cross-sectional survey involving 757 UK PCP found that between 32 and 44 per cent of Health Professionals (i.e., GPs, PNs, and Health Visitors) strongly agreed or agreed that 'patients expect drug treatments when they visit their GP practice' (Douglas, Torrance, et al., 2006). According to Rollnick (2008), irrespective of how they mistreat themselves, the majority of patients seeking health care expect to be prescribed a treatment to nurse them back to health, or a minimum, lessen their symptoms. The ERoY Council Joint Health and Well-being Strategy 2016-2019 described how unhealthy lifestyle

behaviours are deeply embedded within culture, particularly for individuals of a lower SES (Health and Wellbeing Board, 2016). This highlights the potential challenges associated with changing embedded negative attitudes. Matheson et al. (2011) stressed how patients must be empowered to accept responsibility for their own health and behaviours rather than depending on the healthcare system for medical fixes. These authors value the role of motivational interviewing as one method to accomplish this, and also place emphasis on the use of digital technology to empower patients through offering health information that is user-centric, instantly available, and understandable.

Albeit limited, there is some evidence indicating that the patient culture is welcoming of PAP. A questionnaire-based study found that almost half (46%) of general practice patients (N = 94) in England welcome advice, support and guidance surrounding PA (Morton et al., 2016). Brooks et al. (2016) are strong advocates that PCP should not underestimate the broader influence they may have in developing a societal culture that endorses PA. Whilst these authors appreciate that the opportunities to do this may be limited within the confinements of patient consultations in general practice, they argue that it is imperative that the 'physical activity message' is reinforced consistently both within and beyond the consultation room to highlight its importance and challenge existing unsupportive cultures.

3.3.2.2 Reduced Accessibility

3.3.2.2.1 Financial Constraints

Costs associated with PA opportunities have been highlighted by PCP as a factor hindering PAP in European (Bohman et al., 2015; Geense et al., 2013; Leemrijse et al., 2015), American (Tompkins et al., 2009), and UK literature (Carstairs et al., 2020; Craig & Shelton, 2008; Din et al., 2015; Graham, 2006), particularly for patients of a lower SES. It is argued that PA programmes and gyms are not easily accessible for patients of a lower SES, which negatively influences referral practices (Geense et al., 2013; Leemrijse et al., 2015; Tompkins et al., 2009). Leemrijse et al. (2015) examined the collaboration between Dutch General Practitioners (GPs) and local Exercise Providers. These authors reported that patients faced financial constraints with respect to the initiation of PA due to costly exercise facilities. Similarly, a UK-based study exploring PCP experiences of referring onto an ERS operating in Wales reported that PCP feared ERS would perpetuate inequalities as patients who would benefit the most, experienced financial barriers to uptake which limited access to these schemes (Din et al., 2015). This is problematic given that patients of a lower SES face the highest levels of chronic disease risk (Thornton, 2017). Furthermore, limited finances have been found to be a prohibitive factor of continued PA participation post ERS participation (Graham, 2006) and PA participation more generally amongst the UK population (indicated by 77% of a sample representing three substantial UK cities;Charlton et al., 2010). According to Kelly et al. (2016), financial issues are not unique to PA opportunities, but also recur as a major barrier across different health promoting behaviours (e.g. dietary behaviours, smoking, & alcohol intake).

Nevertheless, prior literature does not unanimously agree that a low SES is associated with reduced PA referral rates. Sowden et al. (2008) found that primary care sites (PCS) situated within areas of deprivation in England were more likely to refer patients onto ERS compared to PCS within areas of affluence. To combat SES constraints, the National Quality Assurance Framework for exercise referral systems (Craig et al., 2001) encourages support mechanisms proportionate to the level of disadvantage to encourage referral uptake amongst patients. Examples of these support mechanisms include organised transport for isolated or elderly patient groups, and subsidised costs for those without employment.

3.3.2.2.2 Geographical isolation and transportation issues

UK-based studies have reported that geographical isolation and transportation issues affect both exercise involvement and referrals to community PA schemes. In their study of health professionals referring onto a UK ERS, Din et al. (2015) recruited participants from both affluent and deprived GP practices, and found those practices situated in socio-economically deprived areas were geographically isolated from facilities operating ERS, which hindered referral as patients reportedly were unable or unwilling to travel to these facilities. Indeed, the Public Health Interventions Advisory Committee recognise that within communities of high deprivation, accessibility of facilities providing opportunities to be more physically active (e.g. leisure centres and parks) may pose a barrier (NIHCE, 2013).

Geographical isolation and transportation issues have also prevailed in the literature as prevalent obstructions of PA affecting older adults. A semi-structured questionnaire study

examining the views of 391 District Nurses and PNs in relation to PAP for older adults (i.e., aged ≥ 65) found transportation to local PAP schemes a pertinent problem affecting this patient group (Goodman et al., 2011). This may explain why the majority of Nurses in this study preferred to provide verbal advice around current PA levels (96%), ways to improve stamina (94%), brisk walking (95%) and chair-based exercises (72%) compared to initiating a referral to local PAP initiatives such as specialist exercise groups for older people (5%) or falls prevention services (12%). Local Government Association and PHE co-produced a report underscoring the challenges of health and care provision in rural communities (Local Government Association, 2017). One of the key risk factors centered on infrastructure, specifically, how the growing scarcity of public transport links exacerbates difficulties in accessing health and care services. This report also references 'distance decay', which refers to a decreasing rate of service use with increasing remoteness from the service location. This demonstrates the crippling impact geographical isolation and transportation issues can have on access to PAP schemes.

3.3.2.3 Patient Health Status

There is some contradictory evidence amongst the literature around the influence of a patient's health status in relation to PAP. Some researchers argue that those with a reduced health status are not approached about PA (Geense et al., 2013; Leemrijse et al., 2015), whereas others argue that a reduced health status acts as a prompt or trigger to encourage PA, especially when their condition is linked to PIA (Huijg et al., 2015; Patel et al., 2011; Winzenberg et al., 2009). The notion of targeting health promotion interventions following 'trigger' periods or significant life events has been highlighted in a systematic review examining the factors

influencing uptake and maintenance of healthy behaviours in middle aged adults (Kelly et al., 2016). However, according to Geense et al. (2013), PCP feel the existence of patient co-morbidities hinders their ability to fully engage with health promotion activities, as such this topic is hardly approached. In agreement, Leemrijse et al. (2015) demonstrated how patients reduced health status is one of the most pertinent barriers for advising patients on PA (cited by 34% of GPs). Indeed, a health survey for England report highlighted that poor health is a barrier to PA, which becomes more prevalent with increasing age (cited by 10% of men and 13% of women; Craig & Shelton, 2008). To put PCP at ease when discussing PA opportunities amongst patients with complex, multifaceted health issues, Leemrijse et al. (2015) emphasised the need for acquaintance and collaboration with local exercise providers to increase awareness of programmes appropriate for different patient groups.

Several scholars have suggested that patients with reduced physical health are approached about PAP more frequently, particularly when they present with a condition associated with PIA. For example, Winzenberg et al. (2009) sought to explore Australian GPs perceptions of assessing PA in primary care and found that the presence of chronic disease (e.g. metabolic syndrome, overweight, and obesity) or a condition directly linked with PIA, acted as a conversation trigger about PA levels. Similarly, New Zealand GPs administrating green prescriptions (i.e. written advice to support an increase in PA) to solidify their PA recommendations for both preventive and management purposes such as controlling pain, arteritis, diabetes or excessive weight (Patel et al., 2011). The presence of overweight and obesity, musculoskeletal disorders, high blood pressure, and diabetes have been shown to be amongst the most common reasons for initiating PA referrals within the community (James et al., 2008; Leijon et al., 2009).

3.3.2.4 Lack of Time

Another key factor influencing PA participation is a lack of time. Sequeira, Cruz, Pinto, Santos, and Marques (2011) found a lack of time to be the single most common barrier to PA amongst a sample of 2236 UK adults aged between 30 and 50, irrespective of their gender or socioeconomic status (cited by 55%). The Health Survey for England helps to shed light on the reasons underpinning such significant time constraints in relation to PA (Craig & Shelton, 2008). Based on a sample of 6682 adults aged between 16 and 64, this survey discovered that males and females struggle to be physically active due to competing demands on time. Specifically, for males, work commitments impinged on PA participation (cited by 45% of males), whereas females identified a lack of leisure time as a key hinderance (cited by 37%). Caring responsibilities for either young children or older adults was another common barrier to PA, particularly for females (cited by 25% of females compared to 13% of males). Equally, 42% of males and females believed that increasing leisure time would encourage PA participation. Albeit limited, there is some comparative evidence suggesting that competing demands on time prohibits PA programme attendance. Withall et al. (2011) interviewed 33 UK residents who were not involved in a PA programme as part of a larger mixed methods study examining the barriers and enablers to engagement with PA programmes amongst low-income groups. This study highlighted a lack of time as a key issue pertinent to individuals with jobs or large families whom perceived that the timing of sessions did not coincide with work and life patterns

3.3.3 Factors Relating to Physical Activity Programmes

Many factors influencing PAP in primary care have been identified that relate specifically to the characteristics and functioning of a PA programme. Typically, these include programme effectiveness, referral criteria of the programme, availability of patient feedback, and programme resources.

3.3.3.1 Programme Effectiveness

PCP often cite a lack of programme effectiveness as a barrier to implementing the promotion of PA (Din et al., 2015), and healthy lifestyles (Ampt et al., 2009; Geense et al., 2013). Indeed, Vuori (2016) claim that many perceived barriers highlighted in the literature are secondary to the low priority allocated to PA counselling in primary care. Primarily, this is a result of a lack of confidence in its effectiveness, feasibility, and competitive effectiveness amongst other methods adopted in the context of primary care (Vuori et al., 2013). Geense et al. (2013) found that PAP was hindered by a lack of programme proven effectiveness, which often inhibited GPs and PNs from referring their patients to lifestyle programmes. According to these respondents, many programmes were either unfinanced or financed for a brief time, causing a lack of programme continuity, and this subsequently spurred a lack of trust to implement and refer to such schemes. Similarly, Din et al. (2015) highlighted that PCP were hesitant to promote PA or initiate ERS referrals due to ambiguity about the effect of PA for different patient groups. When compared to other health promotion services such as smoking cessation, this cohort of PCP reported the evidence base for PA was deficient, which contributed to their hesitancy around PAP. Undeniably, the evidence base for the health-related effects of PA is considerably recent in comparison to smoking, and the majority of evidence is

constructed from observational studies (Vuori, 2016). Furthermore, ambiguity surrounding the effectiveness of ERS in facilitating long-term meaningful behaviour change is well documented (Campbell et al., 2015; NIHCE, 2014b; Pavey, Taylor, et al., 2011; Van der Wardt et al., 2021; Wade et al., 2020). This enduring debate regarding the effectiveness and value of PAP to public health fuels limited engagement amongst PCP (Savill et al., 2015).

3.3.3.2 Programme Referral Criteria

There are conflicting findings regarding the influence a PA programmes eligibility criteria may have on referral. Some scholars argue that referral criteria can encumber PA referrals (Din et al., 2015; Geense et al., 2013). Health Professionals in Din and colleagues study (2015) criticised the referral criteria for ERS, highlighting that it is too broad and invites eligibility for almost every patient. These authors argue stricter and more implicit referral criteria are warranted to ease the process of identifying which patients are most suited for referral (Din et al., 2015). Recent NICE guidance (2014b) supports the notion of more stringent referral criteria for ERS. Conversely, Geense et al. (2013) argue that health promotion programmes can often be difficult to access due to restrictive inclusion criteria such as the requirement to meet a specific BMI. Nonetheless, this study encompassed referrals for many lifestyle behaviours including alcohol consumption, smoking, PA, diet, and weight, which may explain this alternative perspective. Nonetheless, it has been argued that having well-defined guidelines and pathways for issuing behaviour change referrals would facilitate a more systematic and objective screening process, and may ease the process of referral (Bohman et al., 2015; Bouma et al., 2017).

Other researchers suggest that referral criteria have limited influence on referral given that referrers tend to ignore existing referral criteria and screening protocols when making appraisals over their patients suitability. Bull and Milton (2010) argue that PCP opportunistically make subjective judgements of patient appropriateness for programmes rather than following existing screening protocols. According to Graham et al. (2005), patients are often identified unsystematically for ERS, and therefore other referral mechanisms are warranted to facilitate more efficient and systematic patient selection. Albeit limited, there is some evidence to support the implementation of referral mechanisms (Gravely-Witte et al., 2010; Johnston, Warwick, De Ste Croix, Crone, & Sldford, 2005). Johnston et al. (2005) discovered that a centralised referral mechanism (CRM) involving an intermediary between the referring health professional, the referred patient, and the leisure provider, successfully removed 16% of inappropriate referrals (n = 458) made to a UK PA referral scheme (N = 2855) over a period of 28 months. Of these inappropriate referrals, almost a third of patients were removed for medical reasons (29%), the main reason being cardiac conditions (18%), and over two thirds of referred patients were removed for psychosocial reasons (71%), the main reason being not ready for change (45%). Similarly, Gravely-Witte et al. (2010) examined the effect of different referral strategies to cardiac rehabilitation, and found automatic referrals to be a more effective mechanism to improve referrals in comparison to usual care (i.e., completion of a referral at the physicians' discretion; 38-85% versus 17-45% respectively). Automatic referral typically involves electronic medical records prompting a PCP to make a referral based on specific patient indicators. Nevertheless, there are significant financial implications to the implementation of such mechanisms, with Johnston et al. (2005) reporting costs in the region of £ 15,000 per annum for their CRM. A cheaper alternative to facilitate appropriate referrals as proposed by PCP in Graham et als study (2005) could be to improve mechanisms of feedback

between primary care and leisure to help build PCP knowledge and understanding so they can ascertain which patients would benefit most from referral.

3.3.3.3 Feedback Provided by the Programme

The feedback process of a lifestyle programme is an integral part of a medical professional's ability to uphold clinical responsibility of the patient (Craig et al., 2001), and yet a lack of feedback regarding a patient's progress and outcomes is a core barrier to PA referrals. PNs have highlighted a lack of procedures for patient feedback, which influences how often they issued PA referrals (Bohman et al., 2015). Similarly, Din et al. (2015) discovered that a lack of feedback regarding a patient's progress on an ERS negatively affected PCP engagement with PAP and referral. Henderson et al. (2017) explored key stakeholder views of a UK ERS and exposed how feedback mechanisms for patient progress reports to PCP were largely unmonitored, and FPs principally dictated the content, quantity, and delivery of feedback. There have been resounding calls for robust methods of communication and feedback between PA scheme coordinators and PCP to facilitate continued referral (Buckley et al., 2020; Din et al., 2015). Improving feedback to PCP will help build an evidence base of who is most likely to benefit from a referral, which will aid PCP in their referral decisions, and may increase their confidence in the effectiveness of such schemes (BHF NCPAH, 2010; Graham et al., 2005).

The content of desired patient progress feedback remains subject to much debate. In relation to ERS, Graham et al. (2005) questioned UK PCP about their preferred feedback

indicators, and found that some sought a basic acknowledgment of attendance, whereas others wanted a comprehensive description of the PA undertaken. Other researchers have attempted to determine how success on PA-based referral programmes is depicted by heterogenous stakeholder groups, which may be useful to inform evaluation procedures and feedback provision. Utilising a mixed methods research approach, Mills, Crone, James, and Johnston (2012) examined what patients (n = 17), exercise providers (n = 2), and referring health professionals (n = 7) perceived success to be on an ERS. This study concluded that success is multidimensional in nature, and therefore it is imperative that traditional positivistic notions of success (i.e., physical outcome measures) are supplemented with more holistic and meaningful markers of success (i.e., psychological, & social outcome measures) to better understand the impact of an ERS. In addition, Mills et al. (2012) argued that weight loss, frequently regarded as the pinnacle of success on an ERS, is rarely central to the perceptions of success, which instead encompassed many concepts including empowerment, improved functionality, inclusion, and confidence. On a similar note, Graham (2006) found that ERS participants based their success on functional (e.g. completion of day-to-day tasks & improved ability to interact with their grandchildren), social (e.g. greater social confidence), mental (e.g. improved confidence), and physiological changes (e.g. improvement to physical health). Thus, it is increasingly recognised that PA-based programmes should identify and report a host of patient-centered outcome measures including psychological indicators such as confidence, mental health, quality of life, and sense of belonging, rather than focusing exclusively on physical health indicators, which in turn, will help to determine true programme effectiveness (Lion et al., 2019; NIHCE, 2014b). Encouragingly, Wade et al.'s (2020) examination of the National Referral Database has evidenced how ERS are beginning to incorporate more holistic pre and post outcome measures such as quality of life (via WHO Well-Being Index & Exercise Related Quality of Life scale), mental well-being (via short Warwick Edinburgh Mental Well-being

Scale), and self-efficacy (via Exercise Self-Efficacy Scale), albeit this is limited to very few schemes and may not be disseminated to referring PCP.

The National Quality Assurance Framework for exercise referral systems (Craig et al., 2001) stress the importance of upholding working relationships with all members of the ERS system (i.e. other referrers, ERS co-ordinators, and FPs) as it facilitates the exchange of information as and when required. However, there is evidence to suggest that working relationships are far from optimal. Henderson et al. (2017) discovered perceived divisions and 'contested power imbalances' at the local level between exercise professionals and health professionals. Interestingly, one of the main barriers to successful referral alliances between primary care and the sports sector revolves around limited communication and feedback systems (Leenaars, Smit, Wagemakers, Molleman, & Koelen, 2015). Whilst inter-sectoral collaboration is challenging given the range of backgrounds, interests, and perspectives of each profession involved (Leenaars et al., 2015), establishing robust means of transmitting patient progress feedback may help to nurture better working relationships, and simultaneously build a stronger evidence base for PAP.

3.3.3.4 Programme Resources

The resources that accompany a PA program can often determine the extent to which a PCP engages with PAP. Huijg et al. (2015) suggested that materials used for intervention delivery (e.g., screening tools & digital registration systems) are just as important to facilitate

PAP as materials devised for participants (e.g., intervention booklets). Nevertheless, it is interesting to note that some Health Professionals disregard validated PA screening tools such as the General Practice Physical Activity Questionnaire (GPPAQ; DoHSC, 2009) because 1), their use is constrained by limited consultation time and the complexity of patient care, and 2), their questions often invite longer discussions with patients, which places added pressures on consultation time (Heron et al., 2014). PCP in prior research have also highlighted an absence of clear educational materials and resources to suit both their own, and the patient's needs (Buckley et al., 2020; Carstairs et al., 2020; Douglas, van Teijlingen, et al., 2006; Tompkins et al., 2009). A questionnaire survey assessing the perceptions and experiences of PCP in relation to offering routine PA advice found that as many as 60% of respondents lacked educational instruments to support PAP (Douglas, Torrance, et al., 2006). Likewise, Bélanger et al. (2015) discovered that a lack of resources posed a challenge to the use of PA prescriptions among GPs who regularly prescribe and those who do not. This study identified that specific resources designed for PAP such as prescription pads and summary sheets may help stress the seriousness of a PA recommendation, and may serve as a prompt for patients to participate in and sustain motivation for PA. Concerningly, contemporary research continues to expose how PCP have limited access to up-to-date resources detailing what PA opportunities are available for patients in the local community (Buckley et al., 2020; Carstairs et al., 2020).

Literature focused on the patient's perspective also provides evidence that resources accompanying PA referrals are unsatisfactory. Wormald et al. (2006) investigated PAP from the patients' perspective who argued that their referring PCP were often unable to provide sufficient information about the programmes or services, and failed to offer an information leaflet upon referral, which spurred great apprehension. Similarly, several studies have

indicated that poorly formatted information resources results in patients disassociating themselves from ERS (Birtwistle et al., 2018), and commercial weight-loss programmes (Allen, Cohn, & Ahern, 2015). To improve lifestyle PA-based services, Wormald et al. (2006) advocated promotional efforts targeting specific patient groups (i.e., unhealthy, older, & overweight individuals). Despite these recommendations, research continues to reveal the dearth of promotion and resources for ERS within the community (Birtwistle et al., 2018).

3.4 Gaps in the Current Literature

Research investigating the factors influencing PAP in primary care is extensive and provides important insights into its complexity. However, because the term 'physical activity promotion' is so broad, the literature has explored PCP experiences of advising PA in primary care (Douglas, Torrance, et al., 2006; Douglas, van Teijlingen, et al., 2006; Geense et al., 2013; Goodman et al., 2011; Lawlor et al., 1999; Winzenberg et al., 2009), counselling for PA in primary care (Bélanger et al., 2015; Bohman et al., 2015; Geense et al., 2013; McKenna et al., 1998; Omura et al., 2018; Patel et al., 2011; Persson et al., 2013; Tompkins et al., 2009), and initiating referrals to Exercise Specialists (Buckley et al., 2020; Carstairs et al., 2020; Din et al., 2015; Geense et al., 2013; Goodman et al., 2011; Graham et al., 2005; Leemrijse et al., 2015; Omura et al., 2018). The research on advising and counselling for PA within primary care is vast compared to the literature on referrals to Exercise Specialists. Moreover, Huijg et al. (2015) argue that factors influencing PAP are specific to each PA intervention and its context. Hence, it is naive to assume that evidence translates easily to different situations, which helps to explain contrasts of published research.

Another limitation of published literature on the factors affecting PAP is the poor participant response rates which many UK (Buckley et al., 2020; Douglas, Torrance, et al., 2006; Douglas, van Teijlingen, et al., 2006; Goodman et al., 2011; Graham et al., 2005), and European studies (Bélanger et al., 2015; Leemrijse et al., 2015; Persson et al., 2013) fall victim to. It is possible these samples are characteristic of those with a greater interest in PAP, and therefore hold more positive views in comparison to those who do not choose to participate. This raises concerns about how representative findings are to other PCP populations. Furthermore, the large majority of literature uses data collection tools designed by the authors with no explicit evidence of pilot testing (Buckley et al., 2020; Carstairs et al., 2020; Din et al., 2015; Douglas, Torrance, et al., 2006; Douglas, van Teijlingen, et al., 2006; Geense et al., 2013; Graham et al., 2005; Patel et al., 2011; Persson et al., 2013; Winzenberg et al., 2009) or evaluation for reliability or validity. Only a handful of studies were found to be the exception, which were generally not the most contemporary literature sources (Bélanger et al., 2015; Goodman et al., 2011; Lawlor et al., 1999; Leemrijse et al., 2015; McKenna et al., 1998; Tompkins et al., 2009; Winzenberg et al., 2009). Questionable data collection instruments undoubtedly challenge the trustworthiness of previous study findings.

Of the considerable literature published on the factors influencing PAP in primary care, only a small minority is focused specifically within the UK (Douglas, Torrance, et al., 2006; Douglas, van Teijlingen, et al., 2006; Graham et al., 2005; Lawlor et al., 1999; McKenna et al., 1998) with only a handful of studies published in the last decade (Buckley et al., 2020; Carstairs et al., 2020; Din et al., 2015; Goodman et al., 2011). The last ten years alone have seen dramatic changes to the NHS and primary care, particularly in terms of increased workload (Hobbs et al., 2016), which is reported to be the biggest job stressor in the latest National GP Worklife

Survey (Walker et al., 2021). Thus, it is possible findings are representative of an older era of primary care. Much of the recent published works in this particular field have been conducted on PCP practicing in Holland (Geense et al., 2013; Huijg et al., 2015; Leemrijse et al., 2015), Sweden (Bohman et al., 2015; Persson et al., 2013), US (Tompkins et al., 2009), and Canada (Bélanger et al., 2015). These studies may not have direct relevance to the UK due to differences in healthcare systems. Furthermore, little is known about the experiences of UK PCP issuing PAP referrals to community exercise specialists (NICE, 2014). This is of upmost importance given that they are an integral component of the referral process, and often the first port of contact for patients accessing such programmes.

Another limitation of prior research is the heavily weighted focus on GP perspectives (Bélanger et al., 2015; Buckley et al., 2020; Lawlor et al., 1999; Leemrijse et al., 2015; Patel et al., 2011; Persson et al., 2013; Winzenberg et al., 2009). Moreover, studies that claim to comprehend the views of multiple primary care conduits of PAP have samples composed mostly of GPs (Din et al., 2015; Douglas, Torrance, et al., 2006; Geense et al., 2013; Graham et al., 2005; McKenna et al., 1998; Omura et al., 2018). For example, 67.4% of Din et als (2015) sample comprised of GPs, compared to 19.6% of PNs and 13.0% of Practice Managers. This is an injustice to wider PCP populations involved in PAP, and narrows the applicability of findings to such groups. Whilst there is a small body of isolated literature focused exclusively on other health professionals involved with PAP such as Nurses and Health Visitors (Bohman et al., 2015; Douglas, van Teijlingen, et al., 2006; Goodman et al., 2011; Tompkins et al., 2009), GP perspectives remain over-represented. Therefore, greater attention must be devoted to understanding the perspectives and experiences of all conduits of PAP in primary care to better understand the complexities at play when initiating PA referrals. This is echoed in a

contemporary study by Buckley et al. who concluded "Future research would benefit from understanding the perspectives of other healthcare professionals (e.g. nurses, physiotherapists) who are well-placed to advocate PA within their practice" (2020, p. 8).

Literature gives trivial recognition to the factors (i.e., facilitators and barriers) influencing referral activities from the perspectives of other relevant stakeholders involved in referral operations besides health professionals. For instance, the NHS Long Term Plan push for social prescribing has seen the rapid emergence of around 1000 CLWs (also known as Social Prescribing Link Workers) and Care Navigators to bridge the gap between primary care, third sector, and community services to provide timely joined-up patient care (NHS England, 2019). Between September 2019 and September 2020, the number of CLWs in England, increase by over 205% (NHS Digital, 2020). These professionals function as an intermediary, and regularly refer and signpost patients to local social prescribing opportunities, including PA programmes. This gap in the research limits the refinement of PA interventions in primary care as alterations in terms of operating procedures and scheme protocols should be grounded on feedback and discussions from all personnel involved (BHF NCPAH, 2010; Graham et al., 2005; Huijg et al., 2015). Thus, to address this gap in the literature, it is imperative that future research focuses holistically on the perspectives and first-hand experiences of all involved in PAP to inform appropriate improvements or modifications to referral processes (Hanson, 2017). This is echoed in the recommendations from Hamilton, Henderson, Burton and Hagger (2019) in relation to discussing lifestyle behaviours in primary care: "Future research should concentrate on better understanding these barriers and methods to overcome them" (pp. 304), and Albert et al. (2020) in relation to PAP: "Future studies could explore the functionality of GP to Exercise Professional referral pathways to determine what currently works and areas

requiring further development" (pp. 1)… to "strengthen referral pathways between key healthcare gatekeepers such as GPs and PA specialists" (pp. 29).

Prior research often neglects the views of FPs (otherwise known as Exercise Professionals or Exercise Specialists) and patients in relation to referral processes. According to Gidlow et al. (2008) "to gain a better understanding of how schemes can be improved, or more appropriately targeted, requires an in-depth understanding of the referral process, a participants' journeys through it, and how this is influenced by the perceptions and attitudes of health and exercise professionals involved" (pp.11). However, as Wormald et al. (2006) points out: "few studies have focused on the views of ERS participants themselves. Issues such as participant's views of the scheme, their opinions on its ability to increase PA behaviour, and their perceptions of how schemes can be improved have rarely been the focus of investigations" (pp. 363). This still holds true today where the body of literature on patient's perspectives generally focuses on their experiences whilst on an ERS or PA-based programme, with the exception of Wormald et al. (2006) and Carstairs et al. (2020).

As Gidlow et al. (2008) identifies, Exercise Professionals are equally as important as Health Professionals and patients in obtaining a holistic and comprehensive understanding of how PA schemes can be improved. On a similar note, PHE (2021b) advocated a whole systems approach to PA integration in local authorities whereby all local stakeholders and community members work together to understand challenges of local system operations, uncover any hidden barriers, and identify key opportunities for change. Thus, there is a drive towards more inclusive research that enables all stakeholders to contribute to knowledge and understanding.

Despite this, research focusing on PAP has given trivial recognition to exercise service providers (Henderson et al., 2017; Moore et al., 2011). This perspective is vital because they are at the receiving end of the referral process and are well positioned to offer insights into the strengths and weaknesses of referral processes, and the practical implications these factors have on the design and delivery of PA programmes. Due to the centrality of their role, it is of upmost importance that a voice is given to service providers such as FPs to contribute new understandings.

3.5 Summary

To summarise, the literature on PAP is primarily focused on advice giving and counselling within the boundaries of primary care. It is often limited to the perspectives of one homogenous group of PCP (i.e., GPs), and is rarely attentive to the experiences of UK PCP, patients, or FPs in relation to community-based PA interventions accessed through a referral. Taking the shortcomings of previous studies into consideration, this thesis aims to make a unique contribution to the evidence base by exploring the perspectives and experiences of all stakeholders involved in referral operations to community PA programmes offered in the ERoY, otherwise known as the Healthy Lifestyle Programmes (HLPs). In line with Gidlow et al. (2008) and the BHF NCPAH (2010), this study appreciates that to understand how to improve PA referral schemes, and operational procedures, it is essential that there is a comprehensive understanding of referral processes, by encapsulating a patient's journey through that process, and capturing the views and experiences of health and fitness professionals involved. Specifically, the focus of this research is on understanding the strengths and weaknesses of current HLP referral processes, from the perspectives of those closely

associated with the service. This study intends to provide novel insights into HLP referral processes, and elicit stakeholder-driven recommendations that may be used as a catalyst for change to simplify and streamline this process. In order to achieve those aims, this thesis utilised a convergent mixed methods design that encompassed two individual research phases- both of which are detailed in this manuscript.

4 CONTEXTUAL OVERVIEW OF THE EAST RIDING OF YORKSHIRE

4.1 Introduction

Having set the scene, this chapter provides a contextual background of the Healthy Lifestyle Programmes (HLPs) and the region in which they operate. Specifically, this chapter aims to offer an overview of the ERoY in terms of geography, overall health and well-being profiles of residents, and the council's assets to encourage positive lifestyle behaviour change and promote good health and well-being.

4.2 Geography of the East Riding of Yorkshire

Established in 1996, ERoY is one of six authorities that make up Yorkshire and the Humber. Geographically, ERoY is positioned in the Northeast of England, confined to the east by the North Sea. Stretched across over 930 square miles, ERoY represents one of England's largest local authorities, and boarders eight other local authorities: Scarborough, Ryedale, Kingston upon Hull, York, Selby, Doncaster, North Lincolnshire, and Northeast Lincolnshire. ERoY encompasses over three hundred individual settlements, with Bridlington representing the largest (population size: 38,616). Other sizable settlements include Goole (population size: 22,452), Driffield (population size: 15,053), and Beverley (population size: 14,045; UK Census, 2011). In contrast, Howden is the smallest ERoY settlement, home to a population of around 4865 (UK Census, 2011).

ERoY is a distinctive rural landscape comprised of isolated hamlets and farmsteads, small towns and villages, open countryside, and coastal communities. Close to one thousand

square miles of the ERoY encompasses coastline and countryside. ERoY's coastline extends from Spurn Point to Flamborough Head, ranging over eighty-five kilometres. Along this stretch lies three seaside resorts: Bridlington, Hornsea, and Withernsea. Almost 50% of ERoY's population reside in isolated communities (ONS, 2011), where public transport is often limited. This has implications for those who do not have access to their own vehicle or alternative transportation, and thus presents challenges for many rural communities in terms of accessing support, resources, and opportunities to improve health and well-being. The peripheral and largely rural nature of ERoY also causes difficulties with broadband coverage (East Riding Intelligence Hub, 2020).

At the time of undertaking this thesis, in ERoY there were a total of 26 individual wards which were grouped into four vicinities: 1) Bridlington, 2) CHERY, 3) Holderness, and 4) Southwest Area Network (SWAN). CHERY represents the largest ERoY vicinity, and includes Leven, Beeford, Beverley, Cottingham, Driffield, Willerby, Swanland, and Anlaby. Geographically, the second largest vicinity is SWAN, covering Goole, Howden, Snaith and Rawcliffe, Gilberdyke, Selby, Hessle, Market Weighton, and North Ferriby. Bridlington singlehandedly represents the third largest vicinity. Finally, Holderness is the smallest of the vicinities and encompasses Hedon, Withernsea, and Hornsea.

4.2.1 Geography of Primary Care Networks

In July 2019, the vast majority of general practices within the ERoY merged to form seven individual 'Primary Care Networks' (PCNs) as a vehicle to promote integration of

working between general practice and community, mental health, social care and voluntary services to enable proactive, personalised and holistic patient care (ERoY CCG, 2019). PCNs were formed on the back of changes to the General Practice contract in April 2019, and the publication of the NHS's Five Year Forward View (NHS England, 2014b), which placed integrated care systems at the core of the NHS primary care transformation plan. ERoY PCNs consist of Beverley, Bridlington, Cygnet, Harthill, Holderness, River and Wolds, Yorkshire Coast and Wolds. Each PCN serves between 35,000 and 51,000 patients (ERoY CCG, 2019). It is worth noting here that a minority of general practices within the ERoY chose not to merge into a PCN and remain as separate entities. Latest figures based on the general practice workforce in September 2020 indicate there were 176 full time equivalent GPs and 176 full time equivalent Nurses across ERoY (NHS Digital, 2020). Receptionists (N =180) formed the main bulk of the non-clinical workforce in ERoY (NHS Digital, 2020). ***Figure* 4.1**. provides a visual demonstration of the ERoY in relation to the division of the seven Primary Care Networks, and details the population count each PCN serves.

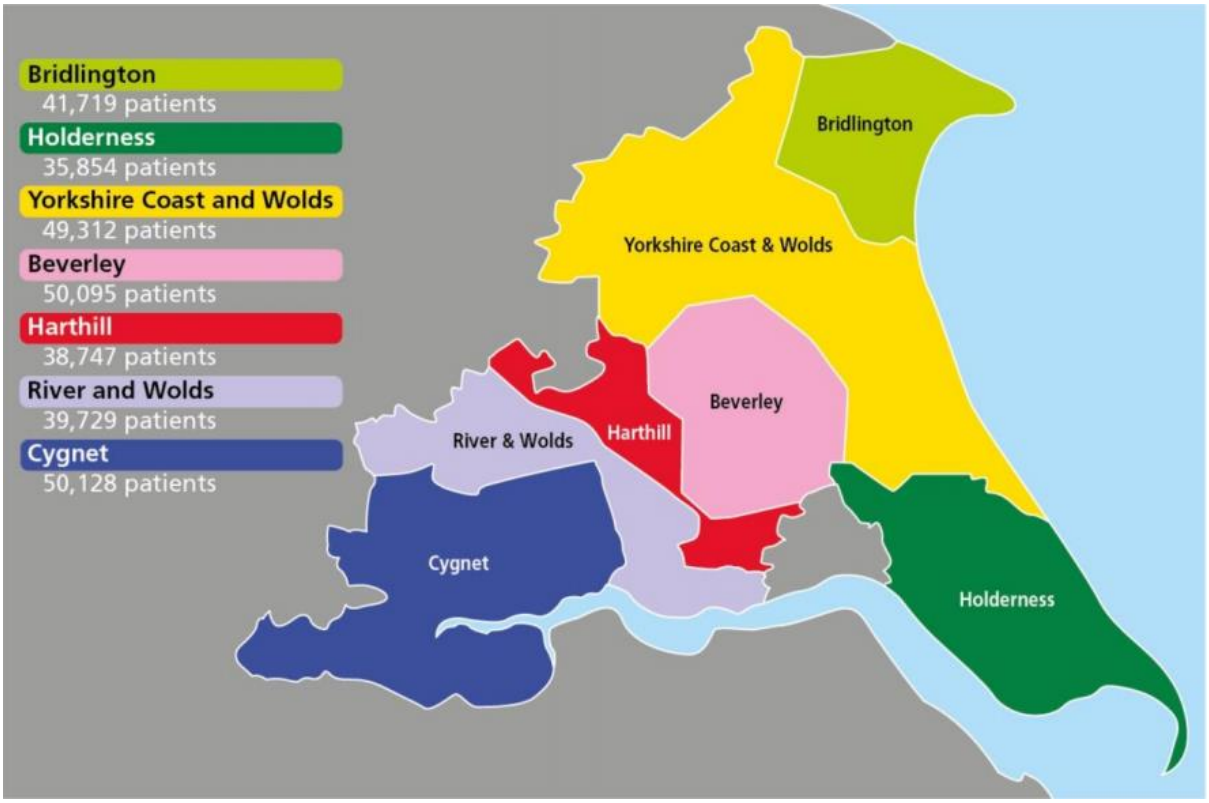

***Figure* 4.1.** A map to indicate the location of East Riding of Yorkshire, the division of Primary Care Networks and its populace

Note: from *General Practice Strategy 2019-24* by East Riding of Yorkshire Clinical Commissioning Group, 2019. East Riding of Yorkshire Clinical Commissioning Group. https://www.eastridingofyorkshireccg.nhs.uk/data/uploads/publications/190924-gp-strategy-2019-24_final-version-use.PDF. In the Public Domain. Reprinted with permission from East Riding of Yorkshire Clinical Commissioning Group

4.2.1.1 Overview of GP Surgery Clinical Software Systems

Clinical software systems, central to the day-to-day operations of PCP, differ amongst individual GP surgeries across the ERoY. Such systems are used in a multitude of care settings to record patient activity and outcomes relating to their care including, but not limited to, GP surgeries, prisons, childcare services, community units, hospitals, palliative care services, and social services. This enables multiple services involved in a patient's care to access and update medical records and obtain their patient's details such as their medical history, medications, and allergies- subject to obtaining consent. In the ERoY, there are two leading clinical software systems used across GP surgeries– SystmOne and Egton Medical Information Systems Ltd (EMIS). SystmOne is the dominant system adopted within the following PCNs: Beverley (66.66% coverage), Bridlington (71.43% coverage), Cygnet (71.43% coverage), Harthill (55.55% coverage), and River and Wolds (100% coverage). EMIS singlehandedly controls Holderness (100% coverage) and Yorkshire Coast and Wolds (100% coverage) PCN. However, across the locality as a whole, there is a 50/50 split between GP surgeries using SystmOne (n = 27), and those using EMIS (n = 27).

4.3 East Riding of Yorkshire's Population

ERoY has a population of 341,173; 278,129 (81.52%) of which are adults (i.e., over the age of 18 years; ONS, 2020).

Table 4.1. *Age and gender distribution of the adult East Riding of Yorkshire Population*

Age range (years)	Persons (n)	Female	Male
18-24	20457	9385	11072
25-34	31676	15979	15697
35-44	35858	18489	17369
45-54	49693	25418	24275
55-64	51099	25908	25191
65-74	49042	25267	23775
75-84	29242	15925	13317
85+	11062	6921	4141
All ages	**278129**	**143292**	**134837**

Note: Adapted from "*Census Population Estimates- mid 2019*", by Office for National Statistics, 2020. Retrieved from https://fingertips.phe.org.uk

ERoY has a populace characterised by a typically older demographic. **Table 4.1**. demonstrates that the highest proportion of adults fall into the 55-64 age category, representing 18.37% of the total ERoY adult population (ONS, 2020b). This is closely followed by the 45-54 age category (representing 17.87%) and the 65-74 age category (representing 17.65%; ONS, 2020). Generally speaking, the more rural the settlement type, the older the population (Local Government Association, 2017). Overall, females account for 51.52% of ERoY adult population, whereas males account for 48.48% (ONS, 2020b).

Latest figures from the ONS (2020c) forecast population projections in the region of 11,118 by the year 2030 within ERoY (an increase of 3.23%), hypothetically bringing the population count to around 352,185. The greatest projections are expected in adults aged between 60 and 90 (ONS, 2020c). This is a typical trend of ERoY, where the aging population has been shown to increase disproportionally to national and regional rates. Data from the ONS (2020b) shows that 25.8% of the ERoY population are aged ≥65 (26.2%) and 3.2% are ≥85 . These figures are much higher in comparison to neighbouring locality such as Kingston upon Hull (≥65 = 15.1% & ≥85 = 1.8%), York (≥65 = 18.4% & ≥85 = 2.6%), and Selby (≥65 = 20.2% & ≥85 = 2.3%; ONS, 2020a). Population projections predict that ERoY residents aged over 65 will account for 34% of the regions total population by 2043 (ONS, 2020c). Inevitably, this disproportionate increase will place pressure on the provision of ERoY public and community services owing to the long-term diseases associated with an aging population. It is predicted that by 2030, an extra 40% of adults aged 65+ will suffer a long-term illness, limiting their day-to-day activities (representative of an extra 24,761 new cases; Health and Wellbeing Board, 2016). Consequently, the encouragement of a healthy independent aging population is

a key precedence outlined in the ERoY Joint Health and Well-being Strategy (Health and Wellbeing Board, 2016).

4.3.1 Ethnicity

According to the ONS census (2011), ERoY is characterised by a predominantly British white population (96.1%), where black and minority ethnic population groups account for only 3.6% of the total population. ERoY is home to a lesser percentage of all minority ethnic groups compared to Yorkshire and the Humber, and England (3.6% versus 13.7% versus 19.2% respectably; ONS, 2011).

4.3.2 Deprivation

The Index of Multiple Deprivation (IMD) is the most common relative measure of deprivation in England, which combines information from seven domains (income, employment, education, health, crime, barriers to housing and services, and living environment) to produce a rank between 1 (most deprived area nationally) and 32 844 (least deprived area nationally). These ranks sit within deprivation deciles to enable comparisons between different areas in England. Deciles are split into ten equal groups ranging from 1 (most deprived 10% of areas) to 10 (least deprived 10% of areas). The most recent indices of deprivation statistics in England were published in 2019 (Ministry of Housing Communities & Local Government, 2019).

ERoY is considered an affluent region, sitting in the fourth least deprived decile. Many areas within this locality fall into the least deprived 10% of all areas across England such as Brough (IMD: 1.87), Kirk Ella (IMD: 2.57), North Ferriby (IMD: 3.31), and Leven (IMD: 3.36; Ministry of Housing Communities & Local Government, 2019). However, pockets of high deprivation exist across the region, specifically within coastal wards such as Bridlington (IMD: 78.1) and Withernsea (IMD: 60.08), and also within some inland wards such as Goole (IMD: 46.16), which all fall into most deprived 10% of areas across England (Ministry of Housing Communities & Local Government, 2019). This is concerning as higher levels of deprivation are strongly correlated with the prevalence of poor health and well-being, multimorbidity, and premature mortality (NHS England, 2019).

4.3.3 Life Expectancy

In the ERoY, inequalities in both life expectancy (i.e., average number of years a person is expected to live) and healthy life expectancy (i.e., average number of years a person is expected to live absent of disease and/or injury) are concealed by the overall affluence of the region (ERoYC, 2019). According to the latest figures from the ONS (2019a), life expectancy at birth in the ERoY stands at 83.8 for females and 80.1 for males. Life expectancy statistics are higher for both genders in comparison to the UK, England, and Yorkshire and the Humber (82.9 & 79.3, versus 83.2 & 79.6, versus 82.4 & 78.7 respectively). Healthy life expectancy at birth in ERoY sits at 65.4 for females, and 64.4 for males (ONS, 2019a). Again, these figures are favourable compared to the UK, England, and Yorkshire and the Humber statistics for healthy life expectancy amongst females and males (63.6 & 63.0, versus 63.9 & 63.4, versus 62.1 & 61.5 respectively). Nonetheless, significant inequalities exist amongst both females and

males between those residing in the most deprived quantiles compared to their gender equivalents living in the least deprived quantiles. For example, males in Bridlington South, have a life expectancy of 8.7 years younger than males in Willerby and Kirk Ella (74 years versus 82.7 years respectively; PHE, 2020a). The same goes for females in Bridlington South, who on average are dying 7.1 years younger than their gender equivalents in Willerby and Kirk Ella (78.9 years versus 86 years respectively; PHE, 2020a). In terms of healthy life expectancy, it has been suggested there is a gap of 14 years for both females and males between those living in the most and least deprived areas in the ERoY (ERoY CCG, 2019).

4.3.4 Health and Well-being

In addition to inequalities in relation to the length of life, health inequalities in terms of quality of life prevail between the most and least deprived areas of ERoY.

4.3.4.1 Overweight and Obesity

The prevalence of overweight and obesity in adults across ERoY exceeds England averages, which is a major concern given their strong association with disease and premature mortality (Abdelaal, le Roux, & Docherty, 2017). Latest local authority health profiles based on data from 2018/2019 indicate that 63.9% of ERoY adults are either overweight or obese, surpassing England's average value of 62.3% (PHE, 2020c). Geographical variation exists in terms of obesity prevalence across ERoY. For instance, general practices situated in Bridlington (an area of high deprivation), record a much higher prevalence of obesity in

comparison to practices in Beverley (an affluent area; 21.36% versus 7.3% respectively; NHS Digital, 2018).

4.3.4.2 Diabetes

Given ERoY's higher than average obesity rates, and the association between obesity and diabetes (Gatineau et al., 2014), it is hardly surprising that the region records a high occurrence of diabetes in adults. The incidence of diabetes currently sits at 7.9% in ERoY (PHE, 2020d). This is significantly higher than England's averages where 6.9% of the population are recorded with the disease (PHE, 2020d). Latest figures from PHE Fingertips demonstrate how GP surgeries in areas of high deprivation have a higher prevalence of diabetes amongst their patient populations. For instance, Field House Surgery in Bridlington (IMD score 2019: 35.9, decile 1) report that 9.8% of their patient group have the disease (PHE, 2020d). Compare this to The Willerby Surgery (IMD score 2019: 5.2, decile 9) where the prevalence of diabetes amongst their patient population sits at 6.3% (PHE, 2020d).

4.3.5 Lifestyle Behaviours

The landmark Marmot Review (2010) into the causes and repercussions of health inequalities in England proposes that such equalities are caused by a multitude of complex inter-related factors which can include housing, economic status, education, social isolation, lifestyle behaviours, and physical and mental health problems. Health inequalities can be both avoidable and preventable. One way to reduce health variations is through the modification of key individual lifestyle choices and health behaviours: physical activity (PA) behaviour,

dietary choices, alcohol consumption, and smoking (Marmot, 2010). These are proximal determinants of health inequalities since they are immediate precursors of disease. To offer context relevant to the present research, brief consideration is given to dietary choices, alcohol consumption, and smoking, with emphasis on PA.

4.3.5.1 Physical Activity

Local Authority Health Profiles from 2019/2020 indicate that 63.5% of adults in ERoY achieve the CMO recommendations for PA (PHE, 2020c). This figure is not significantly different from England averages (66.4%), yet is much worse compared with some surrounding local authorities such as York, where PA levels sit at 70.9% (PHE, 2020c). The same PHE profiles suggest that as many as 25.9% of adults in the ERoY are considered physically inactive, which is significantly worse than England and York averages (22.9% versus 17.6% respectively). PHE Health Profiles for England (2018/2019) demonstrate more than a 10% difference in PA levels amongst adults living in the most and least deprived areas in England (62% versus 72.7% respectively). According to the Department for Transport (2020), the percentage of adults in the ERoY who walk and cycle at least 3 times per week surpasses average values of England and Yorkshire and the Humber (54.6% versus 47.7% versus 45.9% respectively). However, compared to 60.5% of the adult population in York who walk or cycle at least three times per week, ERoY underperforms in this category.

4.3.5.2 Diet

The latest health survey for England report concerning adult health-related behaviours (2019) suggested that in 2018, 28% of adults (males: 25%, females: 30%) were consuming at least five portions of fruit and vegetables per day. However, there are major discrepancies between local authorities. Statistics from the Local Government Association (2020a) estimated each local authorities prevalence of healthy eating amongst their adult population (i.e. 16+ years) based on data from 2006-2008, and speculated that averages in ERoY surpass those of neighbouring local authorities south of ERoY such as Kingston upon Hull and North Lincolnshire (27.1% versus 20.4% and 24.6% respectively). However, bordering local authorities to the north and west of ERoY (i.e., North Yorkshire and York) have a higher percentage of healthy eating adults (28.8% and 28.3% respectively).

4.3.5.3 Alcohol Consumption

PHE's local alcohol consumption survey national report (2017) based on data from 2016 found that a lower percentage of ERoY adults who drink more than 6/8 units of alcohol in a single occasion or have an Alcohol Use Disorders Identification Test score of ≥8 compared to their neighbouring local authority, Kingston upon Hull (12.2% versus 17.7% and 21.5% versus 29.7% respectively). However, the last ten years has seen the trend in ERoY regarding hospital admission episodes for alcohol-related conditions getting steadily worse (PHE, 2020c). Latest data based on the period between 2018-2019 indicates that there were 2121 separate admission episodes due to alcohol-related conditions (PHE, 2020c). Nevertheless, this figure is significantly better than England averages (2367 admission episodes over the same time period), and compares favourably against neighbouring local authorities south of ERoY

such as Kingston upon Hull and North Lincolnshire (3036 versus 2632 respectively), and bordering local authorities to the west of ERoY such as York (2536 admission episodes over the same time period).

4.3.5.4 Smoking

The smoking prevalence in adults within ERoY was last recorded in 2019 at 33,505 (12.1%), a figure lower, but not significantly different from England's average at 13.9% (PHE, 2020c). However, the smoking prevalence amongst ERoY adults compares favourably against Kingston Upon Hull and North Lincolnshire where the prevalence is significantly higher (22.2% versus 17.8% respectively). Across the whole of England, the prevalence of smoking has reduced significantly in recent years following the DoHSC release of the tobacco control plan for England, which strives for a smoke-free generation (i.e. smoking prevalence $\leq 5\%$) by 2022 (DoHSC, 2017). Nevertheless, the percentage of females in ERoY smoking during pregnancy, and at the time of delivery remains worse than England's average (14.3% and 13.6% versus 10.6% and 10.4% respectively; PHE, 2020c).

4.3.5.5 Variations in Lifestyle Behaviours

ERoY's Joint Health and Well-being Strategy (Health and Wellbeing Board, 2016) provides some valid explanations concerning the variance in lifestyle behaviours between the most and least deprived ERoY settlements. First, lower socio-economic groups may not have access to information on how to lead a healthy lifestyle, or it may be that this information does not leave an impression (Health and Wellbeing Board, 2016). Secondly, individuals living in

the most deprived areas may be constrained by their environmental surroundings, which could make adopting healthy lifestyle behaviours difficult (Health and Wellbeing Board, 2016). Thirdly, certain unhealthy behaviours such as smoking are deeply embedded in individuals of a lower SES, and this culture may hinder positive lifestyle behaviour changes (Health and Wellbeing Board, 2016). Lastly, lower socio-economic groups may experience other pressing problems with income or housing, which may relegate behaviour change to subordinate importance (Health and Wellbeing Board, 2016). Combatting health inequalities features heavily throughout ERoY's Joint Health and Well-being Strategy (2016), and is identified as a priority outcome in the current East Riding Health and Well-being Strategy 2019–2022 (Health and Wellbeing Board, 2019).

4.4 Promotion of Health and Well-being in the East Riding of Yorkshire

The threat of a rising aging population, prevailing health inequalities and disappointing health indicators has spurred the local authority to concentrate efforts on asset-based approaches for health promotion and well-being. An asset-based approach is concerned with utilising the skills and knowledge of individuals and the resources available within a community to support health and well-being, shield against negative health outcomes, and enhance quality of life (McLean, 2011; Sigerson & Gruer, 2011). This approach endeavours to empower people in the community so they are less reliant on public services (Sigerson & Gruer, 2011).

One of ERoY's unique assets is the built environment where the council occupy ten leisure centre facilities located in Bridlington, Withernsea, Driffield, South Holderness, Beverley, Pocklington, Goole, Haltemprice, Hornsea, and South Cave. According to the 2019 deprivation deciles, six of the ERL facilities are situated in areas of affluence (i.e., Haltemprice, Francis Scaife, South Holderness, Beverley, Driffield and South Cave) and four are located in deprived areas (i.e., Bridlington, Withernsea, Goole and Hornsea). At polar opposites, ERL South Cave is situated within the 10% least deprived neighbourhoods in the country, whereas ERL sites Bridlington, Withernsea, and Goole are all situated within the 10% most deprived neighbourhoods in the country. These leisure centres present ERoY residents across all stages of life with affordable and accessible opportunities to preserve and improve their health through the pursuit of PA and lifestyle behaviour change.

4.4.1 East Riding of Yorkshire Council Leisure Provision

The variety and depth of provision to support individuals across all life stages is what makes ERL unique. ERL members have access to the pool facilities, tone zone gyms, sports halls, and fitness and well-being classes in all ten leisure centre facilities. ERL centres are also equipped with Boditrax, advanced body composition and cellular monitoring technology. Leisure members are permitted exclusive access to Boditrax and can obtain personal data on a range of sophisticated Boditrax outcomes including, but not limited to, BMI, basal metabolic rate, metabolic age, mass of intercellular and visceral fat, mass of skeletal and smooth muscles, bone mass, and total body water, in around 30 seconds. In addition to the exercise classes, pools, sports halls, and gym facilities, ERoYC run a unique lifestyle promotion structure within the leisure centres, offering a variety of bespoke HLPs. The HLPs are an umbrella term used

to describe a range of local authority Public Health and CCG commissioned programmes and initiatives aimed towards changing lifestyle behaviours to improve health and reduce chronic disease risk. They operate through a partnership approach between the leisure centres and Health Service Trusts (e.g., PCS) within the region. In 2011, a collaboration was established between ERoY council, ERoY Public Health and the University of Hull to support the development and enhancement of these lifestyle programmes.

The ERS, LiveWell programme, Young LiveWell programme, Health Optimisation Scheme, Heart Education and Active Rehabilitation Therapy (HEART), Walking for Health, Swim for Health, and Health Plus collectively form the HLPs (see Table 4.2 for an overview of each programme). Some of these programmes target population groups with specific health conditions such as HEART, a cardiac rehabilitation programme, whereas others target wider population groups such as the ERS, aimed towards sedentary individuals who have, or are at risk of developing long term health conditions. The LiveWell programme, Health Optimisation scheme and the ERS all adhere to the National Quality Assurance Framework for the Exercise Referral Systems (Craig et al., 2001). During the course of this PhD, these programmes were rebranded as the 'HealthiER' programmes. However, for the purpose of this thesis, the term Healthy Lifestyle Programmes (HLPs) is adopted as this term was familiar to study participants.

FPs operating within ERoY leisure facilities are responsible for the operation of the HLPs and have all procured a level 3 Exercise Referral qualification endorsed by the Register of Exercise Professionals. This is the basic requirement to practice as an exercise referral

instructor (Craig et al., 2001). Moreover, there are numerous qualifications that all FPs hold or are working towards including, 1) Nutrition Consultant Level 3 and Weight Management Level 3 (accredited by Open Study College), 2) Motivational Interviewing Level 4 (accredited by the Prevention and Lifestyle Behaviour Change Framework), 3) Mental Health First Aid (accredited by Mental Health First Aid England), and 4) Smoking Cessation training Level 1 and 2 (accredited by National Centre for Smoking Cessation and Training). FPs involved in the delivery of the HEART programme (cardiac rehabilitation) hold a British Association of Cardiovascular Prevention and Rehabilitation certificate. Additionally, many FPs also have First Aid certification (provided in-house by an approved Nuco supported instructor), although this is not a requirement of their role. Likewise, many hold a Level 3 NVQ Diploma in Personal Training and a Level 3 NVQ Certificate in Advanced Fitness Instructing, but this is not a formal role requirement.

In recognition of their distinctive efforts to improve health and well-being in the local community, ERoY council are in receipt of many prestigious national awards and commendations from the Local Government Chronicle who celebrate excellence in local authorities (winners in the 'Public Health' category [2019], highly Commended in the 'Innovation' category [2019] winners in the 'Partnership Working' category [2016], highly Commended in the 'Public Health' category [2016] & highly Commended in the 'Council of the Year' category [2015]). ERoYC has also consistently achieved multiple accolades for their leisure services from the Association of Public Service Excellence Network Performance including awards for the 'Best Service Team of the Year in Sports, Leisure, and Cultural Services' (2009, 2011, 2013, 2015, & 2017) and the 'Best Performing Leisure Centre' (East Riding Beverley in 2011, 2012, 2013, 2014, 2015, 2017, & 2018).

Moreover, the collaboration between the ERoY council and the University of Hull's research team- HealthiER, have received accolades for their developmental work on the HLPs. In 2019, the MadeAtUni campaign of Universities UK, who identify as the collective voice of universities across England, Scotland, Wales, and Northern Ireland named this collaboration as one of the "nation's lifesavers".

In 2016, in the infancy of this PhD project, outcome data for all HLPs was recorded in paper format. To comply with data protection and privacy laws, specifically General Data Protection Regulations (GDPR), there was a gradual move towards electronic data capture and recording on Pharmoutcomes- a web-based system provided by Pinnacle Health LLP and Health Information Exchange Ltd. This web-based system offers a platform for local and national level analyses of data to report the effectiveness of commissioned services. First, in October 2016, Pharmoutcomes was piloted with the most popular HLP: the ERS. By October 2017, data capture for the Health Optimisation Scheme was moved onto Pharmoutcomes and thus, paper-based recording ceased. October 2019 saw the move of the LiveWell programme onto this web-based system. In April 2020, Pharmoutcomes was implemented as the data capture tool for HEART. Data for the Young LiveWell programme and Escape Pain continues to be recorded in paper format with the intention to make the same move to electronic data capture.

4.4.2 Healthy Lifestyle Programme referral processes

Entry onto many of the HLPs (namely the LiveWell programme, the Young LiveWell programme, ERS, and Health Optimisation Scheme) requires a referral from PCP, who are responsible for identifying eligible individuals who may benefit, and providing their basic health and screening information to the leisure centres (See ***Figure 4.2***. for a Flowchart diagram depiction of the referral process). HLP referrals are made for multiple reasons including, but not limited to, respiratory problems (e.g., asthma), psychological issues (e.g., depression, anxiety, & stress), cardiovascular problems (e.g., coronary heart disease, & hypertension), musculoskeletal problems (e.g., osteoporosis), obesity, and diabetes.

There are several ways PCP can refer patients onto the HLPs (see Figure 4.2.). PCP can complete a paper-based referral form (see appendix 1), which the patient countersigns to demonstrate their willingness to change. This is either emailed, faxed, or physically handed in to the patients preferred leisure centre. Alternatively, PCP can refer patients electronically through two distinct mechanisms: 1) through an interactive PDF form housed within clinical software systems, or 2) via the East Riding's electronic referral system- Booking Events and Resource System (BEARS; see appendix 2). Electronic mechanisms of referral were developed in response to the push for the NHS to digitise and become completely paperless by 2023 (NHS England, 2019). At the time of data collection in 2017, there were 25 out of 54 surgeries set up to refer patient via BEARS. BEARS is distinct in that it features a novel booking feature, enabling referrers to book a patients first leisure appointment at the point of making a referral. This provides patients immediate choice about the time and date of their first appointment at the leisure centre. The BEARS system does not however, interface with clinical software

systems across the region (i.e., SystmOne and EMIS) and instead, is accessed via the web. At the time of data collection, it was unclear how many individual surgeries were set up to use an interactive PDF form as this required the '*know how'* of someone in general practice to integrate it into their existing clinical software (i.e., SystmOne or EMIS) and set up the parameters of data extraction from patient records onto the PDF referral form.

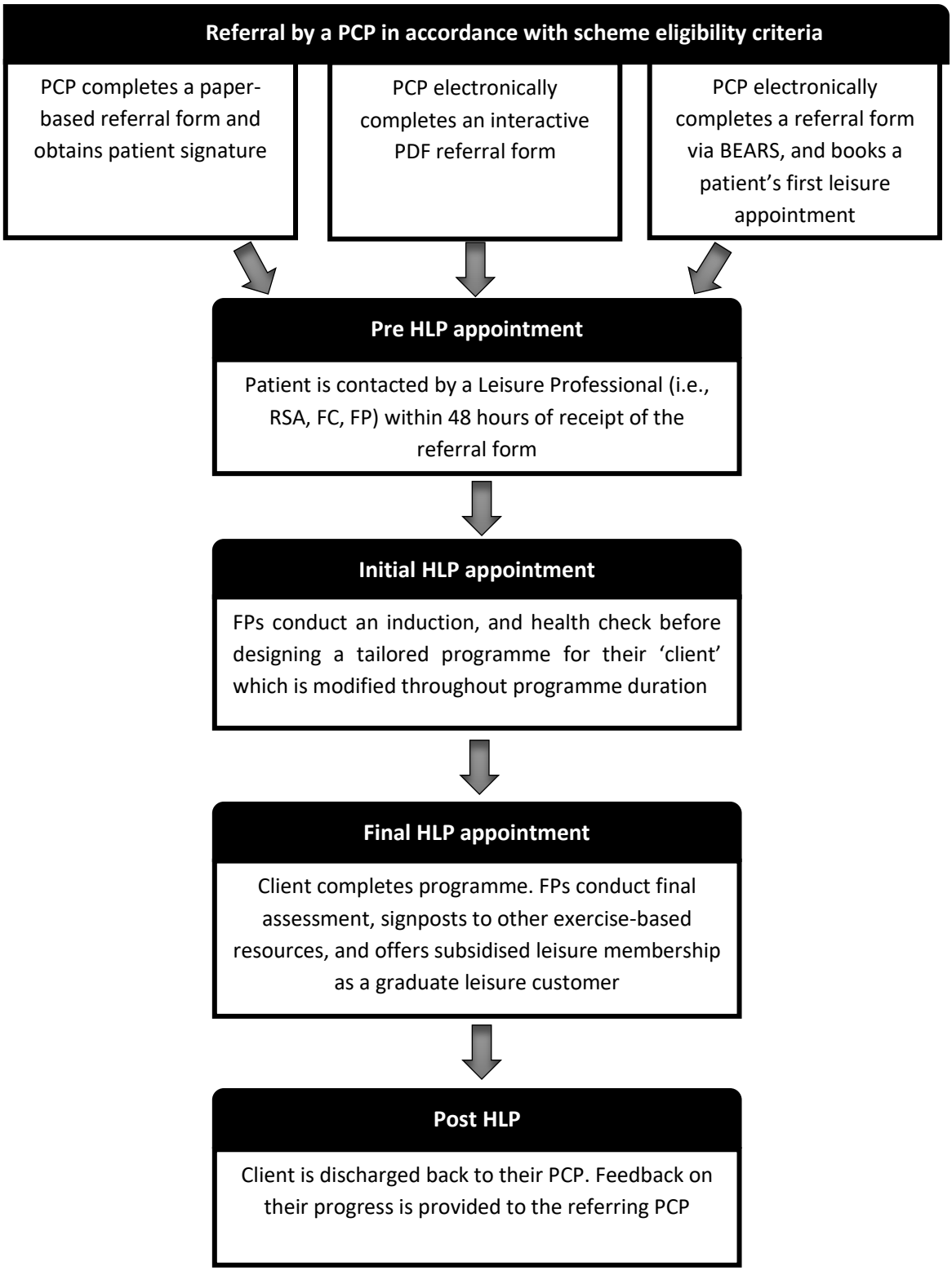

Figure 4.2. Flowchart diagram depiction of the referral process onto the East Riding of Yorkshire Council Healthy Lifestyle Programmes

Upon receipt of a HLP referral, RSAs at ERL centres (i.e., Business Technicians; BTs & FCs) are responsible for processing referral forms and making an initial contact with referred patients via telephone within a 48-hour timeframe. The purpose of the initial contact with a referred patient is to explain the scheme in greater depth, provide reassurance, and confirm or book their leisure appointment at their preferred leisure centre. Specifically, BTs (also known as the central team) are responsible for the processing of LiveWell, Young LiveWell, and Health Optimisation Programme referrals, whereas FCs are responsible for processing referrals for the ERS. Referrals are split this way due to capacity issues (i.e., there is not enough support for the BTs to deal with the quantity of ERS referrals). If, however, RSAs are unsuccessful in contacting a referred patient on three individual occasions over a three-week period, the referred patient is deemed as uncontactable, and the referring PCP is notified accordingly.

Assuming a RSA has successfully made contact with a referred patient and booked or confirmed their initial leisure appointment, the next patient contact is face-to-face with their assigned FP at the start of their HLP. At this point, the referred patient is now considered and referred to as a 'client'. During this first session, a FP will complete a pre-programme questionnaire which collates a variety of baseline anthropometric measures (e.g., height, weight, and waist circumference), physiological measures (e.g., resting heart rate and blood pressure) and psychographic measures (e.g., dietary behaviours and exercise frequency to assess current lifestyle behaviours). Next, FPs devise a safe and effective individualised programme of exercise in accordance with their client's health status, medical conditions, preferences, goals, and ability.

Upon completion of any of the HLPs, a post-programme questionnaire is completed which records final results of anthropometric measures, physiological measures, and psychographic measures. These final results are shown alongside baseline measures and fed back to the GP surgeries either electronically via mailbox or via letter, and the patient is discharged back to their GP. All HLP clients are offered a subsidised ERL membership (monthly cost £22.50 instead of £33) to encourage sustained behaviour change post programme as autonomous 'Leisure Customers'. This membership enables access to the pool facilities, tone zone gyms, sports halls, and exercise classes across all ten leisure centre facilities in ERoY. Clients are also signposted to other resources and community programmes following HLP completion to encourage them to continue with their lifestyle behaviour changes beyond the leisure centre.

4.4.3 Healthy Lifestyle Programmes

What will follow is a detailed explanation of each programme accessed through a referral from a PCP, presented in order of popularity based on latest referral figures. Four of the six HLPs are bespoke to the ERoY: ERS, LiveWell, Young LiveWell, and Health Optimisation Scheme, whereas the remaining two HLPs, Escape Pain and Heart Education and Active Rehabilitation Therapy (HEART), are programmes which are rolled out nationally.

4.4.3.1 Exercise Referral Scheme

The most popular HLP is the ERS. This 10-week scheme offers an introduction to PA in a supervised environment for those who have specific medical conditions and would benefit

from leading a more physically active lifestyle. For an exhaustive list of conditions specified in the eligibility criteria, and absolute contra-indications, refer to Table 4.2. Individuals on the ERS are provided with an individualised programme of exercise tailored to their specific needs and abilities, as well as nutritional and healthy eating guidance. Exercise programmes may include gym-based activities, pool-based activities, chair-based activities, and fitness classes. ERS participants are expected to commit to two weekly sessions for the ten-week period where they are provided with regular progress monitoring according to their tailored needs and goals. The cost of this programme is £33, however, there are one hundred free places each year funded by Public Health to support eligible candidates for whom this charge would be prohibitive. To enrol on the ERS, PCP must complete a referral form for a patient. Most recent data shows that 927 ERoY patients were referred to the ERS between October 2019 and March 2020. This represents 55.18% of the total HLP referrals for this time period, making it the most commonly accessed programme at the ERL centres.

4.4.3.2 The Health Optimisation Scheme

The Health Optimisation Scheme commenced in October 2017 and is aimed towards adults requiring a referral to non-urgent surgical specialties who exhibit unhealthy lifestyle behaviours (i.e., those who smoke and/or have a BMI of ≥ 30). It has since been rebranded as the "Get Fit for Your Operation" scheme, however for the purpose of this thesis, it is referred to as the Health Optimisation Scheme as this was its title at the time of data collection. This programme is free of cost and encourages individuals to commit to a 4-week, 10-week or 28-week programme of tailored support and tuition around encouraging a healthy lifestyle, increasing PA, healthy eating, and reducing sedentary behaviour. The intention of the Health

Optimisation Scheme is to assist in the optimisation of health before a surgical procedure takes place, thereby reducing the risk of complications both before and after surgery. Upon completion of the Health Optimisation Scheme, those who smoke are expected to successfully quit smoking, and those who are classified as obese (determined by a BMI of 30 or over) are expected to reduce their BMI to under 30 and maintain a healthy weight to assist in their recovery following surgical intervention. Obese NHS patients or those who smoke requiring a non-urgent referral to specific surgical specialties are identified by PCP and referred to the Health Optimisation Scheme if they meet eligibility criteria and do not have any contraindications to exercise (see Table 4.2). Most recent data shows that 321 ERoY patients were referred to the Health Optimisation Scheme between October 2019 and March 2020. This represents 19.11% of the total HLP referrals for this time period and the second most popular referral programme at the leisure centre.

4.4.3.3 ESCAPE Pain

First established in 2014, ESCAPE pain was launched in ERL centres in April 2019 as a pilot scheme intended for individuals suffering with chronic joint pain, specifically osteoarthritis of the hip or knee. ESCAPE is an acronym for 'enabling self-management and coping with arthritic pain through exercise'. It is a national exercise-based rehabilitation programme, supported by NHS England, Versus Arthritis and Academic Health Science Network, which combines a progressive circuit-type exercise programme with education, advice, and information around how to manage chronic joint pain. Sessions are group-based, and run over a six-week period, with twice weekly sessions lasting 1.5 hours at a cost of £19.80. The Escape Pain programme is in receipt of many prestigious national awards and

commendations, the most recent being HSJ Value Award for ‘MSK Care Initiative of the Year' (2020). First contact practitioners operating in many ERoY GP surgeries who have expertise in the clinical assessment, diagnosis and management of musculoskeletal conditions are most common referrers to Escape Pain. There were 206 individuals referred to ESCAPE pain between October 2019 and March 2020. This represents 12.26% of the total HLP referrals for this time period.

4.4.3.4 LiveWell

Commissioned in 2010 as part of the bariatric care pathway, the LiveWell programme is a free 26-week Healthy Lifestyle Programme, which fundamentally aims to address weight management in obese adults with a BMI of ≥ 45 to relieve the pressure of bariatric patients on the NHS. This is achieved through individualised support and guidance around increasing PA, reducing sedentary behaviour, alongside psychological support (e.g., addressing an individual’s relationship with food) provided during one-to-one hourly sessions by appropriately qualified FPs. Whilst enrolled on the LiveWell programme, individuals are provided with a free membership that permits access to the gym, swimming facilities, and all classes and activities run at ERL facilities. This maximises opportunity for PA beyond the supervision of FPs. Furthermore, individuals on the LiveWell programme have the option of bringing a friend or family member (often referred to as a ‘buddy’) to support them during their sessions. These individuals are entitled to the same privileges of LiveWell participants, meaning they are granted a funded ERL membership throughout the duration of the programme. PCP operating within ERoY regulate access to the LiveWell programme. Referral onto the LiveWell programme is dependent on a PCP initiating a referral discussion with a

patient and completing a LiveWell referral form, providing the individual meets eligibility criteria and does not have any contraindications to exercise (see Table 4.2 for a comprehensive list of inclusion and exclusion criteria). Most recent data shows that 136 ERoY patients were referred to the LiveWell programme between October 2019 and March 2020. This represents 8.09% of total HLP referrals for this time period.

4.4.3.5 Heart Education and Active Rehabilitation Therapy

HEART is an acronym which stands for Heart Education and Active Rehabilitation Therapy. It has since been rebranded as the "Cardiac Rehabilitation" scheme, however for the purpose of this thesis, it is referred to as Heart Education and Active Rehabilitation Therapy (HEART) as this was familiar to study participants. HEART is an eight-week exercise, advice and support programme specifically aimed towards individuals who have suffered a cardiac event (e.g., myocardial infarction) in the last six months. This programme endeavours to aid recovery after a cardiac event and promote health, well-being, and quality of life amongst these individuals to minimise the risk of recurrence. Qualified FPs work in collaboration with Hull Cardiac Rehabilitation Service and the British Heart Foundation to devise and deliver a progressive exercise programme tailored for each client and their heart condition. Cardiac patients also receive healthy lifestyle advice to encourage sustained positive lifestyle behaviour change. Each session of the HEART programme incurs a cost of £3.80, which is chargeable to the participant. Generally, HEART referrals are sent from cardiac rehabilitation Health Professionals working in hospital settings who are in direct contact with those who have suffered a cardiac event. There were 66 individuals referred to HEART between October 2019 and March 2020. This represents 3.93% of the total HLP referrals for this time period.

4.4.3.6 Young LiveWell

Launched in 2011, the Young LiveWell programme is a 16-week free HLP aimed at overweight adolescents between the age of 11 and 18 (according to the NHS children's centile scale). Young LiveWell intends to address weight management by developing sustained healthier PA and eating behaviours. Qualified FPs work with each Young LiveWell client on a one-to-one basis by devising and delivering a tailored exercise and healthy eating programme. Throughout the course of the Young LiveWell programme, individuals are granted access to the gym, pool facilities, and all activities run within ERL facilities. Identical to the LiveWell programme, Young LiveWell participants can choose to bring a 'buddy' to their sessions for support, who are also permitted to utilise ERL facilities throughout the programme duration free of charge. In addition to PCP, school Nurses, school dieticians and parents are permitted to refer an adolescent to the Young LiveWell programme, providing they meet the eligibility criteria and they do not have any contraindications to exercise (see Table 4.2). Upon completion of the Young LiveWell programme, participants receive a free 8 month 'crew card' membership which permits access to ERL facilities. There were 24 adolescents referred to the Young LiveWell programme between October 2019 and March 2020. This represents 1.43% of the total HLP referrals for this time period.

Table 4.2. *An overview of the referral requirements for each East Riding of Yorkshire Council Healthy Lifestyle Programme*

Healthy Lifestyle Programme	Referral criteria	Referral contra-indications or exemptions
Exercise Referral Scheme Duration: 10 weeks Cost: £33.00	Individuals must be inactive and have one of the following conditions: • Diabetes • Hypertension • Depression • Asthma • Anxiety/stress • Other CHD risk • Osteoporosis/ joint problems • Weight loss Individuals must be willing to change their lifestyle behaviours	Individuals with: • Ventricular or aortic aneurysm • Unstable angina • Resting systolic blood pressure > 180mmHg or resting diastolic blood pressure >100mmHg • Uncontrolled tachycardia • Unstable or acute heart failure. • Uncontrolled arrhythmia • Recent Embolism (in the last six months) • Awaiting investigation for any cardiac complaints • Uncontrolled Asthma • Unstable/severe mental health issues • Unstable valvular heart disease • Recent cardiac event (in the last six months) • A lack of motivation to change their lifestyle behaviours
Health Optimisation Scheme Duration: 3 weeks, 10 weeks, or 26 weeks Cost: Free	Individuals must identify as a smoker and/or have a BMI of ≥30, and have a non-urgent referral to the following surgical specialties: • Cardiothoracic • General Surgery • Neurosurgery • Trauma & Orthopaedics (including MSK*) • Vascular Surgery • ENT • Gynaecology • Plastic Surgery • Urology	Individuals: • Requiring urgent, emergency surgery or require cancer, eye, dentistry, paediatric, oral, maxillofacial, or diagnostic dermatology, or a vasectomy • With a BMI ≥35, but have a waist measurement less then 94cm/37 inches (males) 80cm/31 inches (females) • With a severe mental health illness, learning disability or significant cognitive impairment • Referred for a diagnostic intervention • Under the age of 18 • Who are frail or elderly • With a medical condition where BMI is not a suitable measure • Who only use electronic cigarettes

Healthy Lifestyle Programme	Referral criteria	Referral contra-indications or exemptions
Escape Pain Duration: 6 weeks Cost: £19.80	Individuals: • Over 45 years of age with chronic joint pain of the hip or knee (at least 3 months' duration) • Diagnosis of osteoarthritis • Independently mobile • Willing to change their lifestyle behaviours	Individuals: • Ventricular or aortic aneurysm • Unstable angina • Resting systolic blood pressure > 180mmHg or resting diastolic blood pressure >100mmHg • Uncontrolled tachycardia • Unstable or acute heart failure • Uncontrolled arrhythmia • Unstable diabetes • Febrile illness
LiveWell Duration: 26 weeks Cost: Free	Individuals: • Over the age of 18 • With a BMI of 45 or over • Willing to change their lifestyle behaviours	Individuals: • Under the age of 18 • With a BMI below 45 • Not willing to change their lifestyle behaviours
Young LiveWell Duration: 16 weeks Cost: Free	Individuals: • Aged between 11-18 • Who are overweight (according to the NHS -children's centile scale) • Willing to change their lifestyle behaviours	Individuals: • Under the age of 11 • Over the age of 18 • Who are not overweight (according to the NHS children's centile scale)

4.4.4 Healthy Lifestyle Programme Referral Variance

HLP referrals vary across the local authorities' Primary Care Networks (PCN) and leisure centres. Latest figures collected over a six-month period (October 2019- March 2020) suggest that 22% of total HLP referrals (N = 1680) originated from Bridlington PCN. Yorkshire Coast and Wolds PCN were the next largest contributors to total HLP referrals, sitting at 17%. This was closely followed by Cygnet PCN and Beverley PCN whom each contributed around 15% of all HLP referrals. Holderness PCN represented 11% of HLP referrals, while Harthill PCN represented 9%. The remaining 4% of total referrals were from surgeries who were not part of a PCN group. Referral numbers for the HLPs also vary across leisure facilities. For example, latest figures for the Health Optimisation Programme based on October 2019- March 2020 show that almost 21% of total Health Optimisation clients (n = 1182) were seen at ERL Goole compared to approximately 10% who were seen at ERL Haltemprice (n = 596).

4.5 Summary

This chapter has demonstrated how ERoY is a largely rural area, which on the whole, is home to an older population. Despite the overall affluence, this region has multiple areas falling into the 10% most deprived vicinities in England. This has major repercussions on health and well-being, and lifestyle behaviours. The local authorities' award-winning leisure provision present opportunities to preserve and improve health through the pursuit of PA and lifestyle behaviour change. These Public Health and CCG commissioned programmes known as the HLPs run at the leisure centres and operate through a partnership approach between the leisure centres and Health Service Trusts.

Public Health and the local authorities CCG commissioned this project in an endeavour to streamline referral processes on these HLPs.

5 METHODS: PHASE I

5.1 Introduction

This chapter intends to explicitly detail the methods adopted in the first phase of this research project which intended to explore HLP referral processes from the perspectives of PCP. It precedes by reiterating the research aims before detailing the nuances of participant eligibility and recruitment. Next, the chapter explains the philosophical assumptions underpinning this research phase, and the chosen methods. This is followed by a description of how data was collected and analysed. Subsequently, attention is turned towards the measures employed to facilitate trustworthiness of findings. Finally, this chapter concludes by presenting ethical considerations relevant to the first phase of this study.

5.2 Study Aims

The purpose of phase I was to gain a rich, in-depth understanding into the perceptions and lived experiences of PCP involved in referral to the HLPs. Specifically, the study sought to uncover the nuances of referring patients onto these programmes, with a particular focus on PCP perceived barriers and facilitators to referral to meet the first primary objective (see section 1.6). This insight was anticipated to highlight areas of improvement and inform the development of a more streamline referral process.

5.3 Ethical Approval and Access Permissions

The Department of Sport, Health and Exercise Science Ethics Committee at the University of Hull undertook full ethical scrutiny of the research project. Ethics refers to rules of conduct and principles regarding a researcher's moral behaviour (Illing, 2014). Ethical approval was obtained on December 7th, 2016 (Reference No: 1617093; see appendix 3.6.). Following ethical approval, two separate amendments to ethics documentation were submitted. First, to extend the sample from GPs to any individual involved in the referral of patients to the HLP upon discovery that GPs were not sole referrers across the ERoY (granted January 6th, 2017; see appendix 3.7.). A second amendment was submitted to collect a range of socio-demographics from each participant such as gender, age, and role experience (granted February 10th, 2017; see appendix 3.8.). The NHS ERoY CCG North Yorkshire and Humber Research and Development Service issued a research passport on May 3rd, 2017, for the research project (see appendix 3.9.), which granted rights of access to contact surgeries within the ERoYC CCG from April 3rd, 2017 until 31st March 2020.

5.4 Participants

Twenty-eight PCP volunteered to participate in individual semi-structured interviews. These PCP represented sixteen ERoY PCS across the ERoY (See Table 6.1 for a detailed overview of participant characteristics).

5.4.1 Eligibility Criteria

Prospective participants were required to meet pre-requisites for study inclusion. Eligibility criteria consisted of PCP who were: (a) practicing within ERoY and had done so for a minimum of six months, (b) actively involved in patient referral onto HLPs (c), English-speaking, and (d) able to provide informed consent. Exclusion criteria specified PCP who were (a) practicing outside of the ERoY, (b) practicing in the ERoY for less than six months, (c) not actively involved in patient referral onto HLPs (d), not English-speaking, and (e) unable to provide informed consent, were not permissible as study participants.

5.4.2 Sampling Strategy

Sampling is concerned with how participants from the population under study are selected. Non-probability sampling techniques are typical of qualitative studies, whereas probability sampling techniques are commonly associated with quantitative studies (Ritchie et al., 2013). Justification is provided below for the selection of two non-probability sampling techniques adopted for the first phase of this research project: purposive sampling and snowball sampling.

5.4.2.1 Purposive Sampling

Owing to the precise eligibility criteria as outlined in 5.4.1, purposive sampling was utilised to recruit PCP from each ERoY locality (see section 5.5 for details of recruitment). Purposive sampling, also referred to as criterion-based sampling permits the

deliberate targeting of the most appropriate and informative personnel to meet the research aims based on particular criteria (Anderson, 2010; Ritchie, Lewis, Nicholls, & Ormston, 2013; Stringer, 2013). In the case of this research, purposive sampling ensured that all PCP involved in referral operations across the region were targeted for study inclusion to gain a holistic understanding of the phenomena where nuances across different PCP groups could be teased out. These efforts towards recruiting a diversity of informants from a range of PCS across the ERoY are forms of triangulation (i.e., person and site triangulation) that help to facilitate credibility of qualitative research (Shenton, 2004).

5.4.2.2 Snowball Sampling

Snowball sampling was implemented as a secondary recruitment strategy due to the typical hard-to-reach nature of the target audience. Snowball sampling materialises a sample through a system of recommendations from existing participants to prospective participants (Magnusson & Marecek, 2015). This can be particularly useful when a lack of framework exists (Denscombe, 2014). Given that GP surgeries in the ERoY operated differently in terms of who engaged with HLP referral processes, snowball sampling permitted the accumulation of the most relevant PCP. Thus, upon completion of each interview and during subsequent email chains, participants were asked if they could identify anyone else who may be interested in sharing their perspective. These individuals were subsequently invited to participate in the research.

5.5 Recruitment Method

A key preliminary task was to liaise with individuals in position of authority and influence in endeavour to obtain their consent to conduct research at a time considered organisationally appropriate (Stringer, 2013). At the time of recruitment, fifty-four practices existed within the ERoY, divided amongst four localities: 1) Bridlington, 2) Beverley, Driffield, East Haltemprice and Cottingham, 3) Holderness, and 4) Southwest Area Network. In ERoY surgeries, gatekeepers (i.e., Practice Managers and/or Business Managers) controlled access to the target audience. It was imperative that trusting relationships with these individuals were established as the success of a study is often hinged on negotiations of access to the target audience (DeJonckheere & Vaughn, 2019; Ritchie et al., 2013).

In the first instance, contact information for each surgery was obtained from the ERoY CCG (i.e., address and telephone number, name of surgery gatekeeper[s], and name of GP[s]). Following this exchange of information, recruitment material (i.e., letters of invitations and poster advertisements; see appendix 4) were posted by mail to gatekeepers of each surgery. Recipients were asked to circulate the recruitment material in their surgeries. One week later, the primary researcher (AW) telephoned gatekeepers of each surgery to confirm if recruitment materials had been received, understood, and disseminated accordingly. Further information was supplied upon request, and direct emails of gatekeepers were obtained where possible. AW made contact with gatekeepers again two weeks later to prompt circulation of recruitment material if they had not already done so. Anecdotal evidence from gatekeepers highlighted that lack of time was the most common reason for surgeries choosing not to participate, second to a lack of

reimbursement for participants. Recruitment was further compounded by the fact that many individual surgeries were in the process of merging to form Primary Care Networks, and thus felt that partaking in research would be too onerous. Following futile attempts to recruit PCP, contact details of referring PCP were retrieved from the ERoY healthy lifestyle officer (HLO). These individuals were invited for participation via telephone or email. By January 2018, recruitment had slowly come to a standstill. In attempt to further the sample, the research directors requested an invitation to the Bridlington Partnership board meeting in February 2018, and pitched the research to key organisations including several GPs and Practice Managers. This facilitated access to two Bridlington surgeries. Furthermore, ERoY CCG agreed to distribute recruitment material (i.e., letters of invitations and poster advertisements; see appendix 4) directly to GPs via the CCG internal mailing system, and feature a recruitment bulletin on the NHS East Riding Hot Topics platform. Given the complexity of recruitment and the heavy reliance on gatekeepers to facilitate access to the target audience, it is not possible to calculate an accurate response rate for this cohort.

5.5.1 Pre-requisites of Recruitment

Telephone conversations were arranged with all PCP who expressed an interest in the study to discuss the nuances of the research, answer any questions, and to build initial rapport. PCP who were happy to proceed following these preliminary telephone calls were emailed a participant information sheet to ensure they were fully informed about the project, and an informed consent declaration form (see appendix 3.3.). Completion of the informed consent declaration form confirmed that PCP understood the study protocol, had any questions answered satisfactorily, and recognised their participation was

voluntary. Subsequently, a mutually convenient date and time for a face-to-face meeting was arranged.

5.6 Research Methodology

Ritchie et al. (2013) argue that high-quality research starts with an explicit understanding of a researcher's philosophical foundations, which subsequently determines the most appropriate data collection methods to fulfil the research aims. Hence, the following section intends to provide a clear and transparent understanding of the philosophical assumptions underpinning Phase I of this mixed methods thesis, and the methods from which the first phase was based upon.

According to Chalmers, a paradigm is "made up of the general theoretical assumptions and laws, and techniques for their application that the members of a particular scientific community adopt" (1982, p. 90). In other words, paradigms are overarching philosophical belief systems or frameworks that influence ones approach to formulating and conducting research in a given field (Willis, 2007). There are four key characteristics of a research paradigm, they are: 1) explicit fundamental laws and theoretical assumptions, 2) standardised principles employed to exercise these laws and theoretical assumptions to any given situation, 3) instrumental methods that apply the laws of the paradigm to bear on real life, and 4) broad metaphysical principles that guide and inform research within a paradigm (Chalmers, 1982; Willis, 2007).

Research paradigms have differing philosophical underpinnings in terms of their ontological and epistemological assumptions (also known as metaphysics), which help to inform the resulting research methodologies (i.e., the method/s adopted to conduct the investigation). Ontology refers to the philosophy of reality and existence, and is concerned with what constitutes reality as defined by the researcher (Illing, 2014). In other words, a researcher's ontological stance reflects their perceptions of what is real, and what exists (Willis, 2007). Epistemology, on the other hand, refers to the notion of knowledge in the social world (Ritchie et al., 2013). It is concerned with what knowledge we can acquire about truth and reality, and the processes by which we can obtain that knowledge (Ritchie et al., 2013; Willis, 2007).

5.6.1 Paradigm Wars

Historically, an academic debate has endured within the social and behaviour sciences concerning two dominant opposing paradigms underpinning qualitative and quantitative research: positivism and interpretivism.

Quantitative purists uphold a positivist paradigm. In terms of ontology, positivists believe in the existence of a single reality that is objective, predictable, and quantifiable because it is governed by law-like regularities (Ritchie et al., 2013). Reality is explored through observation and experimentation using traditional scientific approaches, which rely on control and manipulation of reality. Epistemologically speaking, positivism maintains that the observer (i.e., the researcher) is independent of the observed (i.e., the phenomena of interest) thus, knowledge about truth and reality can be acquired

irrespective of the relationship between the two (Johnson & Onwuegbuzie, 2004). This commitment to detach the researcher's personal beliefs and insights from the phenomena of interest endeavours to eliminate bias by denying his or her identity. Fundamentally, researchers claiming a positivistic affiliation adopt hypothesis testing, causal explanations, and modelling methodological procedures (Ritchie et al., 2013) that aim to discover and report a single reality or truth through the production of hard, generalisable data (Johnson & Onwuegbuzie, 2004). This observable and quantifiable data allows for integration of rigorous statistical testing, yet is unable to capture the complexity and richness of human experience and context (Israel et al., 1995).

In contrast, qualitative purists sometimes referred to as constructivists or interpretivists, reject positivist assumptions, and instead favour the interpretivist paradigm. Interpretivism is constructed upon a relativist ontological stance, which assumes that the nature of reality is subjective, individually and socially constructed, has multiple interpretations (Guba & Lincoln, 1994; Riyami, 2015), and is not governed by law-like regularities (Ritchie et al., 2013). Ontologically speaking, an interpretivist position seeks to gain a deeper understanding of a phenomenon, appreciating its uniqueness and complexity (Creswell & Creswell, 2017). Interpretivists adopt a subjective epistemology, which postulates that knowledge can be acquired through an intricate interaction between consciousness and real-world phenomenon, Thus, the researcher is an integral part of the research process, and "unavoidably serves as a research instrument*"* (Yin, 2015, p. 40). Researchers claiming an interpretative affiliation adopt naturalistic methodological procedures that are receptive to appreciating phenomenon from the subjective experiences of those studied and their social context

(Creswell & Creswell, 2017). Such researchers refrain from abiding to a theory, and instead "generate or inductively develop a theory or pattern of meanings" during the course of research, also known as a bottoms-up approach (Creswell & Creswell, 2017, p. 9). Thus, interpretivism is an exploratory approach that strives to comprehend the social world by uncovering the perspectives, experiences, and histories of those studied by appreciating their own personal perspectives (Ritchie et al., 2013; Riyami, 2015). The strengths of qualitative approaches lie in the richness of data, which results in a multi-layered understanding of the nuances of social reality (Hesse-Biber, 2010). However, qualitative research is criticised by positivist researchers who argue it is incapable of providing generalisable findings as a result of small scale and idiosyncratic studies (Anderson, 2010; Atieno, 2009; Creswell & Clark, 2017).

Due to the contrasting philosophical underpinnings of positivism and interpretivism, many researchers are sceptical about combining qualitative and quantitative research methods. However, there is an increasing recognition that "antagonism between paradigms is unproductive" (Johnson, Onwuegbuzie, & Turner, 2007, p. 117). Instead, researchers are encouraged to reject allegiances to a philosophy, and adopt a more pluralistic and pragmatic position, whereby methodological approaches are selected on the basis that they can best address research questions (Chilisa & Kawulich, 2012; Creswell & Clark, 2017; Johnson & Onwuegbuzie, 2004; Ritchie et al., 2013). This mixing of methods has been termed as a "toolkit approach" to research (Ritchie et al., 2013). Mixed methods are celebrated as an inclusive, pluralistic, and complementary philosophy that provides a bridge between philosophical dichotomies (Johnson & Onwuegbuzie, 2004). Underpinned by a pragmatic paradigm or worldview,

this hybrid approach is presented philosophically in the literature as the "third wave", sitting centrally on the qualitative-quantitative continuum. By definition, mixed methods research is:

> "research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (Johnson & Onwuegbuzie, 2004, p. 17).

5.6.2 Philosophical Assumptions Underpinning Phase I

For Phase I of this research project, two key philosophical standpoints embedded within a qualitative research paradigm served as underpinning research methodologies: phenomenology and action research.

5.6.2.1 Rationale for Phenomenological Underpinnings

Phenomenology, a major branch of interpretivism, strives to comprehend phenomenon through the lived experiences of individuals and their social reality (Creswell & Creswell, 2017). Its intention is to capture the meaning or essence of a phenomenon, which is encapsulated within embodied perception (Starks & Trinidad, 2007), and can be uncovered through delicate interactions between the researcher and participant (Guba & Lincoln, 1994). Phenomenological researchers dismiss prevailing understandings, pre-assumptions, or beliefs concerning the phenomenon of interest (also known as creating a state of epoché), and embark on a journey of exploration to allow the participant's reality to unfold truly (Christensen & Brumfield, 2010; Gray, 2013). The embracement of phenomenology is reflected in this studies heavy qualitative research

focus, which sought to comprehend the referral process by generating thick descriptions of PCP subjective thoughts, feelings, perspectives, and individual lived experiences.

5.6.2.2 Rationale for Action Research Underpinnings

The second underpinning approach to inquiry was action research, which is:

> "a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes" which "seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people" (Reason & Bradbury, 2001, p. 1).

Action research contributes to the prosperity of individuals, their communities, and their ecosystems (Reason, 2006). The pinnacle of action research is change, which is informed through a cyclical feedback loop where findings yield prospects for change (Denscombe, 2014). These changes are reviewed further as a preamble to additional enquiry (Denscombe, 2014; Stringer, 2013). Fundamentally, participatory action research seeks to overcome a particular problem through the development of guidelines for more effective practice, inclusive of all involved (Cordeiro, Rittenmeyer, & Soares, 2015; Denscombe, 2014). It is a movement from the 'them' and 'us' mentality, that actively seeks to involve all stakeholders relevant to the phenomena of interest. Ontologically speaking, participatory action research is constructed upon a subjective-objective stance, which maintains that reality is continuously altered and moulded through the participation of the knower in what is known (Heron & Reason, 1997). Action research shares many similarities with a subjective epistemology in that the knower and the known are not regarded as separate entities, and both tend to adopt qualitative methodologies (Chen,

Huang, & Zeng, 2018; Cordeiro et al., 2015; MacDonald, 2012). However, many scholars argue that participatory action research embraces a more inclusive way of knowing that stretches beyond a subjective epistemology. They refer to an *extended epistemology* (Heron & Reason, 1997), which fosters a holistic collaborative inquiry through four interwoven ways of knowing (i.e., experimental, presentational, propositional, and practical; Seeley, 2014).

Action research is most successful when it is both phenomenological and interpretive (Stringer, 2013). It encourages a collaboration between researchers and practitioners, providing the grounding to explore experiences, events, attitudes, and perspectives in great depth and detail (Gray, 2013; Stringer, 2013). This comprehensive understanding facilitates the construction of effective solutions (Stringer, 2013). The embracement of action research is reflected in the intention to streamline HLP referral processes based on the uncovering of difficulties in current referral processes from PCP perspectives.

5.7 Research Method

Typically, action research commences with a qualitative exploration of individual experiences and perspectives, and an examination of the underlying issue (Stringer, 2013).

> "Qualitative research is a naturalistic, interpretative approach concerned with understanding the meanings which people attach to phenomena within their social worlds" (Ritchie et al., 2013, p. 17).

Qualitative research is also primarily linked with interpretivism (Ritchie et al., 2013). This type of research method can provide profound and nuanced insights into the intricacy of individual lives (Creswell & Poth, 2017), and is undervalued for its role to highlight process issues and uncover how the pathway and delivery of PA based pathways can be improved (Gidlow et al., 2008). Thus, qualitative research methods were considered well suited to comprehending PCP individual experiences, practices, barriers, and facilitators of referral in relation to the ERoY HLPs.

Mulhall (2007) argued from a philosophical outlook that human research is conversational given that humans are dialectal beings, and the best way to comprehend language is in the form of conversation. An interview testifies to the linguistic and interactional character of human existence (Brinkmann, 2013), and focuses on profoundness, nuance, and the respondent's dialect as a means of understanding meaning (Ritchie et al., 2013). Interviews exploit knowledge through dialogue and help shed light upon people's subjective emotions, opinions, values, experiences, motivations, perceptions, and behaviours by generating thick descriptions (Hennink, Hutter, & Bailey, 2011; Wellington & Szczerbinski, 2007). Hence, interviews were adopted to encourage participant's subjective realities to unfold truly in their own spoken words.

Interviews were conducted on an individual face-to-face basis as opposed to in a focus group format due to the sample diversity and geographical coverage of GP surgeries. To elaborate, PCP involved in HLP referral operations ranged from non-clinical CLWs operating primarily under the instruction of clinical PCP, to GPs sitting on the CCG board

in position of high authority and influence. It has been suggested that focus groups should be avoided in the presence of power or status issues because they may cause individuals of a lower authority to withhold their feelings and opinions (Morgan, 1997; Ritchie et al., 2013). Moreover, GP surgeries within the ERoY are geographically dispersed, and it was not realistic to expect participants to travel to attend face-to-face focus groups. It was also beyond the scope of this project to provide reimbursement for time and travel expenses. For these reasons, it was deemed appropriate to conduct individual interviews with this cohort.

5.7.1 Semi-structured Interviews

A semi-structured interview format was selected as it allows a researcher the freedom to loosely follow a predetermined list of questions, and pursue emerging topics or responses in greater depth (Brinkmann, 2013; Ritchie et al., 2013). These interviews followed an iterative approach, meaning that emerging topics could be incorporated and explored further through questioning in future interviews (DeJonckheere & Vaughn, 2019; Gratton & Jones, 2010). This enabled further exploration of interesting avenues that were not anticipated or considered pertinent by the research team (Brinkmann, 2013), and facilitated high-quality data by avoiding a transactional question-answer approach (DeJonckheere & Vaughn, 2019). Moreover, semi-structured interviews permit the alteration of the order and style of interview questions as appropriate to foster conversational two-way communication (Harding, 2013). Semi-structured interviews were favoured over structured or unstructured interviews because it enabled the coverage of specific topics, whilst permitting flexibility for participants to spontaneously shift focus and place emphasis on matters of importance to them. To value non-verbal features

of the interview such as body language and gestures, interviews were conducted face-to-face, adding depth to the source of knowledge (Brinkmann, 2013; DeJonckheere & Vaughn, 2019).

A preliminary semi-structured interview schedule was devised based on discussions between the research team, and the foundations of prior related literature such as research by Graham et al. (2005) and Bohman et al. (2015). Questions were designed to explore and elicit PCP perspectives and experiences of referring patients to the ERoYC HLPs, capturing their role and their perceived barriers and facilitators to referral. Following the advice of DeJonckheere and Vaughn (2019), all questions were open-ended, neutral, and exploratory in nature to encourage free expression of opinion. Stringer (2013) maintains that interview questions must be delicately formatted to enable respondents to "present events and phenomena in their own terms and to follow agendas of their own choosing" (p. 70). Hence, pilot interviews were conducted to highlight any potential complications, avert the collection of flawed data, and foster the credibility of findings (Harding, 2013; Van Wijk & Harrison, 2013).

5.7.1.1 Pilot

First, in December 2016, the preliminary interview schedule was piloted with a GP operating outside the ERoY locality. The purpose of this pilot was: 1) to test the appropriateness of the questions to ensure they were formulated in a familiar language (DeJonckheere & Vaughn, 2019), 2) to check that the questions prompted adequate response, 3) to establish if the questions were relevant to the research aims (Berg & Lune,

2016), 4) to determine any other flaws in the interview design (Kvale, 2007), and 5) to provide an opportunity for the primary researcher to practice their interviewing skills (Berg & Lune, 2016). Comments and suggestions elicited during this pilot interview informed the refinement of the interview schedule. For example, where responses to questions lacked depth, additional prompts were included in the second interview schedule revision. A second pilot interview was conducted with an ERoY GP, two months after the initial pilot. This served a triple purpose: 1) to verify the appropriateness and relevance of the amended interview questions, 2) to trial the time taken to conduct the interview, and 3) to ensure questions bare relevance to referral operations in the ERoY. This second pilot confirmed that the questions and interview length were appropriate. Therefore, no further amendments were made.

5.7.1.2 Interview Focus and Content

The final interview schedule focused on five key areas: the HLPs, constraints of patient referral, facilitators of patient referral, patient progress feedback, and support networks. Prior to interview commencement, participants were reminded of the study purpose, reassured of confidentiality and their participant rights, and provided with an overview of the topics that would be covered during the interview. All interviews began with a series of socio-demographic questions to allow participants to settle into the interview. Subsequently, questions were asked about the process of referral to the HLPs, before proceeding to more targeted questions around key barriers to HLP referral, key facilitators to HLP referral, the information provided back from leisure centres regarding a patient's progress, and support networks in their surgery to manage patient load (see Table 5.1 for example questions). Each topical area had a series of open-ended questions

and probes pertaining to each one. According to Ritchie et al. (2013) initial responses to interview questions are surface level, thus researchers should use probes to encourage greater depth of response to comprehend the respondents meaning. Hence, probes such as “Can you tell me more?” and “Can you provide an example” were used to facilitate clarity and increase richness of the data by encouraging participants to expand on their thoughts, feelings, and experiences. The interview schedule was not prescriptive nor were questions asked in chronological order. Instead, questions served as a checklist of discussion points and were carefully selected in an order complementary to the flow of conversation. All interviews concluded by asking participants if they could provide details of any other PCP who may be able to further illuminate understanding of the referral process. The full interview schedule can be found in appendix 5.

Table 5.1. *Example interview questions pertaining to each topical area for Primary Care Personnel*

Topic	Example questions
1. Healthy Lifestyle Programmes	Which HLPs do you find you refer patients onto most often? When are you prompted to refer patients? What is the process of referral in this surgery? How are you made aware of these programmes?
2. Constraints of patient referral	Have you or do you experience any challenges when referring patients? What is your overall opinion of the referral process?
3. Facilitators of patient referral	What eases the process of referral to ERoYC HLP? What improvements would you like to see to the referral process?
4. Patient progress feedback	What information comes back to you about your patient's progress? What information specifically would you want to hear regarding your patient's progress? What involvement do you feel you should have in terms of your patient's progress throughout a programme you have referred them to?
5. Support networks	What support network do you have in this surgery to help manage patient load so you can preserve consultation time for high-risk patients?

5.8 Data Collection

Data collection occurred over a period of thirteen months, beginning May 2017, and ceasing June 2018. Interviews were conducted in a private meeting room at the surgery of each PCP, free from interruptions and distractions. This setting was familiar for PCP and mutually accessible for the researcher and interviewee. The study purpose was reiterated prior to interview commencement. PCP were reminded that their participation was voluntary, that all data collected would be treated in accordance with the Data Protection Act (1998) and General Data Protection Regulations (GDPR, 2018; for interviews conducted after May 2018 when these regulations came into effect), and that they were free to withdraw at any given time without disclosing explanation in which case, any collected data would be destroyed promptly. It was highlighted that partaking in the study would not further their position as a PCP, nor would they receive any incentives for participating. Once more, participants were invited to ask any questions and permission to record the interview was requested. Finally, participants signed and dated an informed consent declaration form demonstrating their willingness to proceed with the interview process.

To capture data in its natural form, a recording device (Trustin professional digital audio voice recorder TR-6622) was employed, which ensured that participant accounts were recalled truthfully and accurately, thus facilitating credibility and dependability of data collected (Stringer, 2013). Interviews commenced with a series of socio-demographic questions pertaining to PCP's gender, age, role, working status, number of sessions delivered in general practice per week, number of years working in role, and number of years working within the ERoY. Following the guidance of Creswell and

Creswell (2017), each interview area was approached in a flexible manner appropriate to the flow of conversation. Comprehensive field notes to record both the mundane and interesting were captured in a reflexive journal throughout and after each interview to help aid reflection on both the process and content of interviews (DeJonckheere & Vaughn, 2019).

At the end of each interview, interviewees were encouraged to add anything extra that they felt was relevant or could further contribute to understanding. Interviews were pragmatic to fit around demanding work schedules of PCP. Upon completion, PCP were asked to identify anyone who may be interested in sharing their perspective as part of the snowball sampling strategy (Guest, Bunce, & Johnson, 2006). All participants were provided with a copy of their transcript via email or post within a 4-6-week timeframe following their interview as part of the member checking process. This served to ensure that their transcripts were a true and authentic representation of what was conveyed during the interview. Member checking is considered one of the most important provisions to enhance credibility (Denscombe, 2014; Lincoln & Guba, 1985; Ritchie et al., 2013). Thirteen participants authenticated their transcripts (46.43%), and the remaining did not respond, therefore satisfaction with interview transcripts was assumed.

Interviews continued until data saturation had been attained, that is, once the information was sufficient for study replication (O'Reilly & Parker, 2013), and when no new thematic information were elicited from participants (DeJonckheere & Vaughn, 2019; Denscombe, 2014; Guest et al., 2006). Thus, it was the researcher's responsibility to

determine when there was no new data generated that would further inform understanding of PCP perspectives and experiences of referring patient to the HLPs, or further inform the development of a more streamline referral process. Data saturation occurred after twenty-four interviews, however before recruitment ceased, a further four interviews were conducted to achieve regional balance, and to further substantiate identified themes (Guest et al., 2006).

5.9 Data Analysis

Data analysis is the process of reducing large chunks of raw data into smaller fragments to unveil a story and interpret it to derive meaningful insights.

5.9.1 Analysis of Socio-Demographical Data

Socio-demographical data was analysed using IBM SPSS Statistics (Version 25) through the descriptive statistics function, which serves to summarise numerical (with quantitative significance) and categorical (without numerical significance) features of a dataset. Mean (M) was used to measure central tendency (i.e., average data values) and standard deviation (SD) were used to calculate variability (i.e., data spread) of numerical socio-demographic data (i.e., number of sessions delivered in general practice per week, number of years working in role, and number of years working within the ERoY). Frequencies (i.e., total count) and proportions (i.e., percentages) were used to analyse categorical features of socio-demographics (i.e., gender, role, and working status).

5.9.2 Analysis of Interview Content

Thematic analysis was selected as an analytic research tool to examine interview data. Broadly speaking, thematic analysis identifies recurrent patterns (otherwise known as themes) within a qualitative data set, describing and interpreting the importance and meaning of these patterns (Braun, Clarke, & Weate, 2016). Since thematic analysis is not married to any particular epistemological or ontological position, it can be applied irrespective of broader theoretical frameworks. Due to the theoretical flexibility thematic analysis offers, it is imperative that researchers are transparent about their theoretical position and stance, and the processes employed to produce the themes reported (Braun & Clarke, 2019). One of these decisions is fixed on whether themes are identified inductively or deductively. An inductive approach to thematic analysis, sometimes referred to as a bottom-up approach, represents a process of coding where the content guides the developing analysis (Braun et al., 2016). Hence, analysis is driven by the data, not the researcher. In contrast, a deductive approach to thematic analysis (top-down approach) denotes a process of coding that is informed or driven by a researcher's analytic or theoretical preconceptions (Braun et al., 2016). Given that this research intended to capture a nuanced account of the referral process based on the perspectives and lived experiences of PCP, an inductive thematic analysis approach was considered most appropriate.

Another crucial decision prior to undertaking a thematic analysis is whether themes are identified at the semantic (explicit) level, or the latent (interpretative) level. At the semantic level, the researcher focuses exclusively on what the participant has said (e.g. explicitly-stated thoughts, concepts, and experiences) and explores nothing beyond

(Braun & Clarke, 2006; Braun et al., 2016). Generally speaking, semantic codes give precedence to the meanings provided in the data and are associated with a more inductive (bottoms-up) approach to thematic analysis (Clarke & Braun, 2014). In contrast, a latent approach seeks to surpass the semantic level of analysis by exploring underpinning ideas, assumptions, and conceptualisations underlying semantic content (Clarke & Braun, 2014). Latent codes are associated with a deductive (top-down) approach to thematic analysis, steered by the researcher's analytic framework and underpinned by existing theoretical foundations (Clarke & Braun, 2014). Since this research intended to embark on a journey of exploration to understand the referral process from the perspective of those involved, themes were identified at the semantic level.

Many criticisms of qualitative research are applicable to thematic analysis. For example, Labuschagne (2003) argued that qualitative research is "unclear, almost foreign, or airy fairy" and "not real research" (p.100). Similarly, thematic analysis is criticised for lacking a structured analytic framework, which encourages an "anything goes" approach to data analysis (Antaki, Billig, Edwards, & Potter, 2003, p. 6). For this reason, it was of upmost importance to provide a detailed account of the analytic process and employ a methodological approach that was both clear and replicable. Braun and Clarkes' (2006) guidelines on the recursive six-phase process to thematic analysis was followed stringently, which is as follows: data familiarisation, coding, searching for themes, reviewing themes, defining and naming themes, and producing a report. As analysis is a recursive, reflexive process rather than a linear procedure, it should be noted that the researcher moved back and forth between phases.

There are several analysis software packages that can help with the analysis of qualitative data which were considered by the primary researcher. NVivo is a popular tool that prides itself on being able to offer a more organised and structured approach to analysis, which also allows for collaborative work due to clear traceability of steps. Despite the primary researcher attending a NVivo training course around the time of data analysis, she found the software difficult to navigate and understand, and felt that the process of coding created a distance between herself and the data, whilst inviting an unwanted deductive focus through the vision of 'node' counts and percentage of coded data. The decision was made to undertake a more manual thematic analysis, which is explained in greater detail within the following section.

5.9.2.1 Thematic Analysis Phase 1: Data Familiarisation

The first phase of thematic analysis involved data familiarisation; the process of deep immersion into the dataset to achieve intimate familiarity (Braun et al., 2016). Initially, each audio recording was listened to carefully. Next, the primary researcher independently transcribed all audio recordings verbatim, being especially attentive to both verbal (e.g., intonation) and non-verbal information (e.g., pauses). Although time-consuming, the manual process of transcription is invaluable as it helps the analyst become highly accustomed to the dataset (Braun & Clarke, 2006). Transcripts were typed up in Microsoft Word within 4 weeks of interview commencement. Field notes and initial ideas about what was interesting were combined with transcriptions, prompting further reflection. Transcripts were read and re-read carefully until the primary researcher felt completely acquainted with the dataset.

5.9.2.2 Thematic Analysis Phase 2: Generating Initial Codes

The second phase of thematic analysis is coding, which is an active process of reducing large amounts of data into meaningful smaller chunks that capture the essence of the data (Maguire & Delahunt, 2017). Each of the twenty-eight interview transcripts were printed and systematically examined to capture interesting segments of data that was of pertinence to the phenomena of interest (Clarke & Braun, 2014). Transcripts were given equal and undivided attention. Any data extracts relating to PCP referral behaviours and experiences (including barriers and facilitators), emotions, values, or attitudes were highlighted and assigned a semantic level code. Segments of the data were coded inclusively rather than in isolation, capturing relevant surrounding data to ensure that the situational context of the code was not jeopardised or lost, a common fault of coding (Bryman, 2001). Flexibility was maintained throughout the coding process; coding remained open and inclusive, acknowledging contradictions and inconsistencies within the dataset (Braun et al., 2016). Once every transcript had been systematically coded, data extracts respective of each preliminary code were copied and pasted into a separate word document to collate a comprehensive list of all initial codes.

5.9.2.3 Thematic Analysis Phase 3: Searching for Themes

The third phase of thematic analysis commenced with the collation of preliminary codes. The researcher widens the focus of analysis to consider how these codes compare and relate to one another. Codes that shared commonality were conjoined to generate overarching candidate themes or subthemes. A theme refers to a patterned response of

shared meaning amongst the data that holds importance or relevance to the research question (Braun & Clarke, 2006; Braun et al., 2016). The formation of themes is dependent on the researcher's analytic judgement about what is meaningful and significant in relation to the phenomena of interest (Clarke & Braun, 2014). The development and formation of themes and subthemes was performed manually using various techniques. One technique used was to print and cut out the codes and consider the similarities and differences between them. This allowed the researcher to contemplate the relationships between the codes visually, which assisted in the development of themes and subthemes and their structure. Another technique the researcher adopted to assist the formation of themes and subthemes was to create a table within Microsoft Word as another technique to visually group codes into themes and assess how themes compared and related to one another. At the end of this phase, the primary researcher generated a comprehensive list of all candidate themes and subthemes alongside all segments of text coded in relation to them. Extracts of coded data that did not fit coherently within the candidate themes were temporarily placed into a miscellaneous theme. At this stage, no themes were discarded. At the end of the third stage, a candidate thematic map was devised on Microsoft Word. This map was discussed amongst the research team to foster a richer, nuanced interpretation of the dataset, rather than seeking consensus on meaning (Braun & Clarke, 2019).

5.9.2.4 Thematic Analysis Phase 4: Reviewing Themes

Phase four concentrated on the refinement of candidate themes and subthemes. At this stage, the researcher may find that there is not enough supporting evidence to justify a theme, a theme may be too diverse and may need dividing into several themes, and new

themes may still generate as analysis is a recursive, reflexive process (Braun et al., 2016). Braun and Clarke (2006) warn of a weak unconvincing thematic analysis, often a result of inappropriate themes. To deter this, Patton (2002) propose a dual criterion for examining themes- internal homogeneity and external heterogeneity.

Internal homogeneity means that coded data extracts demonstrate a clear meaningful pattern expressive of the theme. If data extracts do not form a coherent pattern, this indicates that either the theme is problematic, or data extracts do not belong in that particular theme. Once internal homogeneity has been established, themes must be checked for external heterogeneity. External heterogeneity ensures that themes bear distinct differences, and the thematic map accurately represents the entire dataset. Although it is important that themes are distinctive alone, they must consolidate to form a coherent whole – an analytic tale (Clarke & Braun, 2014). During this refinement process, the primary researcher decided to amalgamate all the subthemes within the theme initially entitled ‘Feedback’, to form the lower-order theme ‘Problems with the Feedback Loop’, as separating these subthemes took the themes out of context, thus stripping the ability to tell an analytic account. Furthermore, the primary researcher contemplated the thematic structure and alignment of the second theme relating to the patient. It was decided that some lower order themes were more appropriately positioned as subthemes, and some lower order themes were more suited as higher-order themes.

The process of establishing internal homogeneity and external heterogeneity helped the researcher further refine themes, develop new themes, and contemplate the

position of ‘miscellaneous’ codes. A thematic map was devised within Microsoft Word to demonstrate the alignment of themes and subthemes. Once again, this refined thematic map was peer reviewed by the wider research team to develop a more nuanced interpretation of the dataset (Braun et al., 2016).

5.9.2.5 Thematic Analysis Phase 5: Defining and Naming Themes

The fifth phase encompassed labelling and defining themes, ensuring that the labels and definitions assigned are detailed, whilst encapsulating the essence of themes individually and collectively to provide a comprehensive account of the phenomenon of interest (Clarke & Braun, 2014). Theme names should be short yet informative, and definitions must capture the essence of the theme. A common mistake made by researchers undertaking a thematic analysis is to use the interview areas or questions to label themes (Clarke & Braun, 2014). This indicates the dataset has been summarised instead of analysed. Analysis at this stage must surpass a simple description or paraphrasing of the data, and instead conjure a nuanced story about the meanings rooted within the dataset (Clarke & Braun, 2014). At this stage, researchers also begin to select the most compelling data extracts that will be used when producing the final report.

5.9.2.6 Thematic Analysis Phase 6: Producing a Report

Once the researcher is able to offer a comprehensive account of the data, capturing the story behind each theme individually and collectively, a report can be produced. During this stage, compelling extracts of data are chosen to best exemplify each theme,

and the story behind the dataset is narrated through the weaving of these data extracts and analytic narrative (Braun & Clarke, 2006). The report, as detailed in this thesis, offers a multi-PCP perspective of HLP referral processes to highlight areas of improvement and inform systemic change to streamline referral processes.

5.10 Quality Measures to Facilitate Trustworthiness

The quality and integrity of qualitative research is evaluated in terms of trustworthiness (Shenton, 2004). According to Lincoln and Guba (1985), there are four key quality criterion that should be considered in pursuit of trustworthiness: credibility, transferability, dependability, and confirmability. The following section will discuss each of these criterions in more depth, and detail provisions employed to facilitate trustworthy findings.

5.10.1 Credibility

Credibility, equivalent to the concept of interval validity in positivistic work, is the extent to which findings reflect a true picture of the phenomena under investigation, and is deemed the most important factor in establishing trustworthiness (Anderson, 2010; Jupp, 2006; Lincoln & Guba, 1985; Shenton, 2004). Several quality-enhancing strategies were employed during the collection and analysis of data to uphold credibility. During data collection, member checks, a form of participant validation (Denscombe, 2014; Ritchie et al., 2013) were conducted, which are considered the single most important

provision to enhance credibility of research (Lincoln & Guba, 1985). Moreover, following the guidance of Shenton (2004), multiple principles of triangulation were applied during data collection to help capture a well-rounded, contextualised picture of the phenomena. This included site triangulation (i.e., collecting data from a variety of sites or geographical areas), and person triangulation (i.e., collecting data from a range of participants). Debriefing sessions with supervisory secondary researchers (CD & SN) occurred at multiple phases of the data analysis process to help facilitate the credibility of this research by fostering a richer, nuanced interpretation of the dataset, rather than relying on primary researcher's [AW] research interpretations (Braun et al., 2016). This is known as investigator triangulation, where both CD and SN represented secondary researchers.

5.10.2 Transferability

Transferability, analogous to the construct of external validity or generalisability in positivistic work, is concerned with the extent to which findings can be applied to different concepts or settings beyond the study context. Qualitative research is often criticised due to its inability to provide findings that are generalisable to wider populations often because studies are small scale and idiosyncratic (Anderson, 2010; Atieno, 2009). Indisputably, all observations are bound by their specific context, and so transferability in the context of naturalistic research is about providing sufficient contextual information and detail about the fieldwork to allow the reader to make inferences about applicability of findings to other contexts and settings (Shenton, 2004). This PhD thesis devotes several chapters to contextualise the research (1 & 4) and provides sufficient detail regarding the number and characteristics of participants (see 6.1) and timeframes of data collection and

analysis (see 5.8). Moreover, comprehensive field notes were taken during data collection which were combined with interview transcripts to enable thick and vivid contextual descriptions. These quality-enhancing strategies serve to allow the reader to appraise if findings can be transferred to other contexts.

5.10.3 Dependability

Dependability is equivalent to the concept of reliability in positivistic work, that is, the extent to which research findings can be replicated under similar circumstances (Shenton, 2004). Attaining dependability is challenging in qualitative work, as findings are fixed in the 'ethnographic present' due to human behaviour being fluid and highly contextual. Moreover, researchers are an integral part of the research process (Yin, 2015), and different researchers will inevitably have different interpretations of data. Therefore, dependability in the context of naturalistic research is about a researcher providing sufficient detail about study methods and processes to enable another researcher to repeat the study, without necessarily aiming to yield the same findings (Shenton, 2004). In line with the recommendations of Shenton (2004), this chapter provides rich and elaborate descriptions of the research design, the data collection process, and the researcher's philosophical foundations and worldview. Moreover, Lincoln and Guba (1985) propose that credibility and dependability are closely aligned, and thus efforts to facilitate credibility such as member checks and triangulation (described in 5.10.1) go a long distance in promoting dependability.

5.10.4 Conformability

Conformability, analogous to the construct of objectivity in positivistic work, is focused on a researcher's efforts to ensure as much as possible that findings emerge from the dataset and are not influenced by the predispositions, biases, or interests of the researcher. Upholding conformability is difficult in qualitative research as researchers are an integral part of the research process, unavoidably serving as the research instrument (Yin, 2015). Therefore, the intrusion of biases is inevitable (Shenton, 2004). However, triangulation techniques (i.e., person triangulation, site triangulation, and investigator triangulation) and member checking, both play a key role in helping to ensure researcher biases are mitigated. Furthermore, all interviews were audio-recorded so vivid participant quotes could be presented to retain the voice of participants and present their lived experiences, not the views of the researcher. Another key criterion for conformability is the acknowledgement by the researcher of their predispositions and beliefs underpinning decisions made throughout the research process. Every effort has been made to detail and justify all research decisions. Furthermore, a researcher's reflexivity practice throughout the research process is integral to upholding conformability through the acknowledgement of potential biases (Johnson, Adkins, & Chauvin, 2020). Throughout this research, reflexivity was valued, and the primary researcher kept a research diary throughout the research process and captured field notes, which helped form the reflexive chapters and aid analysis (see chapters 2 & 12).

5.11 Ethical Considerations

Ethics is concerned with protecting the welfare of research participants. Researchers must be aware of any potential ethical issues that could arise through research conductance, and employ efforts to limit these throughout the duration of the research. The following section will consider some of the ethical issues relevant to this project, namely issues surrounding informed consent and confidentiality, and detail the researcher's effort to safeguard participant well-being.

5.11.1 Informed Consent

Informed consent is an ethical and legal requirement for research including human subjects (Nijhawan et al., 2013). It reflects the principles of autonomy and ensures that participants come to no harm because of their involvement in research (Stringer, 2013). At a minimum, informed consent must explicitly state the studies purpose, the way data will be used, and what participation entails (Ritchie et al., 2013). In the present study, all prospective PCP were provided an informed consent form, accompanied by an information sheet approved by University of Hull's Research Ethics Committee (see appendix 3.3.). This ensured participants were provided with sufficient information regarding the study aims, requirements and intentions. Participants were encouraged to carefully review these documents prior to making decisions around participation. Informed consent was obtained in writing. Furthermore, prior to interview commencement, the primary researcher reiterated the study purpose, provided reassurances about confidentiality and participant rights to withdraw, and referred to the Data Protection Act (1998) or GDPR regulations (2018; if appropriate at the time of

undertaking the interview). This helped to ascertain that participants were informed, competent, and non-coerced.

5.11.2 Confidentiality

Another key ethical consideration is confidentiality, which refers to the avoidance of revealing participant identity through the purposeful separation or modification of all personal and identifiable participant information (Ritchie et al., 2013). Confidentiality was strictly enforced throughout the research process, so identities of respondents were not compromised. At the time of data collection, verbal assurances of confidentiality were given to each participant alongside an information sheet and informed consent declaration form, which included a statement of confidentiality. At the time of data analysis, each participant was allocated a unique participant code and pseudonyms were utilised to safeguard their identity through the creation of a "clean data set" (Kaiser, 2009). All data associated with participants was securely stored and only accessible to members of the research team. Data in paper format that revealed identifying information (e.g., informed consent forms and handwritten field notes collected during interviews) were filed and stored in a locked filing cabinet within the University grounds. All personal data in electronic format (e.g., audio voice recordings, electronic copies of transcriptions and evidence of data analysis) were stored separately on a password-protected computer and backed up onto an encrypted external hard-drive. Moreover, audio voice recordings were permanently deleted off the recording device once transferred onto a password-protected computer. Kaiser (2009) highlights the challenges associated with presenting rich and comprehensive accounts from qualitative findings whilst upholding confidentiality. In

recognition of this issue, the primary researcher used assigned pseudonyms given to each PCP when presenting rich complex accounts of their social world.

5.12 Summary

This chapter served to detail the research design and methodology employed in the first phase of this research project. The study aims, and nuances of participant eligibility and recruitment are elaborated on in this chapter. Next, the rationale behind the philosophical assumptions underpinning this research phase are presented. Specifically, phenomenology was selected on the basis that it strives to comprehend phenomenon through the lived experiences of individuals (Creswell & Creswell, 2017; Starks & Trinidad, 2007), which coincides with this studies intention to gain a rich, in-depth understanding into the perceptions and lived experiences of PCP involved in referral operations to the HLPs. Secondly, underpinnings of participatory action research were embraced as it seeks to inform change to overcome a particular problem by actively engaging all stakeholders (Cordeiro et al., 2015; Denscombe, 2014), which again, fits with the studies aim to inform modifications of referral processes based on the perspectives, insights and opinions of all involved stakeholders. The chapter proceeds to detail the qualitative research method adopted and how data were analysed. Lastly, this chapter gives recognition to the quality measures adopted to facilitate trustworthiness and provisions to safeguard relevant ethical considerations. The following chapter will analyse and present the findings from the first phase of this research.

6 RESULTS: PHASE I

6.1 Participant Characteristics

Twenty-eight PCP volunteered to participate in individual semi-structured interviews, which on average lasted 26.90 minutes (range: 13.37 to 48.04 minutes). The sample consisted of 22 females (78.57%) and 6 males (21.43%), aged between 21 and 60 years (*M = 43.96*, *SD* = 10.6). Age data is based on twenty-six PCP, as two participants did not disclose this information. Participant sample comprised of 9 different primary care stakeholder groups (see Table 6.1), who are differentiated using a coding system, which is used throughout this section (i.e., Practice Manager; PM, General Practitioner; GP, Practice Nurse; PN, Nurse Practitioners; NP, Healthcare Assistant; HCA, Clinical Pharmacist; CP, Community Link Worker; CLW, Medical Secretary; MS and Care Navigator; CN). Experience of working as a PCP ranged from seven months to thirty-four years (*M* = 12.5 years, *SD* = 8.54), where the largest proportion of PCP had between 16 and 20 years of role experience (see Table 6.1). Experience of working within the ERoY ranged from seven months to twenty years *(M* = 9.6 years, *SD* = 6.11). There was a 50:50 split between those who practiced full time (*n* = 14) and those working part time (*n* = 14). PCP worked in one of the four ERoY localities; Bridlington (*n* = 11), CHERY (*n* = 6), Holderness (*n* = 5), or SWAN (*n* = 6; see Table 6.1), where the largest proportion worked in Bridlington. This sample represents sixteen ERoY PCS across the ERoY within areas of both high deprivation and affluence (see Table 6.2)

Table 6.1. *Participant characteristics of Primary Care Personnel*

		***n* =**	**% of sample**
PCP role and abbreviation	Practice Manager (PM)	1	3.57
	General Practitioner (GP)	9	32.14
	Practice Nurse (PN)	5	17.86
	Nurse Practitioner (NP)	5	17.86
	Healthcare Assistant (HCA)	1	3.57
	Clinical Pharmacist (CP)	1	3.57
	Community Link Worker (CLW)	3	10.71
	Medical Secretary (MS)	2	7.14
	Care Navigator (CN)	1	3.57
PCP role experience (years)	0-5	7	25.00
	6-10	6	21.43
	11-15	3	10.71
	16-20	8	28.57
	21-25	2	7.14
	26-30	1	3.57
	31-35	1	3.57
PCP experience in East Riding of Yorkshire (years)	0-5	9	31.14
	6-10	8	28.57
	11-15	5	17.86
	16-20	7	25.00
GP surgery location	Bridlington	11	39.29
	CHERY	6	21.43
	Holderness	5	17.86
	SWAN	6	21.43

Table 6.2. *GP surgery characteristics*

ERoY Vicinity	GP surgery	IMD 2019 score	Participant code
Bridlington	Practice 1	34.2	GP3 GP5 PN2 NP1
	Practice 2	33.2	GP8 GP4 CP1 PN5
	Manor House Surgery	35.4	GP6
	Field House Surgery	35.9	CN1 MS1
Southwest Area Network	The Ridings Medical Group	6.6	PM1 GP2
	Snaith and Rawcliffe Medical Group	11.5	GP1
	Pocklington Group Practice	9.9	CLW2
	Bartholomew Medical Group	27.2	CLW1
	Gilberdyke Health Centre	11.7	PN1
Holderness	St. Nicholas Surgery	35.4	HCA1 CLW3
	Church View Practice	14.8	GP7
	Eastgate Surgery	20.5	NP4 PN4

CHERY	The Beverley Health Centre	10.8	GP9 MS2
	The Old Fire Station Surgery	12.5	PN6
	Walkergate Surgery	12.5	NP2 NP3
	The Willerby Surgery	5.2	PN3

6.2 Interview Findings

The process of inductive thematic analysis identified a multitude of higher-order themes, lower-order themes, and sub-themes that encapsulated the perspectives and experiences of PCP involved in patient referral to the HLPs. At the broadest level, thematic analysis identified three over-arching themes: (1) factors hindering HLP referrals; (2) factors facilitating HLP referrals; and (3) suggestions to improve HLP referral processes. Table 6.3 depicts an overview of the overarching, higher-order, lower-order, and sub-themes. These findings are illustrated and defined in the succeeding section, weaved with compelling raw data extracts from interview transcripts to retain participants' voices (Braun & Clark, 2006).

Table 6.3. *Overview of overarching, higher-order, lower-order, and sub themes*

Overarching Themes	Higher-Order Themes	Lower-Order Themes	Subthemes
Factors Hindering Healthy Lifestyle Programme Referrals (1)	Primary Care Personnel (1.1)	Pressures Placed Upon Primary Care (1.1.1)	Excessive Workload (1.1.1.1) Time Constraints (1.1.1.2) PCP Shortage (1.1.1.3) Delegation of Referrals (1.1.1.4)
		Limited Awareness of Physical Activity Prescription and the Healthy Lifestyle Programmes (1.1.2)	
		Negative Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes (1.1.3)	
	Patient (1.2)	Barriers to Lifestyle Behaviour Change (1.2.1)	Lack of Motivation (1.2.1.1) Financial Barriers (1.2.1.2) A Lack of Time (1.2.1.3) Confidence Issues (1.2.1.4) Geographical Barriers (1.2.1.5)
		Negative Attitudes Towards Lifestyle Behaviour Change (1.2.2)	
		Limited Awareness of the Healthy Lifestyle Programmes (1.2.3)	
	Healthy Lifestyle Programme Referral Processes (1.3)	Problems Associated with Paper Referrals (1.3.1)	
		Problems Associated with Electronic Referrals (1.3.2)	
		Problems with the Feedback Loop (1.3.3)	

Overarching Themes	Higher-Order Themes	Lower-Order Themes	Subthemes
Factors Facilitating Healthy Lifestyle Programme Referrals (2)	Primary Care Personnel (2.1)	Positive Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes (2.1.1)	Lifestyle Promotion Enthusiasts (2.1.1.1) Advocates of the Healthy Lifestyle Programmes (2.1.1.2)
	Patient (2.2)	High Awareness of the Healthy Lifestyle Programmes (2.2.1)	Promotion of the Healthy Lifestyle Programmes (2.2.1.1)
		High Levels of Motivation (2.2.2)	
	Healthy Lifestyle Programme Referral Processes (2.3)	Ease of Paper Referrals (2.3.1)	
		Ease of Electronic Referrals (2.3.2)	
Suggestions To Improve Healthy Lifestyle Programme Referral Processes (3)	Strategies to Increase Awareness of the Healthy Lifestyle Programmes (3.1)	Marketing and Promotion for the Public (3.1.1)	
		Healthy Lifestyle Programme Information Resources for Primary Care Personnel (3.1.2)	
	Improving Working Relationships (3.2)		
	Improving Feedback Provision (3.3)		
	Simplifying Healthy Lifestyle Programme Referral Processes (3.4)	Clinically Compatible Electronic Referral Process (3.4.1)	Anticipated Benefits and Limiting Factors (3.4.1.1)
		Improvements Specific to the Electronic Referral System (3.4.2)	
		Central Point of Access (3.4.3)	

6.3 Overarching Theme 1: Factors Hindering Healthy Lifestyle Programme Referrals

This overarching theme encapsulates an array of factors that PCP perceived negatively influenced HLP referral activities. These were separated into three higher-order themes, i) PCP (higher-order theme 1.1), ii) patient (higher-order theme 2.1), and iii) HLP referral processes (higher-order theme 3.1). Each higher-order theme encompasses several lower-order themes (e.g., 1.1.1), and where appropriate, subthemes (e.g., 1.1.1.4).

Higher-Order Theme 1.1: Primary Care Personnel

Numerous factors hindering referrals relating specifically to the referring PCP were identified. 'Pressures placed upon primary care', 'limited awareness of physical activity promotion and the HLPs', and 'negative attitudes towards lifestyle promotion and the HLPs' were identified as key lower order themes.

Lower-Order Theme 1.1.1: Pressures Placed Upon Primary Care

PCP discussed unprecedented systemic challenges imposed on primary care that made it difficult for them to prioritise lifestyle promotion, and HLP referrals. These challenges included excessive workloads, PCP shortage, and time constraints, all of which were described to be often interrelated. Consequently, some PCP held reservations about the feasibility of providing all necessary information required on referral forms

within the confinements of primary care consultations, and were forced to delegate the completion of such forms to their colleagues.

Subtheme 1.1.1.1: Excessive Workload

Many PCP perceived that their workload was unmanageable and discussed how the "*NHS as an entity is at saturation workwise"* (PM1). Contributing to this excessive workload was the rise in administration demands, which PCP stated was "*putting a lot of restraint on resources*" (PM1). Furthermore, the increasing complexity of patient care was another factor PCP identified as contributing to an unsustainable workload, and unfavourable conditions for PAP. One GP illustrated the variety of requests for support in primary care:

> GP4 *"The paternal thing. Come here and I'll fix everything for you. From your heating to your health, to your kids, you name it, we fix. …We're getting more requests for stuff which we struggle to deal with".*

Similarly, a Nurse described how those in primary care "*try and deal with everything and it's not the way forward",* which explained why it was felt a *"lot of resources"* were not *"used enough"* (PN1).

Subtheme 1.1.1.2: Time Constraints

Since PCP workloads were perceived to be unmanageable, limited precedence was given to lifestyle promotion, or specifically HLP referrals. Time constraints were

considered by one CLW to be an issue especially pertinent to GPs who *"don't have the time to refer" and* feared discussing lifestyle behaviours with patients "*in case they open a can of worms that they can't shut within ten minutes"* (CLW2). As explained by a PN, *"ten minutes sometimes isn't enough"* because patients "*like to talk about their problems"* (PN3). One GP who considered himself an advocate of the HLPs, highlighted the impracticality of completing referral forms within the constraints of a patient consultation:

> GP1: *"To refer somebody to Exercise on Referral I've got to hand fill that in. Now that's probably going to take me five minutes maybe to fill it in and to pull all the patients demographics off …I'm just not going to do it if I'm honest…because I haven't got time, so there's a constraint there".*

This GP voiced a preference to "*signpost"* to lifestyle services such as the "*health Trainers*" because *"it's easy*" and he "*can just give a card*", as opposed to completing a referral form (GP1).

Subtheme 1.1.1.3: PCP Shortage

PCP echoed the crisis the ERoY faces in terms of staff recruitment and retention. GPs stressed how they were *"clinician short"* (GP1), and *"find it hard to recruit"* (GP8) because individuals "*don't want to come and live at this end of the M62*" (GP7). One GP explained how certain ERoY localities struggle more than others with staff recruitment and retention; namely Bridlington which was described as particularly "*under doctored… compared to other areas in the county"* (GP8). Consequently, it was explained how the workloads of PCP were accentuated to compensate for the depleted workforce.

Subtheme 1.1.1.4: Delegation of Referrals

The reality of a dwindling workforce, increasing workload, and strict time constraints meant that many PCP, especially GPs, delegated HLP referral responsibilities to other colleagues with *"a bit more capacity"* (GP6).

> GP6: "*Most of the time we sort of have a chat and recommend exercise on prescription for example, and then would say, 'could you make a nurse appointment'? And then we would have one or two allocated nurses who tend to do the [eligibility] checking*".

Some GPs recognised that delegation created *"two barriers",* one "*for the patient to come back"* to the surgery, and two, for "*the separate nurse appointment"* (GP6). However, other GPs believed that the administration associated with the completion of HLP referrals were more suited to non-clinical PCP.

> GP1: "*I'm an expensive form filler really at the end of the day… put the form filling to someone more appropriate…the reception can do that or the care navigators".*

This was contested by several non-clinical PCP who felt "*GPs should be directly referring themselves when they have the patient with them*" (CN1) rather than delegating. Some argued "*a lot of the clinical stuff it's not for us to put in. It's not our call, you know, We are administration staff at the end of the day"* (MS1).

Lower-Order Theme 1.1.2: Limited Awareness of Physical Activity Prescription and the Healthy Lifestyle Programmes

PCP of varied role experience revealed that they had insufficient knowledge in relation to lifestyle promotion, particularly in terms of PA prescription, which made pre-exercise screening difficult. GPs challenged why blood pressure was a contra-indication for exercise, arguing they were "*unaware of any blood pressure [reading] that would affect someone's ability to exercise*" (GP3; 4.5 years of role experience). Others were unsure of "*what blood pressure is too high to exercise*" (GP9; 10 years of role experience). This was indicative of the fact that they "*haven't had any training"* in PA prescription, despite being *"expected…to know what blood pressure is safe to exercise*" (GP9). The term '*physically inactive'* was also subject to much debate. PCP asserted that it is "*really difficult to define"* (GP9) because patients discuss their PA levels in relation to how much housework they achieved, which was *"anything from washing up to scrubbing floors and breaking out in a sweat"* (GP9). Finally, PCP revealed they "*don't know what medication is relevant to exercise"* (GP9).

This sample also cited difficulties in retaining information pertaining to the HLPs, which made it challenging for them to discuss the option of referral with eligible candidates. In relation to the ERS, one GP stated: "*The patient expectations set that I've got the keys to doing this referral, and yet often I won't always know to start with, is the patient meeting those criteria of being inactive and having those two diseases*" (GP3). PCP also admitted to cobbling together a vague description of the HLPs for their patients. GPs reported they were relaying the "*same thing that [they had] for five years"*, despite thinking the information was "*probably different"* (GP2; 26 years of role experience).

Likewise, nursing staff acknowledged they "*haven't got that level of understanding"* (NP3; 5 years of role experience) to properly inform a patient about the HLPs, and thus found themselves "*half trying to explain*" the programmes (NP1; 15 years of role experience). One CN reflecting on her experiences of being tasked by a GP to make a referral for a patient described some of the implications of GPs having insufficient HLP knowledge:

> CN1: *"I'm fine with the GPs delegating [HLP referrals] so long as they are specific about which actual, which programme they need to be on. They tend to think they can refer them onto anything, whether they are eligible or not so sometimes it would fall upon me to say to the patient, well actually no, that's not free and you don't fall within the remit of the free one, even though the doctors have told them that they probably could do".*

In attempt to overcome the problem of "*remembering*", one GP explained how they signpost "*to the health trainer first*" and "*expect the [health Trainers] to refer on [to the HLPs] if they think it's appropriate*" (GP7). Several GPs blamed the fact there were "*so many different referral options",* (GP3; 4.5 years of role experience), and "*every single thing has got a referral form*" (GP7; 19 years of role experience), which makes it challenging to mentally "*retain them all"* (GP3). This issue was especially relevant for locum GPs, and PCP who worked in PCS on the boundaries of the county due to "*duplication in the services"* available to support patients (GP1; 22 years of role experience).

Lower-Order Theme 1.1.3: Negative Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes

Some PCP asserted that lifestyle promotion was a burden on their workload, and beyond their remit. GPs in particular argued "*it is not medical; it's lifestyle so it needs to be taken away from GPs"* (GP2), and described HLP referrals as "*a waste of a [GP] appointment*" (GP3). According to these GPs, they want to "get *people out of seeing the doctor all the time for stuff [GPs] can do nothing about"* (GP2). Similarly, some Nurses challenged the necessity of the nursing team involvement in lifestyle promotion and stipulated they "*can support [patients] with their health and medications",* however, the promotion of lifestyle was *"not what [they were] qualified to do"* (PN1). In the face of pressing medical matters, lower priority was given to lifestyle promotion.

PCP holding negative attitudes towards lifestyle promotion raised questions such as: "*why can't the patients self-refer?*" and "*why does it need to be a health professional [referral]*?" (PN3), highlighting a misunderstanding of their role and responsibilities in relation to ERS. One GP desired a "*really easy either form or even just a phone number"* (GP2) to give to patients so the responsibility of referral was transferred to them. Some PCP thought it was unfair that other lifestyle services such as smoking cessation permitted self-referrals, but the HLPs did not. According to these individuals, self-referrals to the HLPs "*would increase access*" without PCP needing *"to point it out to the public"* (GP6).

Some PCP also held a negative attitude towards the HLPs, possessing reservations about the effectiveness, and ERLs capacity to manage referrals. In terms of effectiveness,

PNs stated, *"It's an intervention that I don't have any control over once it's gone [the referral form]"* (NP1) and were sceptical about whether the programmes were *"doing any good"* (PN1). One individual assumed *"10 weeks will probably not make a long-term difference to people's lives"* (CP1). PCP utilising the HLPs for preventive purposes appreciated that it is "*very difficult to prove preventable things are having an impact because the impact is so far down the line"* (GP7), which contributed to their ambiguity around programme effectiveness. Some PCP also questioned whether the leisure centres have the capacity to accommodate for an influx of HLP referrals, thus were dubious of referring eligible patients at every available opportunity in fear they *"inundate"* ERL sites (PN6). One PN warned: "*it's in danger of becoming a victim of its own success…if it's really popular, but there's not enough places"* (PN6).

Higher-Order Theme 1.2: Patient

This theme captures the factors hindering HLP referrals that related specifically to patients. Lower-order themes of 'barriers to lifestyle behaviour change', 'negative attitudes towards lifestyle behaviour change', and 'limited awareness of the HLPs" were identified as central deliberating factors influencing HLP referrals.

Lower-Order Theme 1.2.1: Barriers to Lifestyle Behaviour Change

Throughout the narratives, PCP cited many common barriers they perceived patients experienced in relation to changing their unhealthy lifestyle behaviours, and

embarking on a HLP. These related to motivation, finances, time, confidence, and residence.

Subtheme 1.2.1.1: Lack of Motivation

One of the most commonly cited factors that hindered lifestyle promotion in primary care was a perceived lack of patient motivation to change their unhealthy lifestyle behaviours. PCP argued, "*not many people are necessarily very motivated to change their lifestyle*" (CP1), particularly "*very large patients*" who were perceived to be "*not interested*" (PN3). PCP maintained that "*it's very hard to buy [patients] in motivation wise"* (GP6), and find it "*difficult to really identify how motivated they are"* (GP5). Some PCP complained that they "*haven't got anything to give"* to patients who were *"not interested in talking about [the HLPs] there and then"* (PN1) for further reflection. Several Nurses suggested that patients who had been referred to the LiveWell programme "*defaulted their appointments*" (PN3) or "*don't complete the programme*" (NP1), which they attributed to a lack of readiness to change their lifestyle behaviours.

Subtheme 1.2.1.2: Financial Barriers

PCP perceived that patients struggled financially with HLP costing, irrespective of the prosperity of the area they resided. In relation to the ERS, PCP practising in deprived areas of the ERoY stated that patients "*can't afford the £30 charge"* (HCA1-Withernsea) "e*ven at that reduced rate"* (PN2- Bridlington). Equally, PCP situated in affluent areas discussed how the cost of the ERS "*can be prohibitive"* (GP7- Hedon),

especially for "*people who are on universal credit"* (GP9- Beverley). On the topic of financial barriers, one GP referred to the "*inverse care law"*, proposing that "*the people who need help the most, are the least likely to get it"* (GP9). This GP admitted to encouraging patients to "*continue over-eating",* until they met the BMI criteria of the LiveWell programme, and therefore could access support "*for free*" (GP9). Similarly, another PCP suggested that the BMI criteria of the LiveWell programme *"forced*" patients to "*put more weight on"* (MS1) so they were eligible for twelve months of free support. Interestingly, one NP explained, "*I don't talk to them about financial cost because I don't know what it is and well, I think it's even harder to get people through the door*" (NP3). Some PCP were also unaware of the Public Health funded ERS places available: "*I am not aware that there are free places [or] what the criteria are for free places*" (CP1).

Concerns were also raised about a patient's ability to maintain their lifestyle behaviour changes upon HLP completion. Supposedly, patients *"can't afford to buy a gym membership"* at the end of their programme, so "*just stop"* (HCA1) and revert "*back to [their] old ways"* (CP1). To counter-act this, it was described as common for patients to request a second referral from their PCP. A second issue concerning patient cost related to a perceived reluctance to fund any aspect of healthcare. A minority of PCP described a "*certain group of community… who do not want to pay for anything in society"* (PN4). One GP reported how patients over the age of sixty typically "*expect everything for nothing because they don't have to pay for their prescriptions"* (GP7). Consequently, these PCP admitted they *"wouldn't even think of putting [these patients] on an Exercise Prescription"* (PN4).

Subtheme 1.2.1.3: A Lack of Time

PCP suggested their patients resisted to recommendations to increase their PA due to a lack of time. PCP recalled how patients argue they "*never stop all day"* and *"can't possibly fit any exercise in"* because they "*haven't got time*" (GP7). Reportedly, patients asserted that competing priorities (e.g., work commitments) consumed a considerable proportion of their time, leaving limited opportunity to engage in an active lifestyle. One GP argued; "*They obviously are the people who aren't quite as motivated and they're not going to engage*" (GP7). According to this sample, both patients and PCP incorrectly assumed that HLP appointments at ERL centres clashed with typical working hours, which deterred referrals. Patients were reported as complaining that they *"work 9-5, Monday to Friday"* (GP7), and therefore were unable to attend appointments. Likewise, one GP incorrectly criticised how the HLPs were all run *"during the day"* (GP2), which he believed was a barrier to referral uptake.

Subtheme 1.2.1.4: Confidence Issues

PCP assumed that patients suffered from a lack of confidence in the initial phase of lifestyle behaviour change. In relation to the HLPs, it was reported as common for patients to fear the "*gym environment"* because they perceived it was full of people of a healthier, *"slim"* physique (PN6). According to PCP, this made patients *"feel out of place", "uncomfortable"* and "*self-conscious"* (PN6). One GP explained how he tries to convince his patients that "*other people in the same kind of basket*" with the "*same [health] problems*" have attended the HLP and benefitted from participation, which he

felt helped to "*motivate*" them (GP5). Moreover, it was cited that some patients lacked the confidence to embark on a HLP *"on their own"*, which for some PCP, underscored the value of having "*care navigators*" in general practice who functioned as "*a befriender just temporarily to get them into the system"* (GP7). One CLW who also worked as a Health Trainer described how she assessed a patient's confidence prior to any lifestyle referral because of its centrality to behaviour change. For patients suffering with low confidence, she encouraged the ERS to ease patients into PA safely. Other PCP agreed that "*a lot of people would rather start the gym on Exercise on Prescription if they are lacking confidence"* (CLW3), because the supervision of a qualified gym instructor provided a "*safety net*", offering patients *"protection"* and "*security"* (PN5). On the other hand, one GP believed that "*sometimes that first huge step is going to the gym which people just don't do*", so instead this GP advocated social prescribing activities to "*reduce the height of that first step*" (GP4).

Subtheme 1.2.1.5: Geographical Barriers

It was reported that some patients were prohibited access to the HLPs because they did not reside in the ERoY. PCS located within close proximity of ERoY boundaries treat patients of neighbouring localities such as Hull and York, however these patients do not qualify for HLP referral due to their residency. The following GP quote illustrates the implications of this:

> GP1: *"Our biggest problem here is that two thirds of our patients live in the East Riding and one third live in North Yorkshire so they access different Public Health schemes… our North Yorkshire patients cannot go to the East Riding schemes, and our East Riding patients cannot go to the North Yorkshire ones"*.

Barriers such as patient access to transport were also reported to influence a PCP's decision to initiate HLP referrals. Transport in both coastal and inland towns was described as "*awful"* (GP7). Patients without access to their own mode of transport allegedly struggled to "*get to places very easily"* (GP7), especially if they did not have friends or relatives that could help. According to some PCP, this was further compounded by the fact there were "*no bus services"* and *"no trains"* (PN4), which was an pertinent issue for patients living in distant proximity from ERL centres.

Lower-Order Theme 1.2.2: Negative Attitudes Towards Lifestyle Behaviour Change

PCP believed that patients do not endorse lifestyle promotion, nor do they take responsibility for their unhealthy lifestyle behaviours. Reportedly, patients trusted there was "*a medical answer"* to their presenting problems, and thus sought medical interventions or a "*a free pill*" (CP1), rather than accepting any liability. As put by one GP, *"once it comes to the weight issues, not many people are really keen to listen or to do something about it because they feel that this is a disease, and I should do something for the disease"* (GP5). PCP testified that *"it needs to be really made clear to the patients that it's not a medical problem, that it's a lifestyle problem"* (GP2), yet believed it would take a radical change in culture before PA is considered the norm.

> NP3: *"It isn't part of health culture yet…patients come to us expecting a prescription, not expecting a referral to go to the gym. The culture at the minute is they always feel a little bit hard done by and fobbed off, if that's what they get instead of a more traditional medical intervention… We need to change the culture!"*

PCP insisted that if PA were "*normalised*" as "*part of life"* (GP7), and viewed a socially acceptable behaviour, patients would be more accepting of PAP in primary care and HLP referrals. As one GP put it: "*If you are in a healthy environment with other healthy people doing the same sorts of things, people follow the herd"* (GP3). This GP believed that the deprived coastal town where he worked "*misses a trick"* by not making "*exercise available to anybody and normalising it"* (GP3).

Lower-Order Theme 1.2.3: Limited Awareness of the Healthy Lifestyle Programmes

PCP stated that patients were insufficiently aware of the HLPs aimed to support positive lifestyle behaviour change. It was reported that patients had a vague understanding of these programmes, and "*not many people [were] actually aware of what they [could] get"* (CLW2) if eligible for referral. One common misconception from patients according to PCP was that the ERS was *"a free scheme"* (MS2), which sometimes caused PCP uneasiness when discussing the financial implications of this programme.

Limited promotional efforts around the HLP provision were considered by PCP to be a major contributing factor to the widespread vague awareness amongst patients. They speculated that "*more publicly available information"* for patients "*about the benefits"* (NP3) of these programmes would help to increase public visibility and facilitate patient-initiated referrals in primary care. As one PN put it, *"If patients knew about it more, they would ask about it more and we would have to use it more"* (PN1).

Higher-Order Theme 1.3: Healthy Lifestyle Programme Referral Processes

The third theme in relation to the factors hindering HLP referral activities concerned the operation of the referral process. Specifically, PCP highlighted aversions to both paper HLP referral processes, electronic HLP referral processes, and the feedback loop.

Lower-Order Theme 1.3.1: Problems Associated with Paper Referrals

PCP highlighted several aversions towards paper-based HLP referral forms. Two GPs explained their frustrations with paper referral forms:

> GP2: "*The big constraint for us is, it's still done on paper forms, and you never have a copy …you have to start looking for these very grotty little forms for the exercise on referral and they are really poorly written, and they are not spaced out properly and they look a mess… we lose them, and we run out of them*".
>
> GP1: *"To refer somebody to Exercise on Referral I've got to hand fill that in. Now that's probably going to take me five minutes maybe to fill it in and to pull all the patients demographics off …I'm just not going to do it if I'm honest, or I'm not going to do it as often as I should be doing it because I haven't got time".*

Resistance to filling out paper-based HLP referral forms was discussed in relation to the 2023 NHS Paperless ambition. PCP explained how paper-based referrals were increasingly discouraged in primary care, resulting in "*very few referrals these days that get done [by] pen and paper"* (PN3). Furthermore, some PCP reported that they "*don't find [HLP paper-based referral forms] very user-friendly"* (PN3) due to duplication in the referral form fields. According to PCP, they were time-consuming to complete as

these forms forced them to replicate patient information due to "*the same boxes"* requiring "*almost the same conditions*" (GP9).

The requirement for PCP to provide their own written signature and a countersignature from their patient on paper-based HLP referral forms was also challenged by some PCP. One PCP stated: "*I don't want to give blank signatures for safety*" (GP6), whereas another contested why a health professionals signature was necessary: "*what would be better is just the referring clinicians name going in. You don't need signatures on stuff nowadays*" (PM1). Obtaining a patient's signature was considered by some PCP to be impractical as it did not complement *"new modes of consulting*" (GP1) such as telephone and email consultations whereby the patient is not physically present. As put by one GP:

> GP3: "*imagine that I want someone to go it, I've spoken to them on the phone to say, "please can you go", they say, "yes I'd like to go" and I don't have their signature. I need to invite them back into the practice to sign this piece of paper before it can be sent to the far end*".

Moreover, HLP referral forms were often completed during a PCPs "*admin[istration] time… at the end of the surgery"* (NP4) rather than during a live patient consultation due to their cumbersome nature. Therefore, patients were often not physically present to provide their signature and thus HLP referral forms could not be submitted to ERL, which caused "*delay for the patients"* (MS2) in accessing support. The value of obtaining a patients written signature was subject to a lot of criticism: "*I don't think the patient signature is useful at this level unless anyone thinks that psychologically there's more of a buy in but I'm not too sure"* (GP3), "*I am not really sure what the point*

is…It's a barrier. you could have a box that says, 'I've discussed this with the patient' (GP7), "*I don't think it's adding much value for what it is*" (GP3), "*I think verbal consent is sufficient*" (GP9).

Lower-Order Theme 1.3.2: Problems Associated with Electronic Referrals

PCP highlighted several problems they had encountered with the existing electronic referral system, which related to duplication in HLP referral form fields, and the booking of initial leisure appointments. Users of the electronic referral system were often non-clinical PCP who were delegated the responsibility of completing HLP referral forms from clinical PCP (e.g., GPs). Equal to the frustrations experienced by PCP completing paper-based referral forms, users of the electronic referral system argued that many form field requirements were unnecessarily repetitive. This was described as especially irritating because the electronic referral system did not interface with clinical systems such as SystmOne and EMIS, which forced PCP to *"click back and forth"* (HCA1) from a patient's medical record and ERLs electronic referral system to retrieve and "*duplicate*" (CLW1) patient information.

The novelty of booking a patient's first HLP appointment at the leisure centre was viewed as a *"downfall"* of the electronic referral system, and "*really difficult to complete"* (GP9). It was a common belief that "*GPs don't have physical time to [book a patient's initial leisure appointment] whilst they're in practice"* (HCA1). Consequently, these referrals were often delegated to non-clinical PCP to complete in the absence of the patient. However, the additional burden of booking a patient's first HLP appointment was

reported to *"take a bit more of the admin time"* in comparison to paper-based referral forms, and made PCP feel they were *"doing their [ERL's] job"* (CLW1). Furthermore, as patients were not present at the time of completing electronic referrals, it was difficult for PCP to book an appropriate initial leisure appointment slot that suited the patient. Instead, random leisure appointments were selected for patients without any consideration towards their preferences.

Lower-order Theme: 1.3.3 Problems with the Feedback Loop

Concerns around the effectiveness of the HLPs (see lower-order Theme 1.1.3) were largely attributed to the patchy provision of patient progress feedback from ERL. Some PCP reported to receive feedback from the leisure centres but "*not often*" and this information was "*not [presented] in a very clear way*" (GP5). PCP described inconsistencies in feedback provision: "*We definitely get letters back from the LiveWell [programme] to see how they have engaged and what health measures have maybe improved…. I don't actually recall seeing feedback from exercise on prescription*" (GP6), "*I've not had any sort of major feedback for quite some time, certainly not from the exercise referral. LiveWell, I think they do feedback*" (PN2). Others stated they "*don't get any formal feedback at all*" (GP2). PCP explained that "*[feedback] might go straight to the patients GP…not necessarily who has referred them*" (NP4). It was reported that some patients informed their PCP of their progress on a HLP ("*I don't get any information apart from maybe what the patients will tell me;* PN1"). However, this method of feedback was considered unreliable and "*disjointed"* (PM1) as *"there could be a mismatch between what the programme are recording [patients] are engaging with and what the patient perceives that they are engaging with"* (GP9).

6.4 Overarching Theme 2: Factors Facilitating Healthy Lifestyle Programme Referrals

This theme encapsulates numerous factors that PCP believed positively influenced HLP referrals. Following the pattern of the previous overarching theme, these were divided into three distinct higher-order themes relating to: 1) PCP, 2) the patient, and 3) the HLP referral processes.

Higher-Order Theme 2.1: Primary Care Personnel

Interview findings suggested that PCP were more likely to initiate a HLP referral if they possessed positive attitudes towards lifestyle promotion and the HLPs.

Lower-Order Theme 2.1.1: Positive Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes

Whilst some PCP viewed lifestyle promotion as a burden on their workload, many PCP placed high importance on lifestyle promotion in primary care and valued the HLPs. These PCP adopted an active role in lifestyle promotion and HLP referrals.

Subtheme 2.1.1.1: Lifestyle Promotion Enthusiasts

Numerous PCP demonstrated enthusiasm about their involvement in lifestyle promotion and reported to take an proactive approach to healthcare and the identification of lifestyle issues amongst patients. This is reflected in the following statement: *"I'm quite proactive. Even if they [patients] have come with something completely unrelated, I am one of these make every contact count people who will say, do you smoke? Can you get on my scales?"* (GP7). These PCP valued their role as *"a teacher",* responsible for "*educating people"* (GP4), "*signposting them"* and *"giving them options"* (GP1). They also underscored the worth of lifestyle promotion, claiming that "*inactivity and poor health choices and food choices and exercise choices probably have got more of an effect that most of what we are spending our money on"* (GP3). One GP practicing in Bridlington celebrated having a dedicated "*learning group",* where PCP in this locality had undertaken "*self-directed learning programmes"* to upskill in *"social prescribing*" and *"exercise on referral"* (GP6).

The importance of lifestyle promotion for both disease prevention and management was prized by many PCP. One NP discussed how she used the HLPs for primary prevention purposes, stating how she was "*just looking forward"* to the "*conversations in ten, fifteen years if [patients] don't do something about the way they are living"* (NP1). Many PCP stated they seized "*any opportunity to suggest lifestyle behaviour changes"* (PN4) during "*new patient medicals"* or *"annual review[s]"* (PN3) *as* part of the management of chronic disease. PCP also referenced their localities health profiles, particularly in terms of disease prevalence. Many conveyed apprehensions around the "*extremely concerning"* occurrence of type 2 diabetes in patients who were

"*getting younger and younger"* (CP1). One GP compared the ERoY prevalence of disease to a neighbouring regions disease prevalence, which rooted his enthusiasm of lifestyle promotion.

> GP3: "*Our disease prevalence is higher. Our age of death is younger by ten years than York and that's a profound health inequality and it needs to be better matched by having access to these sorts of [behaviour change] services than it would be by health-based services".*

Subtheme 2.1.1.2: Advocates of the Healthy Lifestyle Programmes

The large majority of PCP placed high importance on the HLPs. One Healthcare Assistant from Withernsea described how patients "*don't have many [referral] options…because we're so far away from anything else"* and so the HLPs serve as "*a really valuable resource… used by everybody [in primary care]"* (HCA1). PCP cited many advantages of referring their patients, including health benefits, social benefits, and wider benefits to the sustainability of the NHS. PCP celebrated that patients who were *"totally inactive"* had transformed their lives and were now "*really enjoying doing exercise and getting a great result from it"* (GP3). The HLPs were also celebrated as *"a way of getting people into a community"* (PN4) to combat loneliness and isolation and a "*good investment"* that could save the NHS "*thousands and thousands of pounds on diabetes, and all those other diseases"* (GP5).

Some PCP praised individual HLPs run in ERL centres. For example, one HCA praised how the LiveWell programme is "*a good course"* that is *"not to be wasted"* because *"a friend can go"* (HCA1). Others spoke enthusiastically about the ERS and

testified they "*always talk about Exercise Referral for chronic disease patients, [and] obese patients"* (PN6). The positive working relationships established between GP surgeries and surrounding leisure centres may help to explain this enthusiasm for specific HLPs. Some PCP discussed their experiences of shadowing a selection of HLP sessions at the leisure centres, which they felt helped them have conversations with eligible patients about what to expect. Moreover, Medical Secretaries referred to the leisure staff as "*brilliant"* (MS1) and described feeling comfortable approaching them "*if there [was] a problem for any reason"* (MS2).

PCP explained how they were often prompted to make a HLP referral when a patient presented with health complaints or conditions *"associated with an unhealthy lifestyle"* (PN1) which PCP were keen to "*not medicalise"* (GP4). Such complaints included physical, psychological, or social health concerns that were "*often linked"* (NP2). PCP described how "*overweight, inactive"* patients presented with *"aches, pains"* and *"depression*" (GP2), which was a "*really common picture"* (NP1). Other times, psychological or social issues were reported to be a main trigger for HLP referrals to "*break isolation, or as a stress management thing to build routines"* (GP6).

Higher-order theme 2.2: Patient

High awareness of the HLPs, and high levels of motivation were identified as important facilitators of referral in relation to a patient.

Lower-Order Theme 2.2.1: High Awareness of the Healthy Lifestyle Programmes

Some PCP celebrated that they were reaching the "*tipping point of public awareness"* (GP4) in relation to the HLPs offered at ERL centres. These PCP assumed that a high awareness amongst the public was associated with increases in the number of patient-initiated referrals to these programmes: "*often it comes up when a patient asks me for it rather than necessarily me thinking of it*" (GP3). Specifically, it was reported that there had been "*an increasing number of patients come in asking for Exercise on Prescription"* which they attributed to "*the message getting out there"* (GP4).

Subtheme 2.2.1.1: Promotion of the Healthy Lifestyle Programmes

An increase in promotional material and marketing of the HLPs were regarded as factors contributing to enhanced public awareness. Selected PCS made special efforts to increase their patient's understanding by allowing leisure staff to "*promote"* (HCA1) the programmes within the waiting rooms of GP surgeries. This was described as "*good for getting referrals onto the programmes"* (CLW2), yet only possible when strong working relationships were established between GP surgeries and surrounding leisure centres. One Healthcare Assistant explained how many patients approach PCP requesting a HLP referral because the general practice site *"always have big banners up"* (HCA1) to advocate the HLPs.

Lower-Order Theme 2.2.2: High Levels of Motivation

High patient motivation to change was recognised as a key factor facilitating HLP referrals. In the event of a significant health diagnosis, particularly those associated with an unhealthy lifestyle, PCP reported that patients were more motivated to change their lifestyle behaviours, and more receptive of HLP referrals.

> PN4: "*With a new diagnosis, it's great to be able to give them something and say shall I just send a referral for you? ... it balances off the negativity of the diagnosis…I would say a good 60% are motivated to change their lifestyles at that moment."*
>
> GP5: "*Once we tell them there's a direct link between your weight and a unhealthy lifestyle and your problems that you come with, so they, they really then become keen."*

Other times, it was reported that patients sourced their own motivation to change their unhealthy lifestyle behaviours irrespective of a significant health diagnosis, and requested support from a PCP. It was argued that patients "*ready for lifestyle behaviour change, often come asking"* for a HLP referral, and have "*already found out about it"* (GP1). One NP discussed how it was *"easier"* to refer motivated patients because they were *"halfway there"* (NP2). This Nurse continued to explain, "*You're probably more likely to get a compliant and motivated patient if they have come in and asked for it".*

Higher-Order Theme 2.3: Healthy Lifestyle Programme Referral Process

Some PCP discussed the benefits of different HLP referral processes (i.e., the paper-based referral forms and the electronic referral system).

Lower-Order Theme 2.3.1: Ease of Paper Referrals

In contrast to those PCP who reflected heavily on their negative experiences of making HLP referrals using paper-based referral forms (see lower-order theme 1.3.2), others viewed paper referrals as "*fairly straight forward*" (PN2), "*everyday practice"* and "*no more than filling out an x-ray form"* (GP8). These PCP trusted they could "*discuss it with [patients], get their signature, consent and finish it then and there within ten minutes of consultation"* (GP5), and had "*enough time to go over that and do everything"* (NP1). Moreover, some PCP praised the timely processing of paper-based referral forms at ERL centres, emphasising the psychological benefits for a patients of a quick transition between a PCP initiating a referral and the intervention starting.

> GP3: *"I'm very pleased with how quickly they pick them up… there's a huge benefit of being very quick in the sense that people when making a decision will have two thoughts in their head about, do I really want this, or do I not? At the point that they have told me they will, that motivation is there. I think that's the time that it needs pushing over the line."*

Lower-Order Theme 2.3.2: Ease of Electronic Referrals

Contrary to those who experienced difficulties referring to the HLP electronically (see lower-order theme 1.3.3), others celebrated the benefits of making referrals via this system. These PCP believed the transition from paper to electronic referrals *"made it a lot easier"* (PN5), and *"quicker"* (MS2) to complete. Electronic referrals were considered common practice in general practice and HLP electronic referrals were reported to take only "*minutes"* (MS2) to complete. Additionally, some PCP were supportive of booking a patient's first ERL appointment, a novel feature of the electronic referral system. These

individuals believed that making an "*appointment at the time [of referral] is useful*" (PN1), and especially advantageous for patients *"quite keen to get started"* (CLW2). It is important to state that GPs did not hold the same views and instead were critical of the booking feature as it escalated the time it took to complete a HLP referral.

6.5 Overarching Theme 3: Suggestions to Improve Healthy Lifestyle Programme Referral Processes

In light of the multitude of factors perceived to negatively influence HLP referrals, PCP were forthcoming in proposing different ways to enhance the referral process. Lower-order themes of 'strategies to increase awareness of lifestyle promotion and the HLPs', 'improving working relationships', 'improving feedback provision', and 'simplification of HLP referral processes' were highlighted as main areas for development.

Higher-Order Theme 3.1: Strategies to Increase Awareness of Lifestyle Promotion and the Healthy Lifestyle Programmes

Numerous suggestions were put forward to increase awareness of lifestyle promotion and the HLPs available to support lifestyle behaviour change amongst the public and PCP.

Lower-Order Theme 3.1.1: Marketing and Promotion for the Public

There was a pronounced advocation for improved HLP marketing and "*promotion directly to the patients*" (GP7) and the public to increase programme visibility, and facilitate patient-initiated referrals in primary care. One PN postulated, *"If patients knew about it more, they would ask about it more, and we would have to use it more"* (PN1). Suggested strategies to increase patient awareness of the HLPs were wide-ranging and included displaying leaflets in GP surgeries, cafés, and council services. Media outlets such as local newspapers, GP webpages, local radio broadcasts, as well as public transport advertisement, and celebrity endorsement were also advocated as means to increase awareness. In addition, PCP supposed that "*more publicly available information about the benefits"* (NP3) of PA would help to *"normalise"* (GP7) PAP and increase receptivity towards HLP referrals. This was also anticipated to facilitate a shift in "*the culture"* whereby patients feel "*fobbed off if that's what they get instead of a more traditional medical intervention*" (NP3).

Lower-Order Theme 3.1.2: Healthy Lifestyle Programme Information Resources for Primary Care Personnel

PCP highlighted the value of HLP information resources for themselves, which they predicted *"might improve referral"* (GP2). They explained how it would be "*nice to have something to reference"* (CLW2) such as a "*crib sheet"* (NP3) to enable them to quickly appraise a patients suitability for referral. Moreover, it was suggested that information resources would lessen the pressure on them to "*remember everything"* (CLW2) in relation to the HLPs. GPs in particular stressed that they should be "*reminded*" with "*some bullet points of the salient features of each service*" (GP7) or provided with "*an outline of the criteria…because staff change*" (GP2). It was emphasised that such

resources must be brief. One GP proposed a limit of "*3 points"* because it is "*more likely to stick then 5 pages of small print"* (GP9). Overall, PCP demanded "*more documentation"* and *"more leaflets"* (CN1)**.** They argued the *"consistency is the bit that is lacking",* as the referral form and programme information are *"not both available at the point of making the referral"* (GP3). Reportedly, this prevented them being able to *"reliably deliver the right services to the right people"*.

Higher-Order Theme 3.2: Improving Working Relationships

Some PCP sought closer working relationships with themselves, and ERL professionals. One Practice Manager of several PCS requested more information on "*how the structure works and how they [leisure professionals] do communicate with us [PCP]"*, maintaining "*there needs to be a bit of engagement"* (PM1). Moreover, a PN who had worked in multiple PCS stated that she did not "*know [the Hornsea leisure centre staff] as well [as the Bridlington leisure centre staff]"* (PN4). This was indicative of the hazy collaboration between different PCP and those delivering the HLPs.

Higher-Order Theme 3.3: Improving Feedback Provision

There was a pronounced paradox concerning the patient progress feedback provided by ERL professionals to PCP, and the feedback desired. There was an underlying assumption that PCP "*don't seem to be getting told the full feedback*" (PM1) from ERL. PCP explained how they wanted to be provided with more tangible, meaningful feedback from the leisure centres as it was believed to *"help with [patient]*

monitoring" (NP1), and "*aid [future] consultations"* (GP1) with patients. Moreover, PCP reported that improving the provision of feedback "*would help [them] to understand [the programmes] a bit more*" and "*build [their] confidence*" (GP5) in the effectiveness of these programmes. PCP supposed that improvements to the provision of feedback could be *"use[d] as encouragement"* during future consultations with patients who have completed a HLP, to help them sustain their behaviour changes and prevent them reverting "*back to their old habits*" (GP7). One GP discussed how feedback regarding previously referred patients could be used to motivate and empower other patients eligible for the HLP:

> GP5: *"It makes patients more confident when you give them the data… You can force those points to the patient, and you can empower them."*

There were conflicting accounts regarding the content of desired feedback from ERL, which ranged from the bare minimum to a comprehensive account of patient's progress and "*engagement*" (GP9). Some PCP sought minimal feedback from ERL such as aggregate information pertaining to *"the number of patients who completed"* (GP2) or individual feedback relating only to a referred patients original *"reason for attendance"* (GP1). Other PCP wanted much more advanced feedback such as a *"status report before discharge"* to enlighten PCP on *"what type of exercise [a patient] found useful"*, and "*how well they engaged"* with *"weight loss, healthy eating*" and *"lifestyle advice"* (GP9). Changes to a patient's "*confidence levels", "mood", "personality",* and *"overall future plans"* were amongst other suggestions for more "*holistic"* (GP5) patient feedback. Irrespective of the desired content of feedback, PCP stressed they "*don't want bits of paper*" and instead "*feedback needs to be electronic*", so it can be audited in the patient record on "*clinical systems*" (GP1).

Higher-Order Theme 3.4: Simplification of Healthy Lifestyle Programme Referral Processes

PCP argued that the HLP referral process currently lacks the simplicity for optimal use, and instead must be "*very user friendly*", "*simple*" (MS1), "*quick, and easy*" (GP1). To help simplify the process of making referrals, PCP proposed several changes including ensuring the referral process is compatible with existing clinical systems, modifying the electronic referral system, and having a central point of access for HLP referrals.

Lower-Order Theme 3.4.1: Clinically Compatible Electronic Referral Processes

One of the most vital improvements required according to PCP was that the current electronic referral system must link with existing primary care clinical systems in the region (e.g., SystmOne & EMIS). This was a strong indicator that few surgeries were set-up to refer patients through the HLPs interactive PDF housed within clinical systems. The possibility of interoperability between primary care and leisure IT systems was described as a fundamental step to streamline referral, and to alleviate perceived referral difficulties. GPs insisted they needed *"an electronic referral form that is compatible with SystmOne and the EMIS practices"* (GP2), to *"make it easier"* because it would encompass *"all the information on that needs to go on this [referral] form"* (GP1). Some PCP referenced the GP forward view (2016) and maintained that to reduce GP workload, PCP must "*do everything in a single system"* (PM1). One GP contended that "*until the IT is sorted",* ERL "*won't get any further uptake*" (GP2) on their HLPs.

Subtheme 3.4.1.1: Anticipated benefits and Limiting Factors

Many benefits relating to a clinically integrated electronic referral process were envisioned amongst PCP, which included time saving, proactive referrals, audit trail, and feedback loop. According to PCP, all the information required on a HLP referral form could be "*pre-populated*" from clinical systems at the "*click of a button",* which would *"save loads of time"* (GP9) and provide ERL with "*much clearer and much more accurate information*" (GP2). GPs articulated how they could also programme clinical systems to automatically identify eligible candidates and send these patients information pertaining to the HLPs.

> GP1: "*There should be certain triggers that suggest that, that this is an option. You know, if I put someone's BMI as over 30 then actually you know, we can programme these systems, so it asks, do you want to refer this patient for exercise on referral?"*

This proactive approach to making HLP referrals was anticipated to improve patient reach whilst removing the responsibility for PCP to actively seek out eligible patients. As one GP put it: *"a lot of people are getting missed"* because *"clinicians have a lot to think about in a consultation*" so "*we need to use IT to help*" (GP1). The ability to audit the transmission of patient information to ERL centres was recognised as another benefit of clinical integration. Moreover, PCP discussed how an integrated electronic referral system could provide a means of transferring feedback from ERL centres to PCP regarding a patients progress.

Whilst there was a powerful desire for a clinically compatible electronic referral system, some PCP appreciated that it is *"very difficult to integrate [with existing clinical systems], probably to the point where it would be impossible"* (GP3). One individual alluded to "*money exchanges"* (PM1) that clinical system providers may request to form links between clinical systems and ERL systems. Other PCP discussed data protection and privacy laws governing the movement of patient data (e.g., GDPR) and the importance of coding being "*at the right encryption levels"* (GP3). The idea of a clinically integrated electronic referral process "*populat[ing] everything"* including *not relevant"* or *"sensitive"* information was described as a key *"problem with self-populated forms"* (GP9). This GP discussed the importance of being able to manually omit irrelevant or sensitive information from HLP referral forms if in the future auto-population occurs.

Lower-Order Theme 3.4.2: Improvements to the Electronic Referral System

PCP using the current electronic referral system to make HLP referrals (i.e., BEARS) put forward several recommendations to improve this system. First, they envisioned the electronic referral system offering real-time validation, such as *"feedback at the time that [a referral] is or isn't appropriate"* (GP3). Secondly, PCP emphasised the importance of referral *"prompts"* embedded within electronic referral systems to remind PCP that *"fields must be filled out"* (MS1). This was anticipated to facilitate full and correct completion of HLP referral forms. Thirdly, PCP voiced hostility towards booking a patient's leisure appointment (see lower-order theme 1.3.3) arguing that they wanted to *"just send [a patient's contact] details [for] the leisure services to book them in"* (CLW3).

Lower-Order Theme 3.4.3: Central Point of Access

Numerous PCP were in favour of "*a single point of access*" (GP8) to make HLP referrals via "*a single [referral] form* (PM1). Given the difficulty of remembering individual programme nuances, a universal referral form for all HLPs was anticipated to overcome the *"problem [of] getting people in the right place"* (GP4). PCP envisioned ERL undertaking "*triage at the far side to get people into the right spot*" (GP3) rather than the responsibility falling on them to select the most appropriate programme for a patient at the point of making a referral. Moreover, a small selection of PCP proposed having one intermediary in each GP surgery who could be responsible for completing all HLP referral administration. According to these PCP, these individuals could serve as a *"central point"* which would *"save the nurse's time and the GP's time"* (CN1).

6.6 Summary

This chapter intended to present interview findings from the first phase of this research project. Findings from these 1:1 qualitative interviews encapsulated the perspectives and experiences of twenty-eight PCP involved in referring patient populations to the HLPs. Inductive thematic analysis facilitated the identification of three overarching themes, encompassing multiple higher-order themes, lower-order themes, and subthemes. These have been exemplified using compelling participants quotes.

To summarise these findings, many PCP placed high importance of PAP, yet felt they lacked the necessary skills and training to engage with it. They perceived themselves to be ill-informed about local leisure provision (i.e., the HLPs). Overly complicated and cumbersome referral processes made it challenging for PCP to make HLP referrals. PCP also made subjective assumptions about their patients barriers to changing unhealthy lifestyle behaviours, which in their opinion, compromised their promotion of, and their patient's receptivity towards PA. PCP voiced multiple suggestions to improve the current referral pathway. Amongst the most pertinent suggestions was the need to enhance HLP awareness amongst both the medical community and the public, to improve the provision of patient progress feedback, and to simplify referral processes through the implementation of an interoperable referral system.

7 METHODS: PHASE II

7.1 Introduction

The purpose of the present chapter is to detail the methods used in the second phase of data collection whereby the focus of exploration extends to Leisure Professionals and Leisure Customers. It begins by justifying the use of a mixed methods approach and presents the philosophical assumptions from which this second research phase is based. The chapter precedes to detail the research aims before describing the nuances of participant eligibility, recruitment, and the methods adopted. Subsequently, data collection and analysis procedures are described before consideration is given towards quality measures and potential ethical issues.

7.2 Research Methodology

7.2.1 The Value of Mixed Methods

As outlined in section 5.6.1, mixed methods is an inclusive, pragmatic, and complementary philosophy that provides a bridge between qualitative and quantitative philosophical dichotomies (Johnson & Onwuegbuzie, 2004). Ritchie et al. (2013) argue there are endless opportunities to combine qualitative and quantitative methods within a particular area of enquiry. This mixing of methods enables new possibilities for interpretation and elicits findings superior to mono-method studies because the inherent shortcomings of one method are offset by the strengths of another, which can help to produce more complete knowledge (Atieno, 2009; Creswell & Clark, 2017; Johnson & Onwuegbuzie, 2004; Thomas, 2003). For example, qualitative research is criticised for its inability to produce findings that can be extended to wider populations (Atieno, 2009; Creswell & Clark, 2017). However, by incorporating quantitative methods, numerical

values can be allocated to words and narratives to give statistical weight and precision, and to help infer a degree of certainty regarding their significance (Johnson & Onwuegbuzie, 2004), harvesting greater depth and understanding (Creswell & Clark, 2017; Johnson & Onwuegbuzie, 2004). Furthermore, although quantitative research has its strengths in determining cause and effect, it is incapable of fully capturing the complexity and richness of human experience and context (Israel et al., 1995). By integrating qualitative methods, quantitative findings can be embellished with detailed narratives of human experiences and viewpoints to attach meaning to numbers. Johnson and Onwuegbuzie (2004) argue that mixed methods studies add insights and understanding that are potentially overlooked with mono-method studies, and can facilitate more solid conclusions through converging and corroborating research findings.

7.2.1.1 Mixed Methods Designs

The undertaking of a mixed methods study requires researchers to make decisions around the timing between qualitative and quantitative research strands, the relative importance of these strands (also known as priority or weight), and the integration of results. The timing of individual research strands can be either concurrent (i.e. quantitative and qualitative data is collected at identical times or independent of one another; Clark & Ivankova, 2015) or sequential (i.e. quantitative and qualitative data is collected in sequence either following or dependant on the other; Clark & Ivankova, 2015). Mixed methods studies can have either a quantitative priority (i.e., prominence towards the collection and analysis of quantitative data), qualitative priority (i.e., prominence towards the collection and analysis of quantitative data) or equal priority (i.e.

equivalent emphasis is placed on both qualitative and quantitative data collection and analysis; Clark & Ivankova, 2015).

Integration refers to the combining of quantitative and qualitative methods within a mixed methods study. O'Cathain, Murphy, and Nicholl (2010) define integration as "*the interaction or conversation between the qualitative and quantitative components of a study*" (pp. 1147). Integration can occur at different time points but typically, it occurs either concurrently following the completion of respective data collection and analysis, or sequentially during data collection, where the results of the first research phase are used to inform the design and data collection of the second phase (Clark & Ivankova, 2015). Decisions around the utilisation of mixed methods can be predetermined from the study outset (known as fixed mixed method designs), or used in response to issues during the conductance of the research, which require adjustments to the research strategy (known as emergent mixed methods designs).

There are a wealth of mixed methods designs in the literature and so decisions must be made around which are most meaningful for the research. Creswell and Clark (2017) describe four overarching mixed methods designs: convergent (otherwise known as a triangulation design), explanatory, exploratory, and embedded. The following section gives a brief overview of each of these designs before detailing which design was most appropriate for the present study.

First, researchers adopting a convergent design concurrently collect and analyse quantitative and qualitative data sets separately to produce two sets of findings (O'Cathain et al., 2010). Next researchers combine these findings at the interpretation stage of a study through the triangulation process to elicit a more complete understanding of the phenomena of interest (O'Cathain et al., 2010). Triangulation is a process whereby researchers apply a coding scheme to study components to identify areas of agreement (also known as convergence), partial agreement (some convergence between findings), silence (one set of findings identify a theme, but another does not) and dissonance (disagreement or conflict between findings; O'Cathain et al., 2010). Convergent designs are particularly well suited to mixed methods research comparing different perspectives on a particular topic (Cresswell & Creswell, 2017).

Second, an explanatory mixed methods design is a two-phase mixed method design which lays more emphasis on quantitative methodologies. It proceeds by initially collecting and analysing quantitative data, before collecting and analysing qualitative data, often for the purpose of explaining or building upon initial statistical findings and explaining outliers or surprising results.

Third, in contrast to an explanatory design, an exploratory design gives more prominence to qualitative data, whereby the sequential collection and analysis of qualitative data precedes quantitative data. There are three main premises for adopting this two-phase mixed methods design: 1) for theory or instrument development, 2) to help

establish generalisability of qualitative research findings, and 3) to identify important variables to study quantitatively when variables are unidentified.

Fourth, in an embedded research design, one methodology (e.g., qualitative) provides a supportive, secondary role to an opposing research methodology (e.g., quantitative). This design affords a researcher the flexibility to embed a secondary data strand whenever they deem necessary for the purpose of addressing multiple research questions that cannot be sufficiently answered with a single data set. This secondary data strand can be embedded either before, during or after the collection and analysis of the dominant research strand situated within a traditional quantitative or qualitative research design. According to Creswell and Clark (2017), embedded research designs are primarily suited to researchers embedding a qualitative component within a larger quantitative research design.

7.2.2 Rationale for a Mixed Methods approach

In response to recruitment issues experienced during phase I of this PhD, it was considered appropriate to adjust the research strategy from a purely qualitative stance, and utilise a mixed method design to offer flexibility to data collection. Thus, this was a pragmatic and emergent mixed methods study dictated by circumstance. It was felt a convergent (otherwise known as triangulation) design was the most appropriate as this approach is well suited to mixed methods research exploring different perspectives on a topic (Cresswell & Creswell, 2017). Convergent mixed methods designs are also valued for their ability to produce more complete knowledge, and more solid conclusions

through converging and corroborating research findings (Johnson & Onwuegbuzie, 2004). This is complementary to the overall thesis aim (see section 1.6), which endeavoured to obtain a nuanced understanding of the HLP referral processes from the perspectives of all involved stakeholders (i.e., PCP, Leisure Professionals, and Leisure Customers).

Online surveys (quantitative strand) and one-to-one interviews (qualitative strand) were conducted concurrently within the same time frame with equal weighting to produce two sets of findings. Online surveys were perceived to be both pragmatically and logistically appropriate, allowing participants to complete at a time and place most suited to them. Specifically, data was collected through online surveys from ERL service providers (i.e., RSAs and FPs), and ERL service users (i.e., Leisure Customers) to unpack their perspectives and experiences of the referral process. These surveys also served as a vehicle to access a population to interview to further uncover and understand complexities of referral processes. Thus, individual interviews were undertaken with a self-selected sample of survey respondents. Each data collection method and cohort were given equal priority. In line with a convergent design, qualitative and quantitative research strands were analysed separately to produce two sets of findings (O'Cathain et al., 2010), before being amalgamated to provide a merged account of their significance together to provide an extended, nuanced understanding of referral processes.

7.2.3 Philosophical Assumptions Underpinning Phase II

Phase II of this research project marks a shift in the primary researcher's paradigmatic underpinnings. Specifically, this phase draws upon two key philosophical

standpoints, interpretivism and pragmatism. Researchers claiming an interpretive affiliation favour research methodologies that are receptive to appreciating phenomenon from the subjective experiences of those studied (Creswell & Creswell, 2017). In the case of this mixed methods phase of the research project, phenomenology, a major branch of interpretivism, served as an underpinning research methodology as it strives to comprehend phenomenon through the lived experiences of individuals and their social reality (Creswell & Creswell, 2017). The embracement of interpretivism and specifically phenomenology is reflected in the researcher's loyalty to comprehend HLP referral processes by generating thick descriptions of key stakeholder's subjective thoughts, feelings, perspectives, and individual lived experiences. The acceptance of pragmatism is manifested in the concurrent combination of qualitative and quantitative research strands to build an extended understanding and insight of the referral process. These methodological approaches were selected based on their ability to best address the research questions posed within the contextual circumstances, rather than their ability to demonstrate philosophical coherence.

7.3 Study Aims

Gidlow et al. (2008) is an advocate of research focused on the perceptions and experiences of all stakeholders involved in PA referral schemes to achieve a more holistic understanding of such schemes, and pinpoint developmental areas. For this reason, the second phase of this research project sought to extend the scope of exploration using a mixed-methods study design to unveil the views and lived experiences of others involved in HLP referral processes and attain a more fruitful, nuanced insight. Specifically, it intended to illuminate the perspectives of three separate cohorts through online surveys

and optional follow-up interviews: 1), RSAs involved in the processing of HLP referrals (e.g., BTs and FCs) 2), FPs involved in the delivery of the HLPs and 3), Leisure Customers who had previously completed a HLP. This second research phase set out to meet the second and third primary thesis objectives (see section 1.6).

7.4 Ethical Approval and Access Permissions

Ethical approval was sought by the Faculty of Health Sciences Research Ethics Committee at the University of Hull and granted on January 23rd, 2019 (Reference No: FHS103; See appendix 7.5.). The Senior Business Commissioning Officer of ERL provided permission for the primary researcher to recruit and conduct interviews on ERL premises for the duration of the research project (see appendix 7.6.).

7.5 Participants

Collectively, sixty-eight individuals shared their thoughts, feelings, and perspectives in relation to HLP referral processes through completion of an online survey (see section 7.9.2). Upon survey completion, fifty participants volunteered to participate in a follow-up interview (see section 7.9.3) to further discuss their individual perspectives and lived experiences. Thirty-six follow-up interviews were undertaken before data saturation was reached, at which point, data collection ceased. The following sections provide a breakdown of each cohorts' contribution to data collection.

7.5.1 East Riding Leisure Professionals

7.5.1.1 Referral Scheme Administrators

Twenty-two online surveys were completed by RSAs. Six survey responses were removed from the analysis as they were filled out by FPs who had followed the incorrect survey link. An overview of participant characteristics who completed the online survey can be found in Section 8.2.1. Eleven RSAs agreed to participate in a 1:1 follow-up interview (see 8.3.1 for participant characteristics). These interviews endured until data saturation was reached, which occurred at ten interviews.

7.5.1.2 Fitness Professionals

Thirty-two FPs completed the online survey. Twenty-two consented to participate in a follow-up interview, fourteen of which were undertaken before data saturation was reached. Sections 8.4.1 & 8.5.1 provide details of FP characteristics participating in the online survey and follow-up interviews, respectively.

7.5.2 Leisure Customers

Twenty-two Leisure Customers volunteered to participate in the online survey. Two customer survey responses were removed from analysis, as they did not fulfil eligibility criteria (see 7.6.2). Of the twenty eligible customers, seventeen agreed to partake in a follow-up interview. Interviews were arranged with twelve of these individuals at which point, data saturation was reached. Characteristics of ERL customers

participating in the online survey and follow-up interviews can be found in section 9.2.1 & section 9.3.1 respectively.

7.6 Eligibility Criteria

For study inclusion, all participants must be over the age of 18, English-speaking, and able to provide informed consent. Additional specific eligibility criteria were defined for each of the three cohorts, which is explained in the following section. Participants unable to meet any aspect of the eligibility criteria were excluded from participation.

7.6.1 East Riding Leisure Professionals

7.6.1.1 Referral Scheme Administrators

For inclusion of RSAs, at the time of recruitment, they had to be actively involved in the processing of HLP referrals from PCP.

7.6.1.2 Fitness Professionals

For inclusion of FPs, at the time of recruitment, they had to be actively involved in the delivery of these programmes.

7.6.2 Leisure Customers

For inclusion of customers, they must have been referred onto a HLP by a PCP, successfully completed their programme, and signed up for an ERL membership post programme completion. These criteria were chosen because it enabled these individuals to reflect on their experiences of referral having gone through the entire journey- starting from their early encounters as a patient presenting in their GP surgery to eventually becoming autonomous leisure centre users. It also allowed them to consider how their initial referral experiences in primary care and at the leisure centre affected their experiences on a HLP.

7.7 Sampling Strategy

Purposive sampling and snowball sampling strategies were utilised to target prospective individuals from each of the three cohorts. Purposive sampling was adopted to intentionally pursue appropriate individuals, and deliberately target a diverse and representative sample. Snowball sampling was implemented following interviews, whereby individuals were asked to provide recommendations of others who may be interested in participation. This was especially useful in establishing regional balance, that is, ensuring each sample was representative of each leisure site amongst the ERoY.

7.8 Recruitment Method

7.8.1 East Riding Leisure Professionals

Recruitment was staged into two separate waves for pragmatic reasons. First, recruitment focused on ERL Professionals (i.e., FPs & RSAs). In December 2018, the principal investigator liaised with ERL's Healthy Lifestyle Officer (HLO) to pursue Leisure Professionals. On behalf of the principal investigator, the HLO distributed email invitations (see appendix 8.1. & 8.2.) to all relevant leisure employees (RSAs: n = 16, and FPs: n = 52) across all ERL sites, except one due to its closure for refurbishment (i.e., ERL South Cave). These emails contained a unique QR code and web link that directed interested ERL employees to the correct survey for their cohort. Furthermore, the HLO invited the principal investigator to attend on-site meetings with FPs to facilitate recruitment. Of the sixteen email invitations distributed to RSAs, sixteen RSAs completed the online survey (response rate 100%). Of the fifty-two FPs who were invited to participate, thirty-two volunteered (response rate 61.54%).

7.8.2 Leisure Customers

The second wave of recruitment for customers commenced two months later in February 2019. Recruitment posters (see appendix 8.3.) were displayed in each of the nine operational ERL sites inviting customers to complete the online survey. Posters had a QR code and a web link to permit multiple means of access to the survey. The principal investigator also visited several leisure premises with an iPad to facilitate on site recruitment. It is not possible to calculate an accurate response rate for this cohort because customers were not directly invited to participate.

7.8.3 Pre-requisites of Recruitment

As part of online survey completion, all prospective participants were directed to an electronic Participant Information Sheet, which detailed the studies purpose, potential risks and benefits, what participation entailed, how results would be used and disseminated, and participant rights to withdraw. Participants were required to provide their consent electronically by ticking an Informed Consent Declaration before proceeding to survey questions. Upon survey completion, participants were directed to a debrief statement, which detailed the principal investigator's contact details for the purpose of participant queries or withdrawal. The concluding survey question invited respondents to partake in a follow-up interview. Interested participants provided their name, email address and contact number and were therefore self-selected. Subsequently, the principal researcher contacted these individuals, provided an electronic Participant Information Sheet and Informed Declaration Consent Form (see appendix 7.4.), and arranged a mutually convenient date and time for a 1:1 interview on ERL premises. The primary researcher reiterated the research purpose, provided reassurances of confidentiality, and invited questions prior to interview commencement. Willingness to participate in follow-up interviews was attained through a signed and dated hard copy informed consent declaration form.

7.9 Research Method

Online surveys (see section 7.9.2) were selected as the primary research instrument for pragmatic reasons, given the difficulties experienced during recruitment

of PCP for 1:1 interviews. Surveys were developed using Jisc Online Surveys (formerly known as Bristol Online Survey), which is a secure, reputable platform for developing web-based surveys. Surveys are a descriptive data collection tool, that aim to depict how many individuals within a particular population possess a certain characteristic or belief (Dangerfield, 2018). Surveys are less demanding compared to qualitative interviews, yet still permit the researcher to draw inferences about the wider population based on findings from a sample (Bowling, 2014). It has been argued that survey respondents are afforded more time to think about the questions asked, and provide meticulous, thoughtfully crafted answers in comparison to qualitative interviews, which in essence require an immediate response (Dialsingh, 2011). However, surveys are sometimes criticised for "*forfeit[ing] depth in favour of breadth*" (Denscombe, 2014, p. 50), which may compromise understanding. Jansen (2010) distinguishes between different types of surveys: traditional surveys, that aim to establish quantitative parameters (e.g. means and frequencies), and qualitative surveys, which intend to establish meaningful variation and diversity. In line with a qualitative dominant mixed methods research approach, survey questions for all cohorts were predominantly open-ended with unlimited character free text space to permit unrestricted qualitative expression of opinion. Albeit less common, surveys also featured closed-ended questions to offer some numerical understanding of participant experiences and perspectives through for example, Likert scale questions. However, the primary interest was towards obtaining rich qualitative data. Thus, surveys also served as a vehicle to access a population to interview where all respondents were provided the opportunity to elaborate on their narratives, thoughts, and feelings.

Bespoke preliminary survey and interview schedules were created for each of the three cohorts, encompassing slightly different questions to accommodate for their involvement or interaction with the referral process. Example questions and response formats used within each individuals cohorts online survey can be found in *Figure 7.1*. (RSAs), *Figure 7.2.* (FPs), and *Figure 7.3. (*Leisure Customers). Survey questions were informed by informal conversations with ERL professionals (i.e., FPs and HLOs), formal conversations with the supervisory research team (CD & SN), and findings of prior literature in the context of PA interventions. Specifically, studies such as Moore et al. (2011) and Graham (2006) helped to inform the development of preliminary survey questions and interview schedules for Leisure Professionals (i.e., RSAs and FPs). Research by Birtwistle et al. (2018), Wormald and Ingle (2004), and Graham (2006) assisted in the development of survey questions and interview schedules for leisure customers. Follow-up interview schedules were modified iteratively to encompass anything pertinent from participant responses for further exploration.

7.9.1 Pilot

One month prior to the start of data collection, survey and interview questions for all three cohorts were piloted with a senior member of ERL (i.e., HLO), who was also a former FP. The purpose of this pilot was three-fold. First, questions were checked for appropriateness and clarity to help establish face validity (Lewis-Beck, Bryman, & Liao, 2003). Secondly, it provided an indication of survey and interview length (Van Teijlingen & Hundley, 2002). Finally, it provided an opportunity to assess the functionality of the Online Survey platform. Comments and suggestions elicited during this pilot informed the refinement of questions and terminology to provide a final survey and interview

schedule. For instance, preliminary survey questions for customers initially failed to recognise other health professionals outside of primary care who refer onto the HLPs such as Consultants and specialist Nurses who refer to HEART. Subsequently, this inclusion was made. Furthermore, this pilot clarified the correct terminology for the collective group of individuals involved in the processing of HLP referral- '*Referral Scheme Administrators'*.

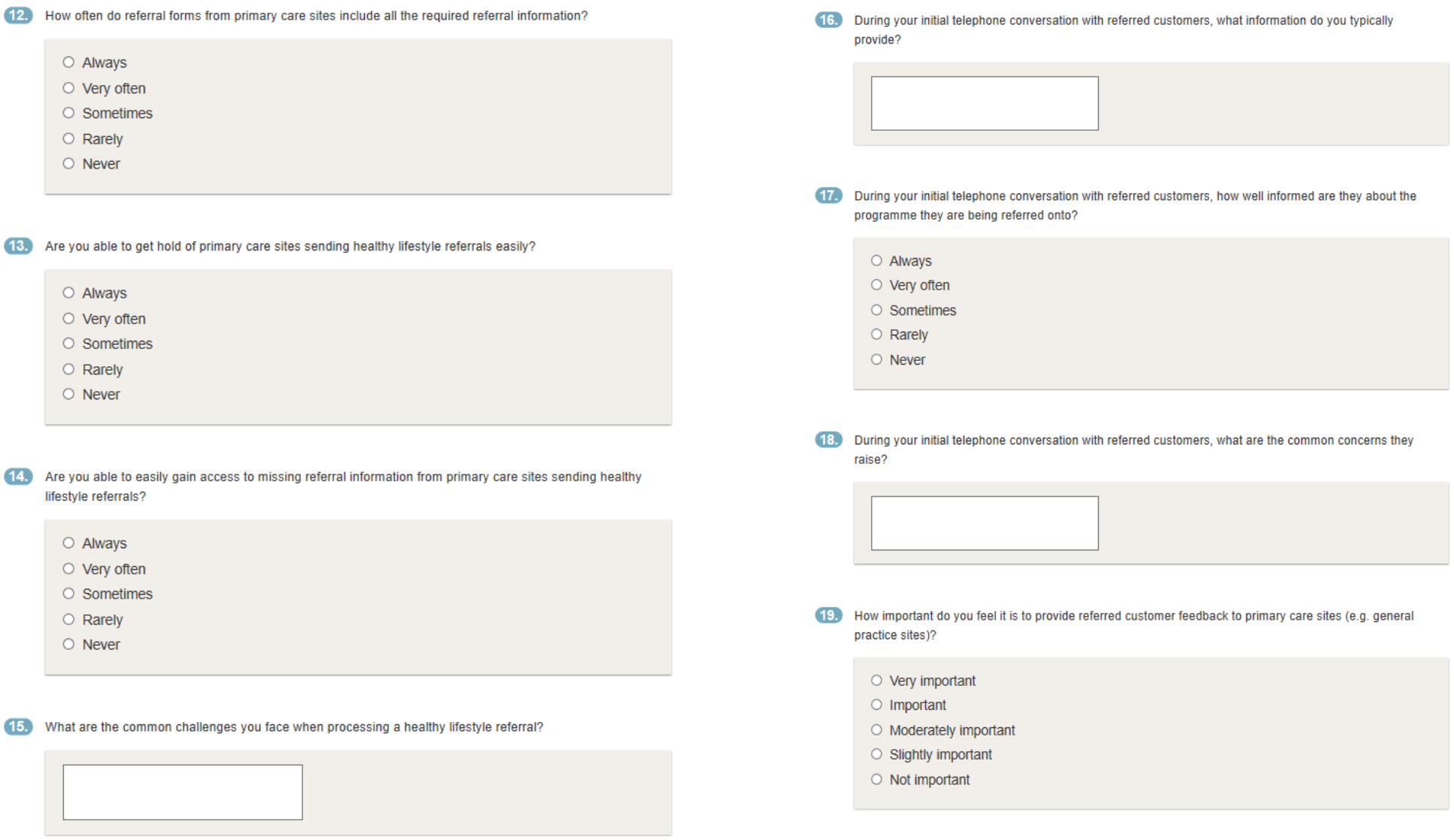

Figure 7.1. Example questions and response formats used within Referral Scheme Administrators' online survey

8. How often are you able to contact a referred customer via telephone prior to their first face-to-face appointment?

- ○ Always
- ○ Very often
- ○ Sometimes
- ○ Rarely
- ○ Never

9. Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply

- ☐ Customer's name
- ☐ Customer's age
- ☐ Customer's current health status
- ☐ Customer's previous medical history
- ☐ Customer's body mass index (BMI)
- ☐ Customer's current prescription/medication list
- ☐ Other

10. Do you feel you are provided with enough information prior to meeting face-to-face with a referred customer?

- ☐ Always
- ☐ Very often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

11. What additional information would be useful to receive prior to your first face-to-face appointment with a referred customer?

12. When meeting your referred customers for the first time, are they typically well informed about the programme they have been referred onto?

- ○ Always
- ○ Very often
- ○ Sometimes
- ○ Rarely
- ○ Never

13. What information would you like referred customers to be provided with prior to their first leisure appointment?

14. When meeting your referred customers for the first time, what are the common concerns they raise?

15. When meeting your referred customers for the first time, what are the common challenges you face?

16. How important do you feel it is to provide referred customer feedback to primary care sites (e.g. general practice sites)?

- ○ Very important
- ○ Important
- ○ Moderately important
- ○ Slightly important
- ○ Not important

Figure 7.2. Example questions and response formats used within Fitness Professionals' online survey

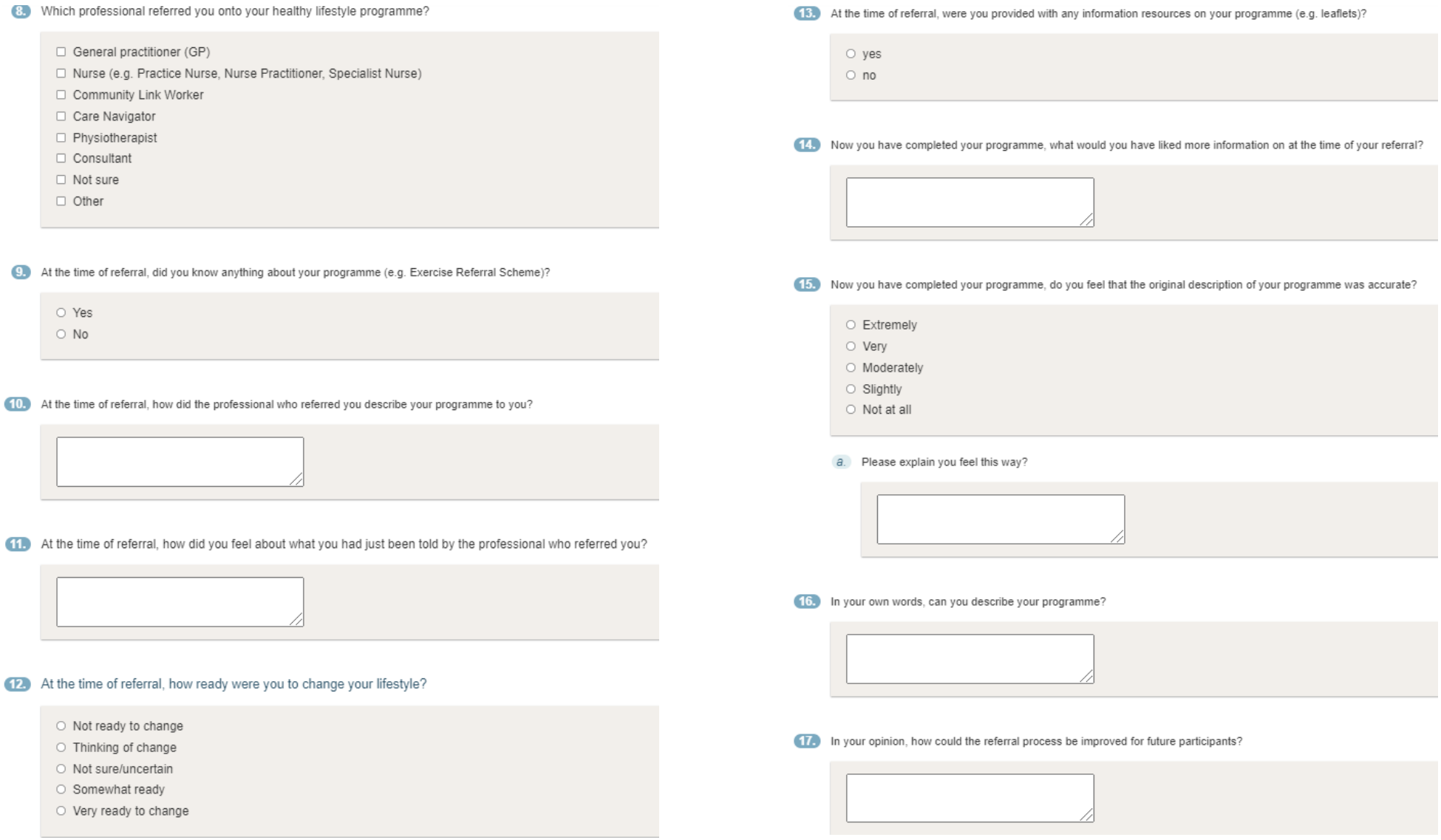

Figure 7.3. Example questions and response formats used within Leisure Customers' online survey

7.9.2 Online Surveys

Each survey commenced with a series of socio-demographic questions, which differed slightly according to each cohort. Following this, questions specific for each cohort were posed, which are detailed in the following sections. Completion of each online survey was anticipated to take around 15 minutes based on pilot tests.

7.9.2.1 East Riding Leisure Professionals Survey Content

7.9.2.1.1 Referral Scheme Administrators

Socio-demographic data collected for RSAs included participant characteristics (i.e., gender and age), and employment characteristics (i.e., role, role experience and base of role). This permitted comparisons between RSA when analysing survey results. Survey questions for RSAs (see appendix 9.1.) focused around four themes: (1) referral information received from PCP (seven questions); (2) their initial interactions with referred patients (three questions); (3) the feedback loop and beliefs about the relative importance of feedback (two questions); and (4) suggested improvements to referral processes (one question). *Figure 7.1*. demonstrates the mix of closed questions (predominantly in the form of Likert) and open-ended questions. This was replicated across all cohort surveys. The final survey question invited RSAs to take part in a follow-up interview to further discuss their perspectives and experiences.

7.9.2.1.2 Fitness Professionals

Identical socio-demographic data extracted from RSAs were also asked of FPs: participant characteristics (gender and age), and employment characteristics (role, role experience and base of role). Survey questions for FPs (see appendix 9.2) revolved around four themes: (1) referral information received by PCP (three questions); (2) FPs interactions with referred patients (four questions); (3) the feedback loop and beliefs about the relative importance of feedback (two questions); and (4) suggested improvements to referral processes (one question). The concluding survey question invited FPs to participate in an optimal follow-up interview to further explore their perspectives and experiences.

7.9.2.2 Leisure Customers Survey Content

Socio-demographics gathered for Leisure Customers comprised of gender, age, and postcode (to compute IMD scores). Programme specific information was also collected to inform the researcher as to what programme each participant was on, and which leisure site was attended, to allow comparisons between lived referral experiences. Furthermore, surgery specific information was collected to relate referral experiences to different general practice sites and PCP stakeholder groups. Survey questions for Leisure Customers (see appendix 9.3.) centered around three themes: (1) experiences of referral (five questions); (2) suggested improvements to the referral process to enhance patient journey (four questions); and (3) progress discussions with PCP and the relative importance of these discussions (three questions). At the conclusion of the survey, Leisure

Customers were given the option to express their interest in a follow-up interview to further discuss their perspectives and experiences of referral.

7.9.3 Interviews

Qualitative interviews were necessary to augment survey data and capture the nuance of each cohort's perspectives and experiences in relation to referral processes. All interviews, irrespective of the cohort, started with a reiteration of the purpose of the study, reassurances of confidentiality and participant rights, and an overview of the broad topics the interview intended to cover. Next, interviews preceded to collect socio-demographic data from each participant, and questions slowly progressed from general to more targeted. All interviews followed a semi-structured format that was neither prescriptive, nor exhaustive to enable respondents to openly discuss their experiences, and raise topics pertinent to them (Brinkmann, 2013; Ritchie et al., 2013). Interview questions were open-ended and exploratory in nature to encourage free expression of thoughts, experiences, and emotions (DeJonckheere & Vaughn, 2019). To add depth and richness to the data and enhance the quality of dialogue probes were used, which are considered equally as important as core questions (DeJonckheere & Vaughn, 2019). At the conclusion of each interview, participants were invited to add anything they felt could further understanding, which was not raised over the course of their interview. The primary researcher kept a reflexive journal to aid reflection on both the process and content of interviews, as recommended by DeJonckheere and Vaughn (2019). All interview schedules were modified iteratively as interviews and data analysis proceeded, allowing the researcher to incorporate emerging trajectories into future interviews.

Participants were given options pertaining to the undertaking of follow-up interviews. The chief advantage of face-to-face interviews lies in the physical presence of the interviewer and the interviewee. This allows the interviewer to appreciate social cues and tailor questioning and probes accordingly (Dialsingh, 2011). Nevertheless, face-to-face interviews can be extremely time-consuming, which often presents recruitment issues. In attempt to avert further recruitment issues, interviewees could choose to participate in telephone interviews for convenience. Telephone interviewing has the advantage of reaching those who would otherwise struggle to participate in face-to-face interviews (Opdenakker, 2006). However, telephone interviewing compromises non-verbal features of an interview (e.g., body language and gestures) due to a lack of physical presence, which can inhibit the interviewer's ability to tailor questioning or probes (Opdenakker, 2006).

The option of a focus group interview was offered to one cohort only- RSAs. Gill, Stewart, Treasure, and Chadwick (2008) identified that interaction is the key ingredients underpinning successful focus groups, which is easier to foster amongst social groups already established as they can usually discuss and challenge one another comfortably. This applied to RSAs who worked in the same office, processing HLP referrals within one leisure centre (i.e., ERL Beverley). Moreover, Berg and Lune suggests that focus groups enable interviewees to "develop ideas collectively, [whilst] bringing forward their own priorities and perspectives" (2016, p. 45), generating a richness to data that cannot be elicited through individual interviews. Therefore, on the grounds of this cohort's size and relationship, it was considered appropriate to hold a focus group interview.

Nevertheless, despite having diverse options, all self-selected survey respondents from each of the three cohorts opted to participate in a face-to-face follow-up interview.

7.9.3.1 East Riding Leisure Professionals Interview Focus and Content

7.9.3.1.1 Referral Scheme Administrators

The interview schedule for RSAs focused on three key topical areas: the referral information received from PCS, their initial telephone contact with referred Leisure Customers, and the feedback provided to PCS. Example questions are evidenced in **Table 7.1** and the entire interview schedule can be found in appendix 11.1.

7.9.3.1.2 Fitness Professionals

The interview schedule for FPs (see appendix 11.2) was designed to explore the referral information received from PCS, their first appointment with referred Leisure Customers, and the feedback provided to PCS. A sample of questions are listed in **Table 7.1**.

7.9.3.2 Leisure Customers Interview Focus and Content

The interview schedule for Leisure Customers centered on their journey onto, during, and beyond their HLP in terms of their interactions with multiple stakeholders (i.e., PCP, BTs, and FPs). **Table 7.1** provides examples of key interview questions and appendix 11.3 presents the full interview schedule.

Table 7.1. *Example interview questions pertaining to each topical area for Referral Scheme Administrators, Fitness Professionals, and Leisure Customers*

Cohort	Interview Topic	Example questions
Referral Scheme Administrator	1. Referral information from PCS	A) What are the different ways you receive HLP referrals from primary care? B) How often do you receive referrals from PCS that include all required information? C) Can you tell me about your experiences of contacting GP surgeries to retrieve incomplete patient information?
	2. Initial telephone conversation	A) During your initial telephone conversation with referred patients, what information do you typically provide? B) When speaking with a referred patient, what are the common challenges you face?
	3. Feedback	A) How important do you feel it is to provide patient progress feedback to PCS? B) What information do you provide to PCS?
Fitness Professional	1. Referral information from PCS	A) What information do you receive prior to your first appointment with a referred patient? B) What additional information would be useful to receive prior to your first appointment with a referred patient? C) How would you describe your relationship with PCS referring to leisure centres?
	2. First appointment with Leisure Customers	A) When meeting your referred patient for the first time, how much do they know about the programme they have been referred onto? B) What information would you like referred patients to be provided with prior to their first leisure appointment? C) When meeting a referred patient for the first time, what are the common challenges you face?
	3. Feedback	A) How important do you feel it is to provide patient progress feedback to PCS? B) Is there anything additional you would like to feedback to PCS?

Cohort	Interview Topic	Example questions
Leisure Customer	1. Primary care visit	A) Can you tell me about what brought you to visit your PCP on the day you were referred to your programme?
	2.Conversation with PCP about the programme	A) Can you talk me through how the topic of referral to your programme was brought up during your consultation? B) Did you feel satisfied with the amount and quality of information provided about your programme? C) What would you have liked more information on? D) At the point of referral, how motivated were you to change your lifestyle?
	3. Process of referral	A) What choices were you given during your referral? B) Did you feel satisfied with your involvement during the referral process? C) Is there anything you would like to see improved about this referral process?
	4. Initial telephone conversations with East Riding Leisure	A) Can you tell me about your initial telephone conversation with ERL? B) What were your initial thoughts/ feelings/ emotions? C) How quickly were you invited to come for your first session on your programme?
	5. Progress discussions	A) How would you feel if your PCP were able to access feedback on your progress? B) What information would you be happy for your PCP to access regarding your progress?

7.10 Data Collection

Data collection occurred over a period of six months, beginning January 2019, and ceasing June 2019. Survey respondents completed the relevant survey via Online Surveys on an electronic device (e.g., mobile phone, tablet, or laptop). The principal investigator visited several ERL sites with iPads (iPad fourth generation) to permit on-site survey completion. All surveys remained live until June 2019. Follow-up interviews with self-selected survey respondents were conducted between January and June 2019, on ERL premises in a quiet space agreeable to the interviewee (e.g., the leisure centre café or a private office space). All interviews were recorded with the same digital device used during PCP interviews (Trustin Professional Digital Audio Voice Recorder). All participants were emailed or posted a copy of their transcription within 4-6 weeks of interview commencement as part of the member checking process. Interviews endured until no new information was generated during the process of analysis, inferring data saturation. This occurred after thirty-three interviews, yet three additional interviews were conducted to ensure that representatives from all ER leisure centres had the opportunity to contribute to understanding.

7.11 Data Analysis of Mixed Methods Data

Data analysis in mixed methods studies involves multiple analytic techniques suited to both quantitative and qualitative research as well as the mixing of these datasets to best address the research question. In a convergent mixed methods study, data is collected and analysed separately to produce two sets of findings, and then findings from each study component are converged (i.e., the process of comparing and contrasting) during the interpretation phase of a study (Creswell & Clark, 2017; O'Cathain et al., 2010).

7.11.1 Data Analysis of Survey Data

Survey response data for all three cohorts (i.e., RSAs, FPs, and Leisure Customers) were exported directly from the Online Surveys platform into a format appropriate for IBM SPSS Statistics (Version 25). Next, the descriptive statistics function in IBM SPSS Statistics was used for each individual cohort's data.

7.11.1.1 Descriptive Statistics of Socio-Demographic Data

Descriptive statistics serve to summarise and describe the numerical (with quantitative significance) and categorical (without numerical significance) characteristics of a dataset. Mean (*M*) is a common measure of central tendency (i.e., average data values), whereas standard deviation (*SD*) is a common calculation of variability (i.e., data spread), both of which were used to analyse numerical (otherwise known as scale) socio-demographic data. Categorical features of participant socio-demographics were "coded" (i.e., assigned numerical values to reflect categorical variables) and analysed using frequencies (i.e., total count) and proportions (i.e., percentages).

7.11.1.1.1 East Riding Leisure Professionals

Socio-demographic data collected on Leisure Professionals (i.e., RSAs and FPs) included participant characteristics and employment characteristics. *M* and *SD* were computed to measure central tendency and variability of RSAs and FPs socio-demographic scale data,

which was participant age and role experience. Frequencies and proportions of socio-demographic categorical data were conducted to report participant gender, their role, which leisure sites they were associated with, and their HLP involvement.

7.11.1.1.2 Leisure Customers

Socio-demographic data collected on Leisure Customers included participant characteristics (i.e., gender, age), geographical information (i.e., postcode used to calculate IMD), and programme specific information (i.e., which HLPs they attended, which ERL site they attended), and surgery specific information (i.e., which general practice site they were referred from and by whom). *M* and *SD* were used to assess socio-demographic scale data including participant age. Frequencies and proportions of socio-demographic categorical data were used to report participant gender, IMD, who they were referred by, which HLP they attended, and which ERL site they attended.

7.11.1.2 Descriptive Statistics of Survey Questions

7.11.1.2.1 East Riding Leisure Professionals

The large majority of RSAs and FPs survey constituted of categorical data. First, numerical value labels were assigned to the data to reflect each categorical variable– a process known as coding. Once data were coded, frequencies and proportions were acquired using the descriptive statistics function in IBM SPSS Statistics. Free text survey responses formed a subsection of RSAs and FPs survey content, which were subject to inductive thematic analysis following the guidance of Braun and Clarke (2006; see section 5.9.2 for a detailed overview).

Collectively, frequencies, proportions, and thematic analysis helped to exemplify RSAs in relation to the processing of HLP referrals, referral information exchanged at the point of referral, initial patient interactions, the feedback loop, key challenges, and suggested improvements to streamline the referral process. The same analyses via frequencies, proportions, and thematic analysis helped to exemplify FPs in relation to the information provided at the point of referral, initial contact with referred patients, the feedback loop, common challenges and suggestions for improvement.

7.11.1.2.2 Leisure Customers

Categorical questions formed the basis of Leisure Customer surveys which were complemented by various free text responses to elicit unrestricted expression of opinion. Categorical questions were analysed through computing frequencies and proportions, whereas free text responses were analysed thematically. Analysis helped to exemplify Leisure Customers in relation to the information provided at the time of referral, initial feelings and emotions experienced at the time of referral, and key areas for improvement to enhance the patient journey.

7.11.2 Data Analysis of Follow-Up Interviews

Follow-up interviews with self-selected survey respondents from all three cohorts commenced with a series of socio-demographic questions, which were analysed using *M* and *SD* for scale data (e.g., age), and frequencies and proportions for categorical data (e.g., gender). Interviews were audio recorded, transcribed verbatim, and analysed thematically in the same

way as free text survey responses. Electronic copies of transcripts were provided to each participant for validation to improve credibility (Ritchie et al., 2013).

Six RSAs (54.55%), six FPs (42.86%), and five Leisure Customers (41.66%) authenticated their transcripts. The remainder of participants did not respond, therefore satisfaction with the accuracy of interview transcripts was assumed.

7.12 Quality Measures to Facilitate Trustworthiness

In light of the qualitative dominant mixed methods research design, quality measures are discussed in relation to qualitative quality measures in pursuit of trustworthiness (i.e., credibility, transferability, dependability, and confirmability). To maintain credibility, the same strategies discussed in section 5.10.1. (i.e., member checking, site, person, and investigator triangulation) were employed. Moreover, utilising mixed methods enhances credibility of findings through facilitating completeness to the area of enquiry (Creswell & Clark, 2017). To uphold transferability, the researcher maintained transparency regarding the number and characteristics of participants (see 8.2.1, 8.3.1, 8.4.1, 8.5.1, 9.2.1,& 9.3.1) and timeframes of data collection and analysis (see section 7.10). As recommended by Shenton (2004), dependability was facilitated through elaborate descriptions of the research design and its implementation (See 7.2.2), the intricacies of data collection (see 7.10), and the researcher's philosophical foundations and worldview (see section 5.6.2, and 7.2.3). Finally, efforts towards conformability included the practice of reflexivity (evidenced in chapters 2 &12), triangulation,

member checking, and presenting raw participant quotes to acknowledge and mitigate researcher biases as much as possible.

7.13 Ethical Considerations

Informed consent and confidentiality were key ethical issues relevant to the conductance of the second study which do not deviate from the ethical considerations of Phase 1. Therefore, the same protocols discussed in section 5.11 were applied to counteract these ethical dilemmas.

7.14 Summary

This chapter served to detail the research design and methodology employed in the second phase of this research project to uncover the perspectives and experiences of Leisure Professionals and Leisure Customers in relation to HLP referral processes. The rational for utilising mixed methods is defined in this section, alongside details underlying philosophical assumptions, the study aims, and nuances of participant eligibility and recruitment. This is followed by a detailed description of the mixed methods adopted (i.e., online surveys and 1:1 interviews), and how data were analysed. Finally, this chapter acknowledges measures to facilitate trustworthiness, and safeguard relevant ethical considerations. The following chapter, chapter 8, will analyse and present survey and interview findings of Leisure Professionals, (i.e., RSAs & FPs), excluding survey and interview findings of Leisure Customers. The decision to present the findings in this way is due to the volume of data, and the need to separate the

perspectives and experiences of Leisure Customers from Leisure Professionals. For those reasons, Chapter 9 will separately present the findings of Leisure Customers.

8 RESULTS: PHASE II EAST RIDING LEISURE PROFESSIONALS

8.1 Introduction

In this section, online survey and 1:1 interview findings of Leisure Professionals (i.e., RSAs & FPs) collected during the second data collection phase of this research project are reported and presented as two separate strands.

8.2 Online Survey Findings: Referral Scheme Administrators

8.2.1 Participant Characteristics

Sixteen RSAs completed the online survey, seven of whom were female (43.75%) and nine of whom were male (56.25%). Participant age ranged from 24 years to 58 years (M = 42.56, SD = 10.28). The highest proportion of participants were aged between 45 and 54 years (see Table 8.1). RSAs were either BTs (n = 4; 25%), FCs (n = 9; 56.25%), Administrators (n = 2; 12.5%), or Service Officers (SO; n = 1; 6.25%), and worked within a variety of ERL sites (see Table 8.1). Experience in their role ranged from ≤1 year to 34 years (M = 7.50, SD = 8.59). The greatest percentage of individuals had 0-5 years of experience in their role (see Table 8.1).

Table 8.1. *Participant characteristics of Referral Scheme Administrators*

		***n* =**	**% of sample**
Age Range (years)	18-24	1	6.25
	25-34	4	25.00
	35-44	4	25.00
	45-54	5	31.25
	55-64	2	12.50
Experience (years)	0-5	10	62.50
	6-10	3	18.75
	11-15	1	6.25
	16-20	1	6.25
	21-25	0	0.00
	26-30	0	0.00
	31-35	1	6.25
East Riding Leisure (ERL) Site	Beverley	6	37.50
	Bridlington	2	12.50
	Withernsea	2	12.50
	Driffield	1	6.25
	Francis Scaife	1	6.25
	Goole	1	6.25
	Haltemprice	1	6.25
	Hornsea	1	6.25
	South Holderness	1	6.25
	South Cave	0	0.00

8.2.2 Information Received at the Point of Referral

RSAs were asked a series of Likert scale questions pertaining to their opinions of the information provided by a PCP on HLP referral forms, and their experiences of obtaining missing referral information from them (See Table 8.2). Only 12.5% of RSAs (n = 2) reported they 'always' received complete information, compared to 50% (n = 8) who chose 'very often', and 37.5% (n = 6) who selected 'sometimes'. When questioned about their experiences of contacting PCS to retrieve missing or incomplete information on HLP referral forms, 62.6% of RSAs selected that they either could 'always' or 'very often' make contact. However, once contact had been made, little over half (50.1%) of RSAs cited that they could 'always' or 'very often' obtain additional referral information, whereas 43.8% of RSA believed they could "sometimes" retrieve this information. As a general rule, Business Technicians or Administrative staff selected they could 'always' or 'very often' retrieve missing information, whereas FCs chose 'sometimes' or 'rarely'.

8.2.3 Processing of Healthy Lifestyle Programme Referrals

It is necessary here to explain what is meant by referral processing. When a HLP referral form is received by a RSA, they are responsible for registering the referred patient onto ERL IT systems, and making contact with them within 48 hours of referral receipt to book or confirm their first leisure appointment. Results from the online survey demonstrated a lack of standardisation concerning the processing of incoming referrals at different ERL sites. Each site differed in terms of who was responsible for dealing with incoming referrals. Incoming referrals were managed by either BTs (n = 7), FCs (n = 8), RSAs (n = 3), FPs (n = 1), or Health and Well-being Coordinators (n = 1). Likewise, each of these individuals processed

referrals differently. Overall, 87.5% of RSAs (n = 14) indicated that they were responsible for processing multiple HLP referrals. The remaining 12.5% of RSAs (n = 2) worked solely on managing ERS referrals.

RSAs identified multiple distinct ways that they received HLP referrals: 1) electronically via ERLs computerised referral system (BEARS; n = 14, 87.5%), 2) through paper-based referral forms (n = 16, 100%), 3) electronically via email (n = 11, 68.8%), and 4) through telephone referrals (n = 1, 6.3%). RSAs reported that electronic referrals via BEARS were the easiest to process (cited by 10 RSAs; 62.5%), followed by electronic referrals via email (cited by 7 RSAs, 43.8%), and paper-based referral forms (cited by 3 RSAs, 18.8%). Themes generated from succeeding open-ended questions exposed some key explanations as to why certain referrals were easier to process than others. It was a common view amongst RSAs that electronic referrals (i.e., via BEARS, or email) were *"very logical"* (Admin2), and *"saves time"* (FC5) as *"all information is readily available*" (BT1). Some RSA raised issues with paper-based referral forms, describing them as *"difficult to sometimes read*" (Admin1), whilst identifying that *"not all info[rmation] required [is] entered"* (FC6), which frequently causes *"issues [when] contacting clients"* (FC8). It was also uncovered that *"Young LiveWell and LiveWell are paper referrals"* (FC5), meaning a PCP can only refer to these programmes via paper-based referral forms, whereas referrals for the ERS and Health Optimisation Scheme can be submitted electronically via BEARS.

Table 8.2. *Referral Scheme Administrators opinion of the information received at the point of referral and their experiences of retrieving missing information*

Survey question	**Always**		**Very often**		**Sometimes**		**Rarely**		**Never**		**Missing data**	
	***n* =**	**%**	***n* =**	**%**	***n* =**	**%**	***n* =**	**%**	***n* =**	**%**	***n* =**	**%**
How often do referral forms from primary care sites include all the required referral information?	2	12.50	8	50.00	6	37.50	0	0.00	0	0.00	0	0.00
Are you able to get hold of primary care sites sending healthy lifestyle referrals easily?	1	6.30	9	56.30	4	25.00	1	6.30	1	6.30	0	0.00
Are you able to easily gain access to missing referral information from primary care sites sending healthy lifestyle referrals?	1	6.30	7	43.80	7	43.80	1	6.30	0	0.00	0	0.00

8.2.4 Initial Interactions with Referred Patients

8.2.4.1 Referred Patient Awareness of their Healthy Lifestyle Programme

RSAs were asked to comment on how well informed they perceived referred patients were about the HLP they had been referred onto. Figure 8.1**.** depicts how the large majority of RSAs (*n* = 12, 75%) believed that patients were only 'sometimes' well informed about the programme were referred onto compared to a small minority (*n* = 2, 12.5%) who regarded referred patients as 'always' well informed.

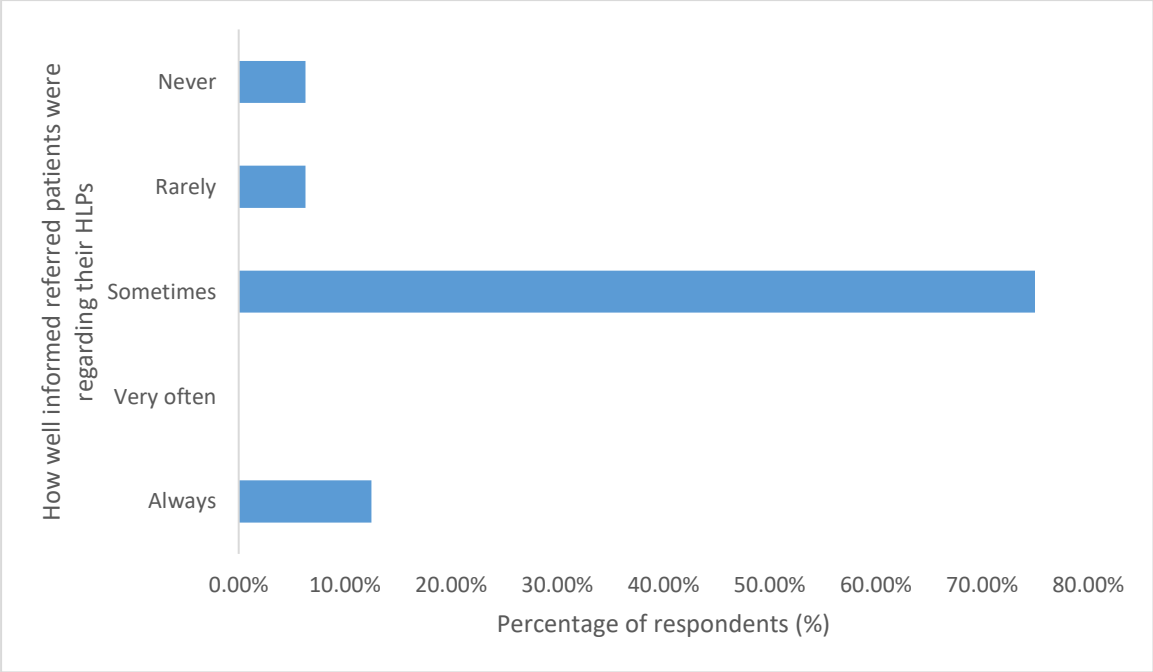

Figure 8.1. Referral Scheme Administrator's perceptions of a referred patient's awareness of their Healthy Lifestyle Programme

8.2.4.2 Referral Scheme Administrators Provision of Information to Referred Patients

Initial telephone interactions enabled RSAs to provide key information to referred patients prior to their first appointment at the leisure centre. When asked what information they supplied during these initial interactions, RSAs responded elaborately about the fundamental things they discussed with referred patients. This included details such as *"information on the scheme"* (FC3), details regarding *"the nature of the initial consultation*" (Admin2), as well as *"what is expected of them"* (FC5) in terms of the *"commitment required"* (BT2) and programme *"cost, if applicable*" (FC4).

8.2.4.3 Initial Patient Concerns

RSAs reported frequent concerns raised by referred patients during these initial telephone conversations, which typically revolved around programme costing, their physical abilities, and their lack of awareness about the programme they had being referred to. Referred patients were reported to be irritated about *"having to pay for exercise referral"* (FC3) because they were allegedly uninformed about the associated costs. Furthermore, many referred patients were perceived to be *"nervous or self-conscious"* about embarking on a HLP, and feared it would be "*more than they [could] manage*" (FC6). According to RSAs, concerns raised by referred patients were a consequence of the limited information provided to them from PCP at the point of referral. Many referred patients were described as *"not aware of what they have been referred for or why"* (BT3).

8.2.5 The Feedback Loop

RSAs were in agreement that the provision of feedback to PCS regarding a referred patient's progress on a HLP was very important (n = 9, 56.3%), or important (n = 7, 43.8%). Despite the importance placed on providing feedback, just over half of RSAs (n = 9, 56.3%) reported to provide feedback. Free text responses revealed that current feedback mechanisms between ERL and PCS lacked standardisation. It was explained how *"letters are sent to non Pharmoutcomes schemes*" (i.e., LiveWell, Young LiveWell, HEART, and Escape Pain), whereas *"Pharmoutcomes provided reports to other [HLPs]"* (i.e., ERS and Health Optimisation Scheme; FC4) electronically. Other RSAs disclosed how they had "*written letters on individual cases"* or had *"spoken directly*" with PCP to update them on a client's progress (FC1). These findings suggest that RSAs largely dictate what information is relayed back to PCP regarding a patient's progress and outcomes on a HLP.

8.2.6 Key Challenges and Suggestions for Improvement

8.2.6.1 Inadequate Awareness of the Healthy Lifestyle Programmes

There was a recurring notion that awareness of the HLPs amongst the public and PCP is inadequate, and thus efforts must be concentrated towards increasing understanding. According to RSAs, "*patients [were] not given enough information about [the] scheme*" (Admin1), and subsequently were *"unaware of what to expect"* (FC6). Moreover, RSAs believed patients were rarely notified of their first appointment at the leisure centre, as "*Doctors just book[ed] people in and don't tell them about their appointments"* (FC5). To overcome the insufficient awareness amongst the medical community and patients, RSAs stressed how the HLPs *"need to be advertised more", and* argued that those involved in the referral of patients

must be *"more informed so clients can be more informed"* (FC5). Put succinctly by one FC: *"the process could be improved if all sites referring understand the schemes they are referring clients onto"* (FC9).

8.2.6.2 Issues with Information Received at the Point of Referral

A core weakness of current referral processes related to the issues with the information provided by PCP to ERL at the point of referral. RSAs described their irritations towards *"incorrect"* (FC6) or "*missing medical information"* (FC5) on referral forms, and demanded *"more detail"* (FC7). They also recalled how many patients referred by PCP were "*not eligible for [any] schemes*" (BT1), or were referred inappropriately to a programme for which they were not eligible. Another main source of frustration conveyed by RSAs related to "*incomplete [non-medical] information*" (BT4) such as *"no contact numbers"* (FC9). Subsequently, RSAs were sometimes not able to fulfil their role of making contact with a referred patient within 48 hours of receiving a referral.

8.2.6.3 Issues with Processing Healthy Lifestyle Programme Referrals

The processing of incoming HLP referral was another key challenge identified by RSA. Many RSAs desired a more standardised referral process, stressing that *"all schemes should now be processed in the same way… by Business Techs [Technicians] for first appointment arrangement*" (FC3). This contrasts with current operational procedures whereby multiple RSA are involved with processing these referrals (see section 8.1.3.). Likewise, many RSAs described their preference for all HLP referrals to be submitted electronically and to discard

paper-based referral forms. A final suggestion from RSA was for "*a single referral form"* (FC4) for all HLP referrals to remove triage decisions from PCP, as they believed they were better placed to "*decide which scheme is best suited"* (FC4) for referred patients.

8.3 Qualitative Interview Findings: Referral Scheme Administrators

8.3.1 Participant Characteristics

Of the sixteen RSAs who completed the online survey, eleven volunteered to participate in individual semi-structured interviews, ten of which were arranged and undertaken. The average duration of these follow-up interviews was 29:37 (minimum 17:03, maximum 43:33). Participants identified as either BTs (n = 2), FCs (n = 6), or Administrators (Admin; n = 2). This subsample equally represented females (n = 5) and males (n = 5), who were aged between 24 and 53 years (M = 42.10, SD = 10.18). Role experience ranged from ≤1 year to 34 years (M = 8.00, SD = 9.78), and participants represented eight ERL centres: Beverley (n = 3), Bridlington (n = 1), Driffield (n = 1), Goole (n = 1), Haltemprice (n = 1), Hornsea (n = 1), Withernsea (n = 1), and South Holderness (n = 1). The large majority of respondents reported to be involved in processing multiple HLP referrals (80%), however some worked exclusively on processing referrals for the ERS (20%).

8.3.2 Interview Findings

In its broadest sense, three overarching themes were generated during thematic analysis that captured the perspectives and experiences of RSAs involved in processing HLP referrals. These included factors hindering referral processing (Overarching Theme 4), factors

facilitating referral (Overarching Theme 5), and suggestions for improvement (Overarching Theme 6). Higher-order Themes (e.g., 4.3.), Lower-order (e.g., 4.3.1.), and Subthemes (e.g., 4.3.1.1.) within Overarching Themes are depicted in Table 8.3 which are defined, illustrated, and supported by verbatim quotes in the following section.

Table 8.3. *Overview of overarching, higher-order, lower-order, and sub themes from Referral Scheme Administrators follow-up interviews*

Overarching Themes	Higher-order Themes	Lower-order Themes	Subthemes
Factors Hindering Healthy Lifestyle Programme Referral Processing (4)	Primary Care Personnel (4.1)	Limited Awareness of the Healthy Lifestyle Programmes (4.1.1)	
		Weak Working relationships (4.1.2)	
	Patient (4.2)	Limited Awareness of the Healthy Lifestyle Programmes (4.2.1)	
		Patient Concerns (4.2.2)	
	Healthy Lifestyle Programme Referral Processes (4.3)	Issues with Information Received at Point of Referral (4.3.1)	Vague Referral Information (4.3.1.1)
			Inaccuracy in Referral Information (4.3.1.2)
		Healthy Lifestyle Programme Referral Workload (4.3.2)	Administration Burden (4.3.2.1)
			Volume of Healthy Lifestyle Programme referrals (4.3.2.2)
		Problems Associated with Processing Paper Referrals (4.3.3)	
		Problems Associated with Processing Electronic Referrals (4.3.4)	
		Problems with the Feedback Loop (4.3.5)	
		Lack of Standardisation (4.3.6)	

Overarching Themes	Higher-order Themes	Lower-order Themes	Subthemes
Factors facilitating Healthy Lifestyle Programme referral processing (5)	Primary Care Personnel (5.1)	Strong Working Relationships (5.1.1)	
	Patient (5.2)	Increasing Awareness of the Healthy Lifestyle Programmes (5.2.1)	
	Healthy Lifestyle Programme Referral Processes (5.3)	Benefits of Paper Referrals (5.3.1)	
		Benefits of Electronic Referrals (5.3.2)	
Suggestions to Improve Healthy Lifestyle Programme Referral Processes (6)	Strategies to Increase Awareness of the Healthy Lifestyle Programmes (6.1)		
	Improving Feedback Provision (6.2)		
	Referral Management Strategies (6.3)		

8.3.2.1 Overarching Theme 4: Factors Hindering Healthy Lifestyle Programme Referral Processing

This overarching theme encompasses the factors that RSAs perceived impeded their ability to process incoming HLP referrals from primary care successfully and efficiently. These were separated into three higher-order themes for consistency, those relating to the 1) PCP, 2) patient, and 3) HLP referral processes.

Higher-Order Theme 4.1: Primary Care Personnel

RSAs reported that limited awareness of the HLPs amongst PCP, and weak working relationships formed between ERL centres and PCS were key factors negatively influencing referral processing.

Lower-Order Theme 4.1.1: Limited Awareness of the Healthy Lifestyle Programmes

RSAs proposed that many referring PCP had an inadequate understanding of the HLPs, which they believed resulted in patients being referred inappropriately to programmes that were not suited to their individual needs or circumstances. Consequently, RSAs felt they were left with the burden of correcting mistakes made by PCP by having to triage referred patients to the most appropriate HLPs. As one RSA described:

> FC1: *"The amount of times we get the wrong ones… we got loads of people being referred to HOP (Health Optimisation Scheme), and when you talk to them, they are not even going for an operation!... we've had people referred to us on GP [referral], and they have been going for an operation so they*

> *could of been on HOP... we've had people referred onto HOP who should be on LiveWell. We've had people on GP [referral] who should be on LiveWell. We have had LiveWells referred to us and really, they should be on HOP".*

Lower-Order Theme 4.1.2: Weak Working Relationships

On the whole, FCs criticised their working relationships with referring PCP, stating that they felt somewhat "*detached*" (FC2) and underappreciated:

> FC4: *"I don't know if the relationship is good enough really…I don't think we are quite getting the full respect of the services that we offer".*

Another FC who challenged working relationships between ERL and PCS, argued that FCs who are in regular contact with PCP over the telephone are rarely given the opportunity to visit them in person to help build a relationship. This FC continued to explain how "*it's very hard to communicate over telephone sometimes, and things can get miscommunicated",* but if it was possible to *"go in and see [PCP] face-to-face, just now and again, it would just eradicate that*" (FC5). This could explain why RSAs cited difficulties in contacting PCS to retrieve missing referral information, as illustrated in survey findings (see 8.2.2). FCs expressed a strong desire to *"build a relationship"* with PCP within surrounding PCS to eradicate any existing *"animosity"* (FC5) and establish a genuine *"connection"* (FC2).

Higher-Order Theme 4.2: Patient

According to RSAs, patients were a key factor influencing the efficient processing of HLP referrals. Specifically, their limited awareness of these programmes, and their concerns were identified as core factors negatively affecting referral processing.

Lower-Order Theme 4.2.1: Limited Awareness of the Healthy Lifestyle Programmes

Follow-up interviews supplemented survey data by illustrating how RSAs perceived patient understanding of the HLPs was deficient. According to RSAs, the "*lack of knowledge [amongst] the general public"* (FC2) meant that patients were often *"not aware of what each scheme entailed"* (FC3), or what was expected of them. RSAs explained how they found this scant understanding "*frustrating"* (FC5), especially in relation to schemes that required a financial contribution from them (e.g., the ERS), as many referred patients were reportedly under the misconception that they were entitled to a *"free membership"* (FC5). RSAs discussed how when they raised the costs associated with specific HLPs (i.e., ERS, Escape Pain & HEART), some patients were deterred from attending. They supposed *"it would help if they [patients] had more information at the point of referral"* (BT1).

Lower-Order Theme 4.2.2: Patient Concerns

RSAs highlighted several concerns disclosed to them from referred patients, adding credence to survey findings (see 8.2.4). Follow-up interviews allowed RSAs to

elaborate on which patient groups they felt were most affected, and the possible implications of these concerns. Specifically, the costing of chargeable HLPs such as the ERS was perceived to be a *"barrier"* (FC3) typically for "*working poor people"* (FC1) and "*the elderly"* (FC6). This was regarded as especially problematic when referred patients were not informed about programme cost prior to being contacted by ERL professionals. As explained by one FC: *"If they [patients] are unaware of the money, you tend to have lost somebody before we've got them in"* (FC6). RSAs also recalled discussions between themselves and referred patients, where logistical concerns relating to accessing ERL sites came to surface. This was suggested to be a pertinent concern for patients who were *"not very mobile",* or those *"relying on somebody else to bring them [to the leisure centre]*" (BT2). Moreover, RSA discussed how "*a lot of people have not exercised before so they are a little bit apprehensive about coming into a gym environment, especially some of the older clientele*" who have "*preconceptions*" that the "*gym will be [full of] all skinny girls in leotards and big hunky men*" (FC3).

Higher-order Theme 4.3: Healthy Lifestyle Programme Referral Processes

This theme captures the factors hindering referral processing that related to the operation of HLP referral processes as perceived by RSAs. 'Issues with referral information', 'referral workload', 'shortcomings of paper referrals', 'shortcomings of electronic referrals', 'problems with the feedback loop', and 'lack of standardisation' were identified as lower-order deliberating factors of referral processing.

Lower-Order Theme 4.3.1: Issues with Information Received at Point of Referral

A major source of frustration for RSAs centered around the referral information provided to them from PCP.

Subtheme 4.3.1.1: Vague Referral Information

Interview findings complemented survey results by uncovering specifically in what way HLP referral forms were inadequately complete. Issues in terms of the sketchiness of referral information were discussed in relation to both paper-based and electronic referrals. With regards to BEARS, RSAs criticised how *"not all the fields are mandatory"* meaning they frequently *"don't get a list of drugs or medication"* (AD2). Since it was considered *"very unusual for someone to come who wasn't on any kind of medication"* (AD2), RSAs challenged the reliability of the information provided on HLP referral forms. Similar problems were also encountered with information provided on paper-based referral forms, yet were suggested to be more significant and frequent. RSAs explained how paper-based referral forms *"might only have their [patient's] name on"* (FC6), and often provided "*vague"* information that *"generalise[d] what they [patients] are being referred for "*(FC3), causing *"major problems"* (FC6) for processing these referrals. Irrespective of the means of referral, RSAs stressed how they need to *"tighten up a little bit more on the information [they] receive"* (FC6).

Retrieving missing information from HLP referral forms or obtaining clarification on vague referral information was identified as one of *"the biggest problems"* (FC5).

RSAs described how it was *"a long process to gain just a [patient's] phone number",* because of data protection and privacy laws governing the transfer of patient information such as *"GDPR"* (FC5). It was described as common for receptionists at PCS to *"insist on ringing the patient and asking the patient to ring [ERL]"* (AD2) to disclose necessary information, as opposed to PCS volunteering missing information in question. According to RSAs, it was sometimes impossible for them to make initial contact with referred patients, which resulted in them *"not being contacted before their first appointment and turning up completely blind"* or *"not being informed that their appointment is there at all"* (AD2).

Owing to the difficulties of obtaining information from PCS, RSAs stated they often "*don't generally go back and get that [information] from a GP surgery"* (FC3), and instead, *"coax"* medical information from referred patients by asking *"probing questions"* (FC1) during initial telephone conversations. Nevertheless, this over-reliance on patients for medical information did not sit comfortably with many RSAs. They explained how *"you can't guarantee it's 100%."* (FC1) because *"not every patient can remember the names of all the tablets they are on"* (AD2), which has implications for how HLP are devised and tailored to individual need by FPs. They continued to explain how FPs *"don't get enough information for the participants to actually work effectively or safely in some cases*" (FC2). One FC who worked two-fold as a FP, elaborated on his experiences of uncovering major health implications during an exercise session:

> FC1: *"We've had one with, came in, was training and you said to him, "Everything ok?" "Yep fine, I'm just inactive. I've put weight on" ... Quarter an hour into it, "Oh, I'm breathing a bit hard. Oh, my chest is hurting a bit". "Everything all right"? "Yeah, it's, erm, I think it's my scar". "Oh, what scar is that?" "Oh, my bypass".*

Similar experiences were echoed by other FCs with dual roles as FPs, where health conditions such as angina which were not highlighted by PCP at the point of referral were uncovered throughout the course of a HLP.

Subtheme 4.3.1.2: Inaccuracy in Referral Information

According to RSAs, it was common to notice major discrepancies between the information provided on HLP referral forms, and baseline measures taken from a referred patient during their first leisure appointment. This discrepancy was mainly discussed in relation to a patient's BMI. One FC explained *"if the GPs have taken an incorrect or maybe an old BMI reading"* then often the BMI measure taken at the first consultation is *"nowhere near the BMI that's on the [referral] form"* (FC4). This meant that referred patients often presented in ERL centres with *"a much bigger BMI than expected"* (AD2), and therefore were not eligible for the programme that their PCP had referred them to. RSA also accused PCP of *"overestimate[ing] the BMI"* (FC3) in attempt to qualify a patient for the LiveWell programme. Other times, referred patients did not qualify for any of the HLPs, meaning their referral was rejected. Consequently, RSAs explained how they must do their *"homework to get the facts right"* (FC2).

Lower-Order Theme 4.3.2: Healthy Lifestyle Programme Referral Workload

Many RSAs perceived that it was difficult to manage their workload which they attributed to the bureaucracy associated with processing HLP referrals, and the volume of referrals.

Subtheme 4.3.2.1: Administration Burden

Some RSAs revealed that making initial telephone contact with referred patients was a difficult and time-consuming task. They explained how PCP sometimes only provided a patient's home telephone number, which make contact challenging as *"most people nowadays work off mobiles",* and therefore it was *"a pain to get hold of them*" (FC5). Moreover, when contact was successfully made with a referred patient, RSA explained how those phone calls could take *"30-40 minutes… depending on how much the customer wants to ask"* (AD2). Making these individual telephone calls was difficult for RSA given the volume of incoming HLP referrals, and the time required to undertake these calls.

Subtheme 4.3.2.2: Volume of Healthy Lifestyle Programme Referrals

RSAs criticised how the volume of incoming HLP referrals were rising disproportionally to the support in place to manage workload. FCs, who were often responsible for processing referrals, and delivering the programmes, stressed how they were *"back-to-back with health agenda work*" (FC6), which left little time to deal with other tasks within their remit such as undertaking gym inductions for regular gym users.

FCs explained how it was increasingly difficult to manage the *"constant stream"* of HLP referrals when *"there's no cap on the amount of [incoming] referrals"* (FC3). The recruitment of "*more instructors*" (FC3) was anticipated to alleviate this "*struggle"* (FC6).

Lower-Order Theme 4.3.3: Problems Associated with Processing Paper Referrals

RSAs discussed many difficulties when trying to process paper-based HLP referral forms. Aside from the criticism towards the information provided on these referral forms (see lower-order theme 4.3.1.), RSAs complained about the *"chore"* of deciphering *"handwritten"* information (BT2). A further disadvantage relating to the processing of paper-based referral forms was the additional steps RSAs had to undertake to register a patient onto ERL IT systems and book their appointment. They continued to explain that once a paper referral is received, RSAs *"use the electronic system the same way that the doctors do to actually book the appointment*", which in their opinion, was *"adding a first step"* to the referral process (AD2). This helps to explain their preference for processing HLP referrals made electronically by PCP using BEARS, as demonstrated in online survey findings (see section 8.3.1). A final area of criticism concerned the length of time it could take for a paper-based referral to be received by ERL sites. One FC explained that paper-based referrals can *"take up to three, four weeks to come through"*, which can dampen the motivation of patients who were *"geared up and ready"* (FC6) at the point of their PCP making a referral.

Lower-Order Theme 4.3.4: Problems Associated with Processing Electronic Referrals

Despite recognition by many RSAs that referrals sent electronically were easier to process in comparison to paper-based referrals, some challenges associated with the electronic referral system surfaced in follow-up interviews. Although this system allowed a PCP to book a patient's initial ERL appointment, it was described as lacking the *"decision making processes"* (FC4) required to pair patients with the most appropriate FP based on their individual needs. Consequently, many RSAs found there was "*a little bit of juggling to do"* (FC4) to ensure referred patients were matched with a suitably qualified FP. Some RSAs perceived there was resistance from PCP to use the electronic referral system, which was reported to be a consequence of the lack of interoperability between primary care and leisure systems. The following quote illustrates this:

> FC4: *"There's a bit of resistance around some of our surgeries to take part in it…. A lot of the NHS operate from a, a portal called SystmOne …our IT isn't, isn't linked with that… they are maybe not as accommodating to take that on, you know? It's, it's just a different way of referring to them as opposed of what they do for everything else."*

Furthermore, RSAs suggested that the electronic referral system was not being used as intended. Reportedly, some PCP "*were making a retrospective decision that somebody would benefit from a referral"* (AD2) and thus made referrals absent of the patients knowledge. According to RSAs, some PCP were also booking a *"random appointment"* on the electronic referral system without informing their patient. These factors were both attributed to "*loads of no shows*" at ERL centres (FC5). In addition, RSAs explained how BEARS does not make it mandatory for PCP to fill out all form field requirements, thus allows them to *"progress without entering anything [on the*

referral form]" (AD2), which contributes to missing and vague referral information (see lower-order theme 4.3.1).

Lower-Order Theme 4.3.5: Problems with the Feedback Loop

Follow-up interviews enabled RSAs to discuss their perspectives of current feedback loops between PCS and ERL centres in more detail than the online survey allowed, which only queried the provision of feedback. Several FCs explained that some HLPs do not have a feedback loop established, and therefore they were unable to transmit information regarding a patient's progress on these programmes to PCP:

> FC5: *"LiveWell never gets fed back, which is your biggest scheme in terms of reducing obesity within the community… With the HOP scheme, if they are awaiting surgery, they've done six months and the Doctor has no idea that they've lost three stone or whatever in the six months, then they are not going to get referred for the surgery. Well, that's the point of the scheme!"*
>
> BT2: *"With the young LiveWell, we don't do letters at all…there's no follow-up letters to GPs or parents"*.

Other FCs argued that when patient progress feedback is provided, it is not necessarily provided to the referrer. One administrator explained how "*quite often, it's the Physio that refers, but the results go back to the GP"* (AD1).

Lower-Order Theme 4.3.6: Lack of Standardisation

In line with survey findings, interviews revealed there was not a standardised process in terms of how HLP referrals were received. Overall, RSAs identified three

different ways that they received HLP referrals (i.e., via paper-based methods, via electronic means, or physically handed by a referred patient). Likewise, there was a lack of standardisation in terms of who incoming referrals were directed to. According to this cohort, referrals for the ERS were directed to the FCs of each ERL site to process, whereas all other HLP referrals were diverted to BTs to process. RSAs expressed a strong desire to "*standardi*se" and "*streamline*" (FC3) referral processing. Interviews allowed RSAs to discuss the anticipated benefits of standardisation. They supposed that *"having the same process for all the schemes… would be helpful"* (BT1) as it would prevent the current "*hesitance"* (FC3) and *"double-checking"* (BT1) of efforts each time a referral is processed.

8.3.2.2 Overarching Theme 5: Factors Facilitating Healthy Lifestyle Programme Referral Processing

This overarching theme encompasses the factors that RSAs perceived helped them to process incoming HLP referrals from PCS. Following the pattern of the previous overarching theme, these were partitioned to reflect 1) PCP, 2) the patient, and 3) the HLP referral processes.

Higher-Order Theme 5.1: Primary Care Personnel

'Strong working relationships' were identified as a lower-order theme perceived by RSAs to facilitate referral processing.

Lower-Order Theme 5.1.1: Strong Working Relationships

Administrative staff considered that they had developed *"good relationships with the surgeries"* (AD2), where surgery staff knew them *"by name"* (AD1). Contrary to the views of most FCs, one FC celebrated their leisure centres "*close working relationship"* (FC1) with surrounding PCS. At this ERL centre, it was explained how a dedicated FP ventured into nearby GP surgeries on a weekly basis to promote the HLPs to patients in the waiting areas, and to provide support and assistance to referring PCP, thereby helping to *"reduce barriers"* (FC1) *to* HLP referrals. It was acknowledged that this takes *"time and resources away*" from this ERL centre, yet was valued as a "*good investment for the return*" (FC1).

Higher-Order Theme 5.2: Patient

Some RSAs perceived that increasing patient awareness of the HLPs made it easier to process incoming referrals.

Lower-Order Theme 5.2.1: Increasing Awareness of the Healthy Lifestyle Programmes

A minority of RSAs described how awareness of the HLPs was gradually improving amongst patients, and the schemes were becoming *"much more well-known"* (AD1). In relation to the ERS, some RSAs argued that patients were *"usually aware of how much it costs"* and *"how long it lasts"* (AD2) which meant RSAs didn't need to spend as long explaining programme nuances. One FC suggested that whilst patients were

becoming more knowledgeable about the HLPs, their exposure to programme explanations and information at the point of referral was determined by who they were referred by: *"It [awareness] varies on who has referred them. It's getting better. I don't get many conversations now where they say, "No I have been told absolutely nothing"* (FC4). Nevertheless, it is important to note that the ERL site where this FC operated is situated adjacent to a GP surgery, which may explain why referred patients from this site were perceived to be better informed.

Higher-Order Theme 5.3: Healthy Lifestyle Programme Referral Processes

This theme captures the factors facilitating referral processing that related to the current operation of HLP referral processes. The 'benefits of paper referrals' and 'benefits of electronic referrals' emerged as important facilitating factors.

Lower-Order Theme 5.3.1: Benefits of Paper Referrals

A minority of RSAs applauded paper-based HLP referral forms, claiming that they were *"nice and easy to process"* (FC4) and *"gather slightly more information"* (AD2) in comparison to referrals made through the electronic referral system. One BT explained how she preferred to *"see the process through from start to finish"* (BT1) by being accountable for making a referred patients first appointment at ERL centres as opposed to leaving the responsibility to PCP referring via the electronic referral system.

Lower-Order Theme 5.3.2: Benefits of Electronic Referrals

The large majority of RSAs regarded HLP referrals via the electronic referral system as *"far better"* (FC6) in comparison to paper-based means of referral for multiple reasons. First, RSAs explained how electronic HLP referrals enable the referrer to have *"booked [a patient] in with a qualified instructor"* (FC6), meaning RSAs did not have to pick up this responsibility. Secondly, patient information send through the electronic referral system were considered to be more secure in terms of *"data protection"* (FC3). Thirdly, RSAs perceived that the electronic referral system had "*made it easier for them [PCP] to refer a patient"*, which in their opinion had *"increased the number of referrals"* (AD2) being made to ERL.

8.3.2.3 Overarching Theme 6: Suggestions to Improve Healthy Lifestyle Programme Referral Processes

RSAs offered multiple suggestions to improve referral processes including 'strategies to increase awareness of the HLPs', 'improving feedback provision', and employing 'referral management strategies'.

Higher-Order Theme 6.1: Strategies to Increase Awareness of the Healthy Lifestyle Programmes

Backing survey findings, RSAs emphasised the importance of implementing strategies to increase awareness of the HLPs amongst the public and PCP. One FC

suggested replicating the NHS health check marketing strategy, whereby patients are sent a letter to prompt them to visit their GP if they meet certain criterion:

> FC2: *"A letter went out. If you are between 40 and 72, I think it is, you are eligible for a free NHS health check… what's wrong with having something similar where, you know, do you know about this scheme? Are you waiting for a non-emergency operation? Do you think your BMI is over 45?"*

RSAs also discussed how ERLs provision is *"easily forgotten about"* in PCS, which they believed was partially attributable to the high *"staff turnaround"* (FC4) of PCP. Consequently, FCs underscored the importance of *"sounding that message out to make sure that [ERL] are still remembered"* (FC4) amongst the medical community. Although this was perceived to be an arduous task due to weak working relationships between ERL and PCS, RSAs stated they were *"fortunate"* that referred patients were their *"advertising"* (FC1), and inadvertently acted as a promotional strategy by sharing their stories of success to PCP during subsequent primary care visits.

Higher-Order Theme 6.2: Improving Feedback Provision

FCs stressed the importance of providing feedback to PCP to update them on their patient's progress on a HLP. They suggested that if ERL were *"better at reporting how well people do"* then it could *"help with the amount of referrals*" (FC4) as PCP may be "*more likely to buy into [the HLPs]"* (FC1). Follow-up interviews allowed RSAs to provide explicit examples of what information they perceived was important to feedback to PCP. They disputed that current feedback provision, which is based on statistical indicators such as BMI, is *"meaningless"* (FC1) as it does not reflect the lifestyle

behaviour changes made by an individual on a HLP. One FC challenged that *"it's not always about weight",* and people instead *"decrease pain, increase self-esteem"* and *"feel more confident",* all markers perceived to be *"hard to measure and hard to get across"* (FC1). RSAs discussed how feedback must acknowledge the holistic lifestyle behaviour changes incurred and suggested that additional feedback should include *"attitudes to exercise", "how they embraced the scheme",* (FC3), and *"level of attendance"* (FC4). One FC proposed that ERL should create and distribute a *"quarterly newsletter"* for local GP surgeries presenting *"headline KPIs [key performance indicators]"* (FC1) to advocate patient successes on HLPs.

Higher-Order Theme 6.3: Referral Management Strategies

Follow-up interviews enabled RSAs to explain how they envisioned incoming HLP referrals being better managed, as the current processing of HLP referrals was subject to much criticism within online surveys (see 8.1.6.3). In agreement with survey findings, many FCs insisted that the referral process needs to be streamlined by having a "*sole referral route to the Biz Techs [BTs]",* or the *"central team"* via a "*generic referral form"* (FC5). An abundance of benefits were discussed in relation to centralising HLP referrals. FCs perceived that PCP *"struggle"* to triage patients to the correct programme, and therefore supposed a *"general referral form*" would remove this burden from them by enabling a central ERL team member to undertake the responsibility of *"triag[ing] people"* (FC1). It was also argued that once they had appropriately triaged referred patients, a ERL team member could then "*offer them the right information*" (FC4) on the HLP they are eligible for. Moreover, FCs considered how a central ERL team member could book all initial ERL appointments during introductory telephone contacts with

referred patients, which they anticipated would reduce the number of people defaulting their initial appointment due to not being notified of their appointment time and date. Nevertheless, there was some caution raised around a centralised referral route, with one FC arguing there's *"the negative of [the central team] not knowing what the team's expertise are"* (FC4), and therefore may not be able to pair a referred patient with the most appropriate FP. It was argued that FCs were much more knowledgeable about the expertise of FPs, and therefore were better placed to appropriately match referred patients and FPs.

8.4 Online Survey findings: Fitness Professionals

8.4.1 Participant Characteristics

Thirty-two FPs consented to participate in the online survey. The sample consisted of 12 females (37.50%), and 20 males (62.50%) aged between 23 and 61 (M = 38.63, SD = 11.20). The highest proportion of FPs fall into the 25-34 age category (see Table 8.4.) Overall, FPs represented all ERL sites delivering HLPs (see Table 8.4) and had acquired anywhere between 2 and 34 years of role experience (M = 10.81, SD = 7.93). Over 93% of FPs delivered the LiveWell programme and the ERS, compared to just over 31% who were involved in the delivery of the cardiac rehabilitation programme (HEART).

Table 8.4. *Participant characteristics of Fitness Professionals*

		n	**% of sample**
Age Range (years)	18-24	2	6.25
	25-34	11	34.38
	35-44	10	31.25
	45-54	6	18.75
	55-64	3	9.38
Experience (years) Based on *n* = 31	0-5	8	25.81
	6-10	11	34.48
	11-15	5	16.13
	16-20	4	12.90
	21-25	1	3.23
	26-30	1	3.23
	31-35	1	3.23
East Riding Leisure Site	Beverley	4	12.50
	Bridlington	3	9.38
	Withernsea	6	18.75
	Driffield	4	12.50
	Francis Scaife	4	12.50
	Goole	4	12.50
	Haltemprice	5	15.63
	Hornsea	1	3.13
	South Holderness	1	3.13
Healthy Lifestyle Programmes delivered	LiveWell	30	93.75
	Young LiveWell	29	81.25
	Exercise Referral Scheme	30	93.75
	Health Optimisation Scheme	26	81.25
	HEART	10	31.25
	Walking for Health	6	18.75
	Swim for Health	2	6.25

8.4.2 Information Received at the Point of Referral

FPs were asked a series of questions pertaining to the information they received on HLP referral forms prior to them making initial contact with a referred patient. Figure 8.2**.** demonstrates how FPs were informed about a patient's current prescription list (51.6%), BMI (54.8%), and previous medical history (51.6%) little over half of the time. By contrast, they were always with a patient's name (100%), and very often their age (96.8%), and current health status (87.1%).

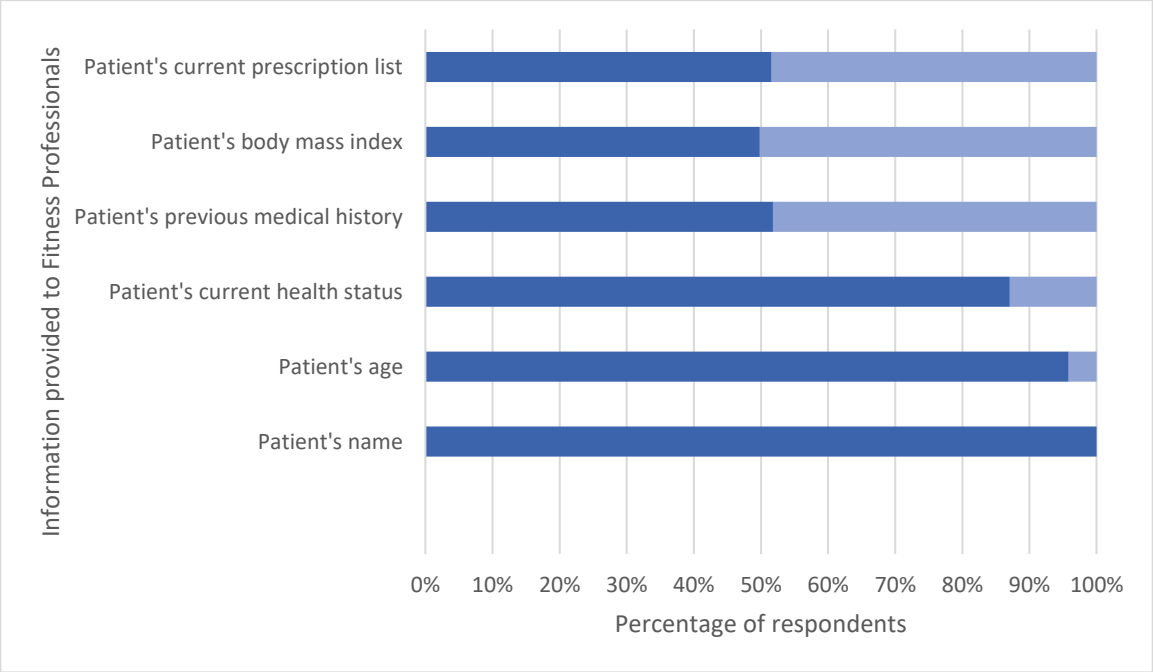

Figure 8.2. Information received by Fitness Professionals regarding a referred patient

FPs indicated on a Likert scale if they felt they were provided with adequate background information concerning a referred patient. 63.3% of FPs (*n* = 19) cited that they 'sometimes' or 'rarely' received adequate information whereas 36.7% of FPs (*n* = 11) believed they were 'always' or 'very often' provided with enough information. Free text responses revealed that FPs sought a *"full"* (FP5) and *"complete"* (FP2) medication list alongside a *"detailed medical history*" (FP21), which must encompass *"all relevant medical conditions"* (FP22). In addition, it was a common opinion amongst FPs that insights into a patient's PA background would be advantageous as it would enable them to determine "*if they need a [full] gym Induction"* (FP23).

8.4.3 Initial Contact with Referred Patients

8.4.3.1 Experience of Making Initial Contact with Referred Patients

When quizzed about their experiences of contacting patients via telephone prior to their first face-to-face appointment, responses were heterogeneous, indicating diversity in experience. 48.4% of FPs selected that they either 'always' or 'very often' could make introductory contact a patient, compared to 25.8% who chose 'sometimes', and 25.8% who indicated either 'rarely' or 'never'.

8.4.3.2 Patient Awareness of their HLP

On the subject of a patient's understanding of the HLPs, the large majority of FPs (41.9%, *n* = 13) believed that patients were 'sometimes' informed about the programme they had been referred onto, closely followed by 38.7% (*n* = 12) who cited that patients

were ‘rarely informed’. By contrast, a small minority (19.4%, *n* = 6) regarded referred patients as ‘very often’ informed. An open-ended question followed prompting FPs to identity specifically what information they would like patients to be provided with at the point of referral. Three themes were identified including 1) information pertaining to cost (if applicable), 2) programme expectations (in terms of “*their obligations and commitment to the course”; FP28*), 3) and programme procedure (in terms of *“what the various schemes entail”;* FP26 with regards to *“programme length”* and *“format of session[s]”;* FP27).

8.4.3.3 Initial Patient Concerns

FPs reflected on some of the key concerns that referred patients had disclosed to them, which were broadly categorised into two overarching subthemes: confidence-related issues and limited patient awareness. FPs recalled how patients were *“apprehensive”* (FP29) about exercising in a gym environment because they were fearful of *“not being able to do what [was] asked of them”* and experienced issues with their *“body image”* (FP10). These confidence-related issues were perceived to be pertinent amongst *“older generations”* (FP25), and *“those with non-exercise backgrounds”* (FP23). Mirroring the perspectives of RSAs (see Lower-Order Theme 4.2.1.), limited patient awareness of the HLPs was another major area of concern raised by patients to FPs. FPs described in free-text boxes how patients were often not informed about programme costing, duration, or what was expected of them, and so the disclosure of this information sometimes came as a shock.

8.4.4 The Feedback Loop

93.5% (*n* = 29) of FPs cited that it was very important (54.8%, *n* = 17) or important (38.7%, *n* = 12) to provide feedback to PCP regarding a patient's progress on a HLP. Despite this, almost half of FPs (48.4%, *n* = 15) cited that feedback was not provided. By contrast, the remaining 51.6% selected that they did offer patient progress feedback to PCS and elaborated on the content of this feedback, where many inconsistencies were highlighted. Some FPs disclosed they provide statistical feedback through their web-based system for data capture, Pharmoutcomes, such as *"weight, BMI, BP, RHR [resting heart rate], body fat percentage, hip and waist measurement*" (FP9). Other FPs declared they supply more anecdotal feedback to PCP, for instance, "*how [a patient] has got on and if they have improved their healthy lifestyle*" (FP15).

8.4.5 Key Challenges and Suggestions for Improvement

8.4.5.1 Issues with Information Received at the Point of Referral

There was an almost unanimous belief that efforts must be focused on improving the referral information provided by PCP to Leisure Professionals at the point of referring a patient, once again resounding the views of RSAs (see Lower-Order Theme 4.3.1.). FPs stressed in free text boxes how they need "*more relevant info[rmation]"* (FP1) such as "*reasons for referral, medication, [and] historical health"* (FP9), and emphasised the importance of having access to this information *"quickly and easily*" (FP21).

8.4.5.2 Inadequate Awareness of the Healthy Lifestyle Programmes

It was a shared view amongst FPs that patient awareness of the HLPs was inadequate and must be a focus for improvement. FPs reported *"correcting [patients] on information that the GP had given them"* (FP5) during initial patient interactions, and felt there should be *"more information from the primary [care] sites*" in terms of "*scheme explanations*" (FP24) so referred patients "*know what [the programme] entail and what is expected of them*" (FP28). FPs also discussed the importance of *"more advertisement"* (FP24) of the HLPs more generally. They also acknowledged that PCP awareness of these programmes must be improved in order for them to better inform their patients at the point of referral.

8.4.5.3 Inappropriate HLP Referrals Received

There was a strong sense of frustration relating to the appropriateness of HLP referrals which manifested in two ways. First, FPs argued that some patients were not *"physically"* or *"mentally suitable to attend"* (FP4) any HLP. Some examples provided were individuals presenting with *"mental health problems"*, *"addiction issues"* (FP3), or a *"reluctance to change"* (FP27). They stressed that a patients "suitability" must be determined prior to them being referred. Specifically, FPs described how PCP must *"make sure clients meet [the] criteria"* (FP21) whilst also assessing their patient's *"physical and mental capabilities*" (FP3) before referral. Secondly, FPs criticised PCP for not being able to refer their patients onto the correct HLP. Some FPs supposed that this may improve with *"more collaboration*" and *"better communication"* between ERL centres and PCS. However, others argued there were simply "*too many schemes for*

Health Professionals to know which is the most appropriate for each patient", and therefore believed that ERL staff were better placed to *"assign [patients] to an appropriate scheme"* (FP5).

8.5 Qualitative Interview Findings: Fitness Professionals

8.5.1 Participant Characteristics

The following results section represents the views of fourteen FPs, derived thematically from follow-up semi-structured interviews lasting 35:41 minutes on average (range 10:08 to 01:30:44). Participants identified as either female (n = 6, 42.9%) or male (n = 8, 57.1%), and were aged between 25 and 59 years (M = 38, SD = 11.72), with the largest proportion of individuals sitting within the 25-34 age range category (n = 7, 50%). This sample operated across six ERL sites: Beverley (n = 1), Bridlington (n = 1), Driffield (n = 3), Goole (n = 2), Haltemprice (n = 1), and Withernsea (n = 4), with two FPs working across multiple sites (Bridlington & Driffield; n = 1, & Beverley & Driffield; n = 1). Role experience ranged from 2 to 26 years (M = 9.38, SD = 7.55). The majority of FPs were involved in the delivery of multiple HLP; however, one FP was involved in the delivery of just one.

In total, three salient Overarching Themes were identified: Factors Hindering HLP Delivery (Overarching Theme 7), Factors Facilitating HLP Delivery (Overarching Theme 8), and Suggestions to Improve HLP Referral Processes (Overarching Theme 9). Table 8.5 provides an overview of the Overarching Themes (e.g., 7), Higher-Order Themes (e.g., 7.3.), Lower-Order Themes (e.g., 7.3.1.), and Subthemes (e.g., 7.3.1.1.) generated during thematic analysis. What will follow is a description of each theme, intertwined with raw data extracts to give voice to the participants and reflect varied experiences.

Table 8.5. *Overview of overarching, higher-order, and lower-order themes of Fitness Professionals follow-up interviews*

Overarching Themes	Higher-order Themes	Lower-order Themes	Subthemes
Factors Hindering Healthy Lifestyle Programme Delivery (7)	Primary Care Personnel (7.1)	Limited Awareness of the Healthy Lifestyle Programmes (7.1.1)	
		Low Promotion of Healthy Lifestyles and the Healthy Lifestyle Programmes (7.1.2)	
		Weak Working relationships (7.1.3)	
	Patient (7.2)	Limited Awareness of the Healthy Lifestyle Programmes (7.2.1)	
		Initial Patient Concerns (7.2.2)	
	Referral Process (7.3)	Issues with Information Received at the Point of Referral (7.3.1)	Vague Referral Information (7.3.1.1)
			Inaccuracy in Referral Information (7.3.1.2)
		Healthy Lifestyle Programme Workload (7.3.2)	Administration Burden (7.3.2.1)
			Volume of Healthy Lifestyle Programme Referrals (7.3.2.2)
			Complexity of Initial Leisure Appointment with Referred Patients (7.3.2.3)
Factors Facilitating Healthy Lifestyle Programme Delivery (8)	Primary Care Personnel (8.1)	Strong Working Relationships (8.1.1)	
		High Promotion of the Healthy Lifestyle Programmes (8.1.2)	
	Patient (8.2)	Increasing Awareness of the Healthy Lifestyle Programmes (8.2.1)	

Overarching Themes	Higher-order Themes	Lower-order Themes	Subthemes
Suggestions to Improve Healthy Lifestyle Programme Referral Processes (9)	Improving the Provision of Referral Information to Leisure Professionals (9.1)		
	Promotional Strategies to Increase Healthy Lifestyle Programme Awareness (9.2)		
	Improving Feedback Provision (9.3)		
	Referral Management Strategies (9.4)		

8.5.2 Overarching Theme 7: Factors Hindering Healthy Lifestyle Programme Delivery

FPs identified several factors they perceived negatively affected their delivery of the HLPs. These were broadly divided into three Higher-Order Themes relating to the 1) PCP, 2) patient, and 3) HLP referral processes.

Higher-Order Theme 7.1: Primary Care Personnel

FPs perceived that 'limited awareness of the HLPs', 'low promotion of healthy lifestyles and the HLPs, and 'weak working relationships' were key factors hindering HLP delivery.

Lower-Order Theme 7.1.1: Limited Awareness of the Healthy Lifestyle Programmes

FPs suggested the absence of patient understanding was a strong indication that those referring were not well informed about the nuances of the HLPs, which results in insufficient or incorrect information disclosed to patients at the point of referral. They argued there is *"a misunderstanding from the Health Professional who maybe doesn't understand fully how we work, how we can work, and what we can help with"* (FP5). Furthermore, FPs claimed there were *"a percentage of people who shouldn't be referred on any programme"* because they did not meet referral criteria. This was considered "*a great indicator that somewhere in the background there's that misunderstanding"* (FP23) amongst PCP. FPs implied that *"doctor surgeries need to be more aware and more informed*" (FP19) to enable them to refer

appropriately. Interview transcripts also suggested that the electronic referral system (BEARS) was not used as intended in terms of booking ERL appointments. FPs questioned *"whether that appointment date is agreed with the client"* [FP25] as many patients were defaulting their initial HLP appointment. For FPs, this raised questions about whether referrers were fully aware of their role and responsibilities in relation to making referrals to ERL.

Lower-Order Theme 7.1.2: Low Promotion of Healthy Lifestyles and the Healthy Lifestyle Programmes

There was an underlying assumption amongst FPs that the HLPs were not utilised as a preventive health strategy in primary care. Instead, these programmes were perceived to be adopted as a *"last resort"* (FP5) by PCP, after prescribing pharmaceuticals. FPs stressed that these professionals must be more proactive and refer to the HLPs to help combat lifestyle-related issues. The following quote exemplifies the frustrations of FPs who were keen to help individuals make healthier lifestyle choices.

> FP25: *"They always treat the issues rather than what the actual cause of it is…Giving them a prescription, pain relief, quick fix. But again, this is where the referral process comes in. Say look, you can actually refer to these people here [FPs] and they will really help you!"*

Another FP echoed these sentiments and believed that patients presenting with unhealthy lifestyle-related conditions should be referred to the leisure centres even "*before a doctor prescribes medication"* (FP19).

Lower-Order Theme 7.1.3: Weak Working Relationships

FPs questioned working relationships between ERL and surrounding PCS, citing that they did not feel "*favoured upon"* (FP5). Some discussed the implications of poor working relationships such as difficulties retrieving information regarding a referred patient (FP27: "*it can be quite hard to get information from the surgeries"*). Many FPs were keen to *"create a better link"* with PCP by having "*regular contact with GP surgeries*", which they felt would help to "*make sure that everybody knows exactly what services [ERL were] offering*" (FP12), and improve confidence amongst PCP in the effectiveness of the HLPs:

> FP25: *"I have been saying for a long time, we need some sort of a partnership with [health professionals] cuz we've got so many people on referral now ... it's about that partnership. Them knowing that we are doing the right thing with those people.*"

In an endeavour to improve partnership working between ERL sites and local GP surgeries, some FPs suggested assigning ERL professionals to function as a mediator or *"link between the GP practices and [ERL centres]"* (FP12). However, one FP raised concerns about who could take on that role and if the council would be willing to fund such role.

> FP19: "*It is getting to know somebody or getting to know a certain [GP surgery] ... But we haven't got anybody here that could go out and do that. Not as far as I am aware anyways. I don't think they would fund it".*

Higher-Order Theme 7.2: Patient

FPs perceived that most patients had negative preconceptions of the HLPs and the leisure centre environment. These initial perceptions were thought to contribute to increased anxiety and apprehension amongst patients prior to their first leisure visit.

Lower-Order Theme 7.2.1: Limited Awareness of the Healthy Lifestyle Programmes

A reoccurring theme in follow-up interviews with FPs was the perception that referred patients were poorly informed about the HLPs, backing quantitative survey findings (see 8.3.3.2.). Upon meeting a referred patient for the first time, FPs recalled how they *"don't know about the programme"* (FP8), *don't always know that they've got to commit to weekly appointments* (FP12), and were unaware of *"what is expected of [the]em"* (FP8). Consequently, FPs found themselves *"explaining the scheme that the client [was] on to every client"* to fill the *"gaps where they are not really aware"* (FP27). It was stressed that referred patients *"need to be better informed about what they are signing up for*" (FP12) prior to a PCP making a referral. Furthermore, follow-up interviews shed light on the potential reasons underpinning this limited awareness. It was suggested the terminology used in GP surgeries to describe the ERS was contributing to this misunderstanding, leading patients to believe that they did not have to contribute financially to the scheme:

> FP27: *"They [patients] don't know that there's a £33 charge for the programme. So that's something then that can be quite awkward… most people would say, oh no, it's exercise on prescription. Cos it is on prescription, I thought it was free."*

One FP explained how a "*misinterpretation of information"* had previously caused a referred patient to "*blow their gasket"* (FP25) after being informed about the costs associated with the ERS.

Lower-Order Theme 7.2.2: Initial Patient Concerns

FPs highlighted an array of concerns that patients reportedly disclosed to them during their first appointment, many of which revolved around their negative preconceptions of a gym environment. The following quote illustrates this:

> FP10*: "There's that pre-defined notion of everyone is going to be completely like goddesses, muscles popping everywhere and grunting in the mirrors and staring at themselves but it's not like that and it's just trying to change that notion."*

According to FPs, patients also raised concerns about their physical abilities, fearing that the programmes were "*going to be difficult"* and they would be "*pushed too hard"* (FP16). Subsequently, it was a common opinion that vast majority of patients were *"frightened of the first appointment"* (FP9). To help put patients at ease, FPs often had to, in their own words, "*convince them that we are not going to expect them to do anything that they can't do, or they are not happy with, or they are uncomfortable with"* (FP10).

Higher-Order Theme 7.3 Healthy Lifestyle Programme Referral Processes

The information provided by PCP at the point of making a HLP referral, and the workload of FPs were identified as major sources of frustration, which had implications for the way the HLPs were devised and delivered.

Lower-Order Theme 7.3.1: Issues with Information Received at the Point of Referral

Reinforcing survey findings, there was a recurring notion that the information provided to FPs regarding a referred patient was inadequate. Qualitative interviews complement survey data by highlighting the implications this had on patient safety and the suitability of the programmes devised.

Subtheme 7.3.1.1: Vague Referral Information

FPs were in unanimous agreement that they were not consistently provided with sufficient patient information from PCP at the point of referral. Consequently, they had a bleak picture of referred patients prior to meeting with them, and frequently relied on patients to divulge information about their medical history at their first appointment. FPs described feeling deceived because they sometimes assumed they had a "*straight forward client"* before uncovering "*four or five different conditions"* (FP16) that they were not appraised about on referral forms. They contested that the information afforded to them was not "*qualitative enough*" (FP25), and cited the negative implications of limited referral information. For

instance, FPs reported they were cautious of designing a bespoke exercise programme based on limited referral information as it "*could cause [patients] further issues" (FP12),* or *"knock them for six"*, and subsequently damage the "*instructor-patient trust*" (FP10).

Subtheme 7.3.1.2: Inaccuracy in Referral Information

FPs raised concerns about the accuracy of patient metrics provided at the point of referral, as it was common to see *"a big discrepancy between the scales"* (FP12) at the leisure centre, and the figures reported on HLP referral forms. Some FPs speculated that the "*significantly different BMI"* scores were a result of PCP taking "*information off their [clinical] system from whenever that was last checked* (FP5), rather than taking an up to date reading at the point of referral. The uncovering of patient information was described as *"a fact-finding mission"* (FP25), and although patients were described as forthcoming, FPs reported feeling uncomfortable relying on patients to recite medical information. Patients were also described as being *"a little bit forgetful"* (FP5) and struggled to communicate this information accurately to FPs. Similar sentiments were echoed amongst RSAs (see subtheme 4.3.1.1). Hence, FPs placed much emphasis on improving the exchange of patient information at the time of referral.

Lower-Order Theme 7.3.2: Healthy Lifestyle Programme Workload

Follow-up interviews illustrated that FPs perceived their workload in relation to the HLPs was becoming progressively unmanageable due to the quantity and complexity of referrals, and the associated administration.

Subtheme 7.3.2.1: Administration Burden

The HLP protocol stipulates that when an individual is referred, they should receive an introductory telephone call from ERL within 48 hours. However, interviews revealed that the reality is different for FPs, as their demanding workload leaves minimal time to fulfil this duty. The possibility of contacting referred patients via telephone was described by FPs as *"very unrealistic"*, despite it being valued as a prime opportunity to "*allay so many fears*" (FP5). As one FP explained: "*We don't get time to ring them up…even though I've got GPs [Exercise Referral clients] in, I am still gym instructing. You are on the floor. You are cleaning. You've got your notes to do. You've got plenty of stuff to get on with*" (FP17). On the rare occasion FPs had capacity to contact a referred patient, they described how they would *"normally end up with an answerphone"* (FP16). FPs spoke favourably about the implementation of additional support mechanisms to help alleviate the burden of telephoning referred patients:

> FP23: *"It will be great if we maybe had some sort of admin team who could make contact with all the different clients for different schemes before they have their initial appointment."*

Subtheme 7.3.2.2: Volume of Healthy Lifestyle Programme Referrals

The quantity of incoming HLP referrals were considered to be increasing disproportionately to the capacity of FPs. Participants explained how they were *"overwhelmed with referrals*" (FP25) because they were *"understaffed for the amount of referrals"* (FP9) received. This left little time for FPs to complete related administration work, forcing them to

deliver "*group sessions because [of] that many GP referrals"* (FP23), as opposed to one-to-one sessions.

Subtheme 7.3.2.3: Complexity of Initial Leisure Appointment with Referred Patients

FPs opened up about their struggles in terms of meeting a referred patient for their first HLP appointment at the leisure centre. They identified a range of factors they believed contributed to the complexity of this first appointment, which was often attributed to limited patient awareness of the HLPs, and issues with referral information received from PCP. Reportedly, FPs spent a substantial amount of time explaining the scheme to a referred patient and probing them to disclose details around their medical history. This left little time to fulfil the objectives of the first appointment: providing a tour of the leisure centre, undertaking a gym induction, registering the patient on ERL IT systems, and taking baseline measurements. The following raw data extract provides an overview of the challenges of conducting initial appointments with referred patients.

> FP5: *"All their details, medical conditions, we have to input that onto Central Referral Mechanism (CRM) whilst we are seeing them…We have to do the Pharmoutcomes [electronic data capture and recording] with them. We have to explain all about the scheme to them. We have to do all their stats. We need to have a chat with them and find out what isn't on the referral form that we need to be aware of. Allay any fears that they've got of coming into the session, or into the centre. You need to take them and show them the gym, show them the pool, show them where everything is. There's quite a bit to do in an hour."*

8.5.3 Overarching Theme 8: Factors Facilitating Healthy Lifestyle Programme Delivery

FPs identified many factors they perceived positively influenced HLP delivery. These factors related to the PCP, patients, and HLP referral processes.

Higher-Order Theme 8.1: Primary Care Personnel

According to FPs, strong working relationships presented opportunities for HLP promotion and increased the number of appropriate referrals.

Lower-Order Theme 8.1.1: Strong Working Relationships

In contrast to most ERL centres, FPs working on ERoY's coastline such as Withernsea explained how they had nurtured positive working relationships with surrounding PCS by actively engaging with them on a face-to-face basis. Consequently, they has clearance to promote the HLPs in GP surgeries through engaging with patients in waiting areas. These FPs spoke elaborately about the benefits of having a "*good rapport*" with those who refer onto the schemes, defining it as the "*key to referrals"* (FP11). FPs supposed *"the Doctors tend to refer because they know the face they are referring to"* and argued *"it's not just the scheme they are investing in, it's the team they are investing in"* (FP11). Furthermore, promotion directly on primary care premises was described as a "*good way of keeping the lines of communication open"* between ERL and surrounding PCS, whilst also demonstrating how leisure can "*engage with the public on a one-to-one basis"* (FP10).

One FP who worked inland in Driffield described some of the benefits of developing good working relationships with PCP:

> FP5: *"They've a better understanding of what we can do, and what we do do, and appreciate us more, and therefore, probably I would say, refer more appropriately."*

Lower-Order Theme 8.1.2: High Promotion of the Healthy Lifestyle Programmes

FPs of ERL Withernsea discussed the lengths they go to in promoting the HLPs amongst patients and the wider community. They stressed how *"you can't rely on somebody else cuz no one is going to sell your product* [because] *nobody else has that invested passion like you do"* (FP11). This highlights the importance they placed on promotional work. There were multiple benefits identified to this unique approach:

> FP11*: "Speaking to clients in the waiting room… and giving them a leaflet so when they go into the Doctors surgery, they can actually say, "Oh, do you think this will help me?" … The Doctor doesn't have to prompt them; they are prompting the Doctor… they are going in fully armed… You've told em what it entails, which one [Healthy Lifestyle Programme] is right for them. You have infused that enthusiasm into them, and they know what they are coming for".*

Higher-order theme 8.2: Patient

A minority of FPs perceived that patient awareness of the HLPs was improving, which lessened the pressure on FPs to educate patients during initial interactions.

Lower-Order Theme: 8.2.1 Increasing Awareness of Healthy Lifestyle Programmes

In contrast to majority accounts, a small number of FPs suspected that patients were becoming more informed about the HLPs, particularly those referred to the LiveWell programme or the ERS. These FPs argued, *"a lot of [patients] seem to know"* (FP18) because they *"have probably looked into it"* (FP16), or *"may have found out from a friend of a friend"* (FP19). It was suggested that awareness was increasing "*through word of mouth"* from a "*little community of people"* (FP8), rather than from Health Professionals whom, according to FPs, "*don't tell [patients] anything*" (FP19). By contrast, one FP reported that some surgeries had created a letter for referred patients outlining basic details of the HLPs such as programme costing, which they celebrated makes their *"lives a lot easier because then the client's expectation is already set"* (FP25).

8.5.4 Overarching Theme 9: Suggestions to Improve Healthy Lifestyle Programme Referral Processes

Several suggestions were proposed by FPs as points for wider consideration to improve HLP referral processes. These included improving the provision of information from primary care, improving promotional strategies, improving feedback provision, and implementing referral management strategies.

Higher-Order Theme 9.1: Improving the Provision of Referral Information to Leisure Professionals

Follow-up interviews enabled FPs to detail what additional information would be beneficial to receive about their clients at the point of referral. They voiced a need for complete and comprehensive information, and as a minimum, wanted to receive all information asked of PCP on current HLP referral forms. In addition to this, many FPs sought *"a full medical list of full comorbidities"* (FP23) and information pertaining to *"old injuries"* (FP9). In their own words, *"the more we know before we speak to that person, the better"* (FP25). FPs cited multiple benefits of receiving comprehensive referral information. They described how it would make them *"look a lot more professional on day one rather than just tryna suss everything out"* (FP27). Moreover, FPs argued it would allow them to *"devise the foundations of the programme prior to seeing [the patient]*", so they can "*get on with the programme quicker"* (FP10) instead *of "probing"* their client for background medical information, which *"takes up quite a lot of time on day one"* (FP27).

Higher-Order Theme 9.2: Promotional Strategies to Increase Healthy Lifestyle Programme Awareness

It was a common opinion amongst FPs that current promotional efforts were inadequate. Qualitative interviews allowed FPs to elaborate on what they felt were the most effective promotional strategies. Findings suggest that except for ERL Withernsea, promotional strategies were not implemented across other ERL centres to benefit patients or referrers. Whilst the reason for this remains unclear, countless references were made to promotional strategies to increase awareness of the HLPs, with many FPs making specific reference to

"*information packs", "leaflets"* (FP27), *"handouts",* and web-based *"links"* (FP10). FPs asserted that improved exposure to HLP information would help patients to make a "*better informed decision"* regarding their referral and anticipated that this may in turn increase adherence and completion rates. Furthermore, the hosting of taster sessions specifically for Health Professionals was another suggestion to help them *"understand what they are signing [patients] up for"* (FP5).

Higher-Order Theme 9.3: Improving Feedback Provision

FPs reflected on current HLP feedback provision from ERL to PCS, and highlighted how they believed the feedback loop could be made more effective, surpassing survey findings. FPs were largely in agreement that feedback collated does not necessarily reflect the positive holistic lifestyle behaviour changes made by a patient over the course of HLP participation. They stressed that feedback provided to referrers must capture novel, "*anecdotal"* (FP5) changes endured "*that can't be measured with a tape measure"* (FP11). FPs praised how their clients "*progress fantastically in emotional well-being, in confidence, in social skills"* (FP11), were *"sleeping so much better"* (FP5) and were able to *"stand up…without clambering over a table*" (FP23). Thus, FPs were strong advocates that effective feedback provision is vital to enable referrers to *"understand that it is a holistic approach"* (FP5), rather than offering them "*very basic information"* such as "*weight", "BMI,"* and *"body fat percentage"* (FP5). In addition to stipulating the content of feedback that should be collated and communicated to referrers, some FPs believed that feedback should be staggered throughout the duration of HLPs rather than exclusively upon programme completion. They indicated that amassing all feedback at the end of a programme risks missing important milestones, particularly for longer

schemes such as LiveWell. It was suggested that for LiveWell, progress reports should be provided "*once a month*" (FP10), whereas feedback should be exchanged "*halfway through"* (FP17) shorter schemes (e.g., 10-week ERS).

Higher-Order Theme 9.4: Referral Management Strategies

This theme complements survey data by providing explicit examples of how the referral process could be streamlined to improve the appropriateness of incoming HLP referrals, according to FPs. Some FPs proposed an additional step in the referral process, which involved having a singular referral form for all programmes, and "*one place or one person for the initial referral forms to go to"* (FP12) for processing. Many FPs supposed that a central team member in ERL would be more appropriately placed to receive all incoming HLP referrals, triage patients correctly, and complete the associated administration (i.e., making first contact with referred patients, registering them on ERL IT systems, and booking their initial appointment with a FP). The most frequent foreseen benefit of centralising referrals was the improvement of patient triage, which was discussed in several contexts. First, in terms of HLP selection, and second, in terms of assigning the most appropriate FP for each referred patient. According to FPs, Leisure Professionals who *"fully understand the schemes*" should undertake "*triage"* (FP5), and should determine "*which clients are best to put with which instructor"* (FP5).

8.6 Summary

This chapter intended to present online survey and 1:1 interview findings collected from Leisure Professionals during the second data collection phase of this research project. Data accumulated from forty-eight Leisure Professionals is presented as two individual strands to separate the views of RSAs and FPs given their vastly distinct roles in supporting referred patients. Phase II data were analysed through a combination of descriptive statistics and inductive thematic analysis.

To summarise these findings, documentation provided to Leisure Professionals at the point of referral was a major source of criticism and had major implications for exercise prescription. Current feedback mechanisms were also largely criticised by Leisure Professionals, which in their opinion, did not capture the novel lifestyle behaviour changes of HLP participants. This was largely attributed to current means of data collection, and was perceived to mask the true impact of participation from referring PCP. It was a common perception that understanding of the HLPs was inadequate across both the medical community and the general public, which leisure professionals identified as a crucial area for future development. Standardising the way in which referrals are managed and what feedback is provided to referring PCP were amongst other key suggestions for improvement.

9 RESULTS: PHASE II LEISURE CUSTOMERS

9.1 Introduction

In this section, online survey and 1:1 interview findings of Leisure Customers obtained during the second data collection phase of this research project are reported in separation from ERL Professionals, as justified in section 7.14. First, online survey data are presented, followed by follow-up interview data with a self-selected Leisure Customer sample.

9.2 Online Survey Findings: Leisure Customers

9.2.1 Participant Characteristics

Twenty ERL customers consented to completing the online survey: eleven females (55%), and nine males (45%). Participant age ranged from 31 years to 78 years (M = 64.5, SD = 10.37), with half of Leisure Customers falling within the 65-74 age range. Collectively, this sample completed one of three HLPs, with 90% attending programmes bespoke to the ERoY (i.e., ERS or LiveWell; see Table 9.1). The large majority of Leisure Customers were referred to a HLP by their GP (n = 15, 75%). This sample represented individuals from areas of varied levels of deprivation as indicated by IMD scores shown in Table 9.1.

Table 9.1. *Participant characteristics of Leisure Customers*

		n	**% of sample**
Age Range (years)	25-34	1	5.00
	35-44	0	0.00
	45-54	1	5.00
	55-64	6	30.00
	65-74	10	50.00
	75 or older	2	10.00
Index of Multiple Deprivation (IMD)	1st	4	20.00
	2nd	6	30.00
	3rd	3	15.00
	4th	3	15.00
	5th	4	20.00
Referring Primary Care Personnel (PCP)	General Practitioner	15	75.00
	Nurse	3	15.00
	Physiotherapist	1	5.00
	Not Sure	1	5.00
Healthy Lifestyle Programmes (HLP) attended	LiveWell	6	30.00
	Young LiveWell	0	0.00
	Exercise Referral Scheme	12	60.00
	Health Optimisation Scheme	0	0.00
	HEART	2	10.00
East Riding Leisure (ERL) Site attended	Beverley	3	15.00
	Bridlington	4	20.00
	Withernsea	5	25.00
	Driffield	2	10.00
	Francis Scaife	1	5.00
	Goole	2	10.00
	Haltemprice	2	10.00
	Hornsea	0	0.00
	South Holderness	1	5.00

9.2.2 Experiences of Referral

9.2.2.1 Initial Awareness of their Healthy Lifestyle Programme

The online survey asked questions pertaining to a Leisure Customer's awareness of the HLPs prior to their referral, and the information supplied to them when their referral was initiated. When questioned if they had any prior knowledge or understanding of their programme, 85% of Leisure Customers (n = 17) selected "no". In comparison, 15% of Leisure Customers (n = 3) chose "yes". Those who selected "yes" explained in a free-text response box how they were informed through various means outside of primary care, including through community retirement groups, through recommendations from hospital staff, and through direct communication with ERL staff.

9.2.2.2 Information Provided to Patients at the Point of Referral

The online survey prompted Leisure Customers to reflect on how their HLP was described to them at the point of referral, and there was a strong consensus in responses that minimal information was disclosed by their PCP. According to this sample, the person initiating their referral provided "*not a lot of detail at all"* (C6; ERS candidate referred by a PN), and specifically, *"nothing about LiveWell"* (C3; LiveWell candidate referred by a GP). Some suggested it was because their PCP initiating their referral did not have a sufficient level of understanding themselves, and were merely "*aware of the conditions to qualify [for referral]"* (C12; ERS candidate referred by a GP). Other leisure customers felt there was a reluctance in primary care to readily disclose information regarding the HLPs:

> C20; ERS candidate: *"The GP didn't tell me anything as I told them. It's like everything, if you don't ask for things or advice or guidance, no one is going to tell you, especially if there's money involved".*

By contrast, Leisure Customers who reported feeling *"fully aware of the programme"* (C10; ERS candidate) prior to approaching their PCP for a referral, explained in free-text responses how they had been offered comprehensive HLP information from a range of individuals outside of the primary care setting. These individuals included FPs at ERL centres ("*It was leisure who told me at the sports centres who suggested I went and asked for a referral from my GP*" [C20]), physiotherapists in community settings ("*Physio told me to visit the doctor who would refer me*" [C9]) , hospital staff ("*Told by hospital in London about [Exercise Referral] scheme*" [C19]), and community groups ("*I was informed of the programme through a group I am in as part of my retirement. I approached the GP and asked if I was eligible to be referred*" [C10]).

The survey asked if any information resources (e.g., leaflets) were provided at the time of referral. Over half of Leisure Customers (57.9%, $n = 11$) cited that they were not given any information resources, whereas 42.1% of Leisure Customers ($n = 8$) indicated that they were afforded information resources. There were also conflicting perspectives amongst those who received such resources regarding their usefulness. Free text responses revealed that some Leisure Customers found ERS information resources *"very informative"* (C5; ERS candidate) and "*very useful*" (C7; ERS candidate) because they *"explained what the procedure would be"* (C10; ERS candidate). Nevertheless, LiveWell candidates argued that the leaflets provided *"wasn't very useful"* (C13; LiveWell candidate) and *"picture[d] a fit young man on a bike",*

which made their experience of referral feel *"daunting"* (C16; LiveWell candidate) as they *"thought [they] wouldn't be able to do it."* (C15; LiveWell candidate). These individuals contested that they had a vague understanding of their programme until they visited the leisure centre, at which point, their FPs provided full details and put them at ease.

Figure 9.1**.** depicts how most Leisure Customers believed that the original description of their programme was either 'moderately accurate' (*n* = 7), or 'not at all accurate' (*n* = 6). Leisure Customers asserted that the person initiating the referral "*didn't tell [them] anything"* (C20, 'not at all accurate', ERS candidate) and "*didn't give any definite expectations except other people had benefitted"* (C11, 'moderately accurate', ERS candidate). Others mentioned that programme explanations were "*accurate in that it would do good"* (C1; 'moderately accurate', HEART candidate). However, one Leisure Customer recalled how he was irritated because he "*had to do all the foot work"* to retrieve programme information, blaming "*little co-ordination between the GP [and] the gym"* (C18; moderately accurate, ERS candidate). A smaller minority of Leisure Customers considered that the original description of their programme was 'extremely accurate' (*n* = 4), or 'very accurate' (*n* = 3; see Figure 9.1**.**). Contrary to the views of many, one Leisure Customer referred by the Health Trainers praised how he was "*told everything beforehand"* (C7; 'very accurate', ERS candidate). Another asserted how "*leaflets helped"* (C5; 'extremely accurate', ERS candidate).

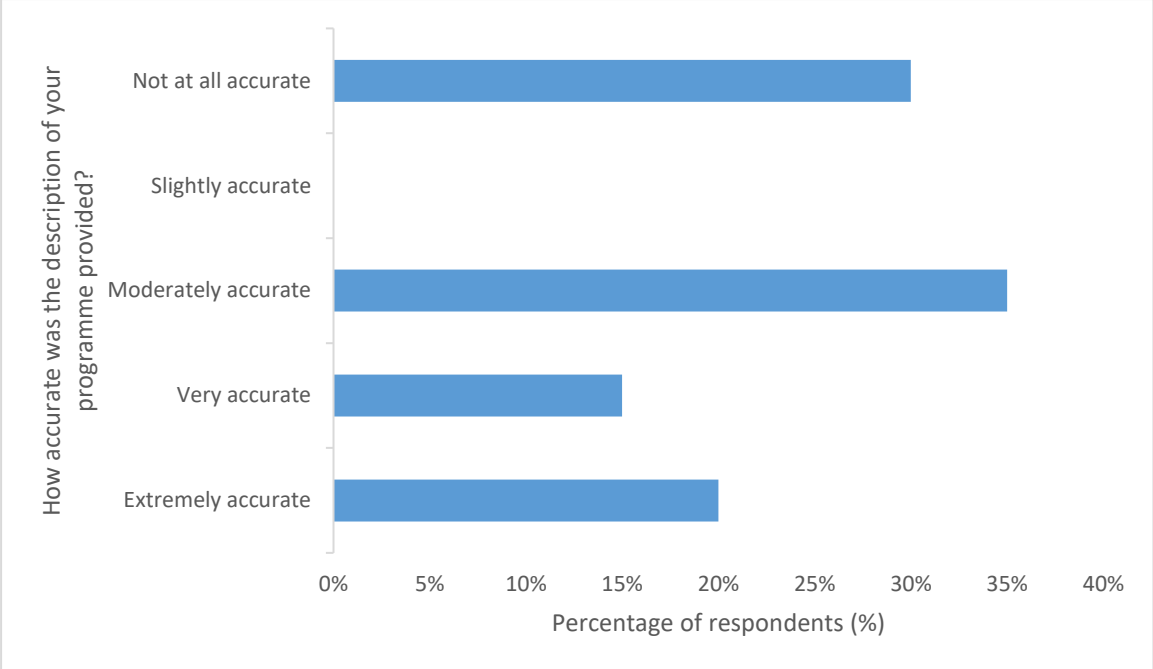

Figure 9.1. Leisure Customer's perspective of programme description accuracy

9.2.2.3 Emotions Experienced at the Time of Referral

Leisure Customers recalled their emotions experienced at the time of referral. Some Leisure Customers explained how they were *"happy to try anything"* (C18; ERS candidate), and therefore were "*excited to come [to the leisure centres]"* (C5; ERS candidate). One Leisure Customer, a self-confessed believer *"in alternative medicine",* stated she was "*excited to try anything that would help rather than having surgery"* (C11; ERS candidate). However, optimism at the point of referral was not widespread amongst this sample. Other individuals described feeling "*nervous and apprehensive"* (C12; ERS candidate), and "*didn't feel there was much support from the GP*" (C20; ERS candidate). Others reported feeling low in *"confidence"* (C1; HEART candidate), and were uncertain whether they would be able to

exercise due to their pre-existing medical complaints and *"pain levels"* (C16; LiveWell candidate).

9.2.3 Patient Readiness to Change

In terms of self-reported readiness to change, 70% of Leisure Customers (*n* = 14) stated that they were 'very ready to change' their lifestyle behaviours at the time of their referral. In comparison, just 5% of Leisure Customers (*n* = 1) considered themselves 'not ready at all' to change. The remaining 25% were either 'thinking of change' (5%, *n* = 1), 'uncertain of change' (10%, *n* = 2), or 'somewhat ready to change' (10%, *n* = 2). Reasons underpinning their motivation to change were highlighted. Almost all Leisure Customers who identified as 'very ready to change' noted two main sources of motivation: 1) to manage or improve pre-existing health conditions such as "*type 2 diabetes*" (C11; ERS candidate), and 2) to regain previous PA levels. Interestingly, those in a pre-contemplation stage who were either 'thinking of change' or 'unsure about change' also focused heavily on enhancing or regaining former PA levels, citing that they *"wanted to improve [their] fitness"* (C6, 'thinking of change', ERS candidate) because they were "*nowhere as fit as [they] use to be*" (C17, 'unsure of change', HEART candidate).

9.2.4 Feedback on HLP Progress with Primary Care Personnel

Three quarters of the sample (75%, *n* = 15) disclosed that they had been to visit their GP surgery since their referral onto a HLP. Only 40% of these individuals (*n* = 6) recalled further discussions in primary care regarding their progress on a scheme. This was particularly

pertinent considering that 70% of Leisure Customers believed it was either 'very important' (50%, *n* = 10) or 'important' (20%, *n* = 4) for discussions around their HLP progress to be raised during subsequent PCS visits. In terms of their progress, Leisure Customers celebrated a myriad of anecdotal changes attained. Interestingly, only a few Leisure Customers mentioned weight loss and instead, emphasised other improvements that were more pertinent to them. For example, Leisure Customers highlighted how they had made progress in *"subtle ways"* (C11; ERS candidate) such as being *"able to stand and transfer from [a] wheelchair"* and reducing their medication intake: *"I am off morphine altogether"* (C16; LiveWell candidate). Psychological improvements were also noted, where Leisure Customers emphasised how their *"mental health has improved"* and how they had gained *"more confidence"* (C15; LiveWell candidate).

9.2.5 Key Challenges and Suggestions for Improvement to Enhance the Patient Journey

9.2.5.1 Inadequate Awareness of Lifestyle Issues and the Healthy Lifestyle Programmes

From a Leisure Customer's perspective, raising public awareness of lifestyle issues and the HLPs was identified as a crucial area of development to enhance a future patients' journey. Leisure Customers stressed how *"prevention is so important"* (C20; ERS candidate), and argued that PCP need to be *"pushing more people… especially those with weight issues"* to take responsibility for their own lifestyle behaviours before it *"leads onto further problems"* (C19; ERS candidate), or the prescription of more medication. One Leisure Customer also made reference to the prevalence of childhood obesity in schools, which they described as *"horrendous*" (C20; ERS candidate). In relation to the HLPs, it was perceived that *"a lot of people don't know about it"* (C6; ERS candidate) and were therefore missing out. Noted

succinctly by one Leisure Customer who had previously completed the ERS, *"to improve the process, there should be more publication of the fact this scheme exists"* (C10). Many venues to advertise the HLPs were identified in free text survey responses, including healthcare venues such as "*chemists…GP surgeries"* (C5; ERS candidate), and "*hospitals"* (C8; HEART candidate), as well as *"council buildings", "libraries"* (C5; ERS candidate), and within *"school"* environments (C20; ERS candidate). As well as more publicity, Leisure Customers emphasised how those referring to the HLPs must provide more comprehensive information at the time of referral so those being referred "*know what to expect*" (C1; HEART candidate). They also suggested PCP should provide *"reassurances"* to patients, so they do not feel they are going to be *"out of place"* in a leisure environment (C16; LiveWell candidate). One Leisure Customer suggested inviting prospective clients for a *"pre-visit"* at the leisure centres, so they have an opportunity to *"see what [the HLPs] entail"* (C11; ERS candidate) for themselves. Similarly, another Leisure Customer highlighted the value of being able "*to talk to somebody else who had done it*" (C15; LiveWell candidate).

9.2.5.2 Gaps in Healthy Lifestyle Programme Information Provision

The online survey encouraged Leisure Customers to identify what additional information might have been useful to receive from their PCP at the time of referral. One Leisure Customer simply wished she were informed by her GP: "*I wish I'd of known about the LiveWell programme in the first place by my GP"* (C4). There were many diverse opinions reported on what additional information may have been valuable including programme *"costs"* (C2; ERS candidate), *"more detail of the programme"* (C6; ERS candidate), and reassurance about leisure centre clientele to circumvent common misconceptions of a gym full of *"young*

fit people" (C16; LiveWell candidate). As one Leisure Customer put it: "*I didn't realise there would be so many referrals here and I have made quite a few friends. I would have liked to have been told there would be more people like me here [because] I was a little worried*" (C13; LiveWell candidate). Many Leisure Customers took the opportunity to give praise to ERL staff, explaining how *"leisure told [them] everything",* and the *"person you see at the leisure [centre] is more important than the doctor*" (C1; HEART candidate).

9.3 Qualitative Interview Findings: Leisure Customers

9.3.1 Participant Characteristics

Of the twenty ERL Customers who volunteered to participate in the survey, twelve consented to partake in a follow-up interview. On average, interviews lasted 21:24 minutes (range: 08:40 to 40:43 minutes). Participants identified as either female (n = 7) or male (n = 5) and were aged between 31 years and 78 years (M = 63.3, SD = 12.4). Leisure Customers completed one of the following HLPs: LiveWell (n = 4), ERS (n = 7), or HEART (n = 1). This sample represented five ERL sites operating HLPs at the time of data collection: Beverley (n = 2), Bridlington (n = 2), Driffield (n = 2), Goole (n = 1), and Withernsea (n = 5).

The process of inductive thematic analysis identified a multitude of higher-order themes, and lower-order themes (illustrated in Table 9.2) that encapsulated the perspectives and experiences of ERL Customers referred onto a HLP. The succeeding section aims to provide an elaborate description of each theme whilst presenting salient raw data extracts to retain the Customer's perspective.

Table 9.2. *Overview of overarching, higher-order, and lower-order themes of Leisure Customer follow-up interviews*

Overarching Themes	Higher-Order Themes	Lower-Order Themes
Negative experiences of Healthy Lifestyle Programme referral journey (10)	Lack of Healthy Lifestyle Programme Awareness (10.1)	Lack of publicity (10.1.1) Lack of Information at the Point of Referral (10.1.2)
	Initial Concerns (10.2)	
	Referral Duration (10.3)	
	Lack of Follow-up in Primary Care (10.4)	
Positive experiences of Healthy Lifestyle Programme referral journey (11)	High awareness of the Healthy Lifestyle Programmes (11.1)	
	Benefits of the Healthy Lifestyle Programmes (11.2)	Physical benefits (11.2.1) Psychological benefits (11.2.2) Social benefits (11.2.3)
Suggestions for Improvement to Enhance the Patient Journey (12)	Promotional Strategies to Increase Healthy Lifestyle Programme Awareness (12.1)	
	Improving Information Provision to Patients at the Point of Referral (12.2)	
	Improving Opportunities to Discuss Healthy Lifestyle Programme Progress in Primary Care (12.3)	

9.3.2 Overarching Theme 10: Negative Experiences of Healthy Lifestyle Programme Referral Journey

Leisure Customers shed a negative light upon their experiences of transitioning from a patient in primary care to starting their journey at ERL sites on a HLP.

Higher-Order Theme 10.1: Lack of Healthy Lifestyle Programme Awareness

Follow-up interviews enabled Leisure Customers to discuss how well informed they were about the HLP prior to starting their programme. Most felt they were not well informed, which also coincides with survey findings from leisure professionals. Two key reasons were cited for this widespread lack of awareness, adding depth to quantitative findings. This included a lack of publicity, and a lack of information at the point of being referred.

Lower-Order Theme 10.1.1: Lack of Publicity

It was a common view amongst this sample that the HLPs were "*not very well advertised*" (C3; LiveWell candidate), particularly in GP surgeries and other healthcare venues where people presented with lifestyle-related complaints. As put by one Leisure Customer: "*there's got to be a bigger awareness that the facility is there to help people*" (C10; ERS candidate). This lack of publicity irritated Leisure Customers, as they believed *"it should of been out there for [them] to see*" (C10; ERS candidate), rather than relying on a health professional to volunteer the information to them when they deemed appropriate. Some Leisure Customers reflected on their frequent visits to primary care

where they presented with health complaints associated with an unhealthy lifestyle, yet stated they were never told about the HLPs or other means of non-medical support available to support lifestyle change.

Lower-order theme 10.1.2: Lack of Information at the Point of Referral

There was a reoccurring notion that minimal information regarding the HLPs was disclosed at the time of referral, irrespective of who initiated referral in primary care. One Leisure Customer referred to the ERS by a PN exposed how she "*didn't give any information at all"* (C6). Likewise, a Leisure Customer referred to the LiveWell programme by his GP discussed how *"the programme wasn't even mentioned",* and he was simply told to *"expect a phone call"* (C3) from ERL. Similar sentiments were echoed amongst HEART candidates, where one Leisure Customer highlighted how "*nobody said, for instance, you need some shorts. You need some gym shoes. You need some exercise gear"* (C1). Time constraints in GP surgeries and PCP lack of knowledge were perceived to be factors contributing to this paucity of information. Leisure Customers supposed that GPs in particular *"don't have time to talk to you for half an hour about what's going on [on a HLP]"* (C1; HEART candidate) because they are "*exceptionally busy"* (C2; ERS candidate), and do not possess an adequate level of understanding themselves: "*Not everybody knows, even in places where you would probably expect everybody does know*" (C1; HEART candidate).

Contrary to RSAs narratives, on reflection of their initial contact by ERL via telephone, Leisure Customers recalled how they were offered very scant information

about the particular programme they had been referred to. In their opinion, these telephone conversations served only to book a convenient time and date for their initial leisure appointment. As described by one individual: *"there wasn't a lot of information at the telephone call*" (C6; ERS candidate). According to Leisure Customers, this left them feeling apprehensive and ill prepared for their first leisure appointment. Consequently, some reported to arrive at the leisure centres for their initial leisure appointment *"in a pair of shoes and jeans"* and were *"unsure of where to go"* (C13; LiveWell candidate), which made their introductory leisure experiences unpleasant.

Higher-Order Theme 10.2: Initial Concerns

Leisure Customers disclosed several concerns that contributed to their anxiety and uncertainty prior to starting their HLP at the leisure centre. Reportedly, many of these concerns centered around their own negative preconceptions of a leisure gym environment, their physical ability, and their confidence levels. These concerns aligned with the perspectives of both RSAs and FPs, largely, that Leisure Customers had a predefined impression that the gym would be full of young "*skinny people"* (C2; ERS candidate) and perceived they would be the *"old flabby person stuck among them"* (C1; HEART candidate). Others raised concerns about their ability to participate on an exercise programme, and feared they would be *"crap"* (C3; LiveWell candidate). Moreover, many Leisure Customers cited confidence issues, arguing, *"When you get old, you haven't got that confidence to put yourself forward for things"* (C7; ERS candidate), which made them feel apprehensive about their HLP referral.

Higher-Order Theme 10.3: Referral Duration

Another source of frustration stemmed from delays experienced by Leisure Customers once they had been referred onto a HLP. One Leisure Customer proclaimed he had waited *"nearly a year"* to be contacted by ERL to arrange his initial appointment, by which point he had *"nearly forgot about it [the referral]"* (C13; LiveWell candidate). Other Leisure Customers took it upon themselves to chase up their referral form at the leisure centre because they had "*wait[ed] quite a long time"* (C2; ERS candidate), and yet had not been contacted by ERL.

Higher-Order Theme 10.4: Lack of Follow-up in Primary Care

One major criticism of referral processes was the lack of follow-up from primary care once they had completed their HLP. As put by one Leisure Customer: *"once they've referred you, I think that's the end of it"* (C10; ERS candidate). Leisure Customers reported feeling "*forgot[ten] about"* (C13; LiveWell candidate) because *"there's no sort of real follow-up"* (C7; ERS candidate) in primary care to discuss their progress. It was contended that enhanced PCP involvement in their progress would make Leisure Customers feel they were "*more interested in [their] health and well-being"* (C9; ERS candidate). This was anticipated to give Leisure Customers a *"lift"* (C7; ERS candidate) and "*incentive*" (C13; LiveWell candidate) to sustain these healthy lifestyle behaviour changes. However, some Leisure Customers were dubious about referrers becoming more involved in progress feedback, stating that GPs will *"only talk to you about what you've gone for"* (C5; ERS candidate), and are *"very hard pushed to ask silly questions*" (C9; ERS candidate) pertaining to progress.

9.3.3 Overarching Theme 11: Positive Experiences of Healthy Lifestyle Programme Referral Journey

Leisure Customers highlighted their positive experiences of transitioning from being a patient in primary care to beginning their HLP at ERL centres.

Higher-Order Theme 11.1: High Awareness of the Healthy Lifestyle Programmes

There was a small selection of Leisure Customers who reported to have had prior awareness of the HLPs, and subsequently approached their PCP for a referral. Interestingly, none of these individuals were informed about their programme by a PCP. Instead, other Health Professionals outside of general practice such as a "*Dietician"* (C4; LiveWell candidate) or "*Physio[therapist] at the hospital"* (C9; ERS candidate) volunteered information about the HLPs to these individuals, and encouraged them to actively request a referral from their GP. There were also alternative means of learning about the HLPs cited during follow-up interviews. For example, some individuals explained how they had been appraised through their "*retirement group"* (C10; ERS candidate), whereas others found out through a *"friend"* (C6; ERS candidate), or from consulting with reception staff at ERL centres.

Higher-Order Theme 11.2: Benefits of the Healthy Lifestyle Programmes

There was a strong sense of enthusiasm amongst Leisure Customers regarding the positive changes to their physical, psychological, and social well-being from HLP participation.

Lower-order theme 11.2.1: Physical benefits

In relation to the physical benefits endured through HLP participation, Leisure Customers celebrated how they had *"lost so much weight*" (C10; ERS candidate), noticed they had "*better balance*" (C11; ERS candidate), and had built their "*muscles back up*" (C10; ERS candidate). One Leisure Customer detailed functional improvements they had endured.

> C11: *"Some of the things are subtle but so important. I find when I get out the car that I am not dragging my leg behind me. I can lift it to get it out, which is quite a big, a big thing when you're always dragging your leg behind you when you do something".*

Lower-order theme 11.2.2: Psychological benefits

Leisure Customers praised how the HLPs were *"rewarding mentally as well as physically*" (C6; ERS candidate), describing them "*as good as therapy*" (C1; HEART candidate). They discussed how they were "*feeling more balanced and more positive*" (C11; ERS candidate) in their outlook, and *"have not felt this well for years"* (C1; HEART candidate). Furthermore, enhancements in confidence levels were attributed to HLP participation. One individual who disclosed she suffered with severe mental health

problems explained how participation on the ERS had a positive knock-on effect on her other unhealthy lifestyle behaviours:

> C7: *"I was lacking in a lot of confidence… If it hadn't of been for the help here, I would have never given up cigarettes… Now if I stop the exercise, I honestly believe I would start smoking again… It's quite a revelation really!"*

Lower-order theme 11.2.3: Social benefits

Aside from the physical and psychological improvements endured through participation on a HLP, some Leisure Customers highlighted social benefits. One individual who participated on the HEART scheme discussed how *"it gets you out"* and *"you get to know a few people"* which "*makes it pleasant because you know you're going to see a smiling face"* (C1; HEART candidate). Another Leisure Customer described similar experiences whilst on the ERS, highlighting the role of these programmes in combatting social isolation:

> C7: *"I see all the girls and I've got someone to talk to. Made a couple of friends… otherwise I'd have been sitting behind four walls".*

9.3.4 Overarching Theme 12: Suggestions for Improvement to Enhance the Patient Journey

Upon reflection of their individual referral journeys, Leisure Customers proposed numerous recommendations to improve the referral process for future HLP participants. These suggestions were categorised into three higher-order themes: promotional strategies to increase HLP awareness, improving information provision to patients at the point of referral, and improving opportunities to discuss progress in primary care.

Higher-Order Theme 12.1: Promotional Strategies to Increase Healthy Lifestyle Programme Awareness

Irrespective of how informed Leisure Customers perceived themselves to be at the point of referral, they unanimously agreed that there must be a higher awareness of the HLPs in the community. Leisure Customers argued that ultimately "*people need to be educated more about it"* through "*advertising*" (C5; ERS candidate), because *"the more people that can know about it, the better*" (C4; LiveWell candidate). Many speculated that increased marketing was the best way to increase public awareness. Avenues for HLP marketing included *"social media"* (C14; LiveWell candidate) platforms, healthcare venues (e.g., *"hospitals";* C4; LiveWell candidate), community venues (e.g., *"cafes";* C14; LiveWell candidate), council venues (e.g., *"libraries";* C6; ERS candidate), and *"newspaper"* (C14; LiveWell candidate) and *"radio"* (C6; ERS candidate) advertisement. The most common marketing suggestion was within GP surgeries, as it was perceived *"those that need to be on [a HLP] will be going to see their GP"* (C5; ERS candidate).

Higher-Order Theme 12.2: Improving Information Provision to Patients at the Point of Referral

Leisure Customers maintained that those completing referrals must provide prospective candidates with a more detailed overview of these programmes, as many recalled feeling *"blind"* (C1; HEART candidate) prior to visiting ERL centres. Specifically, Leisure Customers sought thorough information on what they needed to

bring to the leisure centre, what kind of exercises they might be expected to do, and what was required of them in terms of commitment and price (if applicable). Many benefits were highlighted in relation to enhancing the provision of HLP information to patients at the point of referral. For instance, Leisure Customers argued, *"it might feel a bit less daunting when you do come for your first appointment"* (C9; ERS candidate).

Moreover, some Leisure Customers argued it would be "*good practice*" to invite prospective HLP participants into ERL centres for a "*pre-visit*" (C11; ERS candidate). According to these individuals, a pre-visit would allow patients to *"see what's going on*" (C13; LiveWell candidate), and *"meet the staff"* as well as *"some of the people in the gym"* (C14; LiveWell candidate). This was anticipated to help *"allay any fears"* (C11; ERS candidate) that patients may have, help to alter any negative pre-conceptions of a leisure gym environment, and provide a *"friendly face"* (C14; LiveWell candidate) should they choose to embark on a HLP following referral.

Higher-Order Theme 12.3: Improving Opportunities to Discuss Healthy Lifestyle Programme Progress in Primary Care

Leisure Customers discussed the benefits of a more robust feedback loop that informs referrers of their progress on a HLP so it can be followed up during subsequent primary care visits. They argued that PCP "*shouldn't really refer anybody onto anything without getting some information back*" (C11; ERS candidate). According to these individuals, PCP need to be more aware of the way the HLPs are positively influencing their lives, or they are at risk of being underutilised, or worse, decommissioned. Put

candidly by one Leisure Customer: "*the benefit is theirs because they know when they are referring people on [to the HLPs], they can say they have had some positive feedback and it's more encouraging for other people"* (C11; ERS candidate).

9.4 Summary

This chapter intended to present online survey and 1:1 interview findings collected from Leisure Customers during the second data collection phase of this research project. This data was analysed through a combination of descriptive statistics and inductive thematic analysis. To summarise these findings, the large majority of Leisure Customers reflected positively on their experiences throughout the duration of completing a HLP, drawing attention to the physical, psychological, and social benefits of participation. However, many Leisure Customers reflected poorly on their experiences of referral in primary care, and the subsequent interim period between referral and attending the leisure centre for their first appointment. This was largely attributed to not having enough information from PCP about what to expect on a leisure programme, which contributed to increased anxiety and uncertainty prior to attending the leisure centre. To improve the referral pathway for future patients, Leisure Customers highlighted the importance of increasing awareness of the HLPs amongst the community, where the most common suggestion was for increased marketing both within and beyond healthcare venues. Improving the provision of information to patients at the point of making a referral in primary care was another crucial area identified for development. Lastly, some Leisure Customers sought increased opportunities to discuss their progress made on the leisure schemes with PCP during subsequent visits to the GP surgery.

10 GENERAL DISCUSSION

10.1 Introduction

As highlighted in the literature review, research concerning PAP primarily focuses on advice giving and counselling in primary care, and rarely considers the perspectives of PCP (with the exception of GPs), patients, or FPs in relation to community-based PA interventions typically accessed through a health professional referral. Thus, this study endeavoured to make a unique contribution to the evidence base by using mixed methods to elicit the perspectives and experiences of multiple stakeholders (i.e., PCP, Leisure Professionals, and Leisure Customers) with respects to PA referral programmes (i.e., the HLPs operating across ERoY)

Qualitative and quantitative research strands of this PhD project enabled an in-depth understanding of the barriers and facilitators of making a HLP referral as perceived by PCP (Phase I); a comprehension of referral processes from the perspective of Leisure Professionals involved in the processing of referrals and the delivery of the HLPs (Phase II); and an insight into the lived experiences of patients transitioning from primary care to ERL centres following a HLP referral (Phase II). This research was an emergent convergent mixed methods study design, thus integration of qualitative strands from phase I with quantitative and qualitative strands from phase II was essential to produce an extended, nuanced understanding of referral processes.

10.2 Method for Integrating Research Components

The process by which qualitative and quantitative research strands are integrated is often a criticism of mixed methods research. Several researchers argue there has been

inadequate attention paid towards the process of how findings of mixed method studies are integrated, and a lack of exemplars in the literature, which raises uncertainty concerning what it means to integrate qualitative and quantitative findings (Bryman, 2007; Jones & Bugge, 2006). Consequently, qualitative and quantitative findings may not be integrated at all, or integrated to only a narrow extent (Bryman, 2007). For this reason, it was of upmost importance to provide a clear and replicable account of how data strands of this doctoral thesis were integrated. Thus, the writings of Farmer, Robinson, Elliott, and Eyles (2006) and O'Cathain et al. (2010) on the Triangulation Protocol guided the process of integration. In line with a convergent design, the integration of quantitative and qualitative findings occurred at the interpretation stage of this study.

Figure ***10.1***. provides a diagram depiction of the convergent mixed methods design, which includes the overall research aim, individual research components, the integration of data, and the multiple triangulation methods.

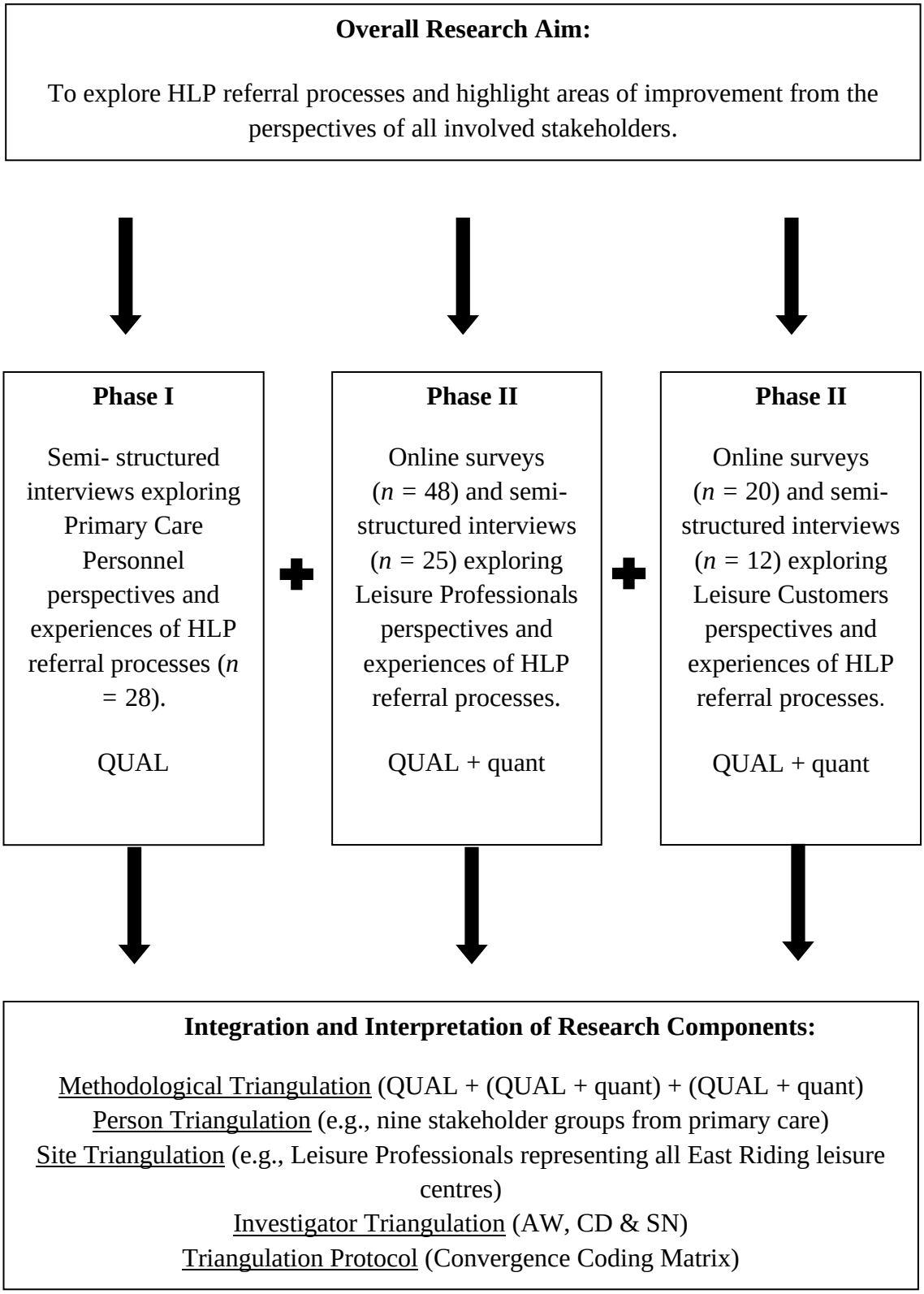

Figure 10.1. Flowchart depiction of the convergent mixed methods design and multiple triangulation techniques

The triangulation protocol moves researchers from reporting findings from separate qualitative and quantitative research phases to considering their significance in relation to each other by identifying overarching patterns called ‘meta themes’ (Farmer et al., 2006; O’Cathain et al., 2010). The identification of meta themes is a process of systematic comparison which helps to fuse individual data sets within a broader study. Once these meta themes are identified, researchers then demonstrate how those patterns manifest in rich, contextually-specific ways, which adds depth to research (Wutich et al., 2021). The rationale for adopting the triangulation protocol was to enable higher level interpretations of research components through the identification of overriding meta themes and meta subthemes, and the examination of convergence, silence, and dissonance inherent therein to provide a more complete picture of HLP referral processes.

The triangulation protocol involves the creation of a convergence coding matrix where findings from each individual study component are listed and considered in relation to one another (O’Cathain et al., 2010). The goal of a convergence coding matrix is to display data forms in a singular visual, which help researchers to systematically compare multiple data sets (Creswell & Creswell, 2017). In the present study, the convergence coding matrix took the form of a mind map (see appendix 14), where quantitative data (i.e., M, SD, frequencies, and proportions of survey responses) and qualitative themes (identified within interview transcriptions and free-text survey responses) from individual study components were amalgamated (Farmer et al., 2006). Next, the primary researcher began to actively seek themes amongst data sets. This resulted in the identification of two key overriding meta themes across all studies, each compassing three meta subthemes. A colour coding scheme was then applied for the convergence assessment, which consisted of four outcomes: agreement (i.e., full agreement between findings; colour: green), partial

agreement (i.e., some agreement between findings; colour: amber), silence (i.e., one set of findings identify a theme, but another does not; colour: blue) and dissonance (i.e., disagreement or conflict between findings; colour: red). The results of data integration using the triangulation protocol facilitated the identification of two overriding meta themes across all research phases: 'Poor Understanding' (presented in Table 10.1) and 'Inadequacies of HLP Referral Processes' (presented in Table 10.2). Several meta subthemes were also identified. Results of the triangulation protocol are detailed in the proceeding sections, where overriding meta themes across all research phases are discussed in relation to their significance or novelty in light of previous relevant literature and theory. To close the chapter, an overview of this studies strengths and limitations are presented.

Table 10.1. *Integration of Results: Convergence Coding Matrix for Meta Theme 1: Poor Understanding*

Meta Theme: Poor Understanding			
Meta Subtheme	Phase I Interviews	Phase II Online Surveys	Phase II Follow-up Interviews
Primary Care Personnel Have a Poor Understanding of Lifestyle Promotion	**PCP:** Lower-Order Theme 1.1.2: Limited Awareness of Physical Activity Prescription and the Healthy Lifestyle Programmes [agreement] Lower-Order Theme 1.1.3: Negative Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes [agreement] Subtheme 2.1.1.1: Lifestyle promotion enthusiasts [dissonance]	**RSA:** [silence] **FP:** [silence] **Customer:** Section 9.2.5.1: Inadequate Awareness of Lifestyle Issues and the Healthy Lifestyle Programmes [agreement] Section 9.2.2.3: Emotions Experienced at the Time of Referral [agreement]	**RSA:** [silence] **FP:** Lower-Order Theme 7.1.2: Low Promotion of Healthy Lifestyles and the Healthy Lifestyle Programmes [agreement] **Customer:** [silence]
Primary Care Personnel Have a Poor Understanding of the Healthy Lifestyle Programmes	**PCP:** Lower-Order Theme 1.1.2: Limited Awareness of Physical Activity Prescription and the Healthy Lifestyle Programmes [agreement] Lower-Order Theme 1.1.3: Negative Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes [agreement] Subtheme 2.1.1.2: Advocates of the Healthy Lifestyle Programmes [dissonance] Lower-Order Theme 3.1.2: Healthy Lifestyle Programme Information Resources for Primary Care Personnel [agreement]	**RSA:** Section 8.1.6.1: Inadequate awareness of the Healthy Lifestyle Programmes [agreement] **FP:** Section 8.3.5.2: Inadequate awareness of the Healthy Lifestyle Programmes [agreement] Section 8.3.5.3: Inappropriate HLP Referrals Received [agreement] **Customer:** Section 9.2.5.1: Inadequate Awareness of Lifestyle Issues and the Healthy Lifestyle Programmes [agreement] Section 9.2.5.2: Gaps in Healthy Lifestyle Programme Information Provision [agreement] Section 9.2.2.2: Information Provided to Patients at the Point of Referral [agreement]	**RSA:** Lower-Order Theme 4.1.1: Limited Awareness of the Healthy Lifestyle Programmes [agreement] Higher-Order Theme 6.1: Strategies to Increase Awareness of the Healthy Lifestyle Programmes [agreement] **FP:** Lower-Order Theme 7.1.1: Limited Awareness of the Healthy Lifestyle Programmes [agreement] Higher-Order Theme 9.2: Promotional Strategies to Increase Healthy Lifestyle Programme Awareness [agreement] **Customer:** Lower-Order Theme 10.1.2: Lack of Information at the Point of Referral [agreement]

Patients Have a Poor Understanding of the Healthy Lifestyle Programmes	**PCP:** Lower-Order Theme 1.2.3: Limited Awareness of the Healthy Lifestyle Programmes [agreement] Lower-Order Theme 2.2.1: High Awareness of the Healthy Lifestyle Programmes [dissonance] Subtheme 2.2.1.1: Promotion of HLPs [dissonance] Lower-Order Theme 3.1.1: Marketing and Promotion for The Public [agreement]	**RSA:** Section 8.1.4.1: Referred Patient Awareness of their Healthy Lifestyle Programme [partial agreement] **FP:** Section 8.3.5.2: Inadequate awareness of the Healthy Lifestyle Programmes [agreement] Section 8.3.5.3: Inappropriate HLP referrals received [agreement] Section 8.3.3.2: Patient Awareness of their HLP [partial agreement] **Customer:** Section 9.2.2.1: Initial Awareness of their Healthy Lifestyle Programme [partial agreement] Section 9.2.5.1: Inadequate Awareness of Lifestyle Issues and the Healthy Lifestyle Programmes [agreement]	**RSA:** Lower-Order Theme 4.2.1: Limited Awareness of the Healthy Lifestyle Programmes [agreement] Higher-Order Theme 6.1: Strategies to Increase Awareness of the Healthy Lifestyle Programmes [agreement] Lower-Order Theme 5.2.1: Increasing Awareness of the Healthy Lifestyle Programmes [dissonance] **FP:** Lower-Order Theme 7.2.1: Limited Awareness of the Healthy Lifestyle Programmes [agreement] Higher-Order Theme 9.2: Promotional Strategies to Increase Healthy Lifestyle Programme Awareness [agreement] Lower-Order Theme 8.1.2: High Promotion of the Healthy Lifestyle Programmes [dissonance] **Customer:** Higher-Order Theme 10.1: Lack of Healthy Lifestyle Programme Awareness [agreement] Higher-Order Theme 11.1: High Awareness of the Healthy Lifestyle Programmes [dissonance] Higher-Order Theme 12.1: Promotional Strategies to Increase Healthy Lifestyle Programme Awareness [agreement]

Note: Colours represent convergence assessment: agreement [green], partial agreement [amber], dissonance [red], and silence [blue]

Table 10.2. *Integration of Results: Convergence Coding Matrix for Meta Theme 2. Inadequacies of HLP referral processes*

Meta Theme: Inadequacies of HLP referral processes			
Meta Subtheme	Phase I Interviews	Phase II Online Surveys	Phase II Follow-up Interviews
Challenges of Making Healthy Lifestyle Programme Referrals	**PCP:** Lower-Order Theme 1.3.1: Problems Associated with Paper Referrals [agreement] Lower-Order Theme 1.3.2: Problems Associated with Electronic Referrals [agreement] Higher-Order Theme 3.4: Simplifying Healthy Lifestyle Programme Referral Processes [agreement] Lower-Order Theme 2.3.1: Ease of Paper Referrals [dissonance] Lower-Order Theme 2.3.2: Ease of Electronic Referrals [dissonance]	**RSA:** [silence] **FP:** [silence] **Customers:** [silence]	**RSA:** [silence] **FP:** [silence] **Customers:** [silence]
Challenges of Managing Healthy Lifestyle Programme Referrals	**PCP:** [silence]	**RSA:** Section 8.1.3: Processing of Healthy Lifestyle Programme Referrals [partial agreement] Section 8.1.6.3: Issues with processing Healthy Lifestyle Programme Referrals [agreement] Section 8.1.2: Information Received at The Point of Referral [partial agreement] Section 8.1.6.2: Issues with Information Received at the Point of Referral [agreement] **FP:** Section 8.3.3.1: Experience of Making Initial Contact with Referred Patients [partial agreement] Section 8.3.2: Information Received at the Point of Referral [agreement]	**RSA:** Lower-Order Theme 4.3.1: Issues with Information Received at Point of Referral [agreement] Lower-Order Theme 4.3.2: Healthy Lifestyle Programme Referral Workload [agreement] Lower-Order Theme 4.3.3: Problems Associated with Processing Paper Referrals [agreement] Lower-Order Theme 4.3.4: Problems Associated with Processing Electronic Referrals [agreement] Lower-Order Theme 4.3.6: Lack of Standardisation [agreement] Lower-Order Theme 5.3.1: Benefits of Paper Referrals [dissonance]

		Section 8.3.5.1: Issues with Information Received at The Point of Referral [agreement] **Customers:** [silence]	Lower-Order Theme 5.3.2: Benefits of Electronic Referrals [dissonance] Higher-Order Theme 6.3: Referral Management Strategies [agreement] **FP:** Lower-Order Theme 7.3.1: Issues with Information Received at the Point of Referral [agreement] Higher-Order Theme 9.1: Improving the Provision of Referral Information to Leisure Professionals [agreement] Lower-Order Theme 7.3.2: Healthy Lifestyle Programme Workload [agreement] Higher-Order Theme 9.4: Referral Management Strategies [agreement] **Customers:** Higher-Order Theme 10.3: Referral Duration [agreement]
Inadequacy of Feedback Mechanisms	**PCP:** Lower-Order Theme 1.3.3: Problems with the feedback loop [agreement] Lower-Order Theme 1.1.3: Negative Attitudes Towards Lifestyle Promotion and the Healthy Lifestyle Programmes [agreement] Higher-Order Theme 3.3: Improving Feedback Provision [agreement]	**RSA:** Section 8.1.5: The Feedback Loop [partial agreement] **FP:** Section 8.3.4: The Feedback Loop [partial agreement] **Customer:** Section 9.2.4: Feedback on HLP Progress with Primary Care Personnel [partial agreement]	**RSA:** Lower-Order Theme 4.3.5: Problems with the Feedback Loop [agreement] Higher-Order Theme 6.2: Improving Feedback Provision [agreement] **FP:** Higher-Order Theme 9.3: Improving Feedback Provision [agreement] **Customer:** Higher-Order Theme 10.4: Lack of Follow-up in Primary Care [agreement] Higher-Order Theme 12.3: Improving Opportunities to Discuss Healthy Lifestyle Programme Progress in Primary Care [agreement]

Note: Colours represent convergence assessment: agreement [green], partial agreement [amber], dissonance [red], and silence [blue]

10.3 Meta Theme 1: Poor Understanding

Poor understanding emerged as an over-riding meta theme across all individual research phases. This meta theme is multifaceted in nature, encompassing three meta subthemes relating to perceived and actual understanding of PAP and the HLPs at the PCP and patient level. The perceived factors contributing to, and the perceived consequences of poor understanding are also central features of this overriding meta theme. Whilst there were strong areas of agreement between individual study components, there were some areas of partial agreement, dissonance, and silence both within and between stakeholder groups, which is explained in the following sections where relevant. Meta subthemes are also discussed in relation to their significance or novelty in light of existing relevant literature and theory.

10.3.1 Meta Subtheme 1.1: Primary Care Personnel Have a Poor Understanding of Lifestyle Promotion

Whilst there were some areas of dissonance and silence both within and between stakeholder groups, the overall consensus was that PCP do not have sufficient understanding in relation to lifestyle promotion.

Interviews with PCP revealed how many of them had a poor understanding of PA promotion and prescription (see lower order theme 1.1.2). GPs in particular often struggled to identify if their patients were physically inactive, and challenged the

necessity of certain contraindications to exercise referral such as high blood pressure. Guideline 6 of the National Quality Assurance Framework for Exercise Referral Systems (2001) states "*all initiators of referrals should understand and be able to explain the efficacy and possible risks of physical activity in relation to specific medical conditions and medications*" (p.28). Findings suggest that PCP did not always have a sufficient level of understanding to fulfil this responsibility. GPs voiced a disconnect between what they were expected to know in relation to PA prescription, and the training they had received to upskill in this area. Comparisons can be drawn with Douglas, Torrance, et al. (2006) where only 7-13% of PCP could correctly describe CMO PA guidelines, and between 46-53% strongly agreed or agreed that there is a lack of training available for health professionals concerning PAP. The under-developed medical education response to PA has long been subject to criticism and is a likely contributor to the poor understanding of, and confidence in PAP amongst the medical community (Chatterjee et al., 2017; Dunlop & Murray, 2013; Osborne et al., 2017; Vuori, 2016). Whilst it is encouraging that there have been recent efforts towards the implementation of PAP educational approaches to help enhance understanding such as the 'Moving Healthcare Professionals programme' (Brannan et al., 2019) and the Moving Medicine initiative (Faculty of Sport and Exercise Medicine UK, 2021), contemporary research indicates that only 15% of GPs are aware of such initiatives, and only 5% have reported to engage with them (Buckley et al., 2020). This highlights the difficulty of enhancing PCP understanding of PAP.

The attitudes of PCP may also have implications for their understanding of lifestyle promotion and PAP. There were areas of dissonance within phase 1 findings in relation to PCP attitudes. Some held negative attitudes towards lifestyle promotion more

generally (see lower order theme 1.1.3), describing PAP activities as beyond their remit and a burden on their increasingly unmanageable workload (see subtheme 1.1.1). It was common for these PCP to question the necessity of their involvement in PAP, and many emphasised the importance of a patient taking individual responsibility in relation to accessing PA support. Din et al. (2015) and Graham et al. (2005) have also reported how some Health Professionals consider PAP to lie outside their expertise and remit, and perceived their involvement in exercise prescription as unnecessary. The traditional medical model which has long prioritised the prescription of pharmaceuticals to manage healthcare (Sallis, 2015) is likely to have contributed to these attitudes towards lifestyle promotion, where some PCP perceive their role to be principally medically orientated. These attitudes may also be a potential reason as to why engagement with initiatives to upskill GPs on PAP have been so poor (Buckley et al., 2020).

In contrast, many PCP in the present study described how they took a proactive approach to health promotion activities (see lower order theme 2.1.1.) and demonstrated enthusiasm around their involvement in lifestyle promotion. These PCP were passionate about the impact of positive behaviour change for disease prevention and disease management. This compares favourably with the findings of Douglas, Torrance, et al. (2006) who also found that the large majority of health professionals in primary care agreed that lifestyle promotion, and specifically PAP is a core aspect of their role. Increasing awareness of educational approaches to PAP amongst PCP is important in their continuing professional development to ensure they are fully appraised of its value, how to assess PA levels amongst their patients, and can recognise absolute contraindications to exercise. Ongoing training around PAP is therefore required as part of continuing

professional development to ensure PCP know why they are being asked to provide particular patient information at the point of making a HLP referral.

There were also assumptions amongst other stakeholders that PCP were not sufficiently skilled in lifestyle promotion, nor do they prioritise it. Through-out follow-up interviews, some FPs assumed that PCP medicalise lifestyle related issues by prescribing pharmaceuticals by default rather than facilitating access to lifestyle support services such as the HLPs (see lower order theme 7.1.2). Similar viewpoints were echoed by Moore et al. (2011) where some FPs believed health professionals only referred to ERS when they had exhausted all possible medical options. These assumptions could be overcome by improving working relationships and enhancing communication between ERL and PCS to enhance understanding of when lifestyle support services such as the HLPs may be appropriate for certain patient groups. Moreover, online survey data from Leisure Customers evidenced the value they placed on prevention work in general practice, where they supported PCP involvement in addressing unhealthy lifestyle behaviours rather than the prescription of pharmaceutical drugs (see section 9.2.5.1), yet some felt there was not much support from their PCP in terms of being actively encouraged to attend the HLPs (see 9.2.2.3). Researchers have repeatedly called for the incorporation of PA-based QOFs to help make PAP a priority in routine consultations (Buckley et al., 2020; Savill et al., 2015). This is an example of 'incentivisation', one of the nine intervention functions within the behaviour change wheel (BCW) which seeks to bring about change through the creation of an expectation of reward (Michie et al., 2014). 2021 witnessed the inclusion of obesity-related indicators in the QOF (NHS England, 2021). GP practices that sign up will receive a payment of £11.50 for every

referral of an obese patient to weight management services including: 1) NHS Digital Weight Management services, 2) Local Authority funded tier two weight management services (e.g., HLPs), 3) Diabetes Prevention Programme, and 4) Tier 3 and Tier 4 services. Since PIA is a primary contributor to obesity, this incentivisation through the QOF may simultaneously increase their understanding of PAP, their receptiveness towards further upskilling in this area, and change negative attitudes towards the value of PAP in primary care.

10.3.2 Meta Subtheme 1.2: Primary Care Personnel Have a Poor Understanding of the Healthy Lifestyle Programmes

Stakeholder groups were largely in agreement that PCP do not have sufficient understanding in relation to the HLPs, however there were some areas of dissonance amongst PCP. The contributors of this poor understanding amongst PCP were also debated.

Interviews conducted as part of the first phase of this research project revealed that many PCP had a poor understanding of the HLPs (see lower order theme 1.1.2). They struggled to remember that the programmes existed, or determine if patients were eligible for referral, and failed to provide any depth of information to patients regarding these programmes at the point of making a referral. Comparisons can be drawn with a contemporary mixed methods study from Buckley et al. (2020) who discovered that limited awareness of PA initiatives and how to refer represented one of the most pertinent barriers for GPs making referrals (cited by 25% of the sample). In contrast to the majority

of PCP in the present study who considered themselves poorly informed about the HLP, there were some who celebrated how these programmes were both well-known and well utilised in general practice (see Subtheme 2.1.1.2). PCP highlighted the value of information resources which highlight salient features of each programme, to enable them to quickly appraise patient suitability (see lower order theme 3.1.2). This finding is in accord with earlier studies where PCP have criticised the lack of, and access to up-to-date educational information resources (Buckley et al., 2020; Carstairs et al., 2020; Douglas, van Teijlingen, et al., 2006; Tompkins et al., 2009). For example, GPs in Buckley and colleagues study (2020) regarded clearer marketing information about scheme content as the second most important facilitator for making more PA referrals (cited by 46% of the sample). According to Moore et al. (2013), scheme information resources are not always disseminated completely to all relevant health professionals, particularly when schemes are newly launched, which perpetuates the knowledge gap amongst health professionals. It has been suggested that hard copy leaflets are as equally important as online circulation of scheme information (cited by 61% of GPs; Buckley et al., 2020).

The application of behavioural insights may prove highly beneficial to the successful co-design and implementation of bespoke scheme information resources. Referral materials for PCP sit firmly within the ‘education’ intervention function of the behaviour change wheel (BCW), which seeks to bring about desired change by increasing knowledge or understanding (Michie et al., 2014). Elements of the EAST framework (Algate et al., 2012) could be targeted to ensure, for example, such resources are ‘easy’ to understand, capture the ‘attention’ of PCP, and help to address any gaps in their understanding. Therefore, referral materials for PCP appear to be a promising avenue to

increase HLP understanding, and reinforce the benefits of PAP, providing these resources are co-designed with PCP, guided by behavioural insights, dispersed appropriately via various formats, kept up to date, and are easily accessible in practice.

Some PCP held reservations around the effectiveness of the HLPs, which influenced their decision to promote them to patients (see lower-order theme 1.1.3). These concerns around programme effectiveness were mainly attributed to the lack of feedback from ERL regarding how successful previously referred patients had been in relation to changing their lifestyle behaviours. Din et al. (2015) also discovered that a health professional's decision to engage with PAP or exercise prescription was influenced by ambiguity around the effectiveness of PA for different patient groups, especially when compared to health promotion campaigns with proven effectiveness such as smoking cessation. On a similar note, health professionals in Graham et al. (2005) study easily articulated the effectiveness of smoking cessation, yet were reportedly oblivious to the effectiveness of ERS, which had implications for referrals. Undeniably, the evidence base for the health-related effects of PA is considerably recent in comparison to smoking (Vuori, 2016), and there remains much ambiguity around the effectiveness of PAP in primary care in facilitating long-term meaningful behaviour (Campbell et al., 2015; NIHCE, 2014b; Pavey, Anokye, et al., 2011; Van der Wardt et al., 2021; Wade et al., 2020). It is also interesting to reiterate how health professionals have been incentivised to consult with patients about smoking through the QOF since 2004, which provides some assurance that engagement with PAP is likely to improve in light of the recent inclusion of obesity-related indicators (NHS England, 2021). The noted ambiguity around HLP efficacy could be lessened by ensuring patient progress feedback is easily accessible to

PCP, allowing them to appraise the effectiveness of these programmes for different patient groups. The provision of patient progress feedback is discussed further within meta theme 2.

Leisure Professionals were also of the assumption that PCP understanding of the HLPs was poor. According to RSAs, there were two key indicators of this: 1) the number of inappropriate referrals to the HLPs (see lower order theme 4.1.1), and 2) the lack of understanding amongst patients due to not being provided scheme explanations at the point of referral (see section 8.1.6.1). RSAs stressed the importance of building this understanding amongst PCP through improved communication and collaboration between ERL and PCS (see higher order theme 6.1.). FPs concurred with RSAs, explaining how it was common for them to interact with patients who were not appropriate HLP candidates (see section 8.3.5.3) or have to fill in gaps in HLP information provision when meeting referred patients for the first time (see section 8.3.5.2). FPs attributed this to poor PCP understanding, and insufficient information disclosed to patients at the point of them making a referral (see lower-order theme 7.1.1). Comparable perspectives are present in the literature concerning similar cohorts and regions. For example, Henderson et al. (2017) unearthed frustrations of Exercise Professionals from East Midlands as a result of inaccurately completed ERS referral forms, which for them was indicative of a lack of familiarity with ERS amongst Health Professionals. Similarly, ERS Officers in North West England have criticised Health Professionals for their lack of consideration towards referral criteria, which resulted in inappropriate referrals and poor-quality information provided to ERS candidates (Graham, 2006). Some FPs in the present study suggested that having an open day

specifically for PCP may help them to understand the HLPs better and refer more appropriately (see higher order theme 9.2.).

Upon reflection of their HLP referral in primary care, Leisure Customers recalled how they were not provided with sufficient programme information, which they attributed to a consequence of PCP not having the knowledge, nor the time to properly inform them (see section 9.2.2.2 & lower order theme 10.1.2). This finding corroborates the work of other UK-based research studies. For example, Wormald et al. (2006) found strong consensus amongst patients that their health professionals did not have a great breadth of knowledge regarding ERS, which, was testament to the paucity of information provided at the time of referral. Similarly, ERS patients in Wormald and Ingle's (2004) study perceived that PCP were not well-informed about the scheme, and thus were not forthcoming about scheme details. It is interesting to note that both these studies recruited patient samples from the same county (Yorkshire) as the participants in this study, building a reasonable case that PCP in this region are failing to properly inform patients eligible for PA referral schemes. Leisure Customers in the present study discussed how they would have liked more comprehensive information around the HLPs from their PCP, so they were better informed about what to expect, and had reassurance that a referral was appropriate based on their individual needs and exercise abilities (see section 9.2.5.1. & 9.2.5.2.). They suggested that this would have made them feel more supported and less apprehensive about entering the leisure environment (see higher order theme 12.2.). Although the Leisure Customer sample focused solely on those who had completed a HLP, comparisons can be drawn with a recent qualitative study which focused on the perspectives of a sample of ERS 'uptakers' (n = 31) and those who 'did not attend' (n =

5). This sample highlighted the importance of receiving information support (e.g., having detailed discussions around the ERS), and emotional support (e.g., receiving assurances concerning their ability to engage in PA) from their health professional, which encouraged programme uptake (Birtwistle et al., 2018). Therefore, to ensure future candidates feel well informed about the HLP and supported prior to initial interactions with ERL professionals, it is vital that PCP have underpinning knowledge, and provide eligible candidates with both emotional and informational support.

Weak working relationships between PCS and ERL were suggested to be one key contributor to the limited understanding of the HLP amongst PCP, yet there were some dissonance within study findings. Some PCP desired closer working relationships with ERL to enable them to understand the referral pathway better (see Higher-Order theme 3.2), whereas others described how positive working relationships had been nurtured, which enhanced understanding of the HLPs (see subtheme 2.2.1.1). Overall, working relationships were subject to much criticism from RSAs (see Lower-Order Theme 4.1.2). Nevertheless, some RSAs were complimentary about these working relationships (Lower-Order Theme 5.1.1). Similarly, whilst some FPs questioned whether the relationships between ERL and PCS was satisfactory (see Lower-Order Theme 7.1.3) and sought stronger working relationships to improve PCP understanding of, and confidence in the HLPs, others were complimentary about working relationships (Lower-Order Theme 8.1.1). Those who were complementary usually operated in coastal regions of the ERoY, and celebrated their regular face-to-face engagements in general practice sites to promote the programmes to PCP and patients. Craig et al. (2001) and Leenaars et al. (2015) argue that communication and good working relationships between health and leisure

providers are vital for successful PA interventions. Therefore, efforts towards nurturing positive working relationships between all ERL centres and surrounding PCS must take precedence.

10.3.3 Meta Subtheme 1.3: Patients Have a Poor Understanding of the Healthy Lifestyle Programmes

There was overall consensus that patient understanding in relation to the HLPs is inadequate. However, there were some areas of dissonance and partial agreement both within and between stakeholder groups. It is worth reiterating at this point that the views of those who did not take up participation on a HLP were unexplored in the present study, and therefore much of this section is based on perceptions of patient understanding from primary care and Leisure Professionals. Nonetheless, Leisure Customers who were once patients, discussed their understanding of the HLP prior to embarking on their programme during online surveys and follow-up interviews. Whilst they may not be representative of all primary care patients, their views were nonetheless insightful. PCP offered their perceptions of how informed they perceived patients were about the HLPs, which was discussed in relation to broaching the topic of referral. Leisure Professionals' perceptions of patient understanding were based on reflections of their initial contact with referred patients.

The majority of Leisure Customers (85%) reported they had a poor understanding of the HLPs when they reflected on their referral experiences (see section 9.2.2.1). Follow-up interviews demonstrated how Leisure Customers largely attributed their poor

understanding to poor publicity (Lower-Order Theme 10.1.1.), and a lack of information provided by their referrer at the point of discussing their referral (Lower-Order Theme 10.1.2). These findings are in line with a systematic review by Pavey et al. (2012) which suggests that GPs do not offer enough information about what PA programmes entail, do not offer patients the opportunity to choose their exercise options, and may inappropriately refer patients to PA programs regardless of their degree of readiness to change their PA behaviours. Moreover, some Leisure Customers in this study recalled how their initial telephone call from ERL did not provide them with adequate information, which left them feeling ill prepared for their leisure appointment and contributed to their initial anxieties. However, there were areas of partial agreement and dissonance whereby a minority of Leisure Customers perceived themselves to have a good understanding of the HLPs at the time of their referral (see section 9.2.2.1 [partial agreement] & higher-order theme 11.1 [dissonance]). These individuals found out about the HLPs through various means outside of primary care, before actively requesting a referral from a PCP. This emphasises the value of HLP promotional efforts both within and outside of general practice sites.

Leisure Customers reported feeling apprehensive about the leisure gym environment, and lacked in confidence as a result of being poorly informed about the HLPs (see section 9.2.2.3 & higher order theme 10.2). These Leisure Customers recalled feeling worried about being in the presence of younger and fitter gym users and had concerns around their own appearance. This supports the findings of previous research from the perspective of ERS populations. For example, Graham (2006) found that ERS participants had concerns over their self-presentation whilst exercising in the gym

environment, which was often discussed in relation to their age and weight. Similarly, Wormald and Ingle (2004) found that some ERS participants felt intimidated by other gym users who they perceived were observing and judging them. Confidence issues were discussed by Leisure Customers in the present study in two ways: first, their general confidence levels, and secondly, their confidence specifically in relation to their ability to undertake exercise in light of existing health conditions. This builds on other studies with similar ERS cohorts. Participants in Graham's (2006) study described how they were fearful that PA may exacerbate their health conditions or worsen their symptoms. Similarly, Eynon et al. (2018) interviewed nine ERS adherers who highlighted a major lack of confidence to commence participation as they perceived they were not physically capable of exercising effectively.

Some Leisure Customers recalled receiving HLP information resources at the point of referral, yet there were conflicting interpretations about the usefulness of such resources (see section 9.2.2.2. [partial agreement]). Similarly, PA referral scheme participants in prior research have criticised information resources provided at the time of their referral, which were sometimes perceived to be inadequate or antiquated (Allen et al., 2015), leading them to disassociate themselves from schemes due to a perception they were unsuitable candidates (Birtwistle et al., 2018). Comparably, some ERS participants in Wormald and Ingle's study (2004) perceived that the marketing image presented within leisure environments is directed at younger healthier generations, which contributed to their feelings of anxiety and disassociation. Health professionals have also noted how patients do not always perceive that PA opportunities are suitable for their individual needs (Carstairs et al., 2020). Thus, it is imperative that HLP information

resources are designed carefully so they appeal to eligible candidates, eradicate any misconceptions around suitability, and provide the information they require to make an informed decision about programme uptake. The EAST framework (Algate et al., 2012), prized as a straightforward way of applying behavioural insights, is likely to be highly beneficial in striking the balance between information being clear, appealing and sufficiently comprehensive, yet easily digestible. This is important because as Hallsworth et al. (2016) notes, making health-related information 'attractive' is challenging because humans naturally have limited capacity for information processing.

Irrespective of HLP understanding, Leisure Customers in the present study were unanimous in agreement that there must be renewed efforts towards promotion to increase public visibility of these programmes (see higher-order theme 12.1). Suggested avenues to promote the HLPs included social media platforms, healthcare, community, and council venues, and newspaper and radio platforms. Prior research has also highlighted the importance of raising public consciousness of exercise on prescription. In their summary of recommendations to improve lifestyle PA-based services in the UK, Wormald et al. (2006) stressed there must be sufficient promotion of such services through marketing, which should specifically target unhealthy, older, overweight individuals, as they are often under a misconception that they are not suitable candidates. Marketing is also regarded as an underutilised opportunity to reinforce the PA message (Brooks et al., 2016; Morton et al., 2016), and change the societal culture that dismisses the value of PA and lifestyle behaviour change (Brooks et al., 2016). Therefore, careful marketing and promotion of the HLPs may help to increase public understanding, and

subsequently reduce anxieties associated with lifestyle change, and the leisure environment.

Another interesting suggestion from several Leisure Customers to enhance HLP understanding and overcome uncertainties in the period between referral and programme uptake, was for a 'pre-visit' at ERL centres. According to them, this would enable eligible candidates to better understand what the programmes entail, and speak with current participants and Leisure Professionals (see section 9.2.5.1). ERS participants in Birtwistle et al.'s study (2018) valued speaking with ERS service users and noted how this enabled them to make more of an informed decision about whether the scheme was right for them. The viability of providing HLP candidates the opportunity to visit ERL centres and interact with current participants deserves consideration. Interactions between prospective candidates, current participants and Leisure Professionals would provide opportunities for questions to be presented and answered, and valuable information to be exchanged. Embuldeniya et al. (2013) argues that information and guidance provided through peer support is more impactful and credible than information-provision alone, as it is grounded in personal experience. Moreover, pre-visits would function as a form of 'modelling', a key intervention function of the BCW which seeks to encourage behaviour by providing examples for others to aspire to or imitate (Michie et al., 2014). Therefore, current HLP participants who possess experiential knowledge may be best placed to provide peer support through emotional (expressions of empathy), and informational (provision of advice and helpful information) support. Whilst it could be resource intensive for ERL, pre-visits may help to filter those who are ready to make lifestyle changes and embark on a HLP, those who have reservations and require more support

before they are ready to uptake referral, and those who decide lifestyle change or HLP uptake is currently not the right option for them.

Interviews with PCP revealed common perceptions that patients were unfamiliar with the HLPs, which they attributed to a lack of publicity and promotion (see lower order theme 1.2.3). These PCP argued that high patient understanding of these programmes was a key factor facilitating referral because it encouraged patients to adopt an active rather than passive role in accessing support. There was also an assumption that patients requesting a referral were more motivated to change their lifestyle behaviours, and were more likely to adhere to a HLP (see lower order theme 2.2.2). Echoing Leisure Customers, PCP felt much more could be done to raise awareness and visibility of HLPs to patients through marketing and promotional strategies to encourage them to actively request a referral (see lower-order theme 3.1.1). Suggested strategies to increase patient understanding included displaying leaflets in GP surgeries, cafés, and council services, using media outlets such as local newspapers, GP webpages, local radio broadcasts, and through public transport advertisement. Echoing preceding paragraphs, marketing and promotional strategies need careful thought, and information resources must be cautiously designed so they appeal to diverse patient groups and prevent common misconceptions around suitability. Nevertheless, there was dissonance amongst a minority of PCP who celebrated how public awareness and understanding was increasing, which many perceived to be a consequence of FP promotion within GP surgeries (see lower order theme 2.2.1). This type of promotion was permitted within a minority of GP surgeries, when strong working relationships endured between ERL and PCS (see subtheme 2.2.1.1). Once again, this emphasises the importance of nurturing positive

working relationships between these two sectors, and supports the value of efforts to enhance patient understanding.

Leisure Professionals largely agreed with the perception that patients have a poor depth of understanding in relation to the HLPs (see lower order themes 4.2.1 [RSA] & 7.2.1 [FP]). According to this cohort, when interacting with referred patients for the first time, they were not clear on the programme they had been referred to, nor were they aware of associated costs. Leisure Professionals reported that patients were apprehensive about the leisure environment and their physical abilities to undertake exercise as a result of being poorly informed about the HLPs (see sections 8.1.4.3. [RSA] & 8.3.3.3 [FP], lower-order themes 4.2.2. [RSA] & 7.2.2 [FP]). Moore et al. (2011) also found that Exercise Professionals perceived patients were poorly informed about ERS, lacked in confidence, and had anxieties around assimilating in a leisure gym environment, which were heightened by their lack of understanding. This sample put forward suggestions to overcome patient anxieties in the period between referral and programme entry. This included FPs making introductory telephone calls to referred patients to allay any initial concerns, and the provision of information packs to enlighten them of what could be expected (Moore et al., 2011). This provides some justification for a 'pre-visit' at ERL sites to help to overcome ambivalence in the period between referral and programme uptake, as proposed by Leisure Customers in the present study. It was also a common perception amongst FPs that energy must be directed towards increasing public awareness. FPs suggested that promotion would enable patients to make more informed decisions about HLP uptake (see lower order theme 6.1 [RSA], section 8.3.5.2 [FP] & higher order theme 9.2 [FP]). Hard copy and web-based information were amongst the

most common suggestions to increase understanding. Different mechanisms of support for referred patients to enhance understanding and encourage uptake warrants further consideration. In contrast to the majority of Leisure Professionals who considered that patients were poorly informed about the HLPs, between 12.5% and 19.4% of Leisure Professionals regarded referred patients as 'very often' or 'always' informed (see sections 8.1.4.1. [RSA] & 8.3.3.2 [FP]). Promotion within GP surgery waiting rooms by ERL representatives was suggested to be a reason for this which facilitated more appropriate HLP referrals initiated by patients themselves (see lower order theme 5.2.1 [RSA] & lower order theme 8.1.2 [FP]). Although these points of dissonance do not represent the large majority of FPs, findings are encouraging and lend support to the involvement of FPs in HLP promotion to increase patient understanding and drive patient-initiated referrals.

10.4 Meta Theme 2: Inadequacies of Healthy Lifestyle Programme Referral Processes

Inadequacies of HLP referral processes emerged as the second over-riding meta theme across all individual research phases, which was a key source of frustration featuring heavily throughout individual study components. This multidimensional meta theme encompasses three meta subthemes relating to HLP referral operations: 1) the challenges of making HLP referrals, 2) the challenges of managing HLP referrals, and 3) the inadequacy of HLP feedback mechanisms. The factors perceived to contribute to, and the perceived consequences of the inadequacies of referral processes are also central features of this overriding meta theme. In turn, meta subthemes are dissected to explain their relevance in relation to the overriding meta theme and to each stakeholder group. Whilst there were strong areas of agreement, there were some areas of partial agreement, and dissonance both within and between individual study components which are detailed. Moreover, meta subthemes are discussed in relation to their significance or novelty in light of previous relevant literature and theory where appropriate.

10.4.1 Meta Subtheme 2.1: Challenges of Making Healthy Lifestyle Programme Referrals

This theme relates to the challenges of making HLP referrals in primary care, thus was not applicable to Leisure Professionals or Leisure Customers, which explains the 'silence' amongst phase II of this study (i.e., one set of findings identify a theme, but another does not). Interviews with PCP revealed a host of challenges they experienced in relation to making HLP referrals, which were often highlighted in the broader context of

organisational pressures in general practice. Specifically, PCP made frequent reference to time constraints (see subtheme 1.1.1.2.), unmanageable workloads (subtheme 1.1.1.1), and their depleted workforce (see subtheme 1.1.1.3.), all of which were perceived to be contributing to unprecedented challenges in primary care. This replicates many traditional barriers to PAP. For example, several systematic reviews identify that a lack of time represents the most common barrier to PAP amongst a broad range of healthcare professionals (Albert et al., 2020; Hébert et al., 2012). It is especially important to recognise that the Yorkshire region has the lowest vacancy fill rates of NHS clinical staff compared to other regions in England (Rolewicz & Palmer, 2020), which is a likely contributor to overwhelming pressures on PCP in the region. It is also no secret that workloads in general have soared in general practice across the board, where for example, GP consultations have risen by as much as 100% over the last decade (Hobbs et al., 2016).

PCP also discussed issues they experienced specifically relating to paper-based and electronic HLP referral processes. Common criticisms of paper-based referral forms included the requirement to obtain a patient's written consent, and the general antiquatedness of manually completing paper-based referral forms, which was considered time-consuming and contrasted with common practice in general practice (see lower order theme 1.3.1). Indeed, there is a push for the NHS to become completely paperless by 2023 to overcome inefficiencies associated with paper-based dealings between the NHS and other providers, yet this is proving difficult due to a lack of interoperable systems (NHS England, 2016; NHS England, 2019). Many GPs also challenged the necessity of the information required for screening purposes, such as the need to provide a patient's blood pressure reading (see lower order theme 1.1.2), a mandatory requirement

on ERS referral documentation (Craig et al., 2001). GPs in Buckley et al.'s study (2020) also perceived that paper-based ERS forms asked unnecessary questions and this deterred them from making ERS referrals. This emphasises the importance of training around PAP as part of a PCP continuing professional development to ensure they understand why they are being asked to provide particular patient information at the point of making PA referrals. Nevertheless, it also highlights the value of redesigning ERS referral forms to try to reduce the burden on PCP and circumvent some of their irritation. Founders of the EAST framework, The Behavioural Insight Team, have been involved in various projects focusing on the simplification of systems and are advocates of keeping content simple, specific, and to absolute minimal (Algate et al., 2012). Behavioural insights should be applied during the redesign of referral forms. However, dissonance existed amongst PCP, where a minority of them, including GPS, compared paper-based HLP referral forms to common practice and trusted they could complete them comfortably within the typical constraints of a ten-minute consultation (see lower order theme 2.3.1.).

Some PCP were critical of the electronic HLP referral pathway, especially of the additional responsibility to book a patient's first leisure appointment, which accentuated existing primary care pressures by placing further strain on their workload and time (see lower order theme 1.3.2). Comparably, Nurses in Bohman et al. (2015) study regarded computerised systems to make PA referrals as needlessly complicated to use, which made the process of referral time consuming. These researchers call for simpler organisational and administrative systems to overcome the complexity of issuing PA referrals (Bohman et al., 2015). Conversely, other PCP in the present study were complementary about electronic HLP referral processes, arguing it was quicker to complete referrals

electronically in comparison to manually filling out paper-based referral forms, and advantageous to book a patient's first appointment (see lower order theme 2.3.2).

In response to the challenges of making referrals, many PCP, especially GPs, delegated this responsibility to other PCP who were perceived to have more time to spend with patients, more knowledge about the HLPs, and more capacity to complete referral forms (see subtheme 1.1.1.4). Parallels can be drawn with the perspectives of GPs in another UK study who perceived that other healthcare practitioners were in a better position to provide PAP and make prescriptions for exercise because they have less constraints on consultation time (Buckley et al., 2020). Whilst the completion of HLP referral forms was delegated to clinical PCP such as Practice Nurses, there were also non-clinical PCP picking up this responsibility on behalf of GPs who sometimes reported feeling uncomfortable due to the clinical information required on referral forms (see subtheme 1.1.1.4). Whilst the DoHSC state that "*only a medically qualified individual, or another health professional working within a protocol with delegated authority, can initiate a referral into an exercise referral system*" (Craig et al., 2001, p. 39), primary care has evolved remarkedly in the last 20 years. There has been a push towards shared collaboration amongst all primary care staff in the promotion of PA, including non-clinical professionals such as CLWs, where PAP represents a key part of the wider social prescribing agenda (NHS England, 2016, 2019; PHE, 2014). This questions whether aspects of the DoHSC's National Quality Assurance Framework for Exercise Referral Systems is suited to an old era of primary care, and whether HLP referrals should be delegated if necessary to the wider primary care workforce. Contemporary literature sources support the value of shared responsibility amongst PCP in health promotion, and

advocate social prescribing as a promising model to engrain PAP into primary care (Buckley et al., 2020; Carstairs et al., 2020). Indeed, CLWs embedded in social prescribing are afforded more consultation time with each patient (up to one hour). It could be argued that they are in a more privileged position to provide PAP, especially in comparison to GPs who are constrained to ten-minute consultations. However, CLWs are limited in numbers across the region, are responsible for delivering the entire social prescribing agenda where PAP forms a small element, and are not required to hold formal qualifications relating to PAP. Therefore, caution must be exercised to ensure that CLW workloads are not overburdened. It may be beneficial to create additional roles in primary care, utilising individuals with PAP expertise such as FPs, to provide extra capacity for PAP, and HLP referrals.

Of the three suggestions were put forward by PCP to overcome the challenges of making HLP referrals (presented in higher order theme 3.4.), the implementation of a electronic referral system linked to primary care systems was considered the most fundamental improvement to simplify referral processes (lower order theme 3.4.1). Similarly, in Buckley et al's study (2020), there was overarching consensus amongst GPs than an electronic referral system was the most important facilitator for improving engagement with PA referrals (cited by 68%) due to its self-populating properties, which was perceived to preserve precious consultation time. The anticipated benefits of an interoperable solution by PCP in the present study bear a resemblance to elements of the EAST framework (Algate et al., 2012), that is, how it has the potential to make the referral process more Easy, Attractive, Social, and Timely to facilitate higher utilisation amongst the primary care workforce. For example, PCP believed interoperability between leisure

and primary care systems could automatically pre-populate the necessary information required on HLP referral forms, thereby reducing the time and effort required to perform the action of referral. This is one example of how the referral system can be made 'easy' and potentially more 'attractive' for its users by reducing burden. The implementation of an interoperable e-referral system was also seen as a mechanism to help PCP identify which patients are eligible for referral through automatic prompts from clinical systems based on specific patient indicators (e.g., BMI over 30), and automatically triage them to the correct HLP. The avoidance of active decision making is considered one of the most effective tactics for making something easier (Hallsworth et al., 2016). Therefore, removing these decision making processes from PCP is likely to streamline referral whilst increasing opportunities for HLP referrals. Implementing an interoperable platform for PCPs would be considered a form of 'environmental restructuring', which is one of nine intervention functions of the BCW, likely to be effective in encouraging a particular behaviour by making changes to the physical context (Michie et al., 2014). An interoperable referral solution therefore lends support to referrals being delegated and completed by any member of the primary care workforce, providing an interface is intelligent enough to accurately make decisions around HLP referrals. The viability of establishing an interface between leisure and primary care systems to automate much of the HLP referral process warrants further consideration.

The perceptions held by PCP about their patients, in particular the barriers they believed patients experienced in relation to changing their lifestyle behaviours, also proved a significant challenge when making HLP referrals. PCP made frequent reference to the general lack of patient motivation to change their lifestyle behaviours (see subtheme

1.2.1.5.) which contributed to the difficulty of making HLP referrals because they were met with resistance from patients. Substantial evidence highlights that a perceived lack of patient motivation is a salient barrier to PAP in primary care (Buckley et al., 2020; Geense et al., 2013; Graham et al., 2005; Huijg et al., 2015; Leemrijse et al., 2015; Omura et al., 2018; Tompkins et al., 2009). According to PCP, patients do not understand the grave impact their lifestyle behaviours have on their health, refuse to take ownership for lifestyle related issues, and seek traditional medical interventions for a 'quick fix' (see lower order theme 1.2.2). Such opinions concur with the work of Douglas, Torrance, et al. (2006) where between 32 and 44% of PCP (N = 757) strongly agreed or agreed that 'patients expect drug treatments when they visit their GP practice', which deterred the provision of PA advice. The traditional medical model which has long prioritised the prescription of pharmaceuticals to manage healthcare has strengthened a patient's reliance on the medical system rather than encouraging them to take ownership of their own health (Sallis, 2015). This is because it conveys a message that pharmaceuticals provide a quick miracle substitution to lifestyle behaviour change (Deutschman & Keeler, 2007). PCP in the present study supposed an increase in publicity around the benefits of increasing PA and the HLPs may help to change the patient culture, which they considered was dismissive of lifestyle promotion (see lower order theme 3.1.1.). Indeed, the process of making a referral was considered to be easier when patient were perceived to already be motivated and actively requested a referral, because PCP did not have to spend time convincing them of the value of lifestyle change (see lower order theme 2.2.2).

Mirroring previous studies (Bull & Milton, 2010; Din et al., 2015; Douglas, Torrance, et al., 2006; Geense et al., 2013), many PCP in the present study described

making subjective, rather than objective appraisals of patient motivation levels. Bouma et al. (2017) argues there remains an absence of guidelines or ongoing professional training to help PCP assess patient motivation. Consequently, referrers may misconstrue a patient's ambivalent expressions as a reluctance to change their PA behaviours and therefore, withhold offers of a PA referral to those who may benefit most (Moore et al., 2011). Moreover, Deutschman and Keeler (2007) argue GPs are unsuccessful in their motivational attempts because they rely on facts of a disease or diagnosis, a patient's fear of mortality, and using their professional status in attempt to force patient engagement and receptivity. This inadvertently results in avoidance coping. In order to avoid unintentionally discriminating against patients perceived to be unmotivated and facilitate appropriate, systematic, and timely referrals for PA, Bouma et al. (2017) insists that all PCP must be provided with appropriate tools to assess and strengthen patient motivation.

There were areas of dissonance within PCP findings in relation to perceptions of patient motivation. Interestingly, non-clinical PCP (i.e., CLWs) did not perceive a lack of patient motivation to be a barrier to referral. They described being more patient centered in their counselling approach, stating how they support "*patient choice to make their own decision*" (CLW2) and consider patient "*levels of confidence*" (CLW3) prior to making a HLP referral. These are key underpinnings of motivational interviewing which can help people explore and resolve their ambivalence about change (Miller & Rollnick, 2013). The DoHSC (2001) advocate motivational communication skills to determine a patient's readiness to change prior to an ERS referral. Bull and Milton (2010) have argued that when PCP (i.e., GPs, Nurses, and Healthcare Assistants) have adopted motivational interviewing techniques, their delivery is inconsistent, where a lack of time and

confidence were cited as key barriers to consistent use within patient consultations. These authors champion the need for more in-depth training and skill development on motivational interviewing for health professionals alongside ongoing support to improve their expertise and confidence (Bull & Milton, 2010). Nevertheless, Morton et al. (2015) queried the effectiveness of single brief intervention sessions underpinned by motivational interviewing in primary care settings, suggesting that a longer duration may be required to elicit health behaviour change (e.g., >30 minutes). Unlike many PCP, the role of a CLW is unique. They are trained in client-centered behaviour counselling approaches and are afforded much more time to practice motivational interviewing and accurately assess a patients motivation and confidence to change (typically ≤60 minutes). Likewise, ERL FPs have expert knowledge in motivational interviewing, which again lends support to widening the primary care workforce capacity to increase PAP, and utilising local FPs who have specialist knowledge in the realm of behaviour change.

It was perceived by several PCP that many individuals eligible for the HLPs suffered from a lack of confidence in the initial phases of lifestyle behaviour change (subtheme 1.2.1.4), which reportedly meant they were resistant towards PAP efforts. According to PCP, patients specifically feared the gym environment, and had doubts over their exercise abilities. With the exception of CLWs who assessed confidence levels, PCP were merely making assumptions about a patient's confidence in relation to behaviour change. Similarly, Carstairs et al. (2020) discovered that health professionals only discussed PA with patients who they perceived had the confidence to make changes to their PA levels, and would act on their suggestions. Whilst this accentuates the value of upskilling PCP in motivational communication skills so they can determine a patient's

confidence in making lifestyle changes, a lack of time remains one of the biggest challenges for effective use in primary care (Bull & Milton, 2010; Morton et al., 2016). This provides support for previous calls to extend primary care consultation length to at least 15 minutes with flexibility according to patient need (British Medical Association, 2015; RCGP, 2013; RCGP, 2019). Leisure Customers in the present study provide some validation to PCP claims about a patients confidence levels. These Leisure Customers reported feeling apprehensive about the leisure gym environment, and lacked in confidence, yet noted that this stemmed from being poorly informed about the HLPs prior to starting their programme (Higher-Order Theme 10.2.). Therefore, it could be argued that if PCP had a better understanding of PAP and the HLPs, they could better inform patients about the benefits of PA and provide more information about the ERL programmes, which may help to address confidence-related issues. It is likely they would need additional time to do this, which might be unobtainable in light of existing unprecedented challenges in primary care and brevity of primary care consultations. Supplementing these discussions with HLP information resources for patients may be beneficial in tackling confidence-related barriers to programme uptake.

Another common perception held by PCP in the present study was that patients resisted to their recommendations to increase their PA levels or change their lifestyle because of competing priorities on their time such as work or family commitments (see subtheme 1.2.1.3). Health professionals across prior research studies have also reported that a patient's lack of time can make it difficult for them to provide exercise counselling (Carstairs et al., 2020; Tompkins et al., 2009). Birtwistle et al. (2018) study on the factors influencing uptake to an ERS from the perspective of patients who did and did not accept

a referral found evidence to suggest that external commitments such as caring responsibilities take precedence and deters scheme uptake. Moreover, a lack of time is one of the most frequently reported hurdles to PA participation generally amongst UK adults irrespective of gender (Craig & Shelton, 2008; Sequeira et al., 2011) or SES (Sequeira et al., 2011; Withall et al., 2011). Given that the underpinning reasons for a lack of time are unique to each individual and their situation, it is important that PCP make efforts towards understanding a patient's situation, and are aware of potential options to support patients to work around competing priorities, which may encourage uptake. Again, this is where wider members of the primary care workforce including CLW, and local FPs may prove especially useful as they are less constrained by time, and could harness their knowledge of motivational interviewing and BCT to encourage patients to develop their own strategies to conquer perceived barriers to change such as a lack of time (Rollnick et al., 2008).

PCP perceived that patients faced financial barriers in the initiation and the maintenance of becoming more physically active, particularly when they were required to contribute financially towards programme costs and/or continuing ERL membership charges (see subtheme 1.2.1.2). Whilst this was perceived to impact patients in both affluent and deprived areas of the ERoY, more consideration was given towards those of a lower SES and how the HLPs risk perpetuating inequalities across the region. PCP perceptions about the issue of patient cost in relation to PAP has been highlighted in UK (Carstairs et al., 2020; Din et al., 2015) and international studies (Bohman et al., 2015; Geense et al., 2013; Tompkins et al., 2009) as a barrier to PAP, especially for patients of a lower socioeconomic status (Leemrijse et al., 2015). ERoY Public Health fund one

hundred places on the ERS per year to support uptake, yet PCP were not always aware of this. No other costs on commissioned HLP are subsidised (i.e., HEART or Escape pain). Shockingly, some PCP encouraged their patients to put on weight so they would meet the criteria for fully subsidised HLPs. Some researchers back the implementation of strategies to support the uptake of PA referral opportunities amongst lower SES groups such as the partial or full reimbursement of PA programme costs, or providing free transport (Craig et al., 2001; Leemrijse et al., 2015). However, some Health Professionals have been critical of initial subsidised ERS offerings amongst vulnerable groups (Din et al., 2015) because they believe patients are often unable to cover membership costs once the subsidised period is over, and subsequently return to previous lifestyle behaviours. Similarly, PCP in the present study perceived that many patients could not afford a reduced-rate ERL membership after HLP completion, and therefore were at risk of reverting to their unhealthy lifestyle behaviours, or requesting a secondary referral. Interestingly, one PCP stated: "*I don't talk to them about financial cost because … it's even harder to get people through the door*" (NP3). This suggests that some PCP are avoiding conversations around HLP costing due to their subjective assumptions that it will pose a barrier to uptake. In light of the weighty evidence that PCP make subjective appraisals of patient motivation levels (Bull & Milton, 2010; Din et al., 2015; Douglas, Torrance, et al., 2006; Geense et al., 2013), it is possible they are making similar appraisals of patient affordability. Therefore, PCP must properly inform patients about any associated HLP costs to ensure they can make informed decisions about uptake and affordability. Moreover, PCP must be appraised of the funding provided by Public Health for ERS participants to encourage uptake of lower SES groups. This may also deter PCP from encouraging patients to continue increasing their BMI until they qualify for a free scheme.

PCP in the present study perceived that some patients experience geographical barriers, which influenced their decision to advocate and refer them to the HLPs. This was perceived to affect patients living in distant proximity from ERL centres, who had limited access to their own means of transport or relied on public transport, which was perceived to be scarce in many areas (see subtheme 1.2.1.5). Geographical isolation and transportation issues have been found to be prevalent barriers to PAP amongst UK health professionals engaging with older patients (Goodman et al., 2011) and patients living in socio-economically deprived areas (Din et al., 2015). In light of ERoY's rurality, where almost 50% of its population reside in isolated communities with infrequent public transport links (ONS, 2011), and the regions populace, which is a typically older demographic who may rely on public transport (ONS, 2020b), geographical isolation and transportation issues may be pertinent to ERoY patients. Rural residents in particular may be disadvantaged compared to their urban counterparts because of their remoteness from ERL centres, and the scarcity of public transport links. This may lead to what the Local Government Association (2017) term 'distance decay', whereby those living furthest away from the leisure centres have worse access and consequently use the service the least. The National quality assurance framework for exercise referral systems recommends that strategies are put in place to encourage referral uptake such as providing transport for those who are constrained by socio-economic reasons (Craig et al., 2001). Therefore, ERL should assess what strategies or provisions they could potentially implement to overcome geographical barriers faced for individuals residing in remote areas. On another note, the HLPs serve as one intervention to promote PA for health gain. CLWs have extensive knowledge on other PA and social prescribing opportunities across the region which may be in closer proximity and more accessible. Therefore, patients

experiencing geographical barriers may benefit from exploring these options with a CLW so they can make an informed decision about what is right for them.

Overall, PCP held many perceptions about the barriers their patients experienced in relation to changing their lifestyle behaviours. It must be reiterated here that the views of patients who did not accept a HLP referral, or did but did not complete their programme were unexplored in this thesis. Without obtaining their perspectives, it is impossible to determine if PCP assumptions of their barriers to lifestyle change are a real issue for patients eligible for referral in the ERoY. Thus, it is imperative that the perspectives and lived experiences of non-attenders (i.e., those who do not take up a HLP referral) are investigated to better understand the complexity of patient barriers to programme uptake, and the best methods to support these individuals. As explained in section 3.3.2.1.2.2, the COM-B model is valued for aiding understanding of what drives behaviour and decision-making, and both the EAST and BCW framework are valued for guiding the implementation of solutions and interventions to support behaviour change. Thus, it may prove useful for future research examining patient barriers to ERS uptake to use such frameworks to understand and map these barriers according to their influence on capability, opportunity, and motivation, and use the BCW and the EAST framework to identify and implement interventions to alleviate the most pertinent barriers and support uptake.

10.4.2 Meta Subtheme 2.2: Challenges of Managing Healthy Lifestyle Programme Referrals

Phase II of this research highlighted many challenges experienced by ERL staff which were associated with the management of HLP referrals. As this was not applicable to PCP or Leisure Customers, they did not identify this as a theme. These challenges experienced by ERL staff manifested in separate ways depending on each groups interaction with the HLP referral process. To elaborate, RSAs discussed their challenges in relation to their ability to process incoming referrals from PCS, whereas FPs described their challenges in relation to their ability to interact with a referred patient, and devise a safe and effective exercise programme tailored to individual need. Nevertheless, there were some areas of partial agreement and dissonance, which are explained where applicable.

RSAs identified two core weaknesses of current HLP referral processes. The first related to the referral information provided by PCP to ERL where it was common for information to be missing, inaccurate, and vague (see sections 8.1.2., 8.1.6.2 & Lower-Order Theme 4.3.1). This hindered their ability to process referrals quickly and efficiently. Nonetheless, 12.5% of RSA reported to ‘always’ receive complete referral information, revealing partial agreement between RSA and diversity in experience (see section 8.1.2.). The implications of inadequate referral information was a major conversation point in follow-up interviews. On the whole, it was portrayed as a gruelling task to retrieve missing information or obtain clarification from PCS, particularly when weak working relationships existed (see subtheme 4.3.1.1). However, there were some evidence of partial agreement amongst RSAs where BTs described finding this process

easier than FCs (see 8.3.1). This is likely owing to the fact that BT are office based and do not have a team of FPs to manage unlike FCs. In agreement with RSAs, there was a strong sense of dissatisfaction amongst FPs with the information they receive regarding referred patients (see section 8.3.2 & lower order theme 7.3.1), which they felt contributed to the complexity of initial HLP appointments (see subtheme 7.3.2.3). For example, FPs revealed that key information such as a patient's prescription list, BMI, and previous medical history was missing from referral forms almost 50% of the time (see section 8.3.2) and sometimes they uncovered serious health conditions that were not disclosed at the time of referral. Amongst FPs, there was an overall consensus that efforts must be focused on improving the provision of referral information to Leisure Professionals (see section 8.3.5.1 & higher order theme 9.1) to enable them to devise tailored programmes of exercise that are both safe and effective. Parallels can be drawn with prior research. For example, Exercise Professionals in Henderson and colleagues' study (2017) voiced frustrations towards inaccurately completed ERS referral forms, and the suppression of key patient information, which they believed was telling that health professionals had a limited understanding of ERS. Comparably, ERS Officers in Graham's research (2006) criticised Health Professionals for their careless consideration towards the referral criteria, and the lack of information provided to patients at the time of referral, which reportedly led to many initial ERS appointments being taken up by people who were inappropriate for scheme uptake. FPs are discouraged from accepting responsibility for a referred patient until comprehensive referral information is provided (Craig et al., 2001), and therefore inadequate referral information represents a pitfall in current referral processes which could have serious repercussions for patient safety. Thus, it is vital that best practice guidelines for exercise referral systems are adhered to which are explicit in what information must be transferred at the point of referral (Craig et al., 2001).

RSAs second main area of frustration concerned the current lack of standardisation concerning how referrals were received and processed (see section 8.1.3). Whilst RSAs described problems inherent within both paper-based referrals (see lower order theme 4.3.3) and electronic referrals (see 4.3.4), the overall consensus was that electronic referrals were much easier to process (see section 8.1.3 & lower order theme 5.3.2). PCP were also keen for an electronic referral system linked with primary care systems to overcome their challenges of making HLP referrals (see higher order theme 3.4.). Nevertheless, there were points of dissonance amongst RSA where a minority described ease of HLP referral processing with both paper and electronic referrals (see lower order themes 5.3.1, & 5.3.2). Many RSAs longed for the referral process to be more standardised, whereby all incoming referrals are received electronically via a universal referral form, and processed by one ERL cohort responsible for triaging referred patients to the correct programme (see section 8.1.6.3, lower-order theme 4.3.6, & higher order theme 6.3). This mirrors the perspectives of FPs (see higher order theme 9.4) whilst also echoing some of the suggestions of PCP to overcome the challenges of making referral (see lower-order theme 3.4.1). The viability of implementing these suggestions into practice must be carefully considered by ERL. Interestingly, several Leisure Customers explained how they had to chase up their referral form at ERL centres or were waiting a significant amount of time (in one case over a year after referral) before being contacted by Leisure Professionals (Higher-Order Theme 10.3), which is indicative that the management of incoming referrals requires improvement.

FPs discussed their challenges of attempting to make telephone contact with referred patients prior to them coming to the leisure centre, and undertaking initial HLP appointments. Over a quarter of the online survey sample reported that they were rarely or never successful in making contact (see section 8.3.3.1). Whilst the HLP protocol stipulates that all patients should receive an initial telephone call from a FP within 48 hours of their referral, research findings indicate this rarely happens. This was attributed to competing demands on their workload, and the improbability of patients answering telephone calls (see subtheme 7.3.2.1). Initial telephone calls to patients were regarded by FPs in this study, and in prior research (Moore et al., 2011) as an invaluable opportunity to promote programme uptake by helping to overcome any patient anxiety and uncertainty through the provision of motivational, emotional, and informational support. Therefore, FPs either need to be better supported to make introductory contact with referred patients, or there must be consideration towards other ways referred patients can be supported that are less taxing on FPs time. This is perhaps where the suggestion from Leisure Customers for a pre-visit could prove worthwhile. This would enable prospective clients to interact with Leisure Professionals and current HLP clients, which could help to allay any fears and anxieties hampering programme uptake. Furthermore, many FPs made reference to the complexity of initial appointments. Whilst inadequate referral information provided by PCP represented one major factor contributing to this complexity, a lack of understanding about the HLP on the patients behalf was reported to be a second key contributor (see subtheme 7.3.2.3). FPs explained how additional time was required to properly inform referred patients about their programme, and undo any misinterpretations of information. This again supports efforts to improve understanding of the HLP amongst the medical community and the public to reduce the burden on FPs to provide education to referred patients at their first leisure appointment. It also provides

further justification for a ‘pre-visit’, and for encouraging Leisure Professional promotion within GP surgery premises, which at the time of data collection was only happening amongst a handful of GP surgeries.

10.4.3 Meta Subtheme 2.3: Inadequacy of Feedback Mechanisms

There was a recurring notion that the information collated throughout a patients HLP journey regarding their individual progress does not reflect the positive lifestyle behaviour changes made, and is ineffectively communicated to PCP through current feedback mechanisms. This was identified as a major weakness of HLP referral processes and featured as a strong area of agreement between component studies. However, there were some areas of partial agreement within online survey findings which are discussed where appropriate.

PCP raised concerns regarding the effectiveness of the HLPs, which they perceived largely stemmed from inconsistencies in feedback provision from ERL centres regarding a patients’ progress (Lower-Order Theme 1.1.3.). For more than a decade, research has demonstrated that PCP are not provided with sufficient feedback from the PA programmes they refer to, which in turn, acts as a prominent obstacle to continued engagement in PAP (Bohman et al., 2015; Buckley et al., 2020; Din et al., 2015; Graham et al., 2005; Henderson et al., 2017; Leenaars et al., 2015; Persson et al., 2013). Comparable to other studies (Graham et al., 2005), the feedback PCP sought from the leisure centres varied, stretching from a simple acknowledgement of attendance and engagement to a range of additional outcome measures such as confidence, personality,

and mood changes (see higher order theme 3.3.). Indeed, Lion et al. (2019) maintains that to help determine programme effectiveness, PA programmes should identify and report a host of outcome measures including psychological indicators (e.g., confidence, mental health, and quality of life), rather than focusing exclusively on physical health indicators. PCP in the present study anticipated that interoperability between primary care and leisure systems could enable bidirectional transfer of information, and provide a means of receiving regular, meaningful patient progress feedback from ERL (lower order theme 3.4.1). By improving the provision of feedback to PCP, a stronger evidence base will be constructed, which may support PCP in their future selection of patients for PA referrals (Graham et al., 2005), increase their confidence to initiate PA referrals (Graham et al., 2005), and can help to nurture successful ERS processes (Leenaars et al., 2015). This may also equip PCP to make more informed decisions about the appropriateness of PA referrals for diverse patient groups, which may increase programme uptake and compliance (BHF NCPAH, 2010).

During qualitative interviews, both RSAs and FPs celebrated the novel, holistic lifestyle behaviour changes that HLP clients achieved, such as being able to stand up without support (Higher-Order Themes 6.2. [RSA] & 9.3. [FP]). This was not captured or monitored through current evaluation procedures, and therefore was not easily communicated to PCP. Mills et al. (2012) argue that similar issues have prevailed for some time because there is inconsistency in evaluation approaches, meaning that success on ERS is depicted in numerous ways as there is not a standard measure of success. Whilst the Exercise Referral National Quality Assurance Framework (Craig et al., 2001) gives prominence to the auditing of more holistic outcome measures such as physical (e.g.,

blood pressure), behavioural (e.g., dietary patterns), social (e.g., social inclusion) and psychological (e.g., mood) measures for evaluation purposes, this study suggests that ERL may not be auditing such outcomes. Leisure Professionals in the present study also described how current feedback mechanisms were not standardised. There were areas of partial agreement in relation to the provision of feedback to PCS. Little over half of Leisure Professionals reported to provide feedback to PCS (see sections 8.1.5 [RSA] & 8.3.4 [FP] & lower order theme 4.3.5 [RSA]). These Leisure Professionals explained how feedback can be provided either verbally, through the post, or electronically via their data capture software Pharmoutcomes, indicating that they could to some extent dictate what information was relayed back to PCP regarding a patient's performance and outcomes on a HLP (see sections 8.1.5 [RSA] & 8.3.4 [FP]). This finding aligns with Henderson et al. (2017, p. 12) who discovered that FPs delivering ERS were "*arbiters of service delivery and feedback mechanisms*", and largely controlled how much feedback was provided to health professionals, to whom it was provided to, and how regular they provided it. Evaluation guideline two of the Exercise Referral National Quality Assurance Framework (Craig et al., 2001) states *"a mechanism for information exchange and collection should be clearly established*" (p46), yet results from this study and prior research suggest these feedback mechanisms largely lack standardisation. There was a sense of urgency to improve and standardise the provision of feedback to PCP, which according to Leisure Professionals must not neglect holistic, anecdotal lifestyle changes by focusing on statistical markers of success (higher order themes 6.2 [RSA] & 9.3 [FP]). This concurs with the perspectives of many PCP who sought more holistic feedback from ERL (see higher order theme 3.3.).

Comparable to other studies (Graham, 2006; Mills et al., 2012), Leisure Customers in the present study prized their physical (e.g., functional improvements), psychological (e.g., more positive outlook), and social (e.g., making friends) benefits endured through their HLP participation rather than focusing exclusively on their weight loss (See Section 9.2.4 & Higher-Order Theme 11.2.). ERS participants in other studies have also celebrated multidimensional benefits of scheme participation, which can also be broadly categorised into physical (e.g., improved functionality; Graham, 2006; Mills et al., 2012; Wormald & Ingle, 2004), psychological (e.g., improved self-confidence; Graham, 2006; Mills et al., 2012; Wormald & Ingle, 2004), and social (e.g., greater social confidence; Graham, 2006) changes. Leisure Customers in the present study also placed significant importance on the sharing of their progress with PCP and opportunities for follow-up in primary care (see higher order theme 12.3.), yet many did not recall follow-up conversations in primary care (see section 9.2.4). This made them feel their PCP were disinterested in their progress (see higher-order theme 10.4). Comparisons can be made with Wormald et al. (2006) whereby some PA referral participants were frustrated that their health professional had not questioned them about their progress which gave them the impression that they did not care. Many Leisure Customers called for robust mechanisms of feedback between ERL and PCS, so their PCP were properly informed about their progress, and the overall effectiveness of the HLPs. They assumed this would encourage PCP to advocate these schemes to eligible patients, and engage in follow-up conversations with those who had completed a HLP (higher order theme 12.3).

Overall, findings compare with those of Mills et al. (2012) who found that patients, health professionals and exercise providers value psychosocial constituents of

success (e.g., empowerment, inclusion, and confidence) more than traditional physical markers of success (e.g., attendance and weight loss). Should HLP feedback continue to be provided to PCP on an inconsistent basis, and prioritise simplistic physiological markers of success, ERL risk underselling the holistic lifestyle behaviour successes of HLP clients, which inevitably will have grave impact on referrals. Therefore, ERL must look to capture and report more holistic outcome measures on their programmes to illustrate anecdotal, holistic lifestyle behaviour changes.

10.5 Strengths and Limitations

In light of the qualitative dominant mixed methods research design, this section outlines the strengths and limitations of the present study in relation to trustworthiness. It precedes with a brief overview of each of the four criterions of trustworthiness, before detailing potential threats to these concepts, and the provisions employed to mitigate these threats as much as possible.

10.5.1 Credibility

The concept of credibility (discussed in 5.10.1) is concerned with the extent to which research findings reflect a true picture of the phenomena under investigation (Shenton, 2004).

10.5.1.1 Potential Threats to Credibility

One potential threat to credibility relevant to this thesis concerns self-selection bias, which could have occurred as a result of non-probability sampling (i.e., purposeful and snowball sampling). It could be disputed that those individuals who volunteered to participate in this study had more favourable opinions of the phenomenon of interest. However, the research aims were clearly communicated to all prospective participants in terms of the overall intention to improve current referral processes based on an exploration of the perspectives and experiences of multiple stakeholders. Therefore, it could be argued that this study may have attracted those who had experienced problems or frustration with the referral process and were keen to contribute to its improvement. In any case, sampling strategies were selected on the basis of helping to ensure that the most informative participants were targeted for study inclusion (Anderson, 2010; Ritchie et al., 2013).

The Hawthorn effect can also compromise credibility, whereby participants disguise their normal response, and instead act in a way they believe reflects them more favourably (Denscombe, 2014). To mitigate this issue, the primary researcher followed the guidance of Shenton (2004) to facilitate honesty of study participants. For instance, all prospective participants were provided with an information sheet, informed consent declaration form and were given the opportunity to speak with the primary researcher prior to data collection. This helped to ensure they were fully aware of the research purpose and aims so they could make an informed choice about participation. Moreover, participant rights were reiterated prior to data collection either verbally (i.e., before the commencement of one-to-one interviews) or visually (i.e., prior to undertaking online

surveys). It is believed PCP were forthcoming in their opinions and were open about their difficulties and incompetency in relation to exercise prescription. Likewise, Leisure Professionals appeared to be transparent about both their positive and negative experiences in relation to the processing and management of HLP referrals, and seemed to confidently put forward suggestions to improve referral processes. Finally, it is believed that Leisure Customers were honest about their referral experiences and were able to articulate important avenues for improvement without hesitancy.

A further limitation of this study which could compromise credibility concerns the sample. For example, the perspectives and experiences of those who did not start a HLP (i.e., non-attenders) were excluded from investigations. It is likely that non-attenders could provide invaluable insights into referral processes, specifically, their barriers to HLP uptake. This perspective is vital to contribute to a more well-rounded understanding and help inform effective solutions to overcome the most pertinent barriers to uptake. Therefore, it is unlikely that findings from Leisure Customers are representative of all patient populations. Moreover, data were collected from Leisure Customers after they had completed their HLP, and so there was a heavy reliance on retrospective accounts of the intricacies of their referral experiences. This may have affected the accuracy of these responses. LiveWell, for example, is a 52-week programme and thus considerable time has lapsed since referral. However, this time lapse was deemed necessary so Leisure Customers could reflect on their programme experiences as a whole and compare and contrast their experiences with their initial expectations of the programme at the time of referral. There is scope for future research to: 1) investigate the experiences of HLP participants closer to the time of their referral to maximise accuracy of accounts, and 2)

appreciate the subjective experiences and perspectives of non-attenders to better understand the complexities of HLP uptake. This would help to inform effective solutions to overcome the most pertinent barriers faced by patients.

A final potential study limitation worth mention concerns the paradigms underpinning this study, which may raise questions about credibility. Undoubtedly, an interpretive paradigm has its strength in encouraging rich in-depth accounts of a given phenomenon; however, research claiming an interpretivist affiliation is often criticised for inaccurately representing the participant's perspective (Anderson, 2010). Critics contend that ontologically speaking, reality is subjective as opposed to objective, and therefore findings are strongly influenced by a researcher's personal biases, and are merely a reflection of their interpretation (Riyami, 2015). Nonetheless, an interpretive paradigm was considered the most appropriate underpinning paradigm to fulfil the aims of the first phase of this research. The acceptance of mixed methods in the second phase of this research reflects a shift in paradigmatic underpinnings throughout the course of this PhD towards pragmatism. However, strong interpretive roots remained, indicative by the qualitative dominant research design. Reflexive narratives are included in this thesis to foster transparency around researcher influences.

10.5.1.2 Provisions to Uphold Credibility

To avert researcher bias and the misrepresentation of participant views, several strategies were employed to facilitate credibility. These are detailed in the following section.

10.5.1.2.1 Member Checks

Member checks, identified as the single most important provision to facilitate credibility (Lincoln & Guba, 1985), were employed in the present study to ensure interview transcripts were a true and authentic representation of what was conveyed during each interview. Between 41.66% and 54.55% of participants from each individual cohort (i.e., PCP, Leisure Professionals, and Leisure Customers) authenticated their interview transcript via email correspondence (see sections 5.8 & 7.11.2). Furthermore, raw participant quotes were presented throughout this thesis to present the lived experiences of participants in their own words and not the voice, predispositions, or biases of the researcher.

10.5.1.2.2 Triangulation

Several principles of triangulation were applied in the present study to help substantiate credibility. First, by utilising mixed methods (i.e., 65 one-to-one interviews and 68 online surveys) and using the triangulation protocol to integrate findings of component studies, data triangulation was adopted which helps to reduce error and mitigate researcher bias, thereby enhancing accuracy in data collection and analysis procedures (Johnson et al., 2020). Secondly, this study collected, compared, and contrasted data from a heterogenous sample of individuals involved in referral processes, including nine different stakeholder groups from primary care alone, which is a major strength of this thesis. This informant diversity, otherwise known as person triangulation, enabled a nuanced, contextual understanding of the referral process, which could not have

been achieved by any of these groups in isolation. This makes a unique contribution to the evidence base that has focused upon the perspectives of GPs, and neglects other significant stakeholders such as other relevant health professionals, FPs, and patients. Thirdly, the present study aimed to be inclusive of individuals from all geographical areas of the ERoY (i.e., affluent, and deprived areas) to facilitate contextualised and ecologically valid findings representative of the entire region. Fourthly, investigator triangulation was applied throughout multiple phases of the data analyses process to foster a richer, nuanced interpretation of the dataset.

10.5.1.2.3 Debriefing sessions

Frequent debriefing sessions between a researcher and their superiors is another provision to help ensure credibility. Over the course of this PhD project (September 2016-September 2021), the primary researcher and academic supervisors had monthly supervisory meetings, which aided the process of data analysis to facilitate nuanced interpretations of the dataset, rather than relying solely on the primary researcher's interpretations. The primary researcher also presented study findings at internal research conferences (Postgraduate Conference at University of Hull [2017 & 2018]) and external research conferences (Yorkshire and Humber Physical Activity Knowledge Exchange Conference at Sheffield Hallam University [January 2018]), which provided opportunities for scrutiny by others detached from the research. Phase I findings were also presented to members of ERoYC (July 2018) as well as Phase II research proposals to ERoY Public Health (January 2019) for their commentary. This provided opportunities for feedback and future direction from non-academic audiences.

10.5.2 Transferability

Transferability refers to the extent to which research findings are applicable to different concepts or settings.

10.5.2.1 Potential Threats to Transferability

As the present study is constrained to one geographical area of the UK (ERoY), it does inevitably place restriction on generalisability to other regions and countries. As identified in Chapter 4, ERoY is unique in that it is characterised by limited ethnic diversity and a sizeable proportion of people living in geographically isolated communities. Moreover, the ERoY is privileged to have ten leisure centres running a broad range of lifestyle programmes to improve the health and well-being of local communities. Findings may reflect peculiarities of the region and therefore it may not be appropriate to extrapolate findings to other geographical regions. However, given the generic referral process presented in the DOH's Exercise Referral Systems National Quality Assurance Framework (Craig et al., 2001), it could be contested that referral processes examined in the present study may hold resemblance for similar exercise prescription schemes in the country, permitting comparisons to be made and crossover of practical implications.

This studies samples could also be viewed as a threat to transferability. GPs for example, represented the vast majority of PCP (31.14%), and thus their views may be

overrepresented, which may narrow the applicability of findings to wider PCP populations involved in PAP and exercise on prescription. This is also a common limitation of comparable studies (Din et al., 2015; Douglas, Torrance, et al., 2006; Geense et al., 2013; Graham et al., 2005; McKenna et al., 1998; Omura et al., 2018). Nonetheless, in comparison to similar qualitative (Bohman et al., 2015; Geense et al., 2013; Patel et al., 2011; Persson et al., 2013; Winzenberg et al., 2009) and mixed methods studies (Bélanger et al., 2015; Graham et al., 2005), a sample of 28 is relatively large despite recruitment difficulties. Likewise, it surpasses the typical sample sizes of PCP seen in similar doctoral studies in the area of exercise referral (Graham, 2006; Mills, 2008). On a similar note, the large majority of Leisure Customers completed the ERS (60%) and were referred by their GP (75%) therefore, the generalisability of their lived experiences to other HLP populations (i.e., those on different HLP programmes referred by other PCP) must be considered. Finally, it must be highlighted that the quantitative strand of this thesis collected data from a small sample (i.e., only 68 individuals across three groups: Referral Scheme Administrators, Fitness Professionals, and Leisure Customers). This does raise questions about the transferability of findings as the general consensus is that the minimum sample size in quantitative studies for population representation is 100 (Martínez-Mesa, González-Chica, Bastos, Bonamigo & Duquia, 2014). Nevertheless, it is worth noting that this research collectively draws on data from a respectable number of participants ($N = 96$) from a large geographical region. Irrespective, the purpose of this thesis was never to produce generalisable findings. Rather, the intent was to yield a novel contextual understanding of referral processes onto the HLPs, and shed light on stakeholder-driven recommendations to support the advancement of referral processes. Consequently, the sample size was determined by thematic saturation as recommended by DeJonckheere and Vaughn (2019), not by sample.

Finally, it is worth noting that the quantitative component of the second research strand (i.e., online surveys) is largely descriptive in focus due to its qualitative priority. This meant that numerical and categorical features of the dataset could only be summarised through descriptive statistics (providing frequencies and proportions) as oppose to being subject to inferential statistics, which would have permitted inferences to be drawn about populations based on the samples. Undoubtedly, this compromises the transferability of research findings, however, this was never a goal of this research. Given how under researched stakeholder experiences and perspectives of ERS processes are, it may be beneficial for future research to adopt quantitative research approaches with adequate samples (i.e., >100) so that meaningful inferences can be drawn regarding different stakeholders perspectives and experiences.

10.5.2.2 Provisions to Uphold Transferability

Shenton (2004) emphasises the importance of providing sufficient contextual detail regarding fieldwork so other researchers can make inference about the transferability of findings to different contexts. Chapter 4 of this study provides a contextual overview of the ERoY in terms of its geography and the demographics of its population. Moreover, participant characteristics are detailed for each research phase (see sections 5.4 [PCP], 8.2.1[RSA], 8.3.1[RSA]. 8.4.1[FP], 8.5.1[FP], 9.2.1[Leisure Customers], & 9.3.1[Leisure Customers]), as well as precise timeframes of data collection and analysis (see sections 5.8, & 7.10). In addition, unlike the large majority of research that focuses around singular ERS, this research draws on participant perspectives in

relation to multiple exercise on prescription programmes. It is therefore plausible that findings have wider relevance to other PA-based programmes in the community.

10.5.3 Dependability

Dependability concerns the reporting of the research method to enable another researcher to replicate the study, without necessarily aiming to generate the same findings (Shenton, 2004).

10.5.3.1 Potential Threats to Dependability

Dependability is threatened when there is insufficient detail provided about study methods and processes, which inhibits the ability of others to repeat the study.

10.5.3.2 Provisions to Uphold Dependability

The primary researcher made every effort to provide rich and elaborate descriptions of each phase of this PhD project. The research design and implementation (see sections 5.7.1 & 7.2.2) and intricacies of data collection (see section 5.8, & 7.10) are clearly outlined for phase I and II of this PhD project. A reflective appraisal in the form of a preamble is presented in chapter 2 as another means of providing rich contextual detail and a transparent insight into the systemic issues of referral processes. Likewise, chapter 12, provides a second reflexive narrative to maintain transparency around the researcher's change is positionality from an 'outsider' to an 'insider' of the primary care

community. Moreover, this thesis is explicit about the researcher's evolving philosophical foundations and worldview (see section 5.6.2, & 7.2.3). As a final point, the concept of dependability and credibility are closely related (Lincoln & Guba, 1985), and therefore the same provisions to uphold credibility (i.e. member checking, triangulation, and debriefing sessions) simultaneously help to preserve dependability.

10.5.4 Conformability

Conformability is concerned with a researcher's efforts to ensure as much as possible that findings emerge from the dataset, and are not influenced by researcher predispositions or biases.

10.5.4.1 Potential Threats to Conformability

The intrusion of researcher biases is unavoidable due to the nature of qualitative work whereby the researcher serves as the research instrument (Shenton, 2004; Yin, 2015).

10.5.4.2 Provisions to Uphold Conformability

First, member checking (see section 10.5.1.2.1) and triangulation (see section 10.5.1.2.2) helps to mitigate researcher biases as far as possible. Secondly, transparency around a researcher's worldview, and their decisions throughout the research process helps to facilitate conformability. Every effort was made to provide clarity around

underpinning worldviews, and sufficient detail regarding all research decisions. Thirdly, reflexivity is integral to upholding conformability (Johnson et al., 2020). In the case of this research, the primary researcher kept a reflexive diary throughout the entire research project, which helped form the Preamble Chapter and the concluding reflexive narrative (see chapter 2 & 12). This permitted transparency around how researcher-participant interactions and researcher's changing positionality may have shaped the research, and influenced the collection, interpretation, and discussion of the results. Fourthly, all study participants were not only asked about their experiences and perspectives of the referral process, but also encouraged to articulate how they thought it could be improved. This pinpointed some important avenues for both future research and professional practice, which emerged from those most closely associated with referral processes.

10.6 Summary

This chapter aimed to synthesise individual qualitative and quantitative research strands of this PhD project by presenting two overriding meta themes identified through the triangulation protocol: 'Poor Understanding' and 'Inadequacies of Healthy Lifestyle Programme Referral Processes'. The identification of these meta themes enabled higher level interpretation of individual research components and helped to explain how these multidimensional patterns manifested across different stakeholder groups through an examination of convergence (i.e., agreement, partial agreement, dissonance, and silence). Overall, the triangulation protocol enabled a more nuanced contextual understanding of HLP referral processes, and should be used to inform future developments. Specifically, meta themes emphasise the importance of directing efforts towards addressing 'poor understanding' and the 'inadequacies of Healthy Lifestyle Programme referral processes'.

The chapter closes with an overview of this studies strengths and limitations. Context-specific and needs-driven recommendations for future research and practice are detailed in the following chapter.

11 RECOMMENDATIONS and CONCLUSION

11.1 Introduction

This chapter intends to fulfil the fourth primary research objective (see section 1.6) by proposing context-specific and needs-driven recommendations to simplify HLP referral processes. These recommendations are informed by the perspectives of all local stakeholders who contributed to this research project, and are centered around the two overriding meta themes identified through the triangulation protocol, discussed in the preceding chapter. Each overarching recommendation encompasses a series of mini recommendations. Consideration is given towards how recommendations could be implemented in the 'real-world'. Moreover, it would be negligent to avoid considering recommendations in light of the Coronavirus (COVID-19) pandemic, which although was not relevant at the time of data collection, has had grave impact on population health and well-being, and the leisure sector (Local Government Association, 2020b). Therefore, consideration is given towards how recommendations fit within the current COVID-19 pandemic to help prioritise which are most pertinent to act upon. Next, this chapter recaps the overall aim of this research project, how each thesis objectives were met, and the key findings of individual research components. Finally, the most pressing recommendations, anticipated to be of greatest benefit to HLP referral processes, are presented.

11.2 Overarching Recommendation 1: Improve knowledge of physical activity promotion and the Healthy Lifestyle Programmes.

This recommendation relates to the first overriding meta theme 'Poor Understanding', which is multifaceted in nature and concerns the understanding of both

PCP and patients in relation to PAP and the HLPs. Four mini recommendations will follow aimed to improve knowledge in these areas.

11.2.1 1A: Support Primary Care Personnel to Undertake Physical Activity Promotion Training.

Stakeholder groups were largely in agreement that PCP do not have sufficient understanding in relation to PAP. Some PCP reported a disconnect between what they were expected to know in terms of PAP, and the training they had undertaken to upskill in this area. This was reflected in their inability to confidently undertake pre-participation screening and provide clearance for exercise participation, and their difficulties influencing behaviour change when patient motivation was perceived to be low. Whilst the under-developed medical education response to PA is a likely contributor to poor PAP understanding (Chatterjee et al., 2017; Dunlop & Murray, 2013; Osborne et al., 2017; Vuori, 2016), there have been recent efforts towards the implementation of educational approaches to better equip PCP for PAP (Brannan et al., 2019; Faculty of Sport and Exercise Medicine UK, 2021). Whilst this is encouraging, current awareness of, and engagement with these initiatives is suggested to be poor (Buckley et al., 2020). Therefore, one recommendation would be to increase awareness of educational approaches to PAP amongst PCP, and more importantly, ensure they are properly supported to undertake this training as part of their continuing professional development. Each month, GP surgeries across the ERoY are closed to allow for essential training-known as Protected Learning Time (PLT). Delivering training around PAP and behaviour counselling techniques such as motivational interviewing within PTL may represent an ideal opportunity to upskill PCP. Moreover, such PTL training is supported in the

Enhanced Service Specification for Weight Management 2021/22 (NHS England, 2021). Enhancing opportunities to improve PCP expertise in these areas seems timely in light of the recent inclusion of obesity-related indicators in the QOF, which provides financial incentive for referring obese patients to weight management services such as LiveWell.

11.2.2 1B: Increase Healthy Lifestyle Programme Understanding through Promotion and Bespoke Information Resources for Primary Care Personnel and Patients.

There was overall consensus that PCP and patients do not have sufficient understanding in relation to the HLPs. PCP limited understanding made it difficult for them to undertake pre-exercise screening, and properly inform eligible patients about the programmes at the point of making a referral. PCP were also often unaware of funding provided by Public Health to subsidise ERS costs for patient of a low SES. Irrespective of how informed they perceived themselves to be, PCP were largely in agreement that clear HLP information resources are needed to increase their understanding and help them to quickly appraise patient suitability. This strengthens the need for PCP education (see recommendation 1A), and goes one step further in providing bespoke information about the local leisure provision to support their understanding. Developing and supplying a solid base of HLP knowledge in accessible formats across ERoY is vital, for PCP to screen and refer, and properly inform patients.

One attractive recommendation to enhance HLP understanding amongst the medical community, described by PCP themselves, could be through developing bespoke

information resources for referrers. It is important for PCP to be involved in the design and development of these resources, especially since they are a recurring source of criticism (Buckley et al., 2020). Care also needs to be taken to ensure they are effectively disseminated amongst PCS and easily accessible in practice. Furthermore, as discussed in section 10.3.2, the application of behavioural insights (e.g., using the EAST framework) may prove useful in the successful design and implementation of bespoke scheme information resources. Therefore, future research is required to co-create information resources with a broad range of PCP representatives across the ERoY, and take into consideration behavioural insights to encourage successful design and implementation.

The perception that patients were poorly informed about the HLPs featured as a common thread in the present study. However, in absence of the patient's perspective, their understanding of the HLPs cannot be determined, and therefore, assumptions cannot be validated. In order to better comprehend a patient's understanding of these programmes, it is recommended that further research is conducted with patients. Should this research reveal that they are in fact poorly informed about the HLPs, then efforts should be directed towards increasing this understanding. One attractive recommendation to enhance understanding amongst patients, according to all stakeholders in the present study, could be through promotion. All stakeholder groups saw value in promotion amongst health and community settings, as well as digitally (e.g., via social media platforms and the radio). They also stressed the importance of ensuring eligible candidates receive more comprehensive information about the HLPs in primary care. One way to improve the provision of information could be through directing patients to digital resources (e.g., standardised web-based resources).

There are several potential benefits to enhancing HLP understanding amongst patients. It may encourage more patients to take an active role in their referral, thus alleviating pressures on PCP to identify eligible candidates. It may also help to tackle any confidence-related issues such as the ones described by Leisure Customers in the present study, which they largely attributed to being poorly informed about HLPs (i.e., negative perceptions of exercise abilities, and fears of a leisure gym environment). Moreover, by facilitating access to digital resources, prospective candidates will be afforded more time to absorb and reflect on HLP information, and will be able to make a more informed decision regarding referral uptake. In turn, this may help to preserve the time of FPs during initial consultations as they will not have to undertake the time-consuming task of educating uninformed patients about the programme. Nevertheless, the suggestion for digital resources must be interpreted cautiously because the ERoY is largely rural (ONS, 2011), and has a populace characterised by a typically older demographic (ONS, 2020b). Rurality has known implications for accessibility and availability of mobile and broadband coverage in the region (East Riding Intelligence Hub, 2020), which can exacerbate the 'digital gap' between urban and rural areas (Local Government Association, 2017). Furthermore, individuals of an older demographic may not be "*so IT happy [and] like to see people or speak to people*" (GP7), which may result in difficulty or resistance accessing digital HLP resources. Therefore, in line with the General Practice Strategy (ERoY CCG, 2019), there should be a blended approach to information provision, incorporating both technological and physical formats to maximise accessibility and avoid exacerbating digital poverty across the ERoY.

Patient and public involvement (PPI) and embedding behavioural insights would be imperative throughout the development of promotional HLP material for the public, especially since PA scheme resources have been subject to much criticism from patients in prior research (Allen et al., 2015; Birtwistle et al., 2018; Wormald & Ingle, 2004) and Leisure Customers in the present study. For example, PPI would be useful for adapting the language and visuals on HLP promotional resources to ensure they are understandable, meaningful, and appealing to lay audiences (Brett et al., 2014). Moreover, the EAST framework is likely to be useful in creating resources that are clear and comprehensive, and do not create a bottle-neck for information processing, which can be a difficult balance to strike when it comes to making health-related information 'attractive' (Hallsworth et al., 2016). Thus, if ERL direct energy towards developing promotional resources for the public, it would be recommended that they actively encourage PPI to co-create these materials, focusing on engaging a wide range of individuals across the region (e.g., different age groups, life stages, genders, and ethnicities), and use behavioural insights where possible.

In summary, it may be highly beneficial for ERL to review and update their current promotional strategy and information resources for both PCP and patients, encouraging the assistance of local PCP and PPI in these developments so they are meaningful. It may also be advantageous for ERL to explore new and innovative ways to increase HLP understanding (e.g., through digital resources for patients), so long as there are alternative provisions in place to avoid digital exclusion (e.g., hard-copy resources). Finally, ERL should develop a timeline to regularly review and update all promotional

and information resources to ensure all stakeholders remain up to date and informed of any changes to ERL provision.

11.2.3 1C: Improve Working Relationships between Primary Care and East Riding Leisure Centres.

The need to improve working relationships across the region between PCS and ERL centres, that in turn would improve understanding of the HLPs, was a common thread throughout individual research components. There is convincing evidence that ERS are more likely to thrive when reciprocal, active collaborations endure between healthcare professionals and exercise providers (Craig et al., 2001; Geense et al., 2013; Heath et al., 2012; Leemrijse et al., 2015). Furthermore, efforts towards improving working relationships align with the ERoY CCG latest General Practice Strategy (2019), where one key intention over the next five years is to "work closely and integrate with broader primary care partners including community services, pharmacy, optometrists, social care, leisure services, and the voluntary and community sectors" (p.1). Investing time to nurture positive working relationships is likely to enhance opportunities for leisure professionals to build HLP understanding amongst PCP, and share feedback to help to build the medical communities trust in the effectiveness and value of these programmes for population health and wellbeing. This might result in PCP advocating the HLPs more to their patients. Given that PCP, specifically GPs, are considered the most trusted profession in the world (Ipsos, 2021), their recommendations for exercise on prescription may help to promote programme uptake.

The BHF NCPAH (2010) offer numerous tips to build strong working relationships between the primary care and leisure sector, and to engage referrers. One of their suggestions includes liaising closely with Practice Managers of GP surgeries to advocate PA schemes during practice meetings, and creating newsletters to highlight case study successes. Gaining access to practice meetings is a strategy which has already proved successful in Withernsea. This allows for direct ongoing dialogue between health and Leisure Professionals and enables FPs to promote the HLPs and disseminate feedback. Thus, other regions of the ERoY should seek active invitations to practice meetings so they can use this platform for promotion. However, the reality of successfully contacting surgery gatekeepers and trying to gain access to practice meetings is much more complex as experienced first-hand by the primary researcher during recruitment of PCP (see section 2.3). Therefore, there must be more joined up efforts and support from Public Health who commission the HLPs to facilitate regular access in primary care, and foster stronger working relationships.

However, there were some excellent examples of strong working relationships between primary care and East Riding Leisure centres, particularly across coastal areas of the ERoY, which resulted in highly informed PCP and patients. For example, the strong working alliances formed between GP surgeries surrounding Withernsea leisure centre are to be admired, where a dedicated FP integrates within GP surgeries on a weekly basis to advocate the HLPs. Whilst it was recognised this took resource away from ERL, it was celebrated as a "*good investment for the return*" (FC1), as it helped to reduce barriers to referral on multiple levels. Unfortunately, these were isolated examples, and thus attention must be turned towards fostering strong working alliances between GP surgeries

and ERL centres across all regions of the ERoY to enable a regular presence of FP within GP surgeries. This would enable FPs to provide education on the HLPs to PCP and patients, harness their knowledge of motivational interviewing to help patients overcome any perceived barriers to change, strengthen a patient's readiness for change, and empower HLP candidates to actively request a referral from their PCP. PCP could also utilise dedicated FPs in their surgeries to better inform and support patients they have identified who may benefit from the HLPs by signposting patients to them, which in turn could preserve precious consultation time. In light of this, ERL should look at the costs and benefits associated with the model adopted in Withernsea, and should weigh up the feasibility of enabling FPs to integrate within surrounding GP surgeries on a regular basis as a means of nurturing closer working relationships, increasing HLP understanding amongst PCP and patients, and supporting programme uptake.

11.2.4 1D: Provide opportunities for a Pre-visit at East Riding Leisure centres.

Improving working relationships, and allowing an ERL professional to advocate the HLPs in GP surgeries, as mentioned in recommendation 1C, is likely to go some way in improving PCP and patient understanding, whilst simultaneously alleviating patient anxiety and uncertainty. A second attractive recommendation to improve patient understanding of the HLPs, and reduce associated trepidation, came from Leisure Customers: to offer 'pre-visits' at ERL centres. The opportunity for a pre-visit would enable candidates to experience the leisure environment first-hand, observe what these programmes entail, and interact with current participants. This may be especially useful when conversations within GP surgeries are not sufficient to reduce their anxiety and hesitation about embarking on a HLP. Moreover, current HLP participants possess

experiential knowledge and could provide emotional, motivational, and informational support during a pre-visit. Given that peer support can encourage health behaviour change (Carstairs et al., 2020; Embuldeniya et al., 2013), and information and guidance provided through peer support is more impactful than information-provision alone (Embuldeniya et al., 2013), there is a real opportunity to capitalise on peer support through pre-visits. Pre-visits could simultaneously benefit FPs who described finding it particularly challenging to make introductory telephone calls with referred patients. FPs recognised that telephone contact supported programme uptake as they could provide motivational, emotional, and informational support, yet they were often unsuccessful in their telephone contact attempts or simply did not have the time to make these phone calls. Therefore, inviting groups of HLP candidates for a pre-visit could serve as an alternative, and potentially better way of supporting programme uptake, which is possibly less taxing on FPs time than making individual 1:1 telephone calls. ERL should therefore consider the viability of hosting 'pre-visits' for patients to attend to help enhance their understanding of the HLPs, overcome any confidence-related issues, and make more informed decisions about programme uptake.

11.3 Overarching Recommendation 2: Address Inadequacies of the Healthy Lifestyle Programme Referral Processes.

This overarching recommendation is related to the second multidimensional overriding meta theme: 'Inadequacies of HLP Referral Processes'. Four mini recommendations will follow, which aim to address these inadequacies.

11.3.1 2A: Seek Interoperability between Primary Care and Leisure Systems to Overcome Challenges associated with Making and Managing Healthy Lifestyle Programme Referrals.

Interviews with PCP revealed a host of challenges they experience in relation to making HLP referrals, many of which were discussed in the wider context of organisational pressures in general practice (i.e., time constraints, unmanageable workloads, and a depleted workforce). An interface between leisure and primary care IT systems to enable interoperability (i.e., the ability of a system to exchange information with partner systems) was unanimously viewed by PCP as the most fundamental improvement to simplify referral processes, and alleviate difficulties associated with making referrals. Many benefits of interoperability were discussed by PCP, including the ability to automatically identify HLP candidates, self-populate referral forms with patient information using built in algorithms, and provide a mechanism of receiving feedback regarding a patients progress from ERL professionals. Feedback provision is discussed in recommendation 2D. Simplifying referral processes and reducing the time it takes to refer and complete necessary referral tasks, are of significant advantage to PCP, otherwise these programmes risk being further underutilised in primary care. This also may have implications for ongoing commissioning and their future existence.

Interoperability between primary care and leisure systems could also serve as a solution to the pressing issues described by Leisure Professionals in relation to managing incoming referrals. Specifically, the patient information provided at the point of making a referral was identified as a weakness of HLP referral processes as it was common for information to be missing, inaccurate, and vague. This contributed to the complexity of

processing incoming referrals, and conducting initial appointments. Interoperability could allow the automatic population of patient information on HLP referral forms by extracting relevant data directly from medical records. This would help to ensure Leisure Professionals are appraised of anything relevant to the conductance of PA, without relying on PCP to provide this detail at the point of referral, or patients to disclose this information. This would be of simultaneous benefit to referred patients as they can be assured that FPs have all the necessary information needed to devise a safe and effective tailored programme of exercise. Advanced background algorithms built into the system could also inhibit the submission of HLP referrals if a patient is not an eligible candidate, thereby avoiding inappropriate referrals- another key source of frustration for Leisure Professionals.

The NHS's long Term Plan notes that a lack of interoperability is a key flaw across many health and social care sectors (NHS England, 2019), which prevents efficient bidirectional exchange of patient information to other professionals involved in their care, and results in fragmented care planning and delivery (DoHSC, 2018). However, "ensuring the interoperability of IT systems" is a key vision outlined by the RCGP (2019, p. 43) for general practice by 2030, and likewise, "compatibility of IT systems to enable improved information sharing and care planning" is a local priority over the next five years (ERoY CCG, 2019, p. 14). Given the momentum towards interoperability, the time is ripe for ERL to assess the feasibility of an interface between leisure and primary care systems to enhance the bi-directional sharing of information. As discussed in section 10.4.1, behavioural insights should guide the development and implementation of an interoperable system in attempt to reduce the time and effect required to perform a referral,

and satisfying where possible, the four ideals of the EAST framework (i.e., making referral behaviours Easy, Attractive, Social, and Timely).

11.3.2 2B: Investigate Patient Barriers to Lifestyle Change and Healthy Lifestyle Programme Uptake, and Introduce Provisions to Alleviate The Most Pertinent Barriers.

In the present study, PCP held perceptions about the barriers patients experienced in relation to lifestyle change, which were consistent with the findings of prior literature, for example lack of confidence (Eynon et al., 2018; Graham, 2006; Wormald & Ingle, 2004), financial issues (Carstairs et al., 2020; Craig & Shelton, 2008; Din et al., 2015; Graham, 2006), and accessibility issues (Din et al., 2015; Goodman et al., 2011). It must be reiterated here that these were merely PCP assumptions, and in the absence of the patients perspective, it is impossible to determine 1) if these are genuine issues for ERoY patients, and 2) what are the most pertinent barriers for ERoY patients. It is also important to recognise that the HLPs encompass eight different programmes targeting specific population groups (see section 0), and therefore, the demographics of clientele on these programmes are likely to be different. This could mean they experience distinct barriers concerning programme uptake. Thus, it is imperative that the perspectives and lived experiences of non-attenders (i.e., those who do not accept a HLP referral) are investigated to better understand the complexities of patient barriers, and how to overcome the most pressing barriers to HLP uptake amongst ERoY patients for the greatest benefit on health and well-being. As explained in section 10.4.1, there is potential value in the utilisation of the COM-B model, BCW, and EAST framework to aid

understanding of key barriers to patient uptake, and develop solutions and interventions to help alleviate the most pertinent barriers.

11.3.3 2C: Increase Workforce Capacity across Primary Care and East Riding Leisure Sites to Overcome Challenges Associated with Making and Managing Healthy Lifestyle Programme Referrals.

Striving for interoperability between leisure and primary care systems, as discussed in recommendation 2A, is likely to go a long way in overcoming the challenges associated with making and managing HLP referrals. However, another important consideration centres around increasing workforce capacity within both the primary care and leisure sector.

PCP, especially GPs, are under unprecedented time and workload stressors in primary care, and intentions to leave the profession stand at a record high in the latest National GP Worklife Survey (Walker et al., 2021). When you combine this with their overall lack of understanding and training in relation to PAP and exercise prescription, as evidenced throughout the literature and this research, it brings into question whether they are best placed to effectively perform this role, and refer to the HLPs. Despite the National Quality Assurance Framework for Exercise Referral Systems, contending that it must be a medical PCP who undertakes an assessment of the risks and benefits of exercise (Craig et al., 2001), this study suggests that they may not be the best vehicle to make referrals for exercise. Furthermore, Maiorana et al. (2018) argues that the onus on medical PCP to

undertake screening and provide clearance for exercise participation “creates an unjustified barrier to exercise” (p. 1294).

One recommendation to help overcome PCP challenges in relation to PAP and making HLP referrals is to enhance capacity amongst the general practice workforce by having more designated staff focusing specifically on PAP. Intermediaries in primary care such as CLWs are valued as an attractive model to support PAP (Buckley et al., 2020; Carstairs et al., 2020). CLWs are already established in all GP surgeries across the ERoY. CLWs are permitted more time with each patient (up to one hour), and are upskilled in motivational interviewing, which arguably puts them in an advantageous position to deliver PAP. Motivational interviewing could help to overcome one of the most significant challenges when making HLP referrals, as perceived by PCP: patient’s lack of motivation to change their lifestyle behaviours. Thus, there is value in motivational interviewing to assess and enhance a patient’s motivation by resolving any ambivalence to change, and helping them to develop strategies to overcome their perceived barriers to change (Rollnick et al., 2008). However, the primary researcher’s first-hand experiences of working as a CLW (see section 12.3.1.1.2) highlight some limitations with the involvement of CLWs in PAP. For example, CLWs are responsible for delivering the entire social prescribing agenda, and PAP forms only a small element of their remit. Moreover, often a single CLW operates across multiple GP surgeries in the region, meaning their workload is at considerable risk of reaching maximum capacity. It is also not necessary for CLWs to have formal qualifications relating to PAP; therefore, it could be argued that they potentially lack in expertise.

To provide additional capacity across the primary care workforce, roles may need to be created for individuals with specific PAP expertise, to better support all PCP involved in PAP. The current model used in Withernsea sees FPs integrating in GP surgeries to identify HLP candidates and enhance understanding amongst PCP and patients, and there is potential value in replicating this model across the region. FPs have expert knowledge in exercise prescription, and a sound understanding of behaviour change counselling techniques obtained through many qualifications (see section 4.4.1). Thus, they have the requisite knowledge, skills, and competencies to make decisions around a patient's suitability to undertake exercise. Interoperability between leisure and primary care systems, as discussed in recommendation 2A, could enable FPs to access relevant aspects of a patient's medical record and make a referral. Arguably, this would put them in a much better position to undertake pre-participation screening compared to PCP, who do not have the same underpinning knowledge of PAP or the HLPs. There is some evidence supporting the role of appropriately trained exercise professionals in health care systems outside of the UK (Maiorana et al., 2018; Thornton et al., 2016). Thus, it may be efficacious for PCP who experience challenges to PAP to direct potential HLP candidates to FPs integrated within primary care. In light of primary care workforce capacity, the long standing push for PAP by numerous global experts and organisations must be better matched with an increase in workforce capacity to enable this to happen. Now could be the time to embed FPs into the primary care workforce to enhance capacity for PAP. This model could remove the burden for medical PCP to provide 'clearance' for patients to engage in the HLPs, and more effectively utilise the skills of FPs.

It is imperative that the workforce capacity within ERL centres is also considered. Leisure Professionals discussed numerous challenges relating to their ability to efficiently

manage incoming referrals. Efforts towards improving understanding of PAP and the HLP (as proposed in overarching recommendation 1), alongside endeavours to address the inadequacies of referral processes (as proposed in the current overarching recommendation), may result in an influx of HLP referrals. This anticipated demand must be matched with an increase in workforce capacity across all ERL sites. If the infrastructure around staffing and capacity is neglected, there is a risk that leisure centres will eventually become inundated with HLP referrals, which cannot be dealt with in a timely nor efficient manner. This may create a backlog of referrals and lengthy waiting lists. Echoing warnings from primary care, this could put ERL "*in danger of becoming a victim of [their] own success"* (PN6), and could damage quality of service delivery due to increased demand; all of which may be detrimental to staff well-being and ERL's reputation. Thus, it is of upmost importance that ERL are mindful of workforce capacity, and invest in staff recruitment to ensure that anticipated increases in HLP referrals can be managed efficiently and timely.

11.3.4 2D: Improve the Content and Provision of Feedback from East Riding Leisure Centres to Primary Care.

The content and provision of feedback was identified as a major weakness of referral processes. It was a common perception, by both PCP and Leisure Professionals, that the information collected on a HLP and fed back to PCP prioritises simplistic physiological markers of success, and neglects anecdotal, holistic lifestyle changes, which may mask the participants true health and well-being benefits. Thus, it would be beneficial to capture more holistic outcome measures on the programmes, such as behavioural (e.g., dietary patterns), social (e.g., social inclusion), and psychological (e.g., confidence) measures to

illustrate the anecdotal, holistic lifestyle behaviour changes (Craig et al., 2001; Lion et al., 2019). By collecting and reporting holistic markers of success, it could aid PCP understanding of how these HLPs have benefitted their patient, increase their confidence in the effectiveness of these programmes, and support them in their decisions about the appropriateness of referral for other patients.

Another pertinent finding was that PCP were rarely in receipt of feedback from ERL, which fuelled their ambiguity around the effectiveness of the HLPs. Therefore, robust feedback loops must be established between primary care and leisure to enable the systematic dissemination of individual data (i.e., information regarding a patient's referral progress and outcomes) and aggregate data (e.g., monthly referrals, uptake, and completion rates) for all HLPs. This is important because feedback is a vital part of a health professional's ability to maintain clinical responsibility for a referred patient (Craig et al., 2001). Interoperability between primary care and leisure systems (see recommendation 2A) could allow ERL to provide feedback directly and seamlessly into primary care software systems (e.g., SystmOne and EMIS) on a systematic basis. However, if interoperability is not feasible, consideration towards alternative feedback mechanisms must be a top priority. In light of the NHS's ambition to be completely paperless by 2023, feedback must be provided electronically. Pharmoutcomes already provides a means of electronic feedback, where reports are generated and emailed to PCS at precise time intervals depending on the specific HLP. Since interviews were conducted with PCP in 2016, the LiveWell Scheme and HEART transitioned to electronic data capture, meaning that feedback reports regarding a patient's progress are now transmissible electronically via Pharmoutcomes. Therefore, it would be highly beneficial

to further investigate PCP perspectives of receiving electronic feedback via Pharmoutcomes, to better understand what information they receive, the mechanisms by which they receive this information, what they do with this information, and their perspectives of the usefulness of this information. Nevertheless, data capture for Escape Pain and the Young LiveWell programme continues to be collected via pen and paper, meaning that information on an individual's progress and outcomes are not captured electronically, nor can it be fed back to PCS electronically via Pharmoutcomes. Therefore, if interoperability is not feasible, and further research indicates that Pharmoutcomes could serve as an appropriate alternative to provide electronic feedback to PCP, there must be a shift towards electronic data capture across all HLPs.

11.4 Consideration of Recommendations and COVID-19

As mentioned in the introduction of this chapter, the Coronavirus (COVID-19) pandemic has had grave impact on population health and well-being, and the leisure sector. Therefore, it would be negligent to avoid considering this theses recommendations in light of COVID-19.

The COVID-19 pandemic has undermined PA participation and exacerbated the obesity crisis. The latest Sport England's Active Lives Adult Survey (2021) based on data from 181,535 adults across England demonstrates a 1.9% decline in adults reaching current CMO PA guidelines (i.e., 150 minutes of moderate intensity PA per week) and a 2.6% increase in the number of inactive adults (i.e., reaching less than 30 minutes of moderate intensity PA per week) in comparison to 12 months prior. This is extremely

concerning because PA engagement can reduce the severity of COVID-19 contraction, as well as facilitate the recovery of long COVID (i.e., symptoms that have persisted for 12+ weeks; Jimeno-Almazán et al., 2021), which is estimated affect one million individuals in the UK (ONS, 2021). Furthermore, a recent Public Health England (2021a) survey of 5000 adults found that 41% have gained weight since the first national lockdown (March 2020), with more than one in five of these individuals reporting to have gained ≥ 14 pounds. Individuals with a BMI of over 40 have a 90% increased risk of death from COVID-19 compared to their non-obese counterparts (Public Health England, 2020a), which highlights the urgency of action on obesity. Increasing PIA and obesity levels may largely be attributed to government control measures to reduce human mobility and control the transmission of the virus. The most recent mobility trends across the UK, which track how peoples' movements have altered during the pandemic, identify a 183% increase in 'time spent at home' when comparing pre-lockdown (February 2020) to the present (September 2021; Ritchie et al., 2021). Moreover, COVID-19 lockdown measures caused the closure of leisure, sport, and recreational buildings, thereby further limiting opportunities to be physically active (Association for Public Service Excellence, 2021; Local Government Association, 2020b).

Leisure services are "integral to COVID-19 recovery" and improving population health and well-being, and therefore have a major role in helping to alleviate pressures on NHS and social care services (Association for Public Service Excellence, 2021, p. 12). July 2021 witnessed the re-opening of ERL centres following the exit of the third national lockdown. However, despite ERLs prolonged closure during lockdown periods, patients were still being referred to the HLPs by PCP, which has resulted in a backlog of referrals.

It can be expected that the exacerbation of the PIA and obesity crisis as a result of COVID-19 will continue to result in increased referrals to ERL centres. Therefore, there is an urgency to match this amplified demand with growth in ERLs workforce capacity (see recommendation 2B). It must be recognised that the prolonged closure of ERL and resultant loss of income may make increasing the workforce financially challenging. However, if the infrastructure around staffing and capacity is ignored, there is a serious risk that ERL will become inundated with HLP referrals, which will place even greater pressures on the existing backlog of referrals. This will result in patients waiting longer to access support from ERL, which could adversely affect their motivation to change their lifestyle behaviours, and result in negative patient experiences. It will also inevitably place enhanced pressures on ERL professionals, which could be detrimental to their job satisfaction and overall staff retention. Therefore, the most pressing recommendation in light of COVID-19, is to increase ERL workforce to match increased demand and reduce referral backlog.

11.5 Summary of Thesis Recommendations and Conclusion

The primary aim of the doctoral thesis was to elicit the perspectives and experiences of multiple stakeholders involved in HLP referral processes to highlight areas of improvement. This represents a unique contribution to the evidence base in this field, which is limited to PAP in the form of advice giving or counselling in primary care, and rarely considers the perspectives of all relevant PCP (with the exception of GPs), patients, or FPs in relation to referral processes to community-based PA interventions. In order to achieve this aim, this thesis had four primary objectives:

1. To explore PCP perspectives and experiences of the HLP referral process, and highlight areas of improvement.
2. To explore Leisure Professional's perspectives and experiences of the HLP referral process, and highlight areas of improvement.
3. To explore Leisure Customer's perspectives and experiences of the HLP referral process, and highlight areas of improvement.
4. To propose recommendations and pragmatic solutions to streamline HLP referral processes through an amalgamation of key findings.

Phase I of this research utilised 1:1 interviews with PCP (n = 28) to fulfil the first primary objective by eliciting an in-depth understanding of their perceived barriers and facilitators of making HLP referrals, whilst highlighting how referral processes could be enhanced. The most pertinent findings to emerge from PCP interviews related to the many factors that made it difficult for them to make these referrals. Whilst many PCP saw value in PAP, they lacked understanding of how to engage with it, and were not well-informed about the HLPs. It proved challenging for them to prioritise PAP or make HLP referrals due to unprecedented challenges on primary care and overly cumbersome referral processes. Another pertinent finding related to the barriers patients were perceived to face, which for PCP, contributed to the difficulties of making HLP referrals within the constraints of primary care consultations. Crucial areas requiring improvement included improving HLP understanding, enhancing feedback provision, and simplifying referral processes through interoperability.

The second and third objectives were achieved through undertaking online surveys and follow-up interviews with Leisure Professionals (n = 48) and Leisure Customers (n = 20) as part of the second phase of this research project. This enabled a deep insight into the factors facilitating and hindering the management of HLP referrals from the perspectives of Leisure Professionals, and the lived experiences of Leisure Customers during their transition from primary care to ERL centres following referral. The most pertinent findings to emerge from Leisure Professional related to the factors that made it difficult for them to manage incoming HLP referrals from primary care. For example, the referral documentation provided to Leisure Professionals was a major source of criticism, as were feedback mechanisms. It was a common perception amongst Leisure Professionals that both PCP and patients lacked adequate understanding of the HLPs, which contributed to apprehension amongst patients prior to starting their programme, and placed more burden on ERL professionals to provide this education and reassurance to these individuals. Increasing HLP understanding amongst PCP and patients, and standardising how referrals are managed and what feedback is provided to PCP were key areas of improvement.

The most significant findings to emerge from Leisure Customers centered around the lack of HLP understanding. On the whole, Leisure Customers described how they had minimal understanding of the programmes prior to attending ERL centres due to a general lack of promotion and an absence of information provision at the point of being referred. Leisure Customers also assumed that their referrer did not have an adequate understanding of the HLPs. This contributed to feelings of apprehension prior to attending their first appointment at the leisure centre. Leisure Customers spoke elaboratively about

the anecdotal, psychosocial benefits endured through participation: they believed this information was not widely available to PCP. Key suggestions for improvement included enhancing understanding of the programmes through promotion, opportunities for a pre-visit at ERL centres, and improving provision of information at the point of referral.

The fourth objective was addressed in this chapter where context-specific and needs-driven recommendations to improve HLP referral processes have been presented based on an amalgamation of individual research components through the triangulation protocol. These recommendations are based around the two overriding meta themes and several meta subthemes discussed in chapter 10, and should be used as a catalyst for change. The future application of implementation science frameworks such as BCW (see section 3.3.2.1.2.2.1) and EAST (see section 3.3.2.1.2.2.2) could help to translate these recommendations to real world practice. To summarise, the eight following recommendations should be considered to support the advancement of referral processes:

1. Support primary care personnel to undertake physical activity promotion training.
2. Increase Healthy Lifestyle Programme understanding through promotion and bespoke information resources for primary care personnel and patients.
3. Improve working relationships between primary care and East Riding Leisure centres.
4. Provide opportunities for a pre-visit at East Riding Leisure centres.

5. Seek interoperability between primary care and leisure systems to overcome challenges associated with making and managing healthy lifestyle programme referrals.
6. Investigate patient barriers to lifestyle change and Healthy Lifestyle Programme uptake, and introduce provisions to alleviate the most pertinent barriers.
7. Increase workforce capacity across primary care and East Riding leisure sites to overcome challenges associated with making and managing Healthy Lifestyle Programme referrals.
8. Improve the content and provision of feedback from East Riding leisure centres to primary care

In conclusion, the study has examined the perspectives and experiences of PCP, Leisure Professionals, and Leisure Customers in relation to HLP referral processes, and has identified at the broadest level two overarching multidimensional meta themes that manifested across different stakeholder groups- 'Poor Understanding' and 'Inadequacies of Healthy Lifestyle Programme Referral Processes'. Whilst eight recommendations were collectively put forward, the most pressing recommendations are to 1) increase workforce capacity across primary care and ERL centres to manage unprecedented demands associated with the COVID-19 pandemic, and 2) push for interoperability between primary care and leisure systems to address multiple issues inherent in HLP referral processes.

Increasing workforce capacity is vital in light of how the COVID-19 pandemic has exacerbated rates of PIA and obesity (Public Health England, 2020a; Public Health

England, 2021a), which is especially concerning given that the ERoY's prevalence of overweight, obesity, and PIA is higher than England averages (PHE, 2020c). Due to leisure's pivotal role in the nations recovery of COVID-19 (Association for Public Service Excellence, 2021), there is inevitably going to be more demand placed on ERL centres, which must be matched with growth in ERL workforce capacity. If rise in demand is not accompanied with workforce expansion, there is a danger that ERL centres will become inundated with HLP referrals which cannot be managed quickly or efficiently. This could have adverse consequences for patients and leisure professionals alike, whilst also potentially jeopardising PCP future engagement in the referral process.

Interoperability is the second most pressing recommendation and may serve as a key solution to overcome many issues inherent within HLP referral processes. Interoperability would enable the seamless bidirectional exchange of patient information. This will be of significant advantage to PCP as much of the information on HLP referral forms can be automatically populated directly from a patient's medical record. This will preserve more time for PCP to provide programme explanations to patients, which could facilitate more positive referral experiences amongst patients and programme uptake. Interoperability could also provide a means of transferring regular feedback between ERL and PCP, which may simultaneously build their understanding of how these programmes are benefitting their patients, and encourage them to actively refer more. Interoperability would also be of huge benefit to FPs, as it will ensure they have all the information necessary to devise a tailored, safe, and effective exercise programme. This will be of simultaneous benefit to referred patients and may result in them achieving better results

on their programme due to more precise and bespoke programme individualisation. Interoperability is supported nationally by the RCGP (2019), locally by the ERoY CCG (2019), and aligns with NHS's ambition to digitise and become completely paperless by 2023 (NHS England, 2019).

To conclude, increasing workforce capacity is one of the most pressing recommendations of this thesis in light of the COVID-19 pandemic. Irrespective of COVID-19, the second most important recommendation centres around interoperability, which may serve as a key solution to overcome many issues inherent in HLP referral processes and aligns with national and local priorities. Therefore, ERL must seriously consider the feasibility of increasing their workforce capacity to manage the immediate pressures associated with COVID-19, and strive for interoperability to enhance HLP referral processes.

12 INSIDER REFLEXIVE NARRATIVES

12.1 Introduction

As discussed in chapter 2, the practice of reflexivity is fundamental to good quality research as a researcher's positionality, experiences, assumptions, and beliefs bare impact on the research (Berger, 2015; Sword, 1999). Whilst the focus of the first reflexive narrative is on interpersonal reflexivity (i.e., researcher-participant interactions), my positionality at that time was an 'outsider' (i.e., an academic PhD researcher) looking into HLP referral processes. This enabled me to remain objective and neutral as much as possible throughout phases of data collection and analysis. However, in the latter stages of this research, specifically the write-up period, I pursued a career opportunity that changed my positionality from an 'outsider' to an 'insider' of the primary care community.

12.2 Purpose and Organisation

The primary focus of this reflexive narrative is to demonstrate how my positionality changed from that of an outsider, to an insider. As my positionality changed, I found it more difficult to remain impartial and objective as my professional experiences became closely aligned with the project. No longer did I stand as the detached researcher and instead, I had shared experiences with my study participants in primary care. This allowed me to experience first-hand the challenges of lifestyle promotion delivery in primary care settings, and the 'insider' lens that I had acquired exposed me to delicate nuances within the research to which I was partially blind to before. I continued to practice reflexivity throughout this transition from 'outsider' to 'insider' by keeping a

diary to record accounts of my first-hand experiences. This prompted the inclusion of this concluding reflexive piece because I could not dismiss my changing positionality. Its purpose is therefore to maintain transparency around how my professional opportunities could have impacted this research through subtle shifts in my interpretation of the data, and thinking towards recommendations to improve referral processes. Alongside my first narrative piece, it also helps to provide a 360 degree view of my experiences of undertaking this PhD project.

What will follow is a brief introduction to the structure of this concluding reflexive narrative. It begins by detailing my experiences of working in the primary care setting during the write-up of this thesis. Next, attention is turned towards the struggles I personally faced during this role, which enabled me to empathise much more with participants of this research. Recognition is also given towards how these experiences may have influenced my thought processes, interpretations of the datasets, and the final study recommendations.

12.3 Career Developments Beyond PhD Research

This PhD project was commissioned for three years, starting September 2016, and ceasing September 2019, during which time a fully funded PhD studentship was provided. Following the lapse of this financial support, I needed to find another income stream throughout the write-up period of this thesis, which was intended to take one year. Due to challenging personal circumstances, and repercussions of the COVID-19 pandemic,

my write-up period of this PhD project lasted two years. Within this time, I gained invaluable work experience as an employee of the primary care workforce.

12.3.1 Employment in GP surgeries

In October 2019, I pursued an opportunity to work for the NHS YourHealth Service in a dual role as a CLW and Health Trainer. The NHS YourHealth Service run Public Health commissioned services aimed towards promoting good health and well-being across the ERoY. Given my prior interactions with CLWs in GP surgeries throughout the first phase of this research project, I saw this as a chance to walk in their shoes, and an excellent opportunity to obtain practical experience in the realm of social prescribing and the promotion of health and well-being. My role was split 50:50. Half of my time was spent practicing as a CLW delivering the social prescribing agenda to address non-medical determinants of health (e.g., lifestyle issues, social issues, financial issues, & housing issues) by capitalising on support from VCSE sectors. For the remaining time, I delivered lifestyle behaviour change interventions in my role as a Health Trainer, where the top five referral reasons in 2020/2021 in order of popularity were weight management, emotional well-being, health promotion, PA, and smoking cessation (Humber Teaching NHS Foundation Trust, n.d.). I was based across multiple GP surgeries across the ERoY in areas of general affluence (i.e., Beverley) and deprivation (i.e., Hornsea and Withernsea). Albeit different, both roles were complementary due to the complex psychosocial, and often inter-related, issues primary care patients presented with, which they believed negatively impacted on their ability to live healthily and happily.

12.3.1.1 The Impossibility of Timeliness

As a CLW, I quickly became privy to the unprecedented and relentless contextual strains placed upon GP surgeries, particularly in relation to workload and time pressures. Despite being in a more privileged position in my role in terms of the time I had available to spend with patients (often between 30 and 60 minutes), it was common for consultations to overrun. I believe this was because these consultations presented a unique opportunity to explore an individual's holistic needs, which is extremely atypical of appointments in primary care settings. Community link consultations were held in high regard by patients and Health Professionals alike, so much so that available appointments were few and far between. This enabled me to empathise with my PCP study participants, where at the time of undertaking interviews, I could not fully appreciate the difficulty of working in such time strained environments. I recall my lens being more judgemental as an 'outsider' when undertaking PCP interviews, where for some time I questioned if statements around 'a lack of time' were a genuine barrier to PAP, or merely an excuse to mask their limited understanding and support. I also held a grudge against surgery gatekeepers fiercely guarding the time of their staff during my relentless efforts to recruit PCP, but now, as a result of my lived insider experiences, realise that this protection was justified.

These mounting workload and time pressures I had personally experienced made me think about the overstretched CLW workforce, and the feasibility of CLWs taking a greater role in HLP referrals delegated from medical PCP. I began to reflect back to my

PhD findings through my ‘primary care lens’, specifically revisiting how non-clinical PCP such as CLWs, Medical Secretaries, and Care Navigators were increasingly assisting in the completion of HLP referral documentation on behalf of medical PCP. Given that my caseloads were at maximum capacity, and the service had begun to introduce waiting lists, I began to question the sustainability of delegating HLP referrals without demand being better matched with additional workforce capacity. I also questioned if I, as a CLW, was best placed to complete such referrals. Undoubtedly, I had a role to play in assessing and increasing a patient’s readiness for change, but I did not feel confident in my ability to navigate through a patient’s medical record, and extract medical information relevant to exercise prescription for referral documentation. In fact, I sometimes felt perplexed by medical terminology within patient records, particularly when an individual had complex medical conditions. It was often like trying to read a book in an unfamiliar language, and it made me consider the model in Withernsea which saw the integration of FPs in GP surgeries. I pondered whether FPs who had expert knowledge of PAP, and exercise contraindications were better placed to assist in HLP referrals, instead of this being delegated to non-medical PCP.

12.3.1.1.1 The Disruption of COVID-19

Time and workload pressures at work mounted considerably amidst the COVID-19 pandemic, where monthly referrals to the YourHealth service soared five-fold, from 592 in March 2020 to 2508 in April 2020 (Humber Teaching NHS Foundation Trust, n.d.) in response to the unique challenges posed by lockdown (e.g., furlough, unemployment, isolation, and loneliness). Mental health issues amongst patients became rife. Referred patients in need of urgent support from mental health crisis services became

an everyday occurrence. On the whole, patients were anxious and pessimistic about what the future had to hold. Many reported to be piling on additional weight, which was often attributed to comfort eating, and reduced opportunities to be active. Additionally, many patients I had supported in my Health Trainer role who had been successful in quitting smoking had relapsed due to the upheaval caused by COVID-19. The NHS YourHealth service was operating at maximum capacity, yet there was limited available community support to capitalise on due to many services ceasing as a result of lockdown measures, including ERL HLPs. Whilst some organisations were quick to offer digital support to their communities (e.g., East Riding Libraries and MIND), times were becoming increasingly desperate, and support was limited. Consequently, sticking to strict time constraints within patient appointments proved even more trying. I could not even begin to imagine how PCP working within even stricter time constraints were managing!

I was exhausted; mentally, physically, and emotionally as were many of my colleagues. The disruption of COVID-19 also impacted negatively on my academic studies, where I was unable to source any energy to write up this thesis. My own mental health plummeted, which was pretty ironic given that I spent the majority of my working day as a CLW supporting patients suffering with mental health issues. I suffered in silence because I was aware that I was in a fortunate position compared to some of my clients. As a key worker operating throughout the pandemic, I had a stable income. I had routine. I had a caring professional, academic, and personal support system around me. I questioned how I could be so selfish for feeling the way I did, but also questioned how much longer I could force a false smile to disguise the turmoil I felt brewing inside.

12.3.1.1.2 Systemic Issues Due to a Lack of Interoperability

It is important to recognise that prior to the unique challenges posed by COVID-19, consultation time was strained due to what I considered to be needlessly cumbersome clinical systems. To elaborate, all referrals to the YourHealth service for any means of support (e.g., Community Link or Health Trainer) had to first be recorded on YourHealth's SystmOne portal. Next, I had to operate the clinical software system used within the particular GP surgery I was working within to access and update a patient's medical record. As I worked across multiple GP surgery sites operating different clinical systems (i.e., SystmOne and EMIS), I was often flitting between these systems. Furthermore, I was required to record patient data from Community Link and Health Trainer consultations on Pharmoutcomes, a web-based system used by NHS YourHealth to house data and report the effectiveness of their Public Health commissioned services. This is the same system used by ERL professionals to record data on their HLPs. To complicate matters further, when face-to-face consultations ceased in response to the COVID-19 pandemic, video consultations via another distinct platform (i.e., Upstream Health) served as the primary mode of patient consultation. Naturally, over time, familiarity with the operation of different systems improved (i.e., SystmOne, EMIS, Pharmoutcomes, and Upstream Health), but the issue remained that none of these systems were interoperable, meaning data had to be manually duplicated from these systems for audit purposes- a tedious and time-consuming task. This process was further complicated when it also involved completing referrals to VSCE organisations, which sometimes involved using other systems.

As a result of these inoperable systems, I spent the majority of my working days eating lunch at my desk in a desperate endeavour to complete my morning administration prior to my afternoon consultations. More often than not, I would also stay behind at the end of my working day to catch up of my afternoon administration. Occasionally, I found myself hoping one of my clients would default their appointment so I could use that time to catch up on my mounting administration, which I am not proud to admit. The administration associated with these inoperable data management systems dampened the genuine satisfaction I experienced when supporting my patients. I frequently raised this issue during my appraisals with senior members of YourHealth, yet the message reiterated was along the lines of "*it is what it is*". I quickly resented data capture as it slowly started to make me feel burned out.

I found myself reflecting back to my PCP interview transcripts, who voiced their frustrations towards inoperable systems. Through my newly acquired 'primary care lens', I was able to comprehend some of the nuances within participant responses, in a way that I couldn't have ascertained in the absence of having been through it. Specifically, I revisited their accounts of frustration towards having to leave clinical software systems to use ERL's electronic referral system (i.e., BEARS) to complete HLP referrals. For the first time through-out this project, I understood what it felt like to constrained by cumbersome IT systems due to my own lived experiences. I felt closer to the data than I ever had been because I could relate to some of their experiences, perceptions, and constraints. At that point, it became so blindingly obvious why they did not want to encompass yet another inoperable system, and celebrated interoperability as the most fundamental improvement needed to streamline HLP referral processes. It was not down

to laziness as I might have once ignorantly assumed. Instead, their frustrations and resistance were attributable to the inherent flaws of inoperable systems. I felt incredibly irritated that nothing had changed in the four years since I had conducted interviews with PCP. This irritation, and despondency for the lack of development may have affected the emphasis I placed on an interoperable referral solution within this thesis' concluding recommendations (chapter 11) due to my own lived experiences of working in primary care.

12.3.1.2 Repressed Feedback

Whilst signposting and referring to a wealth of supportive organisations denoted a sizeable proportion of my role as a CLW, it was incredibly rare that I received feedback regarding what had happened to my patients, except if they personally disclosed that information to me in subsequent appointments. It often felt like I was referring into a vacuum. However, on one particular occasion, I did receive informal feedback, which resonated strongly with me. I had referred a patient with poor mental health and complex personal circumstances to the emotional well-being service for specialist support. A few weeks passed and I received an email from one of the therapists who was working with this individual. She took the time to update me on their progress, and passed on some heart-warming feedback about how my support had been invaluable to this patient in accepting specialist psychological support, and how their life had since transformed. I was moved. Suddenly the burden of completing referrals using inoperable systems seemed worthwhile because I could finally see the impact these referrals were having for my patients. Once more, I pounded over my findings from PCP interviews and their perspectives in relation to feedback provision from ERL, immediately recognising clear

parallels. My experiences of feeling like I was referring into a black hole due to a lack of feedback often echoed their narratives in relation to HLP referrals. Again, this may have affected the emphasis I placed on enhancing the provision of feedback in my recommendations. I feel strongly that exposure to previously unreleased holistic patient progress will help to underscore the value of these programmes, and subsequently lessen the potential resistance from clinical PCP with regards to completing the administration associated with referrals.

12.4 Reflexive Conclusion

This concluding reflexive narrative serves to close the loop on my journey throughout this PhD research, where I began as an 'outsider' studying the unfamiliar (detailed in Chapter 2), and transitioned to an 'insider' who lived and breathed the familiar (detailed in Chapter 12). This change in my positionality during the latter stages of this PhD inquiry as I integrated into the same contextual setting as PCP, exposed me to the realities and inner workings of the primary care environment. I had acquired a new lens which helped uncover delicate nuances within the research. The 'outsider' researcher that I was at the beginning of this PhD journey did not fully appreciate these realities, which is reflected in chapter 2, where I describe feeling like I was in a "battle" with surgery gatekeepers during PCP recruitment, trying to "infiltrate the enemy line". I now recognise the protection around PCP time was absolutely justified and I have lived experience of how time pressures of primary care are accentuated by systemic failures of primary care clinical operating systems. Through practicing reflexivity, I have remained conscious of how changes in positionality may have impacted my interpretation of data, and final recommendations to improve HLP referral processes.

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1 Appendices

Contents

Appendix 1 Examples of Paper-based HLP Referral Forms

EXERCISE REFERRAL FORM

EAST RIDING LEISURE

Exercise referral is a ten week exercise scheme aimed at inactive people with a variety of medical problems.

Name of referring surgery: ..... **GP:** .....

Patient name: .....

Patient address: .....

.....

.....

Tel no: ..... Date of birth: .....

REASONS FOR REFERRAL

Patients must be referred for **TWO** or more of the reasons below. *(Please tick)*

☐ Participant is inactive *(Participants must be inactive to be referred)*

☐ **Diabetes**	☐ **Hypertension**	☐ **Depression**	☐ **Asthma**
☐ Medication	☐ Medication	☐ Medication	☐ **Anxiety/stress**
☐ No medication	☐ No medication	☐ No medication	☐ **Other CHD risk**
			☐ **Osteoporosis/Joint problems**
			☐ **Weight loss**

☐ Other *(please state)* .....

Patients blood pressure: ..... BMI: .....

Current medication *(relevant to exercise)*: .....

MEDICAL HISTORY *(please tick any relevant current and previous conditions)*

☐ Chest pain	☐ Anxiety	☐ Difficulty with breathing
☐ Heart trouble	☐ Depression	☐ Muscle/Joint/Bone problems
☐ Stroke	☐ Epilepsy	☐ Respiratory problems/Asthma
☐ Diabetes	☐ High blood pressure	☐ Stress related illness

☐ Other *(please state)* .....

PARTICIPANT DECLARATION

I have not withheld any relevant information and will advise my GP/Nurse/Health Professional/Fitness Instructor of any future changes to my health. I hereby give my consent to participate in Exercise Referral and give permission for the information given to be disclosed to relevant personnel for monitoring/evaluation purposes.

I understand what this scheme entails and I am fully committed to complete the full scheme ☐ Yes ☐ No

Signature of patient: .....

I refer this patient onto the East Riding Exercise Referral Scheme:

Date of referral: ..... **Signed:** .....

Print Name: .....

Once this form has been completed send it to the Exercise Referral Fitness Instructor at your local East Riding Leisure centre.

PD02071

EAST RIDING OF YORKSHIRE COUNCIL

eastridingleisure.co.uk
EastRidingLeisure @ERLeisure

LIVE WELL REFERRAL FORM

Live Well is a healthy lifestyle and weight loss programme for adults with a BMI of 45 and over. Each person will receive an individualised exercise and healthy eating programme designed by qualified fitness instructors.

Date of Referral: _____

Name of Referring Surgery: _____

Participant Name: _____

Address: _____

_____

Tel. No: _____ Date of Birth: _____

Patient's Blood Pressure: _____ BMI: _____

Relevant Medical History: (Current and Previous)

☐ Chest Pain	☐ Anxiety	☐ Difficulty with Breathing
☐ Heart Trouble	☐ Depression	☐ Muscle/Joint/Bone problems
☐ Stroke	☐ Diabetes	☐ Respiratory Problems/Asthma
☐ Epilepsy	☐ High Blood Pressure	☐ Stress Related Illness
☐ Metabolic Disorder	☐ Mental Health Problems	

Any other relevant information you think we should know about:

Current relevant medication:

I refer this patient onto the Live Well Programme:

Name of GP: _____ Signature of GP: _____

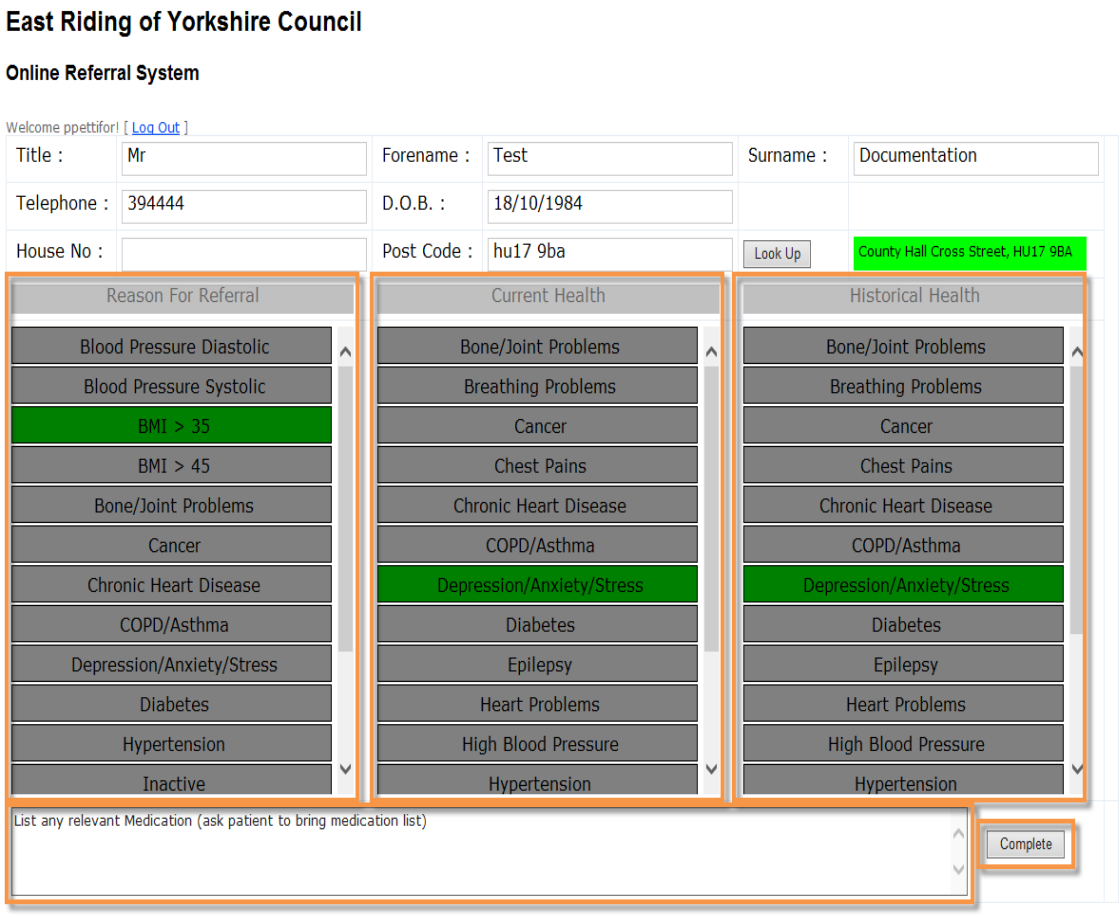
Participant Declaration:

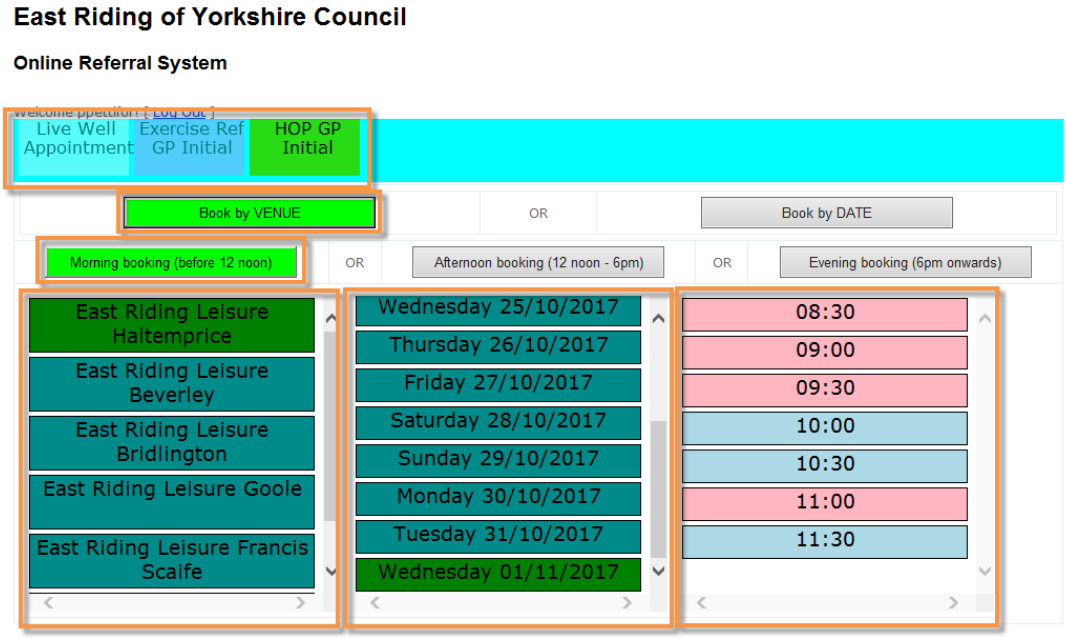
I have disclosed all relevant information and will advise my GP/Nurse/Health Professional/ Fitness Instructor of any future changes to my health. I am motivated and committed to attending this full 12 month programme of Live Well.

Signature of patient: _____

Once this form is complete, please fax to (01482) 395147 FAO 'Leisure Technicians' or send a copy of this form to Leisure Technicians, Beverley Leisure Complex, Flemingate, Beverley, HU17 0LT or contact **(01482) 395145.**

Appendix 2 Visual Representation of the online referral system: BEARS





Appendix 3 Ethics Documentation for research phase I

3.1. EC1A

Department of Sport, Health & Exercise Science

UNIVERSITY OF Hull

If this application is for EXTERNAL CONSULTANCY work go to application details on page.4

RISK CHECKLIST AND STAGE 1 - RESEARCH ETHICS APPROVAL FORM

All research carried out by students and staff in the Department of Sport, Health & Exercise Science must receive ethical approval before the project or study begins.

Forms

- All applicants MUST complete this Risk Checklist and Stage 1 - Research Ethics Approval Form.
- Applicants whose research studies are classified as Risk Category 2 or 3 must also complete the separate Stage 2 - Research Ethics Approval Form (EC1B).

Notes for completion

- *University Research Ethics Policy and Research Ethics Procedures*
  The University Research Ethics Policy and Research Ethics Procedures should be read prior to the completion of this application. Consideration of the application will be undertaken in accordance with the University's Research Ethics Policy and Procedures.
- *Professional, Statutory or Regulatory Bodies*
  Applicants should consider any additional requirements by any relevant Professional, Statutory or Regulatory body; and any other bodies (for example, learned societies such as BASES or BPS) which may be relevant to the subject area in question. Where the project comes under the jurisdiction of the National Research Ethics Service, a copy of the approval from an NHS Research Ethics Committee should be included in the submission.

Submission

Students: please email the typed form/s to your Research Supervisor / Director of Studies. Once returned please email the completed form/s to ethics-shes@hull.ac.uk where it will be forwarded to an appropriate Local Research Ethics Co-ordinator (LREC) for consideration. Please make sure the DISCIPLINE box is completed which will ensure that the appropriate LREC receives the application.

How to complete the form

You can navigate through the form by using the tab keys.

Signatures

Electronic/typed signatures are acceptable for emailed forms.

Outcome

Applicants will be advised of the outcome of the application by:

- The Research Supervisor or Director of Studies for Risk Category 1 student projects;
- The Local Research Ethics Co-ordinator or the Faculty Research Ethics Committee for Risk Category 2 and 3 projects.

You may only begin your research when you receive notification that the project has ethical approval.
If the circumstances of your research study change after approval it is your responsibility to revisit the Risk Checklist and complete a further application.

Advice

Complete the Risk Checklist and Stage 1 - Research Ethics Approval Form first. If you are uncertain about the answer to any question:

- Seek guidance from your Research Supervisor or Director of Studies (students only);
- Contact your Local Research Ethics Co-ordinator (staff only).

CONFIRMATION STATEMENTS	

The results of research should benefit society directly or by generally improving knowledge and understanding. Please tick this box to confirm that your research study has a potential benefit. *If you cannot identify a benefit you must discuss your project with your Research Supervisor to help identify one or adapt your proposal so the study will have an identifiable benefit.*	X
Please tick this box to confirm you have read the Research Ethics Procedures and will adhere to these in the conduct of this project.	X

RISK CHECKLIST - Please answer ALL the questions in each of the sections below

WILL YOUR RESEARCH STUDY……..?

	RISK CATEGORY 1	YES	NO
1	Involve direct and/or indirect contact with human participants?	X	
2	Involve analysis of pre-existing data which contains sensitive or personal information?		X
3	Require permission or consent to conduct?	X	
4	Require permission or consent to publish?		X
5	Have a risk of compromising confidentiality?	X	
6	Have a risk of compromising anonymity?	X	
7	Contain sensitive data?	X	
8	Involve risks to any party, including the researcher?	X	
9	Contain elements which you OR your supervisor are NOT trained to conduct?		X
10	Use any information OTHER than that which is freely available in the public domain?		X
	RISK CATEGORY 2		
11	Require permission or informed consent OTHER than that which is straightforward to obtain in order to conduct the research?		X
12	Require permission or informed consent OTHER than that which is straightforward to obtain in order to publish the research?		X
13	Require information to be collected and/or provided OTHER than that which is straightforward to obtain?		X
	RISK CATEGORY 3		
14	Involve participants who are particularly vulnerable or at risk? (e.g. young people, prisoners, sports disability groups)		X
15	Involve participants who are unable to give informed consent?		X
16	Involve data collection taking place BEFORE informed consent is given?		X
17	Involve any deliberate deception or covert data collection?		X
18	Involve a risk to the researcher or participants beyond that experienced in everyday life?		X
19	Cause (or could cause) physical or psychological harm or negative consequences?	X	
20	Use intrusive or invasive procedures?		X
21	Involve a clinical trial?		X
22	Include a financial incentive to participate in the research?		X
23	Involve the possibility of incidental findings related to health status?		X
24	Involve your own students or staff (this question is for STAFF MEMBERS ONLY)		

CLASSIFICATION - Please answer the following questions in order to classify the risk level of your study

C1 – Did you answer 'YES' to any of the questions (1 to 24) in the Risk Checklist above?

Yes		Please go to question C2
No		If you answered **NO** to all the above questions, your study is classified as **Risk Category 1** (literature reviews will be Risk Category 1)

C2 – Did you answer 'YES' to any of the questions in Rick Category 3 (14 to 24) of the Checklist above?

Yes		If you answered **YES** to any question in Risk Category 3, your study is classified as **Risk Category 3** (unlikely to be appropriate for undergraduate students – with the exception of working with young people)
No		If you answered **NO** to all the questions in Risk Category 3 (but you answered yes to questions in Risk Categories 1 and/or 2), your study is classified as **Risk Category 2**

APPROVAL PROCESS

Category	Student applicants	Staff applicants
Risk Category 1	If your study has been classified as Risk Category 1, your Supervisor or Director of Studies can give approval for the project. You must complete the remainder of this form and submit it to your Research Supervisor for consideration. A copy of the signed form must be given to ethics-shes@hull.ac.uk	If your study has been classified as Risk Category 1, you do not need ethical approval for the project. You must complete the remainder of this form so that your research project is registered with the University. Please submit this form to ethics-shes@hull.ac.uk
Risk Category 2	If your study has been classified as Risk Category 2, your Supervisor or Director of Studies can recommend approval for your study by the Local Research Ethics Coordinator. You must complete the remainder of this application form and also the separate Stage 2 - Research Ethics Approval form. Once you have completed the forms please submit both forms to your Supervisor for consideration. Your Supervisor may disagree with your assessment and ask you to make revisions or reject your application. The Local Research Ethics Coordinator will review your project and then decide to approve it, ask for revisions, reject it or pass it on for review via the Chair to the Faculty Research Ethics Committee.	If your study has been classified as Risk Category 2, your project will be considered for ethical approval by the Local Research Ethics Coordinator. You must complete the remainder of this application form and also the separate Stage 2 - Research Ethics Approval form. Please submit both forms to your Local Research Ethics Coordinator for consideration. The Local Research Ethics Coordinator will review your project and then decide to approve it, ask for revisions or pass it on for review via the Chair to the Faculty Research Ethics Committee.
Risk Category 3	Postgraduate Research Students If your study has been classified as Risk Category 3, you should consult with your Director of Studies as you will normally need to submit to the appropriate Faculty Research Ethics Committee for approval. You must complete the remainder of this application form and also the separate Stage 2 - Research Ethics Approval form and submit both forms to your Director of Studies. Undergraduate and Taught Postgraduate Students If your study has been classified as Risk Category 3, you should consult with your Supervisor without delay as it is highly unlikely you will be able to proceed with your study and you should negotiate a project that is of lower risk. The exception may be working with young people.	If your study has been classified as Risk Category 3, your project will be considered for ethical approval by an appropriate Local Research Ethics Coordinator. You must complete the remainder of this application form and also the separate Stage 2 - Research Ethics Approval form and submit both forms to your Local Research Ethics Coordinator. In some instances, Risk Category 3 projects will need to be considered by the appropriate Faculty Research Ethics Committee.

APPLICATION DETAILS

APPLICANT DETAILS:	
DISCIPLINE	(PLEASE INSERT DISCIPLINE AREA I.E. COACHING, REHAB, PHYS, PSYCH,BIOMECH OR **EXTERNAL CONSULTANCY/ENTERPRISE ACTIVITIES**) Psych
Your name (if a group project, include all names here)	Amy Wilkinson
Department	Sport, Health, & Exercise Science
Faculty	Science and Engineering
Status (tick as appropriate)	
• Undergraduate student	
• Taught Postgraduate student	
• Research Postgraduate student	X
• Staff member	
• Other (give details)	
If student project	
• Student ID	201202743
• Course title with award	PhD Sport, Health and Exercise Science
• Student email	A.M.Wilkinson@2016.hull.ac.uk
• Research Supervisor's name Or External consultancy co-ordinator	Dr Caroline Douglas
THE PROJECT/STUDY/EXTERNAL CONSULTANCY/ENTERPRISE:	
Project /study title/external consultancy/enterprise	A needs-based gap analysis of General Practitioner's (GP) perspectives on the referral process to ERYC health services.
Start date of project/external consultancy/enterprise	December 2016
Expected completion date of project/external consultancy/enterprise	June 2017
Is the project or external consultancy/enterprise funded	N/A
Project Summary - Please give a brief summary of your study or external consultancy/enterprise (maximum 100 words).	
East Riding of Yorkshire Council (ERYC) which serves a population of approximately 340,000 is estimated to hold 67.7% obese or overweight adults. The challenge of managing obesity typically falls upon primary health care providers (e.g., General Practitioners; GPs) to initially diagnose patients. Enormous constraints are placed on GP consultation time making it difficult to assess a patient's underlying condition/s, diagnose their current condition and explain and select the appropriate care pathway. The purpose of this study is to gain a richer insight into the perceptions of GPs currently referring patients onto ERYC health service programmes. The research will qualitatively explore the experiences and opinions of GPs regarding all aspects of patient referral to investigate, for example, what areas of the referral process would be benefit from streamlining, or how to better screen patients for appropriate health care pathways.	

NEXT STEP:

IFTHIS APPLICATION IS FOR **EXTERNAL CONSULTANCY** any data collected must **NOT** be used for research purposes including dissemination at academic conferences or in academic journals. Where staff wish to publish the results of consultancy/enterprise activities a full ethics submission is required. For external consultancy/enterprise activities only – the EC1A and EC3 risk assessment form must be completed and returned to ethics-shes@hull.ac.uk

IF YOUR PROJECT HAS BEEN CLASSIFIED AS **RISK CATEGORY 1,** PLEASE COMPLETE THE DECLARATION BELOW AND:
Students: please submit this form to your Research Supervisor or Director of Studies in the first instance for signature.

- A copy must then be submitted to ethics-shes@hull.ac.uk for information.
- Staff: please submit this form to ethics-shes@hull.ac.uk

IF YOUR PROJECT HAS BEEN CLASSIFIED AS **RISK CATEGORY 2 OR 3** PLEASE DO NOT COMPLETE THE DECLARATION BELOW. Instead you MUST now also complete the Stage 2 - Research Ethics Approval form and submit both forms together with any supporting documentation.

RISK CATEGORY 1: DECLARATION AND SIGNATURE/S

I confirm that I will undertake this project as detailed above. I understand that I must abide by the terms of this approval and that I may not make any substantial amendments to the project without further approval.			
Signed	Amy Wilkinson	*Date*	*31/10/2016*

FOR STUDENT PROJECTS:					
Agreement from the Research Supervisor or Director of Studies for student projects: *I have discussed the ethical issues arising from the project with the student. I approve this project.*					
Name	Dr Caroline Douglas	*Signed*	C. Douglas	*Date*	28/11/16

Local Research Ethics Co-ordinator (LREC) name		*Date form sent to LREC*	

PLEASE MAKE SURE THAT BOTH STUDENT AND SUPERVISOR SIGN THE APPLICATION AND THEN FORWARD ALL SUPPORTING DOCUMENTATION TO THE DEPARTMENTAL ADMINISTRATOR FOR PROCESSING.

Email: ethics-shes@hull.ac.uk

This form will be retained for the purposes of quality assurance of compliance and audit for FIVE years

3.2. EC1B

Department of Sport, Health & Exercise Science

STAGE 2 - RESEARCH ETHICS APPROVAL FORM

All research carried out by students and staff in the Department of Sport, Health & Exercise Science must receive ethical approval before the research or data collection commences.

Forms

- All applicants MUST complete the Risk Checklist and Stage 1 - Research Ethics Approval Form prior to completing this Stage 2 - Research Ethics Approval Form.
- Following completion of the Risk Checklist and Stage 1 - Research Ethics Approval Form, if your research study was classified as Risk Category 2 or 3, you need to complete this form.

Please ensure you include specific details in the appropriate section below especially where a question in the Risk Checklist was answered YES. If a section is not relevant to your project, put 'Not Applicable' or 'N/A'. Please make sure the DISCIPLINE box is completed which will ensure that the appropriate LREC receives the application.

TO BE COMPLETED FOR PROJECTS IN RISK CATEGORY 2 AND 3		
DISCIPLINE	Psych	(PLEASE INSERT DISCIPLINE AREA I.E. COACHING, REHAB, PHYS, PSYCH,BIOMECH)
Your name	Amy Wilkinson	

THE PROJECT	
1	**Project title**
A needs-based gap analysis of General Practitioner's (GP) perspectives on the referral process to ERYC health services.	
2	**Purpose and Aims**
What are the purpose and aims of this research?	
The purpose of this study is to gain a richer insight into the perceptions of GPs currently referring patients onto East Riding of Yorkshire Council (ERYC) health service programmes. The research will qualitatively explore the experiences and opinions of GPs regarding all aspects of patient referral to investigate, for example, what areas of the referral process would be benefit from streamlining, or how to better screen patients for appropriate health care pathways. It is hoped that findings will inform the design and delivery of a more efficient screening system to better enable GPs to categorise patient readiness for change and refer them onto the appropriate ERYC health service.	

3	**Project Description**
Describe the project, identifying clearly any human participants and/or secondary datasets involved (this should be a summary description. Details of methodology are required later). What is the intended project duration?	
One-to-one qualitative interviews will be utilised to conduct an in-depth examination of the GP perspective. Interviews will be semi-structured in design to allow flexibility of discussion within the frame of a set list of themes/topics to explore. An iterative approach will be adopted whereby interview transcripts will be read and checked for accuracy, and new topics emerging can be incorporated into future interviews. The proposed interview guide will be piloted prior to the study, critiqued, and refined accordingly. The interviews are anticipated to last between 30-60 minutes and will be conducted at a comfortable location and time convenient to the GP. The interview will be recorded electronically on a digital voice recording device. Recorded data will be transcribed verbatim and coded. Inductive analysis will be explore to consider emergent patterns in the GP experience of the referral process. The intended project duration is 6 months.	

4	**Risk: participants**
Provide a statement of risk consideration and evaluation in respect of the participants including how any elements of risk will be addressed.	
Overall risk is low. However, minor risks include: participant distress- coercion- anonymity and data handling. A full list of specific control measures is provided in EC3 risk assessment form attached.	

5	**Risk: researchers / other parties**
Provide a statement of risk consideration and evaluation in respect of the researchers and any other parties (eg, the University), including how any elements of risk will be addressed.	
Overall risk is low. However minor risks include: field work. A full list of specific control measured is provided in EC3.	

6	**Health and Safety**
6a	In addition to any factors considered under 'risk' above, are there any other health and safety issues either for participants or researchers? (eg, in relation to premises, equipment, etc)
Research carried out in external institutions could lead to the student investigator being vulnerable in terms of health and safety (e.g. fire procedures, first aid response). However, before the interview commencees, the interviewee will conduct a thorough check of all risk and hazzards that could jeopardise the healthg and safety of all parties involved.	
6b	Has advice been taken on how these might be addressed, from whom, and when?
Issues regarding the health and safety of individuals involved has been discussed with Dr. Caroline Douglas and Dr Sam Nabb during supervisory meetings.	

METHODOLOGY	
7	**Human Participants**
7a	Describe the size and nature of group and the rationale for selection. Describe how potential participants will be identified, approached and recruited. Please include inclusion/exclusion criteria.
Approximately 10-15 individuals will be interviewed during the data collection process. Purposeful sampling will initially be utilised to access to GPs in the East Riding of Yorkshire with at least two years experience of referring patients to East Riding of Yorkshire Council (ERYC) health services. A snowball sampling approach will be adopted following completion of initial interviews whereby participants may be asked to recommend colleagues or peers who might also be interested in sharing their perpective. All potential participants will be initially be approached by email or telephone about the nature of the study to outline the anticipated benefits for both the GPs and patients, and what will required if they decide to participate. Interested GPs will then be provided with a formal EC2 letter of invitation and required to complete and sign the informed consent documentation before any interviews can take place. This will allow the participants the freedom to decide whether they want to be involved in the study. For inclusion in the study participants must be practising GPs, or primary health care provideder (practice nurse / health care nurse) within the East Riding of Yorkshire who actively refer patients onto ERYC health service programmes.	
7b	What information is being given to participants? The proposed Information Sheet must be included.
An EC2 informed consent form will be provided which the participants will fill out before the data collection process. This form will identify potential benefits and risks of the study, subsequently allowing the participants to know what is going to happen and why this is so. This also coincides with the data protection act of 1998 which states that these steps must be taken for the study to be ethically sound. See informed consent form attached.	
7c	How is consent being obtained? The proposed consent form must be included.
An informed consent form will be provided to all participants and signed before the interview can be conducted	
7d	What steps are being taken to ensure that participation is voluntary?

General Practitioners will be made aware that participation is entirely voluntary. It will be further stressed that taking part in this project and/or withdrawal from it at anytime without giving reason will not be detrimental to their position as a GP, nor will it further their position with Public Health. See EC3 risk assessment.	
7e	What provisions for participants' withdrawal from the project are in place?
Data collection will be collected and coded in accordence to confidentiality. Also, the participant will be made aware that any data they have provided will be destroyed promptly both electronically and in paper form if they wish to withdraw from the study at any time.	
7f	Is it intended to pay participants? If yes, include the rationale for this, with payment rates and source of funding.
N/A	
7g	Children and Adults at risk: How is informed consent being obtained? The proposed Consent (and Assent Form where appropriate) must be included. If it is anticipated that consent is not in written form, full justification for this approach must be included.
N/A	

8	**Confidentiality and Anonymity**
8a	How will anonymity of participants be secured?
All information gathered will be stored confidentially. Participtant data will be allocated psyeudonyms and will be presented in an anonymous coding system that will not divulge any names or identities that are involved in the study.	
8b	How will confidentiality of personal information and/or information provided by participants be secured?
Participant consent forms and any other personal forms will be secured seperately from the results data to avoid any unearthing of identities. All paper data will be filed and locked away in a filing cabinet which can only be accessed be the postgraduate researcher or research supervisor. All electronic forms of data will be stored within an electronic device that will require a specific access code, which only the researcher will know. All data that will be gathered and shared will be followed in accordance to the data protection act of 1998, and will be destroyed five years after the data has been collected. During this five years no other party of resource will have access to this data which could reveal any identities.	
8c	Are there circumstances in which the requirements of professional practice might impact on confidentiality and anonymity provisions?
N/A	
8d	Are there any issues relating to information provided by public bodies, corporations, contractors etc?
N/A	
8e	If the identity of a person, company, etc, is likely to be disclosed or inferred or discoverable, how will this be discussed with the potential participant(s), and what impact might the outcomes of this have on the proposed project?
N/A	
8f	How will any participants or subjects be clearly informed about any limits to confidentiality, their rationale and the possible outcomes?
Participant's consent forms and personal details will be stored separately from their data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic information will be stored on a password-protected computer and password-protected USB memory stick. All information and data gathered during this research will be stored in line with the 1988 Data Protection Act and will be destroyed 5 years following the conclusion of the study. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will participant's personal information or data be revealed.	

9	**Project Design**
9a	Has statistical or methodological advice been sought on the size and/or design of the project? If so, from whom?

Yes - the project has been discussed with PhD supervisors- Dr Caroline Douglas and Dr Sam Nabb.	
9b	If a questionnaire is to be used, it is recognised that this may be subject to change during the life of the project. The remit of the questionnaire and an advanced draft of this must be included, with, where possible, an outline indication of the expected development of the enquiry.
N/A	
9c	If interviews (structured or semi-structured) are to be used, it is recognised that these may be subject to change during the life of the project. The remit of the interviews and an advanced draft of their format must be included, with, where possible, an outline indication of the expected development of the enquiry.
A copy of the semi-structured interview guide/schedules are attached. All documents identify the key research themes.	
9d	If procedure(s) are to be carried out on the participants, what are these?
A qualitative design using an iterative approach will be employed, whereby interview transcriptions will be read and checked for accuracy and new topics emerging can be incorporated into future interviews. Prior to the study, participants will be given an information sheet that explains the protocol of the interview. Participants will also be given a consent form to sign prior to taking part. Participants will be given the opportunity to ask any questions or raise any concerns they may have. Participants will be interviewed individually at a location and time convenient to them. Prior to interview participants will be asked to present the sign their consent form if they have not already done so. Participants will be made aware that they can cease participation at any time during the interview without explanation. Participants will have the opportunity to ask any questions or raise concerns they may have prior to interview. The student investigator will then undertake the interview following the questions on the attached interview schedule. The interview will be recorded electronically on a digital voice recording device. Upon completion, participants will be given the opportunity to express any views or raise any relevant points that they may feel they were either not able to do so during the interview, or were not covered within the scope of the interview questions. Participants will then be debriefed on the nature of the study and informed that all data from the interview will remain strictly confidential and anonymity will be ensured if the data is used in any published sources. Recorded data will be transcribed verbatim and a copy of the transcript provided to each participant within 6-8 weeks of the interview.	
9e	Is the researcher and/or Research Supervisor qualified to carry out these procedures?
Yes.	

10	**Covert Research**: if the project involves covert research, give details here
Explain the rationale for the use of this approach and explain why it is necessary to use this particular methodology successfully to undertake the research and achieve its purpose and aims.	
N/A	

11	**Secondary datasets**: if the project involves secondary data, give details here
11a	Describe the size and nature of the group and the rationale for selection. Who holds the documents and data?
N/A	
11b	Are there any limits or restrictions placed on access to and/or use of these documents or data?
N/A	
11c	Statement of permission for use from all document/data holders, including any restrictions, **must** be included here.
N/A	

12	**Dissemination of Results**
12a	What is the planned method of dissemination? (eg, undergraduate dissertation, doctoral thesis, research report, intended publication in…)

Data gathered will form part of a Doctoral Thesis. Data may be published in a scientific journal or be presented at a conference. However, data will be generalised and personal information and data will not be identifiable.	
12b	Will any restrictions be placed on the dissemination/publication of results?
N/A	

13	**Data Security and Disposal**
13a	Is the researcher aware of the requirements of the Data Protection Act? (eg: has the processing of the data been considered; have the operations necessary been identified; and has the issue of the sensitivity of the data been considered in relation both to data protection and general lawfulness?)
As outlined in sections 8A and B, the student investigator is aware of the concept and importance of the information that falls under the umbrella of the data protection act 1998. For instance, the confidentiality concerns have been adressed accordingly.	
13b	What provisions have been considered for the secure retention of sensitive or personal data?
As outlined in sections 8A and B, all paper evidence will be secured within a safe filing cabinet, which only the researcher will have access to.	
13c	What provisions are in place for the secure destruction of this data, and when is it anticipated that this should take place?
As outlined in sections 8A and B, all data recordings and findings will be destroyed after five years of the study end.	
13d	Where results are collected individually, but the outcomes are anonymised, what data protection procedures are in place to ensure the protection of personal details and at what point and how will these be destroyed?
Paper copies of data collected will shredded and destroye. Also, all electronic interview data will be permanently deleted.	

14	**Intellectual Property**
14a	Is the researcher aware of the wide variety of reproduction methods which are restricted in respect of protected data; and the possible implications of any copyright infringements?
N/A	
14b	Have any relevant permissions in respect of this been obtained (eg, the use of unpublished material)?
N/A	
14c	If online material is being used, are there any international laws which impact on this?
N/A	
14d	Is there knowledge of how to use licences and assignment of rights when creating or using material protected as intellectual property?
N/A	

15	**Independence**
15a	Is the project externally funded? If so by whom? Does this entail any actual or potential conflict of interest?
Yes. The project is funded by Public Health England. There are no actual or potential conflicts of interest.	
15b	Has the funding body placed any restrictions on the conduct or publication of the research?
No	
15c	Is it intended that application will be made to an external funding body subsequent to receipt of faculty approval? If so, to whom? Is it fully understood that if any subsequent application is made to an external funding body, and that body seeks to impose any restrictions or conditions on the project, that this must be reported to the faculty and approval granted for these restrictions or conditions?
No	

16	**Overseas Research**: if the project is based overseas (outside of the UK), give details here
16a	In which country or countries is it proposed that the investigation take place?
N/A	
16b	Is the proposal in accordance with the laws of the country or countries in which it is proposed that the investigation take place, and how has this been ascertained?
N/A	
16c	Does the proposal comply with local laws on Data Protection and Intellectual Property? If yes, how has this been ascertained?
N/A	

17	**Collaborative projects**: if the project is a collaboration, give details here
17a	With which institutions is the project being conducted and who is the project director?
N/A	
17b	Has ethical approval been given by all other institutions involved? (Confirmatory documentation **must** be included). If ethical approval is in process, when is this expected to be completed?
N/A	
17c	What processes have been put in place, or will be put in place, to ensure ethical compliance across all elements of the project?
N/A	

FOR PROJECTS INVOLVING RISK CATEGORY 2 AND 3: DECLARATION AND SIGNATURE/S

STUDENT/RESEARCHER/APPLICANT

I confirm that I will undertake this project as detailed in stage one and stage two of the application. I understand that I must abide by the terms of this approval and that I may not make any amendments to the project without further approval. I understand that research with human participants must not commence without ethical approval.

Signed	Amy Wilkinson	*Date*	31/10/2016

RESEARCH SUPERVISOR/DIRECTOR OF STUDIES RECOMMENDATION FOR STUDENT PROJECTS

I confirm that I have read stage one and stage two of the application. The project is viable and the student has appropriate skills to undertake the project. The Participant Information Sheet and recruitment procedures for obtaining informed consent are appropriate and the ethical issues arising from the project have been addressed in the application. I understand that research with human participants must not commence without ethical approval. I recommend this project for approval.

The student has completed a risk assessment form:				Yes ☒ N/A ☐	
The student has read an appropriate professional or learned society code of ethical practice:				Yes ☐ N/A ☒	
Where applicable, give the name of the professional or learned society:					
Name	*Dr Caroline Douglas*	*Signed*	*C. Douglas*	*Date*	*28/11/16*

For projects approved by the Research Ethics Co-ordinator

LOCAL RESEARCH ETHICS CO-ORDINATOR APPROVAL

I confirm ethical approval for this project

Name		*Signed*		*Date*	

For projects that require Faculty level approval **LOCAL RESEARCH ETHICS CO-ORDINATOR'S RECOMMENDATION FOR FACULTY APPROVAL**					
I recommend this project for consideration at faculty level. It cannot be approved at local level due to the following reason(s)					
Name		*Signed*		*Date*	

PROJECTS APPROVED BY THE FACULTY RESEARCH ETHICS COMMITTEE					
I confirm that this project was considered by the Faculty Research Ethics Committee and has received ethical approval					
Chair		*Signed*		*Date*	

This form will be retained for the purposes of quality assurance of compliance and audit for FIVE years

INFORMATION TO SUBMIT WITH THE APPLICATION

INFORMATION SHEET AND CONSENT FORM: You must submit the information sheet/s for participants and assent/consent form/s (where appropriate) with the application. You must submit every communication letter and measurement tool e.g. questionnaire that a participant will see or receive. Failure to do so will result in delays to the application.

SUBMISSION CHECKLIST	**Tick box (where relevant)**
EC1A RISK CHECKLIST AND STAGE 1 – RESEARCH ETHICS APPROVAL FORM	☒
EC1B STAGE 2/3 – RESEARCH ETHICS APPROVAL FORM	☒
Research proposal/protocol (no more than 3 pages of A4)	☐
Participant Information Sheet/s	☒
EC2 Informed Consent Form/s	☒
EC2-U18 Assent Form (for children)	☐
Recruitment documents (eg, posters, flyers, email invitations, advertisements)	☐
Measures to be used (eg, questionnaires, surveys, interview schedules, psychological tests)	☒
Letters/communications to and from gatekeepers	☐
Evidence of any other approvals or permissions (eg, NHS research ethics approval)	☐
EC3 Risk assessment form	☒
For projects involving ionising radiation, approval documentation	☐
Confirmation of insurance cover (required for certain projects – check if in doubt)	☐
Other: give details here: Evidence of (enhanced) CRB certificate (if appropriate)	☐
EC4 Pre-exercise medical history questionnaire	☐
Letters/communications with head teachers	☐

EC5 Participant Debrief form	☒

SUBMISSION DETAILS

Students: please email the completed forms (stage one and stage two) and other relevant documentation (see Submission Checklist above) to your Research Supervisor / Director of Studies.

- **PLEASE MAKE SURE THAT BOTH STUDENT AND SUPERVISOR SIGN THE EC1A FORM IF YOU ARE CONDUCTING A LOW RISK PROJECT.**
- **IF YOU ARE CONDUCTING A HIGHER RISK PROJECT WHICH REQUIRES COMPLETION OF THE EC1B – PLEASE MAKE SURE THAT THIS FORM IS SIGNED BY BOTH STUDENT AND SUPERVISOR.**
- **PLEASE FORWARD ALL SUPPORTING DOCUMENTATION IN A ZIPPED FILE TO THE EMAIL DROP-BOX BELOW FOR PROCESSING:**

Email: ethics-shes@hull.ac.uk

3.3. EC2 : Participant Letter of Invitation, Information Sheet, and Informed Consent Form

Department of Sport, Health & Exercise Science

UNIVERSITY OF Hull

Participant Letter of Invitation

Project title	A needs-based gap analysis of General Practitioner's (GP) perspectives on the referral process to ERYC health services.
Principal investigator	Name: Dr Caroline Douglas Email address: c.douglas@hull.ac.uk Contact telephone number: 01482 463345
Student investigator (if applicable)	Name: Amy Wilkinson Email address: A.M.Wilkinson@2016.hull.ac.uk Contact telephone number: 07845756130

31/11/2016

Dear Sir or Madam

This is a letter of invitation to enquire if you would like to take part in a research project at the University of Hull

Before you decide if you would like to take part it is important for you to understand why the project is being done and what it will involve. Please take time to carefully read the Participant Information Sheet on the following pages and discuss it with others if you wish. Ask me if there is anything that is not clear, or if you would like more information.

If you would like to take part please complete and return the Informed Consent Declaration form.

Please do not hesitate to contact me if you have any questions.

Yours faithfully,

Amy Wilkinson

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Department of Sport, Health & Exercise Science

Participant Information Sheet

Project title	A qualitative investigation into General Practitioner's (GP) perspectives of the referral process to ERYC health services.
Principal investigator	Name: Dr Caroline Douglas Email address: c.douglas@hull.ac.uk Contact telephone number: 01482 463345
Student investigator (if applicable)	Name: Amy Wilkinson Email address: A.M.Wilkinson@2016.hull.ac.uk Contact telephone number: 07845756130

What is the purpose of this project?

The purpose of this study is to gain a richer insight into the perceptions of GPs currently referring patients onto East Riding of Yorkshire Council (ERYC) health services. The research will qualitatively explore the experiences and opinions of GPs regarding all aspects of patient referral to investigate, for example, what areas of the referral process would be benefit from streamlining, or how to better screen patients for appropriate health care pathways.

Why have I been chosen?

You have been invited to participate in this study as you are GP, or have a significant role in referring patients onto ERYC health care pathways. Your experience and expertise will be invaluable in highlighting the strengths and weaknesses of the current referral process. It is hoped that findings will inform the design and delivery of a more efficient screening system to better enable GPs to categorise patient readiness for change and refer them onto the appropriate ERYC health service.

What happens if I volunteer to take part in this project?

First, it is up to you to decide whether or not to take part. Should you decide to take part, you will be given this Participant Information Sheet to keep and asked to complete the Informed Consent Declaration at the back. You should give the Informed Consent Declaration to the investigator at the earliest opportunity possible. You will also have the opportunity to ask any questions you may have about the project. If you decide to take part you are still free to withdraw at any time and

without needing to give a reason. Taking part in this project and/or withdrawal from it any time will not be detrimental to your position as a GP, nor will it further your position as a GP.

What will I have to do?

You will be contacted to arrange a convenient location and time for you to meet with the postgraduate investigator. On arrival, the postgraduate investigator will brief you on the procedure and will give you the opportunity to ask any questions or express any concerns that you might have. You will then be asked to read and sign a consent form. Following this, you will be interviewed individually which will be recorded electronically on a digital voice recording device. Once the interview is over, you will have the opportunity to express any views or raise any relevant points that you may feel you were either not able to do so during the interview, or were not covered within the scope of the interview questions. The interview process should last no longer than 45 minutes.

Will I receive any financial reward or travel expenses for taking part?

No

Are there any other benefits of taking part?

You will help contribute to a better understanding of the challenges faced by primary health care providers in assessing and referring patients who may benefit from the variety of ERYC health programmes.

Will participation involve any physical discomfort or harm?

No

Will I have to provide any bodily samples (e.g. blood or saliva)?

No

Will participation involve any embarrassment or other psychological stress?

With the interview focusing on your feelings and opinions of the health services and referral to such services, this could provoke an emotional response during the interview. Although this cannot always be prevented, you can be assured that the interview will be confidential and anonymous at all times. Moreover, you are free to withdraw from study at any time without having to give a reason for doing so, if, as it states, the interview becomes too demanding.

What will happen once I have completed all that is asked of me?

You will be made aware that the interview has concluded and asked if there is anything you wish to add or clarify. You will be reminded that you will be provided with a transcript of the interview within 4-6 weeks of the session so you a can confirm the recorded material is an accurate representation of the dialogue that occurred.

How will my taking part in this project be kept confidential?

You will be allocated an anonymous participant code that will always be used to identify any data that you provide. Your name or other personal details will not be associated with your data. Your consent form and personal details will be stored separately from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic information will be stored on a password-protected computer and password-protected USB memory stick. All information and data gathered during this research will be stored in line with the 1988 Data Protection Act and will be destroyed 5 years following the conclusion of the study. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed.

How will my data be used?

Any information and data gathered during this project will only be available to the research team. Results from this study will be written up as part of a Doctoral Thesis. If you would like a copy of the thesis we can arrange for you to receive it as soon as it becomes possible. Should the thesis be presented or published in any form, you will not be identifiable.

Who has reviewed this study?

This project has undergone full ethical scrutiny and all procedures have been risk assessed and approved by the Sport, Health and Exercise Science Ethics Committee at the University of Hull.

What if I am unhappy during my participation in the project?

You are free to withdraw from the project at any time. During the study itself, if you decide that you do not wish to take any further part then please inform the person named in Section 18 and they will facilitate your withdrawal. You do not have to give a reason for your withdrawal. Any personal information or data that you have provided (both paper and electronic) will be destroyed or deleted as soon as possible after your withdrawal. After you have completed the research you can still withdraw your personal information and data by contacting the person named in Section 18. If you are concerned that regulations are being infringed, or that your interests are otherwise being ignored, neglected or denied, you should inform Dr Andrew Garrett, Chair of the Department of Sport, Health and Exercise Research Ethics Committee, who will investigate your complaint (Tel: 01482 463866; Email: a.garrett@hull.ac.uk

How do I take part?

Contact the investigator using the contact details given below. She will answer any queries and explain how you can get involved.

Name: Amy Wilkinson Email: A.M.Wilkinson@2016.hull.ac.uk Phone: 07845756130

Informed Consent Declaration

Project title	A needs-based gap analysis of General Practitioner's (GP) perspectives on the referral process to ERYC health services.
Principal investigator	Name: Dr Caroline Douglas Email address: c.douglas@hull.ac.uk Contact telephone number: 01482 463345
Student investigator (if applicable)	Name: Amy Wilkinson Email address: A.M.Wilkinson@2016.hull.ac.uk Contact telephone number: 07845756130

Please Initial

☐ I confirm that I have read and understood all the information provided in the Informed Consent Form (EC2) relating to the above project and I have had the opportunity to ask questions.

☐ I understand this project is designed to further scientific knowledge and that all procedures have been risk assessed and approved by the Department of Sport, Health and Exercise Science Research Ethics Committee at the University of Hull. Any questions I have about my participation in this project have been answered to my satisfaction.

☐ I fully understand my participation is voluntary and that I am free to withdraw from this project at any time and at any stage, without giving any reason. I have read and fully understand this consent form.

.....	.....	.....
Name of participant	Date	Signature
.....	.....	.....
Person taking consent	Date	Signature

Click here to enter text.

3.4. EC3 : Risk Assessment Form

Department of Sport, Health & Exercise Science

University of Hull

Risk Assessment Form

When used as part of a research ethics application it is the principal investigator's responsibility to ensure that this form has been completed properly. This includes ensuring that the level of risk has been appropriately assigned, that the associated hazards are acceptable, and that all appropriate control measures have been put in place before, during, and after the testing procedure in order to ***minimise each specific risk*** associated with the testing procedure. Where the risk assessment is being completed as part of an undergraduate or postgraduate project, it is the student's responsibility to complete the form, and the supervisor's responsibility to evaluate the form and request revisions where appropriate.

1. Procedure covered	One-to-one Interviews	
2. Location covered	The interviews will be held at a location convenient for each participant.	
3. Those at risk	Interviewee and Interviewer	
4. Assessor (principal investigator)	Dr Caroline Douglas	
5. Date of assessment	25/11/16	
6. Review dates (for office use only)	Click here to enter a date. Click here to enter text.	Click here to enter a date. Click here to enter text.
	Click here to enter a date. Click here to enter text.	Click here to enter a date. Click here to enter text.

7. Hazards	**8. Specific control measures**	**9. Risk (S x L)**
The participants may become rude/aggressive/abusive	**Explain Hazard:** The participants may take offence to some of the questions, possibly resulting in them becoming rude/aggressive/abusive	1x2

	Control measure: Participants will be reminded that responses will remain between themselves and the investigator and so have no reason to feel unstable. The interview will be terminated immediately if this proves unsuccessful.	
The participant may become frustrated at the length of the interview.	**Explain Hazard:** Because the interview may be a fairly time consuming process, the participant may become agitated and may not want to carry on the interview. **Control measure:** The participant will be briefed prior to the interview as to the amount of time that will be used to conduct the study. An option for a break during the interview may be necessary.	1x2
Offence due to insufficient immediate feedback.	**Explain Hazard:** The participant may become offended by the lack of immediate results of data. **Control measure:** The participants will be reminded that they will receive typed interview transcripts within 4-6 weeks of the meeting.	1x1
Minor embarrassment for the participant.	**Explain Hazard:** An interview question may uncover experiences that may embarrass the participant. **Control measure:** The investigator will handle any sensitive situations with caution and care, and will also acknowledge any emotions that may cause any sort of pain.	1x2
Coercion	**Explain Hazard:** The participants may feel pressured or expected to take part in the study. **Control measure:** It is the participant's choice as to whether they do or do not want to take part within the study. During the consent process, participants will be advised and reminded that they can withdraw from the study at any time without any particular reason. It will also be stressed to participants both orally and within the EC2 documents that participant in this study and/or withdrawal at anytime will not be detrimental to their position as a GP, nor will it further their position with Public Health.	1x2
Field Work	**Explain Hazard:** Interviews will be conducted at a location convenient for each GP.	1x1

	Control measure: Data will only be collected in an environment that is deemed safe and secure.	
Anonymity and Confidentiality	**Explain Hazard:** The participants involved may worry that their identity may be revealed, thus putting their data under jeopardy. **Control measure:** Collected research will conform and comply with legislation regarding the data protection act of 1988. Identifiable information will not be published or made available to anybody not involved in the research. Access toward the data will be limited toward the research team only. All research that refers to one's identity will be presented in a coding manner; written data will be stored and filed within a secure filing cabinet, whilst electronic data will be saved within a device that will require my access code only. The material will be kept safely stored for five years before it has been destroyed appropriately.	1x2
Informed Consent	**Explain Hazard:** Provision of procedural information. **Control measure:** each participant will be provided with a participant information sheet to decide whether they would or would not like to take part within the research study. Participants will be informed about the aims, interview method, anticipated benefits, and potential hazards of the research. There will be an opportunity to raise any issues or concerns regarding the study.	1x1
Travel Procedure	**Explain Hazard:** The student investigator may have potential issues getting to the premises (GP's office) **Control measure:** The student investigator will drive with due care and attention when driving to the location of the study.	1x2

10. Are controls adequate?	Yes ■
11. Additional controls or remedial action required	Click here to enter text.

12. General control measures	Undergraduate students testing in the department's laboratories will be supervised by a staff member at all times. A first aider will be present at all times. In case of emergency contact Extension 5555. **General Control Measures** 1. Pre-exercise medical questionnaire. Testing may only be permitted following satisfactory completion of the pre-exercise medical questionnaire whereby no contraindications to exercise or any aspect of the full testing procedure have been highlighted. 2. Informed consent form. Testing may only be permitted following the subject's informed consent concerning all aspects of the testing procedure. 3. Strict adherence to test protocol. 4. Close monitoring of subject by a test administrator. 5. Feedback and communication is maintained between the subject and the experimenter throughout the test. 6. Termination of test if discomfort to subject is deemed excessive.
13. Emergency procedures	1. Emergency first aid available on site within the department. All test administrators will have full knowledge of what action to take in an emergency, as outlined in the departmental Health and Safety Policy. 2. Cleaning agents and equipment will be readily available to clean up any sweat, saliva, blood or vomit. 3. In case of emergency contact Extension 5555. 4. If any severe feeling of discomfort is signalled by the subject or seen by the administrator, then testing will be terminated and further action taken if required.
14. Monitoring procedures	1. All equipment checked regularly prior to use for correct and safe functioning. 2. Continued monitoring of procedures and equipment in case modifications can further reduce risk. 3. Continuous monitoring of the participant during and immediately after the test procedure will occur.
	Date to be completed / **On-going**

15. Declaration of the principal investigator and independent reviewer

I am the principle investigator and have read this risk assessment and consider that the level of risk has been appropriately assigned, that the associated hazards are acceptable and that all appropriate control measures have been put in place before, during, and after the testing procedure in order to minimise each specific risk associated with the testing procedure.

This form is periodically updated so please download the latest version from ebridge before completing

Dr Caroline Douglas	25/11/16	C. Douglas
Name of principal investigator	**Date**	**Signature**

I am an independent reviewer who sits on the Department of Sport, Health and Exercise Ethics Committee. I have independently reviewed this risk assessment and consider that the level of risk has been appropriately assigned, that the associated hazards are acceptable and that all appropriate control measures have been put in place before, during, and after the testing procedure in order to minimise each specific risk associated with the testing procedure.

.....	.....	.....
Name of independent reviewer	**Date**	**Signature**

3.5. EC5 : Participant Debrief Form

Department of Sport, Health & Exercise Science — University of Hull

This form is periodically updated so please download the latest version from eBridge before completing

Participant Debrief Form

1. Project title	A needs-based gap analysis of General Practitioner's (GP) perspectives on the referral process to ERYC health services.
2. Principal investigator	**Name**: Dr Caroline Douglas **Email address**: c.douglas@hull.ac.uk **Contact telephone number**: 01482 463345
3. Student investigator (if applicable)	**Name**: Amy Wilkinson **Email address**: A.M.Wilkinson@2016.hull.ac.uk **Contact telephone number**: 07845756130

4. What was the purpose of the project?

The purpose and aim of this study was to gain a richer insight into the perceptions of GPs currently referring patients onto East Riding of Yorkshire Council (ERYC) health services. Your insight will be invaluable in assisting the design and delivery of systems to appropriately screen and direct patients onto ERYC health services.

5. How will I find out about the results?

4-6 weeks after this interview you will be sent a transcript of the conversation so you can confirm the recorded material is an accurate representation of the dialogue that occurred.

6. Will I receive any individual feedback?

No individual feedback will be available, nor will your transcript be available to any other participant. However the overall findings of the study will be available to any interested participants once the research has been completed. You will not be identifiable in any published material.

7. What will happen to the information I have provided?

Your consent forms and personal details will be stored separately from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic information will be stored on a password-protected computer and password-protected USB

memory stick. All information and data gathered during this research will be stored in line with the 1988 Data Protection Act and will be destroyed 5 years following the conclusion of the study. During that time the data may be used by members of the research team (student investigator, Academic supervisors) only for purposes appropriate to the research question, but at no point will your personal information or data be revealed.

8. How will the results be disseminated?

Your data will make up part of a Doctoral Thesis. Your data may be published in a scientific journal or be presented at a conference. However, the data will be generalised and your own personal information and comments will not be identifiable.

9. Have I been deceived in any way during the project?

No.

10. If I change my mind and wish to withdraw the information I have provided, how do I do this?

You are able to withdraw information you have provided at any time. You can do this by sending a letter or email to the principal investigator stating that you would like to withdraw your personal information and data from the study. You do not need to give a reason.

11. What if I am unhappy about my participation in the project?

If you have any concerns or worries concerning the way in which this research has been conducted, or if you have requested, but did not receive feedback from the investigator regarding your results within the time specified in the Participant Debrief Form, then please contact Dr Andrew Garrett, Chair of the Department of Sport, Health and Exercise Ethics Committee, who will investigate your complaint (Tel: 01482 463141; Email: a.garrett@hull.ac.uk).

3.6. EC6 : Ethics Independent Reviewer's Report

V1 Independent Reviewer's Report EC6

This form is periodically updated so please download the latest version from ebridge before completing

Department of Sport, Health & Exercise Science — University of Hull

Ethics Independent Reviewer's Report

This form should be completed by a member of the Department of Sport, Health and Exercise Science Ethics Committee who has been assigned to review a particular ethics application by the chair of the committee. The front section of the Independent's Reviewer's Report should be printed, signed and dated, and attached to the back of the reviewed ethics application. The reviewed ethics application should be given to the Ethics Committee chair once all reviews have been completed. The checklist provided at this end of this form is to help the reviewer complete the review and guide the content of his or her written report, which should be typed into the relevant boxes that are given before the checklist. Any checkbox highlighted red that has been checked requires attention.

Please note that the checklist is for guidance only and reviewers should be aware of other ethical considerations relevant to the ethics application being reviewed.

An electronic copy of the completed report should be stored on the reviewer's computer.

Independent reviewer's name	Dr Ed Cope
Application number	1617093
Principal investigator's name	
Student investigator's name (if applicable)	Amy Wilkinson

Reviewer's recommended outcome			
Approve ☐	Revise ☐	Reject ☐	Refer ☐

Reviewers comments	
Section	**Comment**
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V1 Independent Reviewer's Report EC6

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V1 Independent Reviewer's Report EC6

This form is periodically updated so please download the latest version from ebridge before completing

Please note that this section of the form should NOT be printed out and attached to the ethics application.

Independent Reviewer's Checklist				
Section	**Question**	**Yes**	**No**	**N/A**
1,2,3,4,5	Have all details been provided in full?	☐	☐	☐
6	If there are collaborators, has the name, affiliation, email address, and telephone number for each collaborator been provided?	☐	☐	☐
7	Is the location of the project a safe place to undertake the project for both the participants and investigators?	☐	☐	☐
7	If equipment or facilities are been used other than in SHES, has a letter of support from an appropriately authorised person been included?	☐	☐	☐
8	Have realistic dates been provided?	☐	☐	☐
9	If the project has been funded, could there be any conflicts of interest between the investigators and the funding they have received?	☐	☐	☐
10	Has the purpose and benefit of the project being clearly identified?	☐	☐	☐
11.1	Is the sample size adequate?	☐	☐	☐
11.2	If not an undergraduate project, has the sample size been sufficiently rationalised (this will typically be the results of a power analysis)?	☐	☐	☐
11.3	Does the research involve people with any of the following: aged less than 18 years, suffering from acute or chronic health conditions, communication or learning difficulties, in police custody or with Her Majesty's Prison Service, engaged in illegal activities?	☐	☐	☐
11.3	Are the inclusion/exclusion criteria sufficiently detailed that it is clear who will be recruited into the project?	☐	☐	☐
11.4	Are the screening procedures appropriate for ensuring only those people that satisfy the inclusion and exclusion criteria are included in the project?	☐	☐	☐
11.5	Are recruitment strategies such that they might unduly influence someone to participate in the project that would not otherwise do so?	☐	☐	☐
11.6	Are the incentives to participate such that they might unduly influence someone to participate in the project that would not otherwise do so?	☐	☐	☐
12	Is the experimental design and methodology sufficiently comprehensive that someone could conduct the study by reading the information provided?	☐	☐	☐
12	Is deception involved?	☐	☐	☐
13	If substances are to be administered is the following information provided for each substance? The specific substance to be administered, the dosage, the timing of administration, and who will administer the substance.	☐	☐	☐
13	Are there any concerns regarding the health and safety of any substances to be administered?	☐	☐	☐
14	Are participants or investigators exposed to unacceptable risks,	☐	☐	☐

V1 Independent Reviewer's Report EC6

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	discomforts, or burdens?	
12,13,14	Have all relevant risk assessments been included?	☒ ☐ ☐
15	Are the investigators sufficiently competent to undertake each of the procedures involved in the project, or are otherwise being adequately supervised by a competent person?	☒ ☐ ☐
15	If an undergraduate student is testing in one of the laboratories is there a statement that a SHES member of staff will be present at all times?	☒ ☐ ☐
16	Is the participant debriefing sheet adequate?	☒ ☐ ☐
17.1	Will the confidentiality and anonymity of participants be preserved?	☒ ☐ ☐
17.2	If the principal investigator is not responsible, has the name, affiliation, email address, and telephone number of the person responsible been provided?	☒ ☐ ☐
17.3	Has anyone got named access to the data that is unnecessary?	☐ ☒ ☐
17.4	Have issues of data storage been adequately considered, particularly relating to security of the stored data?	☒ ☐ ☐
Informed consent	Is the informed consent written so that a lay person could clearly understand what is expected of them in relation to potential risks, discomforts, time commitments, and other burdens?	☒ ☐ ☐
Other forms	Have all other relevant documents been submitted and completed properly?	☒ ☐ ☐

3.7. EC9 : Ethics Application Amendment Form 1

V1 Ethics Application Amendment Form EC9

Department of Sport, Health & Exercise Science — University of Hull

Ethics Application Amendment Form

This form should be submitted when your ethics application has already been approved by the Department of Sport, Health and Exercise Science Ethics Committee, but you would like to make changes to the approved application. You should provide details of the changes you would like to make, with a clear rationale for why you would like to make each change. **Important**: If the initial approved ethics application is for a project that is part of undergraduate or postgraduate study, this form MUST be signed by you AND your supervisor (principal investigator). In all other cases only the principal investigator needs to sign the form.

Office use only

1st amendment submission ☐ 2nd amendment submission ☐ 3rd amendment submission ☐

Log date	Date of approval	Chair's signature
.....19/12/2016.....	.....06/01/17.....	..... E. Cope....

Application number	1617093
Project title	Primary care practitioner (PCP) perspectives on the referral process to East Riding of Yorkshire Council health services: A need-gap analysis.
Principal investigator's name	Dr Caroline Douglas
Student investigator's name (if applicable)	Amy Marie Yvonne Wilkinson

Amendments
A minor amendment has been made to the project scope and title from, "General practitioners (GP)" to "Primary care practitioners (PCP)" to broaden the range of participants who can be included in this research. In many East Riding surgeries GPs are not the only individuals who make referrals onto health care pathways. This responsibility is often shared by a variety of other PCPs including; Practice nurses, or Practice health advisors etc. In order to achieve a full understanding of the nuances involved in referring patients onto ERYC health services, it is essential to extend the sample to acknowledge and capture the experiences of all PCPs who perform referral activities.

1 | Page

This form is periodically updated so please download the latest version from ebridge before completing

Supervisors of investigators who are undertaking the project in pursuant of an undergraduate or postgraduate qualification: I have read this Ethics Application Amendment Form (EC9) before submission to the Department of Sport, Health and Exercise Science Ethics Committee and approve the amendments.

Dr Ed Cope	06/01/17	E. Cope
Dr Caroline Douglas	16/12/16	C. Douglas
Name of principal investigator	**Date**	**Signature**
Amy Marie Yvonne Wilkinson	16/12/16	A.Wilkinson
Name of student (if applicable)	**Date**	**Signature**

3.8. EC9 Ethics Application Amendment Form 2

Department of Sport, Health & Exercise Science — University of Hull

Ethics Application Amendment Form

This form should be submitted when your ethics application has already been approved by the Department of Sport, Health and Exercise Science Ethics Committee, but you would like to make changes to the approved application. You should provide details of the changes you would like to make, with a clear rationale for why you would like to make each change. **Important**: If the initial approved ethics application is for a project that is part of undergraduate or postgraduate study, this form MUST be signed by you AND your supervisor (principal investigator). In all other cases only the principal investigator needs to sign the form.

Office use only

1st amendment submission ☐ 2nd amendment submission ☐ 3rd amendment submission ☐

.....07/02/2017.....	.....10/02/2017....	.....E Cope.....
Log date	Date of approval	Chair's signature

Application number	1617093
Project title	A needs gap analysis of primary care practitioners (PCP) perspectives on the referral process to East Riding of Yorkshire Council health services.
Principal investigator's name	Dr Caroline Douglas
Student investigator's name (if applicable)	Amy Marie Yvonne Wilkinson

Amendments
A minor amendment has been made to the interview schedule, as we would prefer to collect a range of demographic information from the participants and gather some characteristics of their practice. Specifically, we would like to collect GP demographics including: sex, age (in years), GP role (Partner, Salaried or locum), working status (full time or part time), number of sessions in general practice per week, years practicing as a GP, years working within the ERY, other roles (GP trainers, appraiser, CCG roles, Out-of-hours, none), and weight status (BMI). Additionally, we would like to collect information regarding the practice. This will include the list size, location (rural, semirural, suburban, urban), dispensing (yes or no), number of other GPs, number of clinical staff who are not GPs, and the number of non-clinical staff. By collecting this additional

information, this is going to contribute to a fuller understanding of the differences between each PCP with regard to their referral activities and barriers experienced.

Supervisors of investigators who are undertaking the project in pursuant of an undergraduate or postgraduate qualification: I have read this Ethics Application Amendment Form (EC9) before submission to the Department of Sport, Health and Exercise Science Ethics Committee and approve the amendments.

Dr Caroline Douglas	08/02/17	
Name of principal investigator	**Date**	**Signature**

Amy Marie Yvonne Wilkinson	08/02/17	
Name of student (if applicable)	**Date**	**Signature**

Dr Ed Cope (LREC)	**10/02/17**	**E.Cope**

3.9. Research Passport Access Letter

NHS
East Riding of Yorkshire
Clinical Commissioning Group

North Yorkshire and Humber Research and Development Service
Health Place
Wrawby Road
Brigg
North Lincolnshire
DN20 8GS
Telephone: (01652) 251088
Fax: (01652) 258110
E-mail: angie.beacroft@nhs.net
Website: www.eastridingofyorkshireccg.nhs.uk

03/05/2017

Amy Wilkinson
Sport, Health and Exercise Science
207 Don Building
University of Hull
Cottingham Road.
Hull.
HU6 7RX

Dear Amy

Letter of Access for Research

Title of Study: **Primary care practitioner perspectives on the referral process to East Riding of Yorkshire council services:A needs-gap analysis.**

CCGs: **East Riding of Yorkshire CCG**

This letter confirms that the North Yorkshire & Humber R&D Service have reviewed the Research Passport application V3 (01/09/2012) and has granted you a right of access to conduct research through the independent contrators based within the above CCG(s) for the purpose and on the terms and conditions set out below. This right of access commences on **3rd April 2017** and ends on **31st March 2020** unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of assurance for research from this NHS organisation. Please note that you cannot start the research until the Chief Investigator for the research project has received a letter from us giving assurance that the research meets our criteria. You must also act in accordance with the Research Governance Framework.

The information supplied about your role in research within the independent contractors based within the above CCG(s) has been reviewed and you do not require an honorary research contract with this NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

You are considered to be a legal visitor to premises of the independent contractors based within the above CCG(s) and their associated primary care providers. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to

employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through the independent contractors based within the above CCG(s) you will remain accountable to your employer, the University of Hull, and you are required to follow the reasonable instructions of Dr Marie Girdham, Research and Development Lead(Humber) North Yorkshire and Humber R&D Service or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings. You are required to co-operate with the independent contractors based within the above CCG(s) in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation.

You must take reasonable care for the health and safety of yourself and others while on premises of the independent contractors based within the above CCG(s) and any associated primary care providers and independent contractors. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and the NHS organisation (using the contact details at the bottom of this letter) prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence.

You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you. The independent contractors based within the above CCG(s) will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Dr Marie Girdham
Research & Development Lead Manager(Humber)
North Yorkshire and Humber Research and Development Service

Appendix 4: Recruitment Material for Research Phase I

4.1. Letter Distributed for Recruitment

Sport, Health & Exercise Science
School of Life Sciences
The University of Hull
Cottingham Road
Hull
HU6 7RX

Name of DR
Surgery Name
Surgery Address
City
Postcode

[Date]

Dear [Doctors Name],

We would like to invite you to be involved in a collaborative project between the University of Hull, East Riding of Yorkshire Council (ERYC) and East Riding Public Health.

The University has been commissioned to investigate the perceptions of primary care practitioners currently referring onto ERYC Health Service programmes, such as Live Well and the Exercise Referral Scheme. We are keen to hear about your experiences of referring patients onto these programmes and any constraints you may face. This will help inform the development of more streamlined screening and referral systems to release valuable consultation time for high risk patients. Please find an information sheet attached with more details on the project.

There are great opportunities to build on the success of the programmes such as "Live well" and enhance the opportunities for people to get access to effective programmes for improving their health. As with all interventions it is important that we have good evidence and information about the services and your help in this would be greatly appreciated.

Dr Tim Allison
Director of Public Health East Riding

I would greatly appreciate the opportunity to interview you to explore your thoughts on the referral process. Would it be possible to identify a date and time for a telephone conversation to briefly outline the research, and to arrange a face-to-face meeting at your practice?

I look forward to hearing from you.

Yours Sincerely/faithfully,

Amy Wilkinson, MSc
PhD Researcher in Sport, Health and Exercise Psychology

T: 07845756130
E: A.M.Wilkinson@2016.hull.ac.uk

Project Directors: Caroline Douglas, PhD, and Samantha Nabb, PhD CPsychol (University of Hull)

4.2. Posters Distributed for Recruitment

Primary care personnel perspectives on the referral process to East Riding of Yorkshire Council (ERYC) health services: A need-gap analysis

Amy Wilkinson (MSc), Sam Nabb (PhD), and Caroline Douglas (PhD)

What is the purpose of this research?

The ERYC serves a population of 340,000 of which approximately 68% of adults are obese or overweight (Public Health England, 2015). Being overweight or obese is associated with the development of numerous co-morbidities including type II diabetes, cancer, hypertension and cardiovascular disease (Guh et al., 2009).

To support obese and overweight residents, the ERYC offers a unique non-surgical weight management service, Live Well, in addition to health services such as Exercise Referral to help manage other health care issues (e.g., diabetes). These services operate in ten leisure centres within the East Riding of Yorkshire.

As primary care personnel are typically the outlet for these services, the responsibility falls upon them to initially screen patients and direct them onto appropriate health services. However, the sheer volume of patient appointments means many primary care personnel experience constraints on consultations, which can hinder referral.

Source- Google Maps

Figure 1. Location of operating leisure centres within the East Riding of Yorkshire.

What are we going to do?

We would like to interview primary care personnel across the East Riding of Yorkshire who perform referral activities onto ERYC health services. Specifically, we would like to explore your perspectives of the referral process and to understand any challenges you experience.

How will this benefit you?

Your insight will be invaluable in highlighting the needs of patients and practitioners, and to help identify gaps in the referral process onto ERYC health services. This will help inform the development of more streamlined screening and referral systems to free-up valuable consultation time for high risk patients.

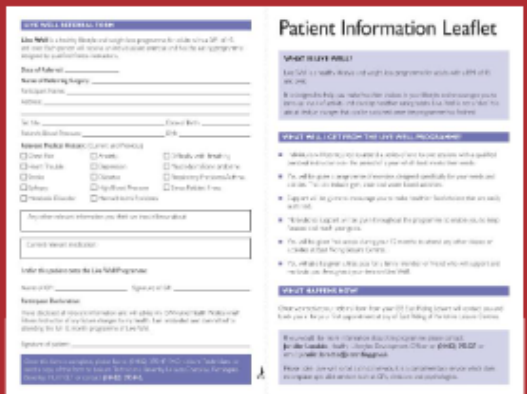

Figure 2. Example referral forms for ERYC health services.

How do I get involved?

Contact: Amy Wilkinson
Email: A.M.Wilkinson@2016.hull.ac.uk
Tel no: 07845756130

UNIVERSITY OF Hull

EAST RIDING OF YORKSHIRE COUNCIL

Appendix 5: Interview Guide for Research Phase I

Interview Guide

Primary care personnel (PCP) perspectives on the referral process to East Riding of Yorkshire Council (ERYC) healthy lifestyle programmes: A need-gap analysis

Introduction

Hello, I am Amy Wilkinson from the University of Hull. Thank you for participating in this interview. For this session, we will be talking about your perspectives as a PCP concerning patient referral onto ERYC healthy lifestyle programmes.

Purpose of the Study

The purpose of this study is to gain a rich insight into perceptions and experiences of PCPs who perform referral activities onto ERYC healthy lifestyle programmes, focusing particularly on the challenges you face with regard to referral. This insight will highlight the unmet needs of patients and practitioners, and to help identify constraints in the referral process onto ERYC healthy lifestyle programmes. This will help inform the development of more streamlined referral process to free-up valuable consultation time for high-risk patients. Does that all that make sense?

Confidentiality

I would like to remind you that all information received during the interview will remain strictly confidential. It may be that I choose to select some of the information that you give for my thesis. However, you can be assured that this will not in any way reveal your identity. A recording device is going to be used purely to ensure I get complete and accurate information. This also allows me to type the information into a transcript which will be used for later reference.

Participants Rights

You have several rights as a participant in this study. Firstly, it should be said that your participation in this study is completely voluntary, and you are free to decline to comment on any question at any stage. Please remember that there are no right or wrong answers to any of the questions. All I ask is that you respond in an honest manner as this will have implications for my study. May I therefore remind you that none of the data will be shared between anyone outside of this room and your identity is under total protection. If, however, you feel a question is too uncomfortable for you to answer, please feel free to state, 'no comment'. Following this response, the next question will be asked immediately. You are in your right to do so and, therefore, this will not be frowned upon by the researcher. If you have any questions during the interview, please feel free to ask straight away.

Orienting Instructions

Throughout the interview, I will be asking you about the ERYC healthy lifestyle programmes you refer patients on to, the information and referral resources for these programmes, any issues or constraints you face when referring patients onto these programmes, any factors that facilitate referral, the feedback you receive from these programmes, and any support networks you have to ease your role/patient load. Although the questions may sound relatively easy to

1

answer, please do not provide answers that you feel I want to hear or that will save you from embarrassment. It is worth a reminder here that whatever you reveal will be held strictly confidential. Also, please do not attempt to guess answers. Although it is appreciated that the questions will be asking you to look back on previous experiences, please only do so if you are sure of your response. Therefore, your answers should be made in an honest manner and not guessed. Once the interview has been completed, you will be given the opportunity to add anything that you feel you were not able to express or that was not covered in the interview.

Themes

- ERYC healthy lifestyle programmes (information resources)
- Constraints of patient referral to ERYC healthy lifestyle programmes
- Facilitators of patient referral to ERYC healthy lifestyle programmes
- Patient progress feedback from ERYC healthy lifestyle programmes
- Support networks

Demographics collected on:

- Gender: (Male/ Female)
- Age: (years)
- GP role: (Partner/ Salaried/ locum/ Other)
- Other roles: (e.g. GP trainers,/ Appraiser/ CCG roles/ Out-of-hours/ None),
- Working status: (Full-time/ Part-time),
- Number of sessions in general practice per week: ( )
- Experience as a practicing PCP: (years)
- Experience of working within the ERY: (years)
- Email:

ERYC healthy lifestyle programmes

What ERYC healthy lifestyle programmes are available for patients in this locality?

- Which ones do you find you refer patients onto most often? Why is that?
- Can you tell me what the process of referral is in this surgery?
- Who's best placed to refer? Why?

Live Well	Health Optimisation	Exercise Referral	Walking for Heath	Swim for Health	Health plus	H.E.A.R.T (cardiac rehab)

How are you made aware of these programmes?

Do you feel you've been provided a satisfactory level of information of what these programmes entail to enable you to make an informed decision about what to refer your patients on?

- Are some programmes better publicised/ have greater information resources?
- What would you like more information on?
    - How would you like to receive this information? (Online/Training sessions?)

LiveWell and Exercise Referral have these booklets, is there any other information for you to give to patients regarding the programmes you've mentioned?

- How useful are these booklets or resources? Are they patient friendly?
- What could be improved on?

What are your expectations from referring patients onto these ERYC health care programmes?

- What is it going to achieve for you and for the patient?

When are you prompted to refer patients onto ERYC healthy lifestyle programmes?

- How do patients respond to lifestyle referrals? Can you give me an example?
- How confident are you issuing lifestyle referrals? [As oppose to medication]
- Was physical activity for health a part of your medical training? How have you developed knowledge in this area?

Constraints of patient referral to ERYC healthy lifestyle programmes]

Have you or do you experience any challenges when referring patients onto the healthy lifestyle programmes?

- Can you give an example?/ How do you overcome that?
- How do patients respond? If a patient shows no interest, what happens?
- How informed are patients about the healthy lifestyle programmes? Does that influence response?
- What's your overall opinion of the referral process? Could anything be improved?

3

PCP's are required to complete a referral form and take some patient measurements to refer them onto ERYC healthy lifestyle programmes. Can you tell me about your experiences of using these documents?

- Are they any issues when it comes to referring patients using this form?
- Are the measurements required appropriate? Why?
- Is this form typical of referral forms? Can you comment on its usability?

Facilitators of patient referral to ERYC healthy lifestyle programmes

- What eases the process of referral to healthy lifestyle programmes?
- What improvements would you like to see to referral process? What would help streamline?
- You mentioned….. as a barrier, what would help overcome this?

Patient progress feedback from ERYC health care programmes

What information comes back to you about your patient's progress on the health care programme you've referred them to?

- Does this information help you to understand if a change in a patient's behaviour has been made?
- How do you feel about feedback provided? Satisfied?
- What do you feel are the most appropriate indicators of lifestyle change?
- What information specifically would you want to hear regarding your patient's progress and how often?
- What involvement do you feel you should have in terms of your patient's progress throughout a programme you've referred them to?

Support network

What support network do you have in this surgery to help manage your patient load so you can preserve consultation time for high-risk patients?

For example, do you have a triage system? Do you use any social prescribing strategies? Do you have dedicated healthcare assistants? Does this practice engage with web GP?

- Are they successful?
- How do you see this area developing? Is it something you would like to see adopted? Why?

Key end question

Is there anybody else in this practice who you think I should speak to and ask these questions to help illuminate our understanding?

- What would be the best way to contact this person and invite them to speak to me?
- Is there anything else you wish to add that you feel is important?
- Would you be open to me coming back and talking to you about something else along these lines at a later date?

Appendix 6: Interview Transcripts for Research Phase I

AW: Interviewer **Interview date**: 06/05/2017

GP1: Participant Interview **location**: Snaith & Rawcliffe Medical Group

AW: OK, so can I just ask what you're er, role is as a GP? Are you a partner? 00:09

GP1: Yes 00:11

AW: A GP partner fab, and are you full time at this surgery? 00:13

GP1: Er, no, I'm not no. 00:15

AW: So, part time? 00:16

GP1: Yes 00:18

AW: If you had to estimate how many sessions you deliver in general practice per week? 00:22

GP1: yeah, I do erm, here, erm, seven sessions. 00:26

AW: Seven sessions per week 00:27

GP1: yeah, 00:28

AW: Is that split over so many days or? 00:30

GP1: Er, I work 4 days 00:32

AW: 4 days 00:33

GP1: yeah, 00:35

AW: And how long have you been working as GP? 00:38

GP1: er, twenty, I think, er twenty two years 00:43

AW: Twenty two years? 00:43

GP1: yeah, 00:44

AW: Has that always been within the East Riding of Yorkshire? 00:46

GP1: No 00:47

AW: Ok, how long, if you had to give a rough estimate? 00:50

GP1: Fifteen years within the East Riding, yeah, 00:51

AW: 15 years in the East Riding of Yorkshire fab. And do you have any more roles, so for example do you have any CCG roles or anything like that? 00:59

GP1: Yep,. I'm er, a chair of a local federation of GP practices, I'm a GP trainer, I do out of hours work 01:10

AW: Ok 01:10

GP1: yeah, 01:12

AW: quite a lot, bit of everything 01:14

GP1: Yeah, bit of everything 01:15

AW: Ok, so the first section will be on the ERY healthy lifestyle programmes that are available, so what's available for patients in this specific locality? 01:24

GP1: What can we refer to? 01:26

AW: yeah, what can you refer to? 01:27

GP1: erm we can refer to the er, exercise of prescription, the LiveWell, programme and then the living with diabetes programme 01:38

AW: Yep, 01:40

GP1: And then we've got the health trainers 01: 42

AW: Health trainers as well. And do you find that you refer patients to one more than the other? 01:48

GP1: Er, I, I will signpost people to health trainers a lot 01:53

AW: Ok and why is that? Why health trainers? 01:58

GP1: It's easy I can just give a card 01:59

AW: Right ok. So, is that something you have in the surgery that you can easily distribute? 02:04

GP1: yeah, 02:06

AW: Ok. erm, so aside from the cards that you have for the health trainers, do you have any more information resources for....02:13

GP1: Yeah, we have got, we have got some leaflets and obviously, we got the referral forms that we have, but that's about it really. The nurses have some more information 02:22

AW: So, is that the exercise referral form 02:24

GP1: yeah, 02:25

AW: So, with the nurses having more information, do they typically tend to refer on? 02:30

GP1: yeah, I mean, obviously they do a lot of the chronic disease monitoring so they will come across patients who you know, I guess it's a lot of your type 2 diabetics who are overweight who are referring to them sort of schemes, but a lot of people I am sure are getting missed or not getting put into the system 02:49

AW: Ok, do you feel perhaps they are in a better position to refer patients on? 02:54

GP1: yeah, I think, I think, they perhaps you know, we have a ten minute consultation, they may have 30 or 50 minutes with some of the patients so yeah, 03:04

AW: Ok, and have you found that some of the programmes are better publicised then some of the other ones? 03:10

GP1: Erm… 03:12

AW: Or do some have greater information resources? 03:13

GP1: I think, I mean, our biggest problem here is that two thirds of our patients live in the East Riding and one third live in North Yorkshire. So, they access different public health schemes 03:28

AW: Ah 03:28

GP1: So, our North Yorkshire patients cannot go to the East Riding schemes and our East Riding schemes cannot go to the North Yorkshire ones 03:33

AW: Ah right, ok 03:34

GP1: So, we've got duplication in the services that are available to our patients as well, which kind of makes it more complicated 03:39

AW: And obviously some of these programmes won't be available, so the LiveWell, programme is not available to the North Yorkshire patients? 03:45

GP1: No, they will probably go to whatever is the equivalent in North Yorkshire if that's available 03:49

AW: Right ok, so as well, as you knowing about the East Riding of Yorkshire...03:54

GP1: We've got to know about the North Yorkshire ones 03:54

AW: Right ok, and do you find that difficult with patients coming in if er, 04:01

GP1: yeah, it can be difficult yeah, because " oh, which village do you live in? OK which village? Is that in North Yorkshire? Is that in East Riding?" yeah, because obviously for health they can access the East Riding services for Public Health with it being a council service, they have to go to the appropriate thing 04:16

AW: How do they respond to that? Do they know...04:21

GP1: They are aware, they are aware. It's been like that for twenty years on and off, so you know. Sometimes they will come in and go "my friends been to this I want to go" and you say, "well, actually you're in the wrong village you can't" so. But they're not, it's not a problem 04:34

AW: yeah, that's kind of accepted 04:35

GP1: It’s more a clinician problem in that you’ve got to be thinking about that all the time 04:44

AW: yeah, about what you're able to refer them on to and stuff 04:44

GP1: yeah, 04:45

AW: That makes sense. And what are your expectation from referring patients onto the programmes? 04:51

GP1: What do I expect from them? I want them to be relatively responsive and for the patients, and to engage with the patients really. I need the referral process to be quick and easy. 05:07

AW: And what issues do patients typically present with where you may think a referral may be appropriate? 05:17

GP1: Well, the classic, so lifestyle, isn’t it? it's obesity, poor conditioning, getting old, unfit, osteoarthritis of the knee, you know type, prediabetes 05:30

AW: All lifestyle related issues? 05:31

GP1: Yeah, yeah, smoking cessation, some alcoholic and drug issues perhaps with the health trainers. So, er, yeah, yeah, lifestyle really. This epidemic we've got going on! 05:48

AW: Ok, so that is sort of about what’s available for patients. The next section of the interview is about constraints of patient referral. So, do you experience any constraints when referring patients onto these programmes? 06:02

GP1: yeah, I, I, I just think it’s clumsy! It’s difficult. 06:07

AW: Ok. What do you mean by clumsy, difficult? 06:11

GP1: Well, you know, I mean example is, you know, to refer somebody to exercise on referral I've got to hand fill that in. Now that's probably going to take me, dunno, five minutes maybe to fill it in and to pull all the patients demographics off and to fill it in. I'm just not going to do it if I'm honest or I'm not going to do it as often as I should be doing it because I haven't got time so there's a constraint there. And, you know we've got these fantastic clinical systems with all the information on that needs to go on this form and I need that to be able to be extracted onto a a4 piece of paper and boof off it goes 06:49

AW: Yes. So, for you it's about integrating your clinical systems with the referral form, so you don't have to mess about hand writing that in? 06:57

GP1: Yeah, yeah, yeah. And a little bit more than that in that you know there should be certain triggers that suggest that, that this is an option. You know, if I put someone's BMI as over 30 then actually you know, we can programme these systems, so it asks, "do you want to refer this patient for exercise on referral?" 07:21

AW: Ok 07:22

GP1: So, that it's reminding the clinician all the time that that can be done. That patient lives in the East Riding, these are the services that are available ABC and then you know I.T can help us, and clinicians have a lot to think about in a consultation and will miss things or will make easy options sometimes, so, I think we need to use I.T to help us 07:47

AW: yeah, absolutely so if it was integrated in the I.T systems, it's not only about time, erm as you say it can act as a reminder 07:54

GP1: yeah, definitely yeah, yeah, 07:56

AW: Because obviously you've got a lot to think about in ten minutes 07:58

GP1: Absolutely and often, it will be an off the cuff remark about something, so they've actually come to you about something else and, to go into that, you're thinking about other things 08:09

AW: So, aside from the referral forms being very clumsy, it's handwritten, time. Erm, do you experience any other constraints with regard to patient referral? 08:24

GP1: No not particularly no, to be fair. I mean geographically the patients perhaps are sometimes reluctant to go to Goole, but generally not if I'm honest. Those that want to do will go 08:35

AW: Right ok, so with you saying, those that want to, erm, do you try and access patient motivation before you refer them onto a programmes? 08:44

GP1: yeah, 08:45

AW: And how do you do that? 08:45

GP1: Erm, you know, "would this be something that you would be interested in?". You know "what stage are in your thinking around changing lifestyle?" 08.52

AW: And are they generally quite responsive to that or do sometimes they become a little resistant? 08:59

GP1: I mean it's patient to patient isn't it. I mean some people are ready for lifestyle change and they will often come asking for this because they've already found

out about it and those who are not at that point of change yet. Even if you just suggest it at least you're sowing the seed, aren't you? And then they may come back later down the line and say look you mentioned last time about...09:22

AW: yeah, so even if you don't quite get to a referral again as you say it's just about that awareness 09:27

GP1: Signposting them, giving them options, making them aware, yeah, 09:31

AW: And you say that majority of them come asking for 09:34

GP1: Not majority, but some do. You certainly get some patients, you know. I was talking to so and so and they've done it or can I, so yeah, or they've read it on a poster in the waiting room 09:45

AW: So, we've spoke a little bit about the referral forms. Erm, if we talk specifically about the patients measurements that are on the referral form. What are your experiences of filling all that in? Do you feel like those measures are appropriate? 10:00

GP1: Er, as in their biometrics? 10:06

AW: yeah, 10:06

GP1: yeah, I think it's, I think it's, I'm a great fan of weighing patients and, and, and, yeah, because, I think that actually, and again IT systems make that really useful in that you can show a patient "look, look at your weight" you know graphically this is where you were five years ago this is where your weight is now, and patients are quite often quite shocked by that and when they can see a visual representation of how their weight has changed. You know and the graph is always like that [indicates a positive linear graph with

arm] it’s going up and up and up. So, that that does make people change and when they come in, you know, six months down the line and they've lost weight you can say "ah look, your weight...", I think that's really useful 10:45

AW: And that's obviously something that can’t be done on a referral form 10:48

GP1: No, it can’t no, but you know that's where the clinical systems are really useful 10:52

AW: Great and is there any other issues with using the form, apart from that its hand written? 11:00

GP1: No, not at all. It’s a bit erm, it’s not particularity well, laid out if I’m honest. It’s busy, but it’s nothing again that couldn't be sorted out on an integrated form. I mean all these can be pulled out, all these bits of information so I wouldn't actually have to do that it would pull it out from the clinical codes on the system so 11:27

AW: Mhmm so it would be really simple things like obviously the patients, even the details can all be transferred...11:34

GP1: yeah, I mean all the demographics can come out, but whether they've got hypertension, or whether they've got depression or diabetes or they're overweight, or anxiety you know all these are all coded on the system so they can all be automatically filled in. Erm, so you know you, the BMI can be pulled out the blood pressure can be pulled out. Everything can be pulled out and then you might just have a little section at the bottom for comment from the doctor and a signature 11:57

AW: Yeah. So, that's kind of the constraints of patient referral. The next little bit about what actually helps referral, so what facilitates that referral. Erm, so is there anything that eases that process for you? 12:09

GP1: In what sense, that would make my, easier for me? 12:15

AW: yeah, 12:16

GP1: No, I mean, should I, I suppose one is actually having an integrated form, that's going to make it easier for me. Er, second would be that it could be done by any member of the practice really. So, you know if that could be done by a care navigator, so. I mean it says signature of health professional. Does it need to be a health professional who sends someone? Who, who signposts somebody? I don't, I don't know 12:55

AW: So, ideally that could, it would be ideal if that could be done by a whole range of people? 12:58

GP1: yeah, it would, and it may be directed by the er, the clinician, it probably is going to be directed. The clinician is going to go, you know, and I could say yeah, fine OK, well, go to the front, here's a slip of paper and they will sort you out with the referral form, and the reception can do that, or the care navigators can do that. It doesn't necessarily have to be clinicians and...13:23

AW: So, just an idea, is you could perhaps not initiate that referral, but give your consent for that 13:30

GP1: yeah, 13:30

AW: And then ideally triage them patients onto reception who can 13:34

GP1: Yeah, yeah, yeah. so, you're signposting really and then you know you've got an administrator who's then sorting out the details 13:41

AW: And what would be the benefits of doing it that way? 13:42

GP1: It's just time saving, isn't it? You know we're clinician short in the East Riding of Yorkshire. Erm, we're moving away from, from, we're trying to get clinicians spending their time seeing patients. Whether that's doctors or nurses or healthcare assistants and their spending all their time seeing patients rather than doing administration tasks. So, it's reducing their administration burden and making them concentrate on what they… I'm an expensive form filler really at the end of the day 14:16

AW: yeah, absolutely. So, for you again it's just about lowering that burden of administration tasks and freeing up that valuable consultation time? 14:22

GP1: Yeah, yeah, yeah, and actually you know putting the form filling to someone more appropriate 14:26

AW: Ok 14:27

GP1: yeah, 14:30

AW: Ok so is there else aside from what we've just discussed, anything else you'd like to ask in terms of what would ease that patient referral? 14:39

GP1: I think there should be, the referrals should be emailed across as well, 14:46

AW: Ok 14:46

GP1: So, again, 14:49

AW: So, what's the process at the, at the minute? Do the patients take the form away?14.52

GP1: We send these. The patients have to come in and sign it so, and that's, I guess that's the other thing actually is er, why, why do the patients have to sign these forms? You know I don't get the patients to sign any other referral form that I do. I appreciate that might show their commitment, but yeah, we do a lot of things over the telephone now. Er, we do a lot of you know we're doing email consultations, so, that doesn't quite fit in with the new modes of consulting with patients 15:28

AW: Yep, yep, so again it's about updating that and trying to get everything on the same scale 15:33

GP1: yeah, 15:35

AW: So, for you, you're not really sure if that signature is necessary and again if you was able to email that across 15:41

GP1: Is it necessary? I mean what, why, what, what are we getting by putting that signature on there? 15:46

AW: yeah, 15:46

GP1: yeah, I don't know 15:49

AW: I'm not too sure either, but that's definitely something I can raise with the trainers to make sure 15:52

GP1: Yeah. I understand it. They're trying to get people committed to it before the, you know, because it's expensive and you want, and it's a limited service so you want people to be committed before they enter it, but you know. Is there

any evidence that signing that form proves commitment compared to a verbal consent? I don't know 16:12

AW: yeah, you're not too sure if that completely reflects patient commitment levels 16:15

GP1: yeah, 16:17

AW: That makes sense. So, in terms of patient progress feedback. Do you receive any sort of feedback from either of the programmes that you refer patients onto? 16:24

GP1: No 16:25

AW: Nothing whatsoever? 16:28

GP1: No 16:31

AW: And how do you feel about not receiving anything? 16:32

GP1: Er, well, I'd get more paper in then I'd need so. Would it be useful to have a form saying, that they had completed it? I suppose it might be useful to say at the end of the programme, they've completed it. This was the weight when they started, this is their weight now. You know something like that might, might, might be useful. I suppose it aids my consultation when I see them next time so you know "how did you get on?" or if it says did not attend or, then again, I can go "well, you didn't go along, what happened there?" 17:10

AW: So, feedback for you who prompt further discussion with that patient 17:16

GP1: And again, feedback needs to be electronic. It needs to come into my clinical system via an email. You know I don't want bits of paper 17:27

AW: OK. Completely paperless 17:32

GP1: yeah, 17:32

AW: So, you've mentioned that you'd like ideally to know if they've attended, if they haven't attended and their weight. Is there anything else specifically that you want to hear regarding their progress? 17:42

GP1: I suppose it depends on what, what they attended for doesn't it really? You know, if it's exercise on referral, what, what level of exercising was they achieving? Er, if it's the health trainers for smoking cessation, have they stopped smoking? Er, yeah, so, would depend on the reason for attendance 18:04

AW: Yeah, on the reason absolutely. But again, not too much because... 18:07

GP1: It just need to be brief. They've got better things to do then. So, you know it needs to be erm, a very quick er. And I might not even look at it to be fair, but it, but we would want it on our clinical systems so then if we ever needed to, you know, it would probably not come to a clinician to see, it would just be filed automatically to be honest 18:29

AW: OK, OK so that's kind of everything I wanted to ask about patient progress feedback. Is there anything else you'd like to add? 18:37

GP1: No 18:37

AW: No ok, so at the minute you're not getting any feedback, just to summarise from any of the programmes. Ideally, you'd like a little bit, but obviously through email and so it can be stored on your system? 18:48

GP1: Yeah, yeah. That would, yeah, 18:51

AW: Yep, So, kind of the last section is on support networks. So, you've mentioned a little bit about how you telephone patients now, er, so what support networks do you have in this surgery to ease patient load? So, for instance, do you have any triage systems? 19:07

GP1: yeah, so we, we telephone triage all same day appointments 19:11

AW: Oh, ok 19:13

GP1: So, anybody who wants to be seen on the day who feels they need to be seen, they speak to the duty doctor who then will deal with them on the phone, or give them an appointment with the appropriate health professional on the day or onwards. On top of that, if you can't get an appointment with the clinician you want, they go on to something called the doctors queries list, where er, again they will get a telephone call from the duty doctor who will try and er, meet their needs for the, their appointment needs. 19:48

AW: Yep, And do you feel having that telephone triage systems effective? 19:52

GP1: It's brilliant! We all hate it. We all hate doing it, but it's a valve, isn't it? You need a valve because you know your demand fluctuates relatively consistently from winter to summer, but you know you have days where it's very busy and you need to be able to meet that capacity. So, the duty doctor system for us does that. Er, and it's responsive 20:22

AW: And how long has this system been in place? 20:24

GP1: We've been doing it for about six years now 20:25

AW: Ah right so a really long time 20:26

GP1: Yeah. We've fine-tuned it over that time yeah, 20:30

AW: And do you feel that you don't have as many patients coming in er, for unnecessary things? 20:35

GP1: For rubbish yeah, yeah. It filters out a lot of the same day rubbish really. I mean, we've, we've looked, we've looked at, I mean, you've got to kind of be filtering out at 50% haven't you to make it worthwhile because you're taking a clinician out of seeing patients. And er, so they're sat there just talking to people all day and then on a Monday morning the two doctors, we have two on a Monday morning, they will speak to about 85 patients 20:59

AW: Wow 20:59

GP1: And we'll see on the day, we'll see about 36% of those. Er, but in the week we'll see about 50% so it's, it, it, it just about washes it's face 21:12

AW: So, it pretty much half's it. I was going to ask how long does it take? So, those two doctors would they spend the full morning? 21:19

GP1: yeah, one doctor is, will be on that all morning, the second doctor is on it until half 9. From 8 til half 9. So, so we have a doctor on the phone basically, all day. Erm, morning duty doctor and an afternoon duty doctor. We don't, we don't have one person do it all day because its horrific [laughs] yeah, 21:39

AW: So, it's not something you like doing, but you can see the value 21:41

GP1: I think we see the benefit of it., I think we see that it, you know, it protects the other doctors in that when you're not duty doctor, you can get on with your

day and when you are duty doctor you know, you know that that's just what you're going to have to do, and you get on and do it 21:57

AW: yeah, so that's shared out amongst all the doctors on some kind of rota. 22:01

GP1: Yeah, yeah, yeah, 22:04

AW: Brilliant. That's kind of all the sections in terms of patient progress, and also in terms of constraints in the referral to healthy lifestyle programmes. Is there anything else about anything we've spoken about that you would like to elaborate on or anything you feel we've missed? 22:19

GP1: No that's fine 22:19

AW: And just to end, do you think there's anybody else in this practice that would be happy to answer these questions to help illuminate our understanding? 22:26

GP1: I can ask if you like. I mean, they're quite an affable bunch, but I can ask if that will be useful? 22:33

AW: Yes, certainly if that's possible 22:37

GP1: yeah, 22:39

AW: Brilliant 22:40

GP1: Do you want me to get them to email you if they're interested? 22:41

AW: Yes, if possible. I was going to ask what would be the best way to contact them. 12:42

GP1: yeah, I'll get them to, if got your email so I'll get them email you 22:46

AW: Brilliant. Thank you 22:49

GP1: I've got a practice meeting today at lunch time, so I'll get them to email you. Good luck! 23.01

AW: Interviewer **Interview date**: 05/07/17

GP2: Participant **Interview location**: South Cave Surgery

AW: If you don't mind me asking how old are you? 00:09

GP2: 53 00:12

AW: 53. And what is your role as a GP? Are you a partner? 00:12 53

GP2: Partner 00:16

AW: Partner, GP partner. And do you have any other roles? 00:16

GP2: I work, um, I'm chairman of the LMMC which is the local medical committee 00:21

AW: Yep, 00:26

GP2: And I sit, I'm on the CCG governing body. 00:26

AW: Right. And do you work full time or part time? 00:31

GP2: Between them. It's pretty much full time, but I'm classed, I'm a part time partner 00:35

AW: Ah right, ok 00:41

GP2: See what I mean? The week is full, but it's not, it's because I have different jobs 00:41

AW: Yep, (laughs) and if you had to give an estimate as to how many sessions you deliver in general practice per week... 00:44

GP2: Actually, see patients? 5 00:52

AW: Yep, 5 per week. And how long have you worked as a GP? 00:54

GP2: Erm, about 26 years now 00:59

AW: Has that always been within the East Riding of Yorkshire? 01:04

GP2: No. I qualified in London 01:06

AW: Ah right, ok 01:07

GP2: And I did work in Glasgow for a while as well, 01:08

AW: Wow London, Glasgow 01:10

GP2: That was a long time ago. I mean it doesn't count really! (Laughs) 01:11

AW: If you had to give a rough estimate of how long you've worked specifically within the East Riding of Yorkshire 01:16

GP2: I've been here erm, 14 years 01:20

AW: 14 years... Brilliant. So, the first section of the interview will be focused on the East Riding of Yorkshire Council Healthy Lifestyle programmes. So, what, erm, programmes are available for patients in this locality? 01:22

GP2: Well, I don't know where the different fundings come from. I mean that's, I suppose that's one of the troubles. I mean for just general things there's the health trainers and that's what we would use. Erm, and then the LiveWell, for the over 40 or 45's BMI 01:37

AW: Yep, 01:54

GP2: And erm that's it 01:56

AW: So, the LiveWell, is commissioned by the East Riding of Yorkshire. I'm sure it's the NHS who commissioned the Health Trainers. 01:56

GP2: The health trainers yeah, 02:03

AW: So, these are the ones that we're aware of. (Shows table of ERYC healthy lifestyle programmes on interview schedule) erm, so we know there's LiveWell... 02:03

GP2: LiveWell, yep, 02:07

AW: The young live well, exercise on referral 02:08

GP2: Oh, yeah! No, no, we do use that 02:11

AW: That one as well? 02:12

GP2: Yep, 02:14

AW: Erm, the walking for health, swim for health, health plus and H.E.A.R.T the cardiac rehabilitation programme 02:15

GP2: The cardiac rehabilitation. That, they tend to get referred by the hospital 02:21

AW: Ah right, ok 02:23

GP2: You see because they have the heart attack and then that's picked up there, we... 02:24

AW: That's when they would make the referral? 02:29

GP2: Yes, so that's not a GP referral 02:31

AW: So, in this locality there's LiveWell… 02:32

GP2: And exercise 02:34

AW: And exercise referral? 02:35

GP2: Erm, and we can refer for bariatric surgery, but that's only for BMI's 50+ which is really rare 02:36

AW: Yeah, yeah. So, out of the LiveWell, and the Exercise referral, which one do you find that you refer patients onto more often? 02:43

GP2: Well, the exercise on referral has an easier you know, basically, anybody can be referred to exercise, so the numbers are bigger because it's much looser, the referral criteria you know erm, depression, anxiety, just being overweight you know BMI over 30. Whereas the LiveWell, is only for BMI's over 40 02:51

AW: Yep, 03:14

GP2: So, so it's the numbers really. It's not that either of them are difficult there's just bigger numbers in the exercise referral 03:15

AW: It's just in terms of the referral criteria? So, do you find in this locality there tends to be a lot more people eligible for exercise on referral? 03:24

GP2: Precisely, yeah, we don't actually have a particular problem with obesity. Not morbid obesity 03:29

AW: Yep, Ok 03:36

GP2: But I'm sure if you spoke to the Holderness and Goole GPs, they would probably be different. 03:38

AW: yeah, it's been very different, that's why I am trying to visit as many different surgeries as possible 03:42

GP2: Hm, the East Riding has a huge difference in health. You know we have quite deprived, but we also have very wealthy people so, erm, so that's probably… We won't use any of them a lot I don't think compared to like this way, like the Goole GPs. It's very different, isn't it? 03:47

AW: Ok, erm, and LiveWell, and exercise on referral have information resources for patients. Erm, are there any other information resources that you can give patients regarding the programmes? 04:05

GP2: No, I just tell them to contact them and get on with it really (laughs). I am quite happy for them to do it themselves 04:14

AW: So, you don't go through the booklet with the patient? 04:21

GP2: No 04:22

AW: No? OK 04:24

GP2: Somebody else can do that! 04:26

AW: And do you feel you've been provided with a satisfactory level of information regarding what each of the programmes entail? 04:27

GP2: It's a bit basic. It wouldn't do any harm to have an update every now and again you know, a new letter, on a yearly basis. You know say sort of once a year. It would just remind us you know with an outline of the criteria because you do sort of tend to forget and then you wonder like exactly what it is. So, but I mean it's not difficult, but that sort of thing might improve referral, you know just a reminder. You know say Public Health sent out a reminder to all GPs once a year- these are currently the schemes available to East Riding GPs. You know literally that much. It would... 04:34

AW: So, just tiny, but just to reiterate, as you say, what the referral criteria is 05:11

GP2: Yes 05:14

AW: So, is it mainly the referral criteria that you think... 05:15

GP2: Yes, yes, yes, because we don't want, well, we haven't got time. The whole idea is, we want preferably to give patients a really easy either form or even just a phone number and then they transfer everything 05:19

AW: To signpost them away from the GP surgery. 05:31

GP2: Yes, yes, yes, that would be… 05:32

AW: And how would you like to receive erm, the update? 05:35

GP2: Email 05:40

AW: Email that would be most preferred. And what are your expectations from referring patients onto these programmes? 05:40

GP2: (Laughs) Take them away! 05:50

AW: Take them away? (Laughs) 05:52

GP2: Take them away from us. Erm, yeah, weight loss and all the associated benefits. Not smoking, but again we have a few smokers, but obviously or smoking because erm, they go through that as well, don't they? Really, it's the weight loss! Yeah, get them moving! They are not moving, yes, get them moving! Make them realise their aches and pains and everything else, you know, lifestyle-related, not medical! That's the big thing is to get people out of seeing the doctor all the time for stuff we can do nothing about! 05:52

AW: yeah, 06:25

GP2: yeah, that's really, really what we want from it yeah. So, good luck with it! 06:26

AW: So, when are you prompted to make a referral? So, you've spoke a little bit about lifestyle there. 06:28

GP2: Well, it is usually. It's certainly the exercise referral which I suppose it the one I have more experience with. It's just people who are overweight, inactive and getting nowhere in life, you know. They are constantly seeing us with usually aches and pains, erm, some depression you know because they don't like it that they're so big, but not serious depression, but you know mild, mild sort of depression. Erm, and especially the ones you know in the 'at risk' group of developing diabetes to try and you know turn the corner back. So, it's the at risk of diabetes and muscular pain I would say are the two big ones that make me remember to do it 06:39

AW: Yep, and are the patients that come in with these sort of symptoms are they aware that it's because they are inactive? 07:16

GP2: I don't know they say they are not, but I can't believe it! I don't know (laughs). I don't know you would have to ask the patient. You'll need to do a patient study to sort of complement this I would have thought. 07:24

AW: To see how they would receive that information. And do you receive any incentive for referring patients onto the exercise on referral or LiveWell? 07:35

GP2: No 07:41

AW: No. Do you think that influences your referral habits? 07:42

GP2: Nope 07:45

AW: Ok. So, the next section will be focused on the constraints of patient referral. So, do you experience any issues or constraints when referring patients onto any of these programmes? 07:47

GP2: I mean not really. I mean I know that they're all sort of during the day and of course a lot of our patients work, but that's really a constraint for the patient you know. I would sort of warn them about that and say well, you contact them, and you know really all we do is hand the contact details over. 08:00

AW: Ok 08:15

GP2: So, erm, I mean I suppose the big constraint for us is, it's still done on paper forms, and you never have a copy anyways. What we could do with is erm, we want an electronic referral form that is compatible with system one and the EMIS practices and then we can do it and print it out, give it to the patient there and then and then, erm, you know a trail in the patient's notes that we have done it and we don't have to keep forms. And that I can tell you is what nearly everybody else is doing now 08:16

AW: Ok 08:47

GP2: So, it needs to be system one erm, compatible template letter and EMIS (Egton Medical Information Systems), but the two are very similar because the computers now have patches. Erm, and until, yeah, until the IT is sorted you won't get any further uptake 08:48

AW: So, just erm, kind of summarise, what would be the benefits of it been electronic in system one compared to having the paper referral forms 09:07

GP2: Well, it's much, it's much, it's much easier for us to do it because at the moment you have to start looking for these very grotty little forms for the exercise on referral and they are really poorly written, and they are not spaced out properly and they look a mess! Whereas, if you had a decently written template and it was in the patients notes you would just do it and also, we could then see that we have given it. So, when the patient comes back and says nothing has been done, we can say, well, [Dr's Name] has referred you to exercise on prescription on the 10th of June. You know and erm, there's no, and it's clear that's been done. Likewise, if you know you could even do it so if everybody who had a code of 'at risk of diabetes', somebody else could then go into the referrals template, print off it, and they wouldn't actually need to see the doctor 09:16

AW: Right. Ok 10:04

GP2: Because you know it's all linked together so everything should be electronic and within the patient record. 10:04

AW: Yes, because then you can delegate that to somebody else 10:10

GP2: Yes, you could delegate it to somebody else, much neater. It would be pre-populated the form because if you do it through somebody's notes it all you

know, Mr smith has the date of birth, NHS number…It would all automatically pre-populate it and you could even set it up so its pre-populates it with their last blood pressure reading, you know. So, much clearer and much more accurate information. 10:12

AW: And I guess that would save you quite a lot of time filling in the form 10:33

GP2: It would save a lot of time and like I say if you wanted, if the practice wanted to, they could set it up so as soon as somebody got a code of 'at risk of diabetes', they could get one of these letters 10:35

AW: yeah, it automatically flags them for that... 10:45

GP2: Erm, so, erm, which, you know which would probably be quite a good idea. Whether or not the patients could go, well, that would be another study, wouldn't it? But you know it, it, it means that you can do, if, if, if it's done electronically, you can delegate the work and it's much more likely to get done 10:47

AW: Yep, you can flag up people that as you say might be at risk... 11:01

GP2: Yes, and you can just run a search every three months or run a search for everyone with a BMI over 35, you know, and send them the information. You know you could do all sorts, it also makes research much easier because you know exactly, you know you could then come in, get permission to look at our records and just run a search and everybody who has had a referral done in the past year you can see what's happened to them. 11:05

AW: And again, it's all documented... 11:28

GP2: And, so, it, it's just hugely better, hugely better! 11:29

AW: So, in an ideal situation away from paper format altogether to electronic embedded within system one 11:34

GP2: yeah, 11:41

AW: That's the hope, that's what we're aiming towards (Laughs) 11:43

GP2: And yeah, yeah, and most people are getting to that, you know things like dieticians and OT and stuff, that's all electronic now. Some of them and I don't know which exactly, but they have to print them out and post them, but some of them you can even send the form electronically, but this, I think would be quite nice to give to the patient because unless the patient wants to do it it's a complete waste of time, isn't it? 11:44

AW: yeah, 12:06

GP2: So, if you could just print it out and give it to them there and then you know that's the thing and then they don't have to come back and see us 12:07

AW: And they can make their own informed decision 12:13

GP2: And the ones that then follow it up and the ones that are most likely to actually turn up, aren't they? 12:15

AW: Absolutely. So, it not only gives them that choice, but you then have an indication of how ready they are to change given if they make that referral or if they choose not to. So, we've spoke a little bit about the referral forms a little bit in terms of what we have at the minute the paper ones. You said, they are a little bit poorly designed... 12:20

GP2: yeah, that are half, half, they are A5 and it's just, I don't know it's a squash you don't even seem to have room to write their blood pressure on it. 12:43

AW: So, I've got the [hands over exercise referral form] 12:52

GP2: yeah, I mean it's just a bit, it's just too small isn't it really! [Laughs]. So, basically, it needs to be A4 I suppose, and I would, I would just let the

medical history be pre-populated you know. And you need a bigger space for blood pressure because it's you know two figures, isn't it? It's a fraction and stuff like that so, but you see it would start off just ben pre-populated you know on an a4 piece with our logo so it would be obvious where they came from and then you can put a summary erm and then a bit at
the bottom. This bit, obviously for the patient to sign because that's important because unless the patient wants to do it and agrees to it. I mean that's really the key, isn't it? 12:52

AW: yeah, absolutely! 13:36

GP2: So, so the, yeah, it just needed neatening over, but that wouldn't take long... 13:37

AW: It terms of the patient measurements and things that you've got to look for, do you think that's all appropriate? 13:42

GP2: It's blood pressure and weight, isn't it? [looks through form] Nope, yep, that's fine. Yeah, no., I think it's not necessarily the words, but it's just a bit grotty and you can imagine we lose them, and we run out of them and… 13:48

AW: And considering its hand written it's so condensed. So, this is something we want to look at changing even if it's just something temporarily in the meantime until we get into system one. yeah, that's fine... Do you feel your medical training prepared you for the physical inactivity epidemic? 14:05

GP2: [Laughs] Well, when I was young no-one, it wasn't a problem! Well, well, yeah, I mean I wouldn't pretend to be like a personal trainer, but you can soon pick up. I mean it's so blatantly obvious to us all that people are sat at home in front of a screen and it's not good for you, is it? 14:24

AW: No not at all! 14:41

GP2: But it's not medical! I mean the trouble is it's not medical its lifestyle, so it needs to be taken away from GPs. It's not necessarily the health trainers fault at all it's the patients thinking that there's a medical answer to these problems. So, it needs to be really made clear to the patients that it's not a medical problem, that it's a lifestyle problem and that the people to help them are basically, the health trainers whatever guys they are, sports people, you know. And that the patient has to do it every day for the rest of their life 14:42

AW: yeah, it's not something you can just... 15:19

GP2: It's not like it can be solved with antibiotics no. It's that, erm, so yes, it's not medical and yes, it is easy to pick up I mean to be honest it's a common. But I don't want any more training in it because you don't need to be a doctor 15:21

AW: Because it's not medical? 15:36

GP2: It's not medical and really it would be nice to even get them before they even saw us, you know. 15:36

AW: Right ok 15:41

GP2: You know and certainly the diabetic nursing team, they should be referring to this all the time because you know. I mean not all diabetes, but so much of it is related to it. And erm, the physiotherapists even if they're done some physio for a particular joint, you know the ongoing, just keeping people active could be this couldn't it? And lots of practices now, nurses see patients you know without GPs and they, we have physio's we see, you know without necessarily seeing a doctor. So, so it needs to be those sorts of people... 15:40

AW: Who make the referrals? I was just going to ask, do you have any form of triage system to delegate patients away? 16:18

GP2: We don't yet because we're not quite ready. We are training up physio's and things, but no, at the minute the patient rings up and says I want to see the doctor. Now we sort of, a lot of them know we have nurse practitioners and will ask to see them, but there isn't a formal triage service at the moment because we haven't quite got it ready. We're hoping next year to completely redesign the way we do things, but we are not there yet 16:26

AW: But it's something you can see developing in the future? 16:50

GP2: yeah, and, I think most, certainly big surgeries will be doing that, but you've got to be very careful you've got the right staff in the right place before you start telling the patients anything different. But certainly, this would be something, erm, we've got physio's and pharmacists training to do minor ailments and, I think they will pick up a lot of this and they, and that's why if the form was there in the patients notes 16:51

AW: It can be moved out.... 17:14

GP2: You know whoever is seeing the patient can just say well, look, you know in a very brief one minute chat about there's this scheme to help you become more active, and here is the form 17:13

AW: yeah, so in the future that will help 17:27

GP2: Well, like I say we're hoping to change the way we do things next year, but it's a lot more complicated [laughs] 17:30

AW: I can imagine! So, at the minute is it just the GPs who initiate the referrals? 17:38

GP2: No, I am pretty sure that nurse practitioners do 17:43

AW: Ah right 17:45

GP2: Because we have got um, well, we've two nurse practitioners that work completely independently. One who's nearly finished her training and they will see people like this and then we have another nurse practitioner who runs all our diabetic clinics and everything and she certainly should, but I've never asked her in all honesty. 17:45

AW: Right ok 18:02

GP2: Well, that's why, yeah, you know reminding people every year or so is a good idea because staff change you know 18:03

AW: And so do the schemes! [Laughs] 18:13

GP2: yeah, and we're probably saying, the same thing that we have for five years, and it is probability different so, but you know emails to all GPs is the way to do that and practice managers because they would then send them all on all the nurses and the physios that are doing minor ailments and diabetics you know, and it would get out 18:13

AW: So, just a reminder as you say not anything to... 18:32

GP2: No, we don't want [laughs] 18:34

AW: Just nice and clear this is the referral criteria for this programme. Erm, so in terms, the next section will focus a little bit on facilitators of patient referral. So, is there anything that eases the process at the minute of referral to the programmes? 18:38

GP2: No, no, no, I mean it's not really yeah, 18:52

AW: Ok and in terms of feedback from the programmes, do you receive any information whatsoever? 18:58

GP2: No. I mean the odd patient might say they quite enjoyed it, or they hated it, but we don't get any formal feedback at all. But we're not, you know we're not

that bothered about that. Erm, I mean if it became that, because it would be nice to know the number of patients who completed just from an academic point of view. So, if you sent it, but it's not a letter that would need to go to the doctor it would just go straight to, and again if you did it all electronically this is possible, you could then you would then come in and code it so you would know, and then say if you wanted to come back after a year, you would then be able to just do a search on referrals and completed course letters and you would be able to run that search in a few minutes and you know, are we getting value for money? And if hardly anybody completes it then you would be able to, you know, look why or whatever wouldn't you? Or if it's a good one, good course then you would be able to see that, but we don't, we don't want to know anything. I don't mind you know, but on a personal level I don't want to know. If the patients just, just constantly refuses to go, well, they're the ones with the poor health, aren't they? You know all you can do is try! Erm, there are academic advantages to coding, yeah. 19:06

AW: So, again if it is in system one it can be on patient notes, and you can quickly search. So, in terms of feedback, you don't want it sent to you, but sent to the patients notes, is it just a case of if they've completed if they haven't completed? Is there anything else that you'd like to know? 20:18

GP2: Well, I suppose erm, if they've never contacted you, we will know because they will be nothing in the notes. Erm, so you could say attended once DNA (did not attend) twice, discharged because that would be one thing, and then completed 20:34

AW: Yep, yep, 20:51

GP2: But we do not want to know any more than that and in fact a lot of people will probably say that's a bit much, but I can see that would be useful to know, wouldn't it? 20:54

AW: yeah, I mean the scheme will obviously be taking blood pressure, erm weight loss, as in if they've achieved 5% or not 21:03

GP2: Yes 21:07

AW: But as we say we don't want to be sending you unnecessary feedback so if you don't want to receive that then we need to somehow get it in the system so if it needs to be in the patients note it can be there if you want to look at it 21:08

GP2: yeah, I suppose if they do actually loose anything like 5% actually obviously that would be good, though to be honest say we needed their weight, say for an orthopaedic referral we would get them in and weight them anyways, you know. So, erm, erm, but I suppose you know if they've got that there and it's just literally on the letter you know as long as we don't have to action it, or it doesn't have to go to the GP because letters like that just go to the admin staff 21:18

AW: Right ok 21:45

GP2: So, you know it's only letter where there's prescriptions involved or re-referrals usually 21:46

AW: So, GPs wouldn't receive it anyways. 21:50

GP2: We wouldn't receive it anyways 21:53

AW: Right ok. And then for the final section we've talked a little bit about erm, the future triage system, but do you have any other support networks in this surgery to help manage your patient load at the minute? At present? 21:54

GP2: What do you mean load of people who what? 22:10

AW: Who come in for appointments so do you have any erm, telephone triage in the morning when they ring up? 22:12

GP2: Erm, we don't do telephone triage no, because it's, well, there's very variable research on it because the trouble is you waste a doctor doing a morning of telephone calls and then somebody has to see all the ones they want to see. So, erm, so the patients ring up, erm I mean we have different people doing different things you know there's different appointments available, but the receptionists have a protocol 22:18

AW: Ah so the receptionists are kind of direct people to the most appropriate place? 22:43

GP2: yeah, mostly and certainly if the patient doesn't want to say anything they get a doctor appointment 22:45

AW: Right ok 22:50

GP2: We've just started doing this web GP, you know this internet thing. 22:53

AW: Oh, I've not heard of it 22:56

GP2: So, patient can send in email queries. I have to say at the moment it has just done nothing, but increase workload, but you know. But it wouldn't, well, actually it could it? Because what you could do is if I want some help in losing weight, you could direct them and send out this form. 22:56

AW: From the GP? 23:14

GP2: From the web GP. Web GP is linked to our website so if you look on our website there's a blue banner at the top and that's to put queries in and it can be over clinical things or sick notes, or you know wanting to look at results. But you know if, if the query along the lines was about wanting to lose weight

you know the answer could be, because it then has to go to either to admin or a doctor you know pick up this form 23:16

AW: And then it would stop them coming in? 23:45

GP2: There you go, but yes, and well, all practices in East Riding have got web GP now 23:45

AW: I was going to ask is this something that's implemented.... 23:53

GP2: yeah, it has been bought by the CCG 23:55

AW: Ah right, ok 23:56

GP2: I don't think every practice is using it, but certainly the majority are. But it only started in, well, it was bought for April and there's been a sort of roll out so you could, I think most patients would come in. I mean they like to come in they like to see us or the nurses. I mean our diabetic nurses are very good and they will see most of the diabetics to be honest, but patient still like to see people's faces 23:56

AW: But if it just helps divert some of them coming in... 24:18

GP2: And you could advertise on the website anyways, couldn't you? Because it is open to anybody almost isn't it, the exercise on referral I mean 24:23

AW: The exercise on referral yes, 24:33

GP2: People that would need to see somebody with exercise on referral and you could, you could link it in to that though I suspect they would still want to come in and chat about it. [Laughs] 24:32

AW: But some of them might not [laughs] 24:43

GP2: But you know you could put it as an idea that it's advertised on the website and could be erm, an option for users of web. It is literally called web GP 24:45

AW: yeah, I didn't know about it so that is really interesting because I can ask other surgeries if they are engaging with it 24:54

GP2: And if you look, because you can just go to Ridings you know website, and you'll see the blue banner because you're not a patient, well, I'm assuming you're not a patient 24:57

AW: No, no, 25:08

GP2: Erm, you wouldn't be able to do it, but if you are registered with an East Riding GP, you could try your own website and then just play with it because you can always exit 25:08

AW: Yeah, yeah, aw that's really good, I didn't know about that, that's really good. Ok, is there anything we've spoke about today that you feel we can expand on further or anything you feel relevant? 25:19

GP2: No, I mean, I think it's just plodding on, keeping people away isn't it, and making it, yeah, just a bit more efficient the actual referral system that would make a difference to be honest 25:31

AW: And I guess if it's on the web GP just getting that awareness out there for patients. Do they tend to be quite familiar, when you do approach them let's say about exercise on referral, do they seem to be knowledgeable or are they...? 25:43

GP2: No, no, no, 25:55

AW: Not at all? 25:57

GP2: It's usually the first, you know they haven't heard of it. It's not an offence or anything like that 25:57

AW: So, not only have you got to make the referral you've got to try to convince them it's a good programme 26:04

GP2: Yeah, yeah, 26:10

AW: Ok, do you think there's anybody else in this practice, so you spoke a little bit about your nurse practitioner who deals with diabetes... 26:10

GP2: I wonder if it might be worth… she's called [Nurses's name] and she's the nurse practitioner. She basically, runs the diabetic services and sees the diabetes, but she's also very involved in the long term conditions 26:18

AW: Right ok. The chronic conditions 26:30

GP2: You know most of them have diabetes, but she's also involved with the ones with heart disease and stuff so actually she might be a very good, and you can contact her, well, she's on the... 26:32

AW: How do you spell her last name sorry? 26:43

GP2: [Nurses's name] yeah, and then little [Nurses's name] and then big [Nurses's name] 26:45

AW: [Nurses's name] 26:52

GP2: I don't think she'll mind me giving you the, erm, [looks on emails for email address of nurse practitioner], just a minute 26:51

AW: I just think it will be interesting from her perspective erm, especially because she's... 27:24

GP2: She would, she probably would be erm interested as well. I've spoken to every [Nurses's name] in the country now! [Laughs] I didn't realise, I thought it was doing to do the [Nurse's name]! Erm, must be [Nurses's name] actually! [Types and clicks] I definitely emailed her! [Clicks again] There we go [Nurse's name]! You know I never knew that you know! She's called [Nurses's name]! She's down as [Nurses's name] 27:26

AW: [Nurses's name]? 28:25

GP2: yeah, there you go so erm [Nurses's name] 28:32

AW: [Nurses's name] 28:37

GP2: [Nurses's email] 28:39

AW: @nhs.net brilliant thank you 28:39

GP2: No that's alright yeah, that's the right one East Riding medical group and erm, yeah, fancy that. Anyways and she erm like I say runs the diabetic side and involved with long term conditions 28:42

AW: yeah, brilliant thank you very much 28:55

GP2: And she might be a good one to get it more into the sort of nursing side of things erm, and erm, but otherwise, I think the doctor just plod on really 28:57

AW: Aw [laughs] no, that's brilliant thank you very much and thank you for your time again 29:07

GP2: No, it's ok and good luck with it all! 29:10

AW: Thank you very much! 29:14

AW: Interviewer **Interview date:** 27.07.2017

GP3: Participant **Interview location:** Practice One, Bridlington

AW: 00:03 is it OK if I take a few demographics just before we begin?

GP3: 00:05 yeah

AW: 00:07 how old are you if you don't mind me asking

GP3: 00:09 37

AW: 00:11 37 and what's your role as a GP?

GP3: 00:13 partner

AW: 00:16 do you have any other roles within the surgery?

GP3: 00:17 erm no

AW: 00:19 no, ok

GP3: 00:23 counts as all the roles anyways, but yeah

AW: 00:22 ok (laughs) and are you full time or part time?

GP3: 00:25 full time

AW: 00:26 full time. How many sessions do you deliver in general practice per week?

GP3: 00:30 8

AW: 00:31 8 and how long have you worked as a GP?

GP3: 00:35 mmm 4 and a half years

AW: 00:38 4 and a half years. Has that always been within the East Riding of Yorkshire?

GP3: 00:40 yep

AW: 00:41 brilliant. So, the first section of the interview as I say is centred on the healthy lifestyle programmes. So, what, what healthy lifestyle

programmes that are run by the East Riding of Yorkshire are available in this locality specifically in this area for patients?

GP3: 00:53 erm, we've got LiveWell

AW: 00:54 yep

GP3: 00:55 and Exercise on Prescription that I am aware of

AW: 00:57 Exercise on Prescription and LiveWell

GP3: 01:01 yep, not aware of any others

AW: 01:01 right OK. And how are you informed about LiveWell, and Exercise Referral?

GP3: 01:05 erm there's no, just basically, that, it's been, erm well, through working here., I think patients sort of mention it rather than anything else and the worse and ref, some sort of prompt sheet about it you know the only things we've have. So, I think most GP's find it hard to know, there's so many different referral, you know options, it's very hard for you to retain them all in your head. To know all the different areas and what's possible

AW: 01:33 absolutely

GP3: 01:34 because there tends to be thousands

AW: 01:35 what do you think would help, sort of increase that awareness? Is there

anything you would like specifically? I'm just thinking off the top of my head

GP3: 01:43 yeah, no, it depends on how many different things there are to offer people and to try and target the right things to the right people because often it comes up when a patient asks me for it rather than necessarily me thinking of it which isn't quite right, but anyways. It's not always front of

mind and it's not always obvious which criteria people meet to be able to have which service. It's not always obvious.

AW: 02:08 right OK. So, as well, as obviously there are so many different services it's also remembering all the different criteria for all those services. So, out of the live well, and exercise on referral, which one do you tend to refer onto most often?

GP3: 02:21 exercise on prescription

AW: 02:24 ok and why is that?

GP3: 02:24 erm just because the criteria it's so much easier to get involved with. It's a lower level

AW: 02:29 so do you find that more patients are eligible for...

GP3: 02:31 loads more, loads more

AW: 02:36 and exercise on referral and LiveWell, both have information booklets such as, such as these ones. Are you given anything else? Any other sort of resources?

GP3: 02:48 there's different versions for the, for the, LiveWell, one. There's a different booklet that we have been giving out than that. So, it's not glossy and it's not printed, it's a photocopy of something and it's different anyway.

AW: 03:03 right, ok

GP3: 03:04, I think that is what you will probably see throughout is that the consistency is the bit that is lacking, and that lack of consistency means that you know, you can't reliably deliver the right services to the right people. Erm, so yeah, and for the exercise on prescription I was unaware that there was a booklet at all

AW: 03:22 right, ok

GP3: 03:23 it just so happens where we have kept the referral sheet itself, the pdf of the referral sheet. Basically, it doesn't have anything else attached to it on the way that we have stored it in this practice.

AW: 03:33 ok so for you, you just have the referral sheet and that's the only kind of way that you find out about exercise on referral.

GP3: 03:38 yeah

AW: 03:39 so do you feel like you've been provided with a satisfactory amount of information about each of the programmes?

GP3: 03:46 it's probably there somewhere, but point is, the available information as in the point that we make a decision of if someone is eligible or not, I need to know, I need to be able to match that at the time of making a decision erm otherwise it's a waste of time, isn't it?

AW: 03:58 yeah, absolutely. So, for you it's not only about, as you say it's about being able to match the demands of the patient, the criteria, and it's almost impossible to know every single service and their criteria. And you mentioned earlier about patients. Does it tend to be patients who initiate the referrals?

GP3: 04:19 usually more than half I'd say and occasionally it's come to me from other areas like the health trainers have said, "ah, I think you might be eligible for exercise on prescription", but when they say that I'm not always clear. The patient expectations set that I've got the keys to doing this referral and yet often you know I won't always know to start with, is the patient meeting those criteria of being inactive and having those two diseases and they will have no, idea at point they have suggested it to me.

They won't know which has made me wonder why. And even yesterday I've had a patient come through for a full GP consultation. Costs globally £36 to someone somewhere for the health trainers to basically, send someone to me to say can you do exercise on prescription and that just seemed like a waste of an appointment.

AW: 05:06 yeah. So, it seems as if…

GP3: 05:10 we want as many people in the system to be as autonomous as possible. Erm, and, I think that health trainers are part of the health system and it's important for them to be able to work within their capacity to answer things as much as possible. I was thinking after the event to know, obviously they have to do some screening to know is someone eligible and there are health-related criteria. They could have found that out from our reception they did not need me.

AW: 05:29, but instead they have passed that onto you and as you said, it had taken a full ten minute consultation

GP3: 05:34 full ten minute chat about it yeah

AW: 05:36 ok. So, who do you think is best placed to make these referrals? Do you think it should be a collaborative thing where different health professionals can all do it?

GP3: 05:45 yeah, I think make it as broad as possible so long as you can show that people are meeting the criteria, or there is some triage at far side to get people into the right spot you know. I don't see it as particularly, it should come from health at all, but I do see that it has a massive impact on health erm so it's important that we are all doing it, but centralising extra work on other colleagues from one service makes no, sense.

AW: 06:07 yeah, absolutely agree. So, is there any form of triage at the minute or is it just opportunistically?

GP3: 06:13 opportunistically if it comes up. We are certainly not searching people out for it we are not doing trawls of the database of who is overweight or any of that other stuff. There is no, proactive work

AW: 06:23 is that something you can see developing in the future?

GP3: 06:24, I think so. Like I said, I think, it's quite good data. We are looking at how long people live and to do with health inequality stuff and what was interesting for me about it erm with the data that I had seen was it was American data from 1970 to now looking at increased length of life becoming 13 years longer and they reckoned that 12 of those years were due to other things other than medicine. Which just made me laugh! So, inactivity and poor health choices and food choices and exercise choices probably have got more of an effect that most of what we are spending our money on which doesn't make any sense to me whatsoever. And especially we're in a high deprivation area and therefore you end up with some extra things happening which is our disease prevalence is higher, our age of death is younger by ten years than York and you know that's a profound health inequality and it needs to be better matched by having access to these sorts of services than it would be by health-based services. So, yeah, well, behind it

AW: 07:31 so it's particularly pertinent in this area. As you say because of the disease prevalence

GP3: 07:34 well, for health, for health you have an inverse care law as well, meaning that the poorliest people feel the least need to come to the doctor

than they turn up to the hospital with their very end stage, late presentation of a serious disease which then shortens their life and that is cultural. Interesting for me about cultural things is people do it because of the environment they're around. If you are in a healthy environment with other healthy people doing the same sorts of things, people follow the herd. So, my sense is that this town in particular misses a trick in making you know, exercise available to anybody and normalising it. Where actually I have got loads of patients who have been totally inactive and when they get referred in, or when they refer themselves just to, just the presence of the gym being there, separate to the referrals, the people who are inactive are now really, really enjoying doing exercise and getting a great result from it

AW: 08:23 and that's amazing. So, as you say there needs to be prevention and a bit of a culture change, so people are not getting to them late stages and presenting with those conditions that are related to an inactive lifestyle really.

GP3: 08:36 yeah, yeah

AW: 08:37 ok so in terms of patient referral, do you experience any constraints or issues when referring patients onto these programmes?

GP3: 08:47 yes

AW: 08:47 ok

GP3: 08:49 so for exercise on prescription there has not been particular issues with the referrals. They go through. I'm very pleased with how quickly they pick them up., I think there's a huge benefit of being very quick in the sense that people when making a decision will have two thoughts in their head about do, I really want this or do I not. At the point that they have told me

they will, that motivation is there., I think that's the time that it needs pushing over the line to then say well, can you come in on Monday and we will see you get things moving. Erm, so, I think it's important that it's a quick turnaround., I think it is, that's my experience. The problem I've had its probably more to do with the more expensive one which is the LiveWell, programme and the problem is, if people are asking for it and they have had it before, then it's unclear whether they need an independent funding request i.e., extra support for money, or whether or not they can be re-accepted. So, I had one patient for example she is more than five years since she's, erm, been on it. She had good results when she was on it, bad when she was back off it. Was more than five years. I thought I needed a funding request, rang the funding request people, waited six weeks for an answer and they said, you don't need one because it's more than five years and then I sent off the request and lo and behold I get the answer back saying, we can't accept them we have seen them before. So, there is a mismatch in criteria between the two which resulted in lots of wasted time

AW: 10:11 because from my understanding erm that area, it's a bit of a strange one because, I think it's just down to their judgement whether they accept patients again. Whether they have been once, I don't know if there is a strict criteria so it's definitely something that does need accessing so for you, you're sure….

GP3: 10:26 it's the same on both sides and if we were all clear of it. It should be part of the referral. If it's integrated into either the referral process or part of the paperwork by however, we choose we are doing it, then it's available information for the person at the point of doing it. They won't make that

mistake. We won't waste the IFR panel time and equally we won't have duplication at our end it will just happen once and seamlessly

AW: 10:49 absolutely. So, that's one thing, so as you say the exercise on prescription they have really timely referrals, it sustains the patients motivation, but in terms of the criteria for LiveWell, that's where you have had some of the issues particularly with re-referrals

GP3: 11:06 yeah

AW: 11:06 is there anything else that perhaps makes it difficult to refer?

GP3: 11:10 nothing, nothing particularly. Well, there are some things that make no, medical sense that are on there. I have to document the blood pressure of the patient I'm referring to go and do exercise. I'm totally unaware of any blood pressure that would affect someone's ability to exercise. There is huge, huge variability in blood pressures anyways and by that, I mean within the person. Biological reasons, you can be out by 30 based on stress. There's apparently a ten systolic difference based on the time of the year, and it's not widely known, not widely talked about so it makes utterly no, difference to what we are doing, and I will argue it was a complete waste of their and our time. And also, the data on malignant hypertension, so super high blood pressures, they have now looked back at the original data when they first introduced blood pressure tablets and they looked back at all of it and that's the best place they can find out how dangerous is it to have very high blood pressure, and the answer is still not very dangerous. So, on that basis so long as they're identified as having high blood pressure, it should have a background treatment, but it has nothing to do with exercise right now.

AW: 12:20 yep, I'm really glad you mentioned that because, erm when we do make it electronic, well, if that's what we decide to do in surgeries, a lot of the, I find on the referral forms, I'm thinking why, why are you taking blood pressure because on the first session they take blood pressure again anyways so there is no, reason. But obviously we can't make changes until we hear it from our participants, so I'm really glad you mentioned that

GP3: 12:46 good

AW: 12:46 in terms of the referral forms, is there anything else that you find it perhaps not relevant I have one here if you'd like...

GP3: 12:48 yeah, if you can that would be great

AW: 12:51 are you using the online referral or paper referrals?

GP3: 12:53 no. Paper referrals, but as I say we've got so many different places we can refer to…

AW: 13:02 there's the exercise on referral [gives forms]

GP3: 13:02 yep

AW: 13:05 and there is the LiveWell, form [gives forms]

GP3: 13:09 yeah, I mean this is a slight joke as well. I get that the patient has the sign the patient declaration prior to me filling out the form and no, part of it says erm, that we have not withheld you know, I've not withheld any relevant information and yet the person signing it, me, is signing it based on the medical record, so it should be me signing to say I'm not withholding., I think it is an irrelevance, so I don't think that necessarily needs to be there I don't see how it protects anyone legally. It just doesn't. And then you've got them to say they give their consent to erm, participating in it, and again

by them turning up they've given consent to participate in it, so I don't think you need that either.

AW: 13:49 OK

GP3: 13:50 and the yeah, 'information to be disclosed to relevant personnel for monitoring and evaluation', yeah, maybe that is needed, but it's certainly not a permission that is needed by me at the point of referral

AW: 14:02 right OK

GP3: 14:03 well, imagine if twenty percent of people now didn't turned up at the far end, then I've taken 20% more signatures that I needed to. And imagine that I want someone to go it, I've spoken to them on the phone to say please can you go, they say yes, I'd like to go and I don't have their signature. I need to invite them back into the practice to sign this piece of paper before it can be sent to the far end. I don't think there's anything legally there that sounds like...

AW: 14:31 that makes sense. so, do you tend to erm, do you tend to send patients away, they have a think about it, then do you give them a call?

GP3: 14:38 erm it depends. They tend to make the decision when I've spoken to them, and they say yes. They want to go and do it. If they are that you know ambivalent about going, I don't suppose they will get much out of it anyways. So, if they are not sure we tend to leave it be, it's not our place to chase them up to make them do it. But if people have, on discussion, said, they want to do it, my sense is that if is that you need a signature, fine a GP referral signatures fine, if that comes with costing and stuff. I don't necessarily see how that's helpful in the sense that if you end up with a system with direct access, you know if you are screening people at the far

end, imagine that you open up to the public and say if you'd to refer yourself, and think you're eligible please tell us. Then that won't come with a GP referral, erm so anyways, it's just trying to work out. I don't think the GP, the patient signature is useful at this level unless anyone thinks that psychologically there's more of a buy in, but I'm not too sure.

AW: 15:37 yeah, it's you chasing them up, you ringing them, getting them back in the surgery for them to sign

GP3: 15:40 yeah, I don't think it's adding much value for what it is. Erm, so yeah, other than that I don't know if the reason for referral, whether these are because there is evidence based around these things where exercise helps it, or whether it's to do with just straight rationing you want to give it to more poorly people. I don't know what the rationale is.

AW: 16:00 OK. In terms of the measurements that are required do you think they are all appropriate? So, we spoke a little bit about blood pressure you think that's not entirely...

GP3: 16:10 I don't think that adds anything from a risk perspective. Erm, and I am sure if can be tested at the far end. And if it was consistently, apparently to get a really, really accurate blood pressure, you need to have done 40 different readings so that you know that the variability you are seeing, an average of 40 means that the variability means you are definitely the number you think you are.

AW: 16:26 yep, and nobody has time for that

GP3: 16:28 nobody is ever going to do that erm so that's why we have moved away from GP clinic reading. We've moved much more towards home readings to try and get rid of some of that stress response, and we get

average home readings and it gets rids of a little bit of that variability, but not all of it. Equally with the BMI, there isn't a reason why we have to do that here I don't think. It just means weighing someone or, I'm not sure it's consistently filled out anyway. It might be relevant for people choosing which ones they are eligible for. So, if you had a search thing it might…

AW: 17:00 yeah, I think the LiveWell, criteria is 45 plus BMI and Exercise referral is 30 plus, so I guess that's the only thing it determines.

GP3: 17:07 OK I wasn't aware that it was 30 plus BMI for the exercise referral form and that's just yeah, it's just if you imagine that's the form the information that goes with it is elsewhere. They are not both available at the point of making the referral.

AW: 17:21 absolutely and if you've only got that referral form and you've not got any other information....

GP3: 17:25 it would make more sense at the point of doing the information as you put it in that it gives you some feedback at the time that it is or isn't appropriate

AW: 17:31 yeah, absolutely I agree completely. And would you like to see this type of form online or integrated into your system? Perhaps with some sort of feedback

GP3: 17:44 well, either., I think it's quite hard to integrate into the system we use which is system one, but you could very easily have a link to a website from within in., I think system one don't like having other partners. They make it very, very difficult to integrate probably to the point where it would be impossible to do unless you're with one of their existing partners and get them to do it. Even then I'm not sure if any of the existing partners if any of

them erm there's a whole bunch of government stuff around moving of patient specific data. So, it's all got to be, all the coding has got to be at the right encryption levels so nobody else can access it. Even if your moving across a BMI, it's got patient information that's, it's got to be the same level of encryption and all the rest of it and that's what sometimes makes these things tricky

AW: 18:33 so perhaps an easier alternate would be a link to another website

GP3: 18:37 yeah, one way would be a link to another website, but then, even then I don't know what the security stuff is around putting the patient data and or, their names, date of births, and or NHS numbers, and, or whatever so that's not totally straight forward. Another way would be, within system one you can use the referral wizard erm which allows you to do a referral. It can bring up a form within system one that you can populate and fill out. Perhaps with more prompts on it to get this stuff right and the referral can then go electronically to the far end. If you've then got system one at the far end, I don't know how you receive these ones, whether it would turn up as an email or whether it only turns up for another system one user, certainly for lots of hospitals they do electronic referrals that can go through via that sort of system

AW: 19:21 right, ok

GP3: 19:23 and then it's all secure

AW: 19:23 and do you think it would be easier, as you say if it was populated the form, would that be

GP3: 19:30 well, that's the other thing isn't it if you've got a form within system one that is linked to a, yeah, that's linked to system one within the existing

system it will auto-populate most of what we spend our time doing here. So, it could already, if you've got the codes in there for hypertension, it could already have put in their names, address, date of birth, NHS number, BMI, and most recent blood pressure. It could do all that

AW: 19:56 so all of that would already be filled in for you, and then as you say...

GP3: 20:00 and that's quicker than filling in an online, you know decision aid might be for patients to give their available information about what they can apply for, the actual referring from GP's, that's the neatest way I can think of

AW: 20:11 yeah, great so in terms of, is that all the constraints you can think of

GP3: 20:18, I think so

AW: 20:20 great so is that all for the constraints you can think about? So, next is a little bit about patient progress feedback. So, do you receive any information or feedback from any of the programmes regarding a patient's progress?

GP3: 20:28 I don't think so

AW: 20:31 OK

GP3: 20:32, I think some of the letters are filed by the people so I don't see absolutely everything coming into the practice, but I've not come across any letters at all in two and a half years so I don't think so that I can remember anyways

AW: 20:46 and what involvement would like you like with patient progress? Are you happy…

GP3: 20:51 not too fussed I mean if, if no, there's nothing extra that would be particularly useful., I think sometimes the health trainers have written and

they share notes with us in this area. So, if it is that they have shared notes and it, you know, documents that they have lost weight or being more active, that's fantastic. If not, it's medically unchanged from where they were and it's not, it doesn't make much difference to us

AW: 21:13 so in terms of feedback you're quite happy…

GP3: 21:16 I don't think there would be much that we would do things with let's put it that way. So, if someone's lost a stone in weight that's fantastic. If someone else has done the reinforcement about, how do you feel? How are things better? You know are you more active? Do you feel less breathless? And they have said, yes, yes, yes, yes, yes, and they are happy, as long as someone has done that feedback that's fine. I don't see there's any reason to bring that into being medical because it's not it's just sort of general lifestyle and things

AW: 21:41 and is there anything that eases the process of referral to either live well, or exercise referral? You mentioned a little bit about timely referrals, is there anything else that makes it easy to initiate a referral?

GP3: 21:54 no, we're currently always doing the same process so yeah, I just wonder if the process can be slickened or slick even

AW: 22:04 yeah, and as you say just to save time. If I can pre-populate, you're going to have more time in consultations

GP3: 22:10 yeah

AW: 22:10 Great and the last section about support networks. So, do you have any form of support network in this surgery to help manager patient load? So, for instance, do you have any form of erm, triage system?

GP3: 22:25 erm we, our practice uses a reception triage which is erm you know quite an interesting concept, so there's different ways you can triage the workload on a day. Erm, the way that we've got it is patients call up and ask for an appointment at which point they will have a discussion with the receptionist who typically will have worked here for a long time, typically will know the patient, typically erm knows what that patient's presentation is usually like, what they are usually like on the phone. They hear what they are saying, and will use that as part of the decision making. They will know whether that person has been in recently and they will look at their notes to see if anything more serious is going on. And based on all of that, as part of a subconscious complex decision making, will make a decision about what the next best available is that would suit that patients need plus our need and if they get feedback and the patient says they are not happy or they are worried it's more serious, they will then bring it up, erm bring it forward or bring it to a doctors attention. That sounds unusual that you could have somebody not medically trained as a doctor doing that job and yet it basically, smooths out the workflows from a Monday to a Friday so our variation disappears. It erm, it means that I don't have to have a clinical team member spending endless amounts of time doing the triage. So, I get all the clinical team working and because of that, we are quicker at meeting patient demand erm, and we basically, get very few complaints. Almost nothing missed via that system. It's really important to how we work.

AW: 23:51 and how long have you been using the receptionist to telephone triage?

GP3: 23:56 forever

AW: 23:57 for a long time

GP3: 23:59 yeah

AW: 24:02 and is it something, I'm just thinking of the top of my head, if there was a way that perhaps if a patient rang the surgery and mentioned about lifestyle issues or they'd like lifestyle advice, I wondered if there would be a way where the receptionists could signpost to these...

GP3: 24:20 yeah, yeah, if it's tied with what we're doing and what we would like to do. So, there's other erm other areas where there can be direct signposting from our receptionist, our staff are doing it to some extent anyways. They have not been formally trained and taken it to further levels, but they have certainly been directing people directing to physio in the past, they have directed to mental health phone numbers, or erm to self-help on occasions so yeah

AW: 24:42 and it is an area you can see developing the receptionists doing more signposting

GP3: 24:45 yeah, yeah, absolutely, absolutely

AW: 24:48 and as you say then you have more of your clinical staff to meet the demands of your patients

GP3: 24:53 yeah

AW: 24.55 fantastic. So, that's kind of all the areas that I wanted to cover. Is there anything else that you would like to add about any of the areas, that you feel might be important?

GP3: 25:04 yeah, and just about referrals, isn't it? It's not about any of the problems with the system or anything else that's happened

AW: 25:09 what do you mean in terms of the system?

GP3: 25:13 erm we've got a patient referred under mental health for the exercise on prescription and they ended up, I haven't sorted it out I need to speak to the manager of the leisure centre where she, she's quite strange, she's quite a strange lady, that's the reason she got referred on exercise on prescription. She basically, erm, had, erm worked and functioned in society until the breakdown of her relationship and then was totally isolated, left, left her job, got depressed and had seven years living on no, money. She then had run out of money and came asking for benefits and then it became apparent no, your whole life hasn't been working. We offered her mental health support, and she didn't really want to do it at that time, but she was happy to start using the gym and get more socially active. At the same point we referred her to the voluntary erm, service for volunteering type of stuff and they was working with her towards getting more active. But where she had been referring for mental health on prescription, erm, she ended up having an argument, ended up escalating this argument with the gym on account of the fact that on five occasions male operatives came into the female changing room to change things over a one week period when she was there. And she brought it up with the manager and said, I am not comfortable I've had horrible experiences when I was younger, I don't want in mixed female open changing rooms to have males walking in whether it's to change lights or otherwise. I'm not very comfy with it and that then resulted in an argument with them such that now she's only ever seen with two member of staff, and they referred her to mental health team saying, that they thought that she was mad and not very well. And they saw her, did

an assessment and said, no, you're not suicidal and you don't need sectioning you're fine!

AW: 26:57 oh, God

GP3: 26:57 and that was the whole point of the referral. I don't think they understood mental health very well, and with that trying to shoehorn her into how the public normally is rather than how someone with mental health in the public might behave. And she didn't do anything that was dangerous to anyone else, she's just odd. And she will be odd whether she is with them or not. She's much better with them and included than excluded

AW: 27:21 absolutely

GP3: 27:21 so and I just thought it was a shame that they had not spoken with us about her since we've done the referral and now I am unclear having had the tariff go off to say she's had exercise on prescription, I am unclear, I think it has been ended with hers, they are not doing anything more with her, but I've not had any feedback to say "oh, by the way we booted her off because she was too difficult"

AW: 27:40 right

GP3: 27:42 none of that got said, so it's just sort of left a little uneasy really

AW: 27:45 yeah, so what happens now?

GP3: 27:47 so I will follow up that individual case myself, but as a general feedback, I think that's really important if you're taking mental health as part of exercise on prescription, there needs to be a really good understanding of how mental health works and what's OK and what's not OK. And how you deal with people who are not your average

AW: 28:06 yeah, absolutely so in them cases feedback would be useful

GP3: 28:11 that would be really useful and I am now going to have to get the feedback by me chasing that up

AW: 28:13 by you chasing that up yeah. What we are hoping to do is when we develop some kind of online screening and referral system, we'd like to incorporate some questions that are going to help direct people to the most appropriate programme for them. So, whether that's by the criteria and they will be a few mental health questions because with LiveWell, in particular they do accept mild mental health problems such as mild depression, but when it's severe they're triage to other, mental health services. So, if we had that put in place in the first place, you'd be able to better direct people to the most appropriate place and support for that patient. So, that is a big area that we are looking at as well. Because as you say you can refer these people, but if leisure centres aren't equipment to manage, or if they don't have any idea of the history of that patient, then it's not going to bare well, for the patient

GP3: 29:12 yeah, good

AW: 29:15 brilliant. So, that's everything that I wanted to speak about today. I am speaking with [PN's name] little bit later on, I think half past three

GP3: 29:27 I don't think it's as late as that, I think she has patients in

AW: 29:26 oh, it might be three then

GP3: 29:27 so yeah, she will want to get on with that, I think

AW: Interviewer **Interview date**: 31.08.2017

GP4: Participant **Interview location**: Practice 2 Bridlington

GP4: 00:06 No I had the boiler man coming and my 18 year olds heading off to university this weekend, but he, he's at home and I said, you've got to remember the boiler man. So, obviously he texted, *what boiler?* (laughs)… I even spoke to you this morning before I left, you know. Anyway!

AW: 00:22 He'll have so much on his mind.

GP4: 00:24 er no, not really

AW: 00:24 What university is he going to?

GP4: 00:25 his mind is completely empty as a rule. He's going to Dundee

AW: 00:29 ah right

GP4: 00:29 er so he's going to do, erm, biomechanical engineering

AW: 00:32 wow

GP4: 00:33 so he's erm, well, I think he's going to do rugby and boxing mostly and partying followed by a little bit of biomec... My other sons at Edinburgh and he does rugby and boxing and drinking and a little bit of chemistry and, so I'm sure he will just follow the traditions

AW: 00:51 probably until the final year (laughs) and then he will buckle down. So, just before we begin, I'll just give you, so I've talked to you about the purpose of the research, a little bit about confidentiality. So, anything you do say today will be held strictly confidential. It may be that I choose to use some for my thesis, but you will not be identifiable in any which way

GP4: 01:09 that's fine, good

AW: 01:09 you've got several rights during this interview. So, if there's anything that you don't want to answer just say no, comment and we will move on

GP4: 01:15 ok

AW: 01:17 erm, and we are going to be talking about 5 key areas. So, the first key area being what healthy lifestyle programmes are available in this locality specifically- Bridlington. I will then be asking you about the information and referral resources for these programmes, any issues or constraints that you are faced with when referring patients, a little bit about the feedback that you receive if any from either of the programmes, and finally the support networks that you have in this surgery to sort of manage your patient load. Does that all make sense?

GP4: 01:44 yeah

AW: 01:44 brilliant. OK so I'll just start by taking some simple demographics before we begin

GP4: 01:50 ok

AW: 01:50 so how old are you if you don't mind me asking

GP4: 01:51 I do mind. I had a horrible birthday this year. I'm 50

AW: 01:56 50. 50 this year. So, 49 presently?

GP4: 01:58 no, I am 50. I was 50 in April

AW: 02:02 ah congratulations

GP4: 02:02 thank you

AW: 02:03 and are you a GP partner?

GP4: 02:05 I'm a partner yeah

AW: 02:06 do you have any other roles within this surgery?

GP4: 02:09 erm, I'm the chairman of the Brid Inc. which is our organisation across all the practices, and I sit on the council members, CCG counsellor members

AW: 02:24 and do you work full time or part time as a GP?

GP4: 02:26 depends on who you ask. Erm, my family are never...erm, I am part time officially. I do erm, seven sessions, seven ninths whatever that is

AW: 02:39 and how long have you worked as a GP?

GP4: 02:41 erm, 22 years

AW: 02:44 22 years. Has that always been within the East Riding of Yorkshire?

GP4: 02:47 yes, Driffield and then here. 10 years in Driffield. 12 years here

AW: 02:51 10 years in Drif... fantastic. So, the first section of the interview will be focused around the healthy lifestyle programmes. So, what ERYC run programmes are available in this locality for patients?

GP4: 03:04 this is where I need [PN's name] to come in my Nurse colleague, she, she does these. So, erm, so we have erm, [PN's name] and [CN's name] is our care navigator

AW: 03:15 ok

GP4: 03:16 and so she erm, kind of runs all our social prescribing programmes between the two of them they match people to what programmes would be appropriate for them. So, erm, my role tends to be to identify those patients for who social prescribing would be of benefit and obviously exercise is part of that social prescribing. And erm, so, erm, well, we've got all that stuff run at leisure world, we've got LiveWell, erm, we've got… what's the other one they have? I can't remember to be honest. Tell me the other ones

AW: 04:01 er, so there's LiveWell, the young LiveWell, programme, Exercise on referral

GP4: 04:04 Exercise on prescription

AW: 04:07 on prescription

GP4: 04:07 yeah

AW: 04:08 erm, there is also the Walking for Health and Swim for Health, but obviously that doesn't require a referral as such. It's more signposting them programmes erm, and a lot of people mention the health trainers, but obviously that's NHS run not ERY

GP4: 04:24 Yes exactly yeah

AW: 04:25 so out of them you've mentioned that you refer to the LiveWell, and Exercise referral

GP4: 04:29 yes, yes

AW: 04:29, but your role is more identifying the patients?

GP4: 04:33 so if I have a patient particularly who is quite overweight, the LiveWell, so we know that we have to, even if they wanted to get into bariatric surgery that have to have done LiveWell, first so erm we tend to push that way quite a lot. I have an increasing number of patients come in asking for exercise on prescription erm, which is fantastic because obviously the message is getting out there. It feels like we're almost getting to a tipping point of public awareness which is what we've always wanted to do. Erm, so, so, we are getting patient initiated, person initiated referrals which is fantastic! Erm, and er, so yeah, I just say go and see [PN's name] or I task [PN's name] our practice nurse

AW: 05:15 oh, right

GP4: 05:17 and she does the referrals, or I send to Di for if it's, say I wanted to do exercise on prescription, but I also want you to think about let's do

some dancing or do some, some of the other clubs that we have access to through our social prescribing networks. Rather than saying, it's all gym or nothing, you know, or swim or nothing, it's like well, have a think about that, but also, we link with U3A, we link with erm, the voluntary sector, ERVAS the East Riding voluntary action who are our erm, social prescribed link workers who then will match the person to the activity locally

AW: 06:01 so it's about giving the patients the options also, not just saying...

GP4: 06:05 yeah, exactly so it's not just gym or nothing which is, which has always been a barrier as I imagine it would be for me. You know, it's like well, I don't want to do that, but I wouldn't mind doing erm tea dancing. I wouldn't mind doing a walking group. I wouldn't mind doing whatever, or let's do a non-exercise based one just to get you out of the house and then let's have in the back of our mind that a year from now, once we've got them doing a knit and natter club or men in sheds, these are other things which we do, then some of these people are very lonely, once we've overcome that loneliness, then we say OK now you're doing men in sheds why don't convince your mates to go for a little walk together. And so it's part of that social programme which we're building on

AW: 06:47 yeah, so it's a step approach

GP4: 06:49 because sometimes that first huge step going to the gym which people just don't do, they won't do. I mean I had a women yesterday, I won't wear a swimming costume. I said, but you know you need to lose weight, how are we going to do it? I'm not going in a swimming costume, and I won't go to the gym. OK well, let's think about other things first and then we will build up to that. So, we try to reduce that first, the height of that first step really

AW: 07:09 so it's kind of a step approach again just to encourage them to ease them into it I guess

GP4: 07:13 yeah, yeah, yeah

AW: 07:13 OK and of them programmes, which do you tend to signpost or refer to the most often?

GP4: 07:19 I've probably just answered that. It is, I just signpost into, into the fact that there is another way. Right so I do this to everybody, all our patients [draws pie chart on paper] you know, that's how much of your health I look after [Indicates a 25% portion], and most of peoples problems they come to see me with are in the bits that's I don't, I can't influence. So, you know, loneliness, most of mental health, things like that, erm aren't in this bit of, you know, 20-25% of health that I can influence. And I said, you know the other day I said, all your problems are kind of here [points to remaining 75% of pie chart] yes, you've got diabetes, but that's not an issue. So, it's more getting people to understand that that's where they are, but they're coming to see me. And I say, but I'm useless look at me I am a potato myself, you know. Let's get you addressing, seeing that's there's help here and seeing how we get to that and then you're not always trying to look into here [points to his 25% influence] to drugs, you know, to medicines, to me, or to hospitals, or tests and that actually that's where the solutions are. So, it's more that and if that is received, that message is received then it's OK what about Exercise on Prescription? What about LiveWell? What about whatever, or what about going to have a chat with Di and let her go through the whole damn lot with you. Erm, so we do EASYCare

AW: 08:45 ah I've not heard of that one

GP4: 08:45 so er EASYCare are an organisation, international and they, they look at health needs in over 75's. Erm, so it's worldwide and so we took part in a research programme er, actually two years ago now and it finished last year. And it was erm, looking at unmet need. So, we did this assessment and we ended up with about 1500 people that we assessed over 75 in this town either via telephone or face-to-face and it's been done all over the world, but we was doing an economic evaluation project for them with the University of Hull

AW: 09:21 ah right, ok

GP4: 09:22 and it's just been published and presented at the World Health Organisation in October

AW: 09:26 wow

GP4: 09:26 and it's huge. Er so we did that for them, and we come up with four problems wherever you go in the world- loneliness, worries about money, worries about care as in self-care or who's going to look after me, and bodily pain, but I don't want any drugs for it. So, you do that in, they've done that in China, in Indian, in North America, South America, Europe, er, all over the world, er Iran, and it always come up with the same four problems. And guess what, so did we. And erm and so the loneliness and the finance, we get lots of benefits for people, but the loneliness and the pain thing is exercise, that's the activity stuff. The community bit plus the physical bit for the muscle strength and stopping the knees from hurting by getting the quads and things. So, we did that and that then further emphasised the need for us to be doing this kind of work. I talk far too much I am sorry

AW: 10:14 no, no, it's really interesting. I am really interested about this kind of concept that er you try to make patients aware that there are alternative ways to manage their conditions without medication

GP4: 10:25 Right. I poison them first and they come back and say that made me feel awful and I say I told you so

AW: 10:30 (laughs) you need to exercise

GP4: 10:30 I'll poison you again if you don't.... really badly...but people, it's almost like you've given them permission not to come and see me. Because we have a term medical- parochial erm, that you know paternal erm model, that you know, I'm dad I'll look after you, you're my children. It's a load of rubbish, isn't it? You know I'm a doctor, a teacher, I should be here educating people, so I like to kind of push them away from me a little bit and just say you, know. I only go to my doctor to annoy him really because he was my student years ago (laughs). I say I've come to annoy you again and, and, but my kids never go to the doctor. They never go to casualty or anything like that because they are empowered. You know my wife and I are doctors, so you know, they go and play pretty good rugby for a while so they know about injury, they know about illness, they know about nutrition so they don't need health care. Well, so far you know. My daughter is very ill, but that's a whole different matter, but the two boys are, you know, resilient because they are educated and it's like giving that to my patients and saying, if you know what I know then you wouldn't come and see me and that helps me

AW: 11:40 so again just increasing that education and awareness

GP4: 11:41 yeah, huge! That's what we need them doing

AW: 11:42 erm so I'm terms of the healthy lifestyle programmes, are you given any resources or materials that you can give to patients?

GP4: 11:50 so erm, if they've referred to exercise on prescription or LiveWell, [PN's name] will either ring them or arrange for them to come and see her and go through the referral process with them. I'm Sorry, I've probably just realised you're seeing the wrong person here, but erm so [PN's name] will go through that and we direct people to websites, we direct patients to... To be honest I say to most people just go and walk down to leisure world because A) that's then a walk and, B) you can have that initial contact and also via the health trainers go by them as well.

AW: 12:28 so is that where the programmes are run at leisure world?

GP4: 12:34 leisure world yep

AW: 12:34 and you said, earlier so the, the kind of patient awareness has increased because it's now patients coming to you and asking for it

GP4: 12:41 yes, and saying, can I have exercise on prescription yeah

AW: 12:44 OK is there any other way around that to try and stop them coming to you in the first place? Can you think of any…?

GP4: 12:50 well, what we're working on is this make every contact count with our receptionists, so they are coming here. There's er, with Public Health through our partnership board, which is, the Brid Inc. is our GPs group and then parallel to that is Bridlington partnership board which is chaired by [name] who is head of the health trainers so she's the manager of health trainers for East Yorkshire. But sitting on that are er Public Health, CCG, COCP, Humber, Education, University, Voluntary sector, patient group so we get everyone together and that's been going for about three years now. And erm,

so, we all kind of sit together and sorry I forgot the start of the question I was thinking about the partnership board because they're fantastic!

AW: 13:41 that's OK you was speaking about the receptionists...

GP4: 13:42 sorry yes, so, we've done, some Public Health er, work on the make every contact count agenda so MECC we call it and erm so we're trying to develop a programme across the community pharmacy, the commercial pharmacies out there, health trainers, us, er health visitors, schools. So, we see someone with a problem you can say you know you're a bit out of breath, you know. Have you thought about getting a bit fitter? You know, diabetes, have you thought about doing some exercise? Er, people come into reception to get their prescriptions you can say ah you know have you heard about this and it's just ways of little nudges to get people to maybe think about about, that. And the work on this is sort of across the whole community really, ways to get the message out there erm it's about building resiliency basically, because we are very badly in this town

AW: 14:43 right, ok in Bridlington specifically. So, it's about not only you being able to signpost, but from all angles the receptionists the pharmacies all these different people

GP4: 14:51 yeah, the fireman because the fireman do a lot of checks in this town. The fireman go and see exactly the same patients we do.

AW: 14:58 so is that something in place at the minute? Will the receptionists signpost?

GP4: 15:02 so we start that, with [CN's name] because she's our head receptionist she, she does the navigation so there has been a trickle down going on there. There is some er, Health Education England funding for er receptionist to

train up to be care navigators. So, it's coming up to a band 3 plus, 3-4 whereas most reception is band 1, 2. So, it's a good kind of career progression er so we've been trying to access that for a while, but it's just that there's so many things to do

AW: 15:38 yeah

GP4: 15:41, but that's the eventual plan that we will have er

AW: 15:45 will that permit the receptionists to make the referrals or just to

GP4: 15:48 yes, yes

AW: 15:48 ah so they can use the referral form and book them themselves?

GP4: 15:51 yeah, yeah, yeah, yeah, that's the plan. Anything special about me. Anyone should be doing it. Everyone should be doing it

AW: 15:57 yeah, absolutely and do you receive any feedback from any of the programmes that you've referred to or signposted patient to?

GP4: 16:05 LiveWell, refer back to us er, er partly because of the bariatric, bariatric work. They have to have completed six months of LiveWell, before we can refer

AW: 16:18 Is this a new sort of thing that has been implemented where you've got to prove they have been on a programme?

GP4: 16:23 er yeah, I mean there's the new CCG guidance which has come out…BMI over 35 going for joint replacement has to have done a programme and if they are smoking, they have got to try six months of smoking cessation before we can refer. That's the new, new rules that have just come out from the CCG. Erm, but erm exercise on prescription I can't remember (laughs)

AW: 16:52 no, that's OK

GP4: 16:58 LiveWell, we get back saying, they've completed so many and obviously there's health tracks that the health trainers do opportunistically, so we get feedback from them

AW: 17:03 ok and can you remember what was sort of said? Do you get any more information except if they've completed or how many sessions?

GP4: 17:11 I'm sorry I don't remember

AW: 17:12 no, that's ok not to worry at all

GP4: 17:12 I get so many pieces of paper every day!

AW: 17:14 so for you is it not really useful to have feedback?

GP4: 17:18 well, it depends on what it's for because if it's, we refer so few people for bariatric surgery because of availability and also the criteria are quite strict. I mean you've got to have a BMI of over 45 which is quite, quite impressive. Er, and a lot of people are just under that you know. They're big, but they're not big enough and then you've got to push this and there's all the reasons why they've got big in the first place which is why they struggle with that first step to, to change. So, erm, yeah, so, a lot of the, see why should it be coming back to me? That's our point. I'd see the benefit from them, but preferably, from their children their grandchildren in terms of societal change er. I'm not big on individuals I prefer the society thing. The group NEWKA in Alaska, the Newka Organisation

AW: 18:16 right I've never heard of that either

GP4: 18:15 it’s a great thing to look up. I just love social prescribing. They went from being the worst group in America, in the United States for all health outcomes from child vaccinations, mortality, through to elderly life expectancy. And er in five years they turned around to become the best in the

US. There's actually some brilliant health organisations in the US, really good groups and you can become the best. In five years, they did it

AW: 18:43 Wow just in five years!

GP4: 18:45 getting the old people to go for walks. Getting the young people to take vaccination seriously and they're super, they're amazing, and they're coming. They used to have their conferences in an anchorage or Hawaii none of which is any use anyways they're coming to Liverpool in November and I'm thinking about going to see them, but they talk about whole society change and the value of change agencies for society. Getting them to change and disseminating it and that's what, I think, with my immensely raised tinted glasses, we're beginning to see a little bit here. Over these last years we've been pushing, pushing, pushing, and now people are started to come and ask which means that something's happening out there

AW: 19:23 yeah, something changing

GP4: 19:23 er the work we're doing with the schools is helping it as well, and so yeah, NEWKA are my

AW: 19:34 idol? If you like

GP4: 19:34 aspiration organisation

AW: 19:38 absolutely. And what work are you doing in schools?

GP4: 19:40 erm, we've erm, we've set up our Health Academy erm which is starting next month, tomorrow, hurray! So, that's for people to get into health careers basically, so by being in the cadets in sixth form you, you, you'll join a health academy in sixth form if you want to be a midwife or a paramedic or a doctor or nurse whatever. And then we teach you for the first year and then the second year of sixth form we buddy you up with someone who's what you

wanna be. So, you know work experience with them so when you do your UCAS application you've got the best application on the planet, and you walk onto whichever course you want which for deprived areas is very difficult. They've done it in Hull now at a place called St Marys…

AW: 20:23 yeah, I use to teach there

GP4: 20:25 ah right yeah

AW: 20:25 yeah, only well, as a coach, but they use to employ me to do a bit of P.E teaching- lovely school, really lovely school.

GP4: 20:34 yes, so they've done their health academy now they're in their second year must be third year, third year starting tomorrow. And erm, they just got 45 out of 45 into university which is for an inner city comprehensive sixth form is erm pretty good. So, we're kind of modelling them. So, we're erm, setting up here. So, it's starting to get more people into health careers and that's the trickledown effect. We take part in the health fairs erm, so yeah, that is how we do things!

AW: 21:09 very on board with it all! And does this practice engage with WebGP?, I think it's called E-consult?

GP4: 21:16 no

AW: 21:19 that's fine it’s a new system bought by...

GP4: 21:19 We know about WebGP!

AW: 21:20 oh, you know about it yeah. Some of them do some of them don't so I just wondered

GP4: 21:23 we're trying to restrict access

AW: 21:26 right, ok

GP4: 21:27 we, we, erm, Tom would have said, Bridlington is very short staffed we don't have new staff coming to Bridlington and one of the problems we have is getting people in the right place. And, back to the paternal thing you know come here and I'll fix everything for you from your heating to your health, to your kids, you name it we fix. But we don't. So, we just saw GP of being a way of, I shouldn't say this should I, but anyways, it's almost unrestrictive access which we struggle with, we really struggle with because we're getting more er requests for stuff which we struggle to deal with and we're trying to do it differently anyways. We're trying to improve signposting rather than opening the gates. We're trying to get the signposting and clever ways in the system

AW: 22:15 yeah, so people can be directed before they even come to you

GP4: 22:17 rather than a tsunami of emails every day which would, we just have a different philosophical approach really

AW: 22:24 it would probably increase your patient load massively as well

GP4: 22:26 and we're trying to be direct at the moment and it just seemed to go in the face of everything we've been trying to, to do with, with signposting. Suddenly, yeah, I get an email with everything and it's like urgh!

AW: 22:40 we're not trying to do that (laughs)

GP4: 22:42 along with the other stuff. We didn't see that as being an asset and we was watching other people doing it and you know getting feedback, which was fine er, but we are still not totally convinced it's for us

AW: 22:51 yeah, ok. And you've mentioned the care navigator a few times, I've only heard of that when [Dr's Name] mentioned it. Is that something that you only have in Bridlington or is it a new sort of role?

GP4: 23:02 Just my practice actually

AW: 23:03 ah right OK

GP4: 23:05 [Dr's Name] didn't say he had one, did he? No, he'd be lying!

AW: 23:06 maybe I'm getting confused

GP4: 23:07 lying! Er so care navigation is erm is a generic term for well, for just anything really. So, I am a care navigator er I help people navigate through the care system. I say you've got chest pain I need to send you to hospital to see this person rather than turning up at the front door and saying, help! So, in a sense I do that. But this is more about the interface between health and social and community. And, and, and er, going back to this thing about under differentiated access and saying, well, actually what you've got isn't really health it's a social thing or it's a society thing or it's a leisure thing and, and, and, and we give direction, but it's also about proactively going out to people, seeking people who don't contact us. So, bereaved people, lonely older people who maybe we use to see and now we don't see er and if we were intelligent used our intelligence on our systems, we would be able to find bereavement that's the easiest one. You know, someone dies, guess what's going to happen to their partner? You know they are going to lose a lot of social contact and we know that they have mass adversely health outcomes a year later. Their mortality is huge, er following the death of your partner. So, we know who to look for, er and so part of what we do say if someone dies, and if I'm on a good day I'll pretty much tell [CN's name], she'll know anyways because she's on board er and we'll just contact the person and say you know can we help? We use the EASYCare programme, which is a 40-line question structure interview that identifies needs so there is physical stuff,

emotional, financial, erm community, and then at the end of it you identify your four main priorities. So, you might have someone, who quite often is the most ill people on my system, their needs are totally the opposite. So, all these drugs, all these hospital appointments, but I am lonely, you know. But you see hundreds of people, yeah, but it's for my diabetes they don't see me, they see my illnesses and it's that contradiction. So, yeah, what triggers for me I have a heart sink concept, you know heart sink concept? Oh, God, I'm emphasising all the horrible GP things. A patient comes in and your heart sinks

AW: 25:29 right, ok

GP4: 25:28 er and it's been defined, described for many, many decades. Books written about it and articles written about it and what do we do because your, you feel hopeless. You know, heart sink feeling you know you feel hopeless and helpless. So, erm and the patient feels that they're not been helped as well, and often they keep coming back because you're not answering their need

AW: 25:51 and they feel like you're the person…

GP4: 25:51 which exacerbates your feelings of hopeless and helplessness, so your heart sinks further. And er anyways, I kind of was reading a lot about this and I thought hang on a sec that's because I can't fix them. And often what you find is my heart sink patients aren't my partner [GP's name] heart sink patients or [GP's name] heart sinks. We all have different ones because they react differently with us. It's because we feel we are not helping them and that's now my trigger for care navigation. The reason I am not fixing is because I can't fix you. Not that I am the best doctor on the planet, God help me I am certainly not that, but it's more that maybe your problem are not medical maybe it is here [points to the non-medical section of the pie

chart]. You know, and I've just not recognised that. I've been trying to expand out my circle to encapsulate that problem and it should never have being in there anyway and that's where I am going wrong. So, now if someone makes me feel ah I'm missing it, ah ha, but I know, I tend to say let's have another think about this and do it a different way. And guess what they never come back! It's brilliant!

AW: 26:50 which is great for you

GP4: 26:52 It's good because they are getting the care they needed and I'm not… you're more efficient with your time, but understanding their needs which I haven't done so it's actually quite a great thing really. So, that's my cure for heart sinks erm just don't see me. It's usually non-medical

AW: 27:12 which is the reason you can't help them! So, again, if you're, again with the bereavements if you're proactive and able to screen them, you can then signpost them somewhere or to somebody that can address their needs

GP4: 27:21 quite so, quite so. And not medicalise, oh, here's your antidepressants, here's your sleeping tablets, here's all this ghastly stuff which you know two years from now they are still on anti-depressants. But grief is natural, why have I medicalised grief? So, why not go to a grief support group, go to you know. What did you use to do? I used to go dancing, but I can't because my husband is dead. OK, well, let's go to a dancing group and there will be beavered men there. It's not a dating agency, but it's a community. You know, it's what communities use to do. So, it's erm yeah, I'm doing the work of Margret Thatcher, I'm doing the work of Margaret Thatcher! A stronger society!

AW: 27:56 that's sort of all the areas I wanted to explore today. Is there anything that you feel we can add or expand further on that you think may be important?

GP4: 28:04 No I've just rattled on horribly I'm sorry

AW: 28:08 No, no, it's been really interesting! I really enjoy speaking to GPs because it's so much different to speaking to the likes of practice nurses which is still incredibly interesting er, but because you don't necessarily do the referrals all the time, you give a slightly different angle and it's nice. There's a lot of concepts that I haven't heard about i.e., the heart sink

GP4: 28:27 heart sink syndrome

AW: 28:27 yeah

GP4: 28:27 if you go, you know, there's huge amount of research written on it, and you know about what causes it and why is it and why is it only between one doctor and a patient not another doctor and a patient. You need to go look into more of the research, but that is the problem and it's either because my knowledge actually should be there, I should know more about it, or it should be dealt with by a group or somebody else, somebody else. And not keep it, try to keep it under my cloak so...

AW: 29:01 er, you mentioned earlier on about [CN's name] and [PN's name]. Do you think they would be happy for me to ask these questions to them because a lot of these questions are focused on the referral forms and measures?

GP4: 29:11 I'm sure they will. Shall I go and ask?

AW: 29:12 yeah, if you will that's great or I could come back another day...Thank you!

AW: Interviewer **Interview date:** 18.09.2017

GP5: Participant **Interview location:** Practice 1 Bridlington

AW: 00:02 How old are you if you don't mind me asking?

GP5: 00:04 42 years

AW: 00:05 42 and what is your role as a GP?

GP5: 00:08 GP er partner

AW: 00:09 partner. Fantastic. Do you have any additional roles?

GP5: 00:13 no

AW: 00:14 ok

GP5: 00:16 sorry I do out of hours here so I'm sorry if that is a question yes

AW: 00:20 er out of hours. Yep,

GP5: 00:21 yep

AW: 00:21 no problem and are you full time or part time?

GP5: 00:23 full time

AW: 00:24 full time and how many sessions do you deliver in general practice?

GP5: 00:26 8

AW: 00:29 8. How long have you worked as a GP?

GP5: 00:30 er since 2008. So, 8, er, 8 years now yep

AW: 00:37 and has that always been within the East Riding of Yorkshire?

GP5: 00:40 er 1 year in Scotland and then the rest here. So, I moved here in December 2009 and since then I'm here in Bridlington

AW: 00:46 brilliant thank you. OK, so the first section is about the healthy lifestyle programmes. So, what healthy lifestyle programmes are available for patients in this locality, that are run by the East Riding of Yorkshire?

GP5: 00:59 I mean first of all if you are really looking into only the East Riding then we've got the health trainers er offices in the locality and they could be accessed by patients directly without any particular… like walk-in clinics. Er and, I think er smoking programmes, alcohol and drug services. Er so there is smoking clinics, alcohol and drug clinics. Er, and, I think maybe we do have some er school education programmes as well. I don't know the name, but er they have been running into the schools. We got this school health and nurses, those who really help the er, you know, children directly. Er, and on top then er we have diabetes clinic in our locality and in the hospital guidelines er, and er a whole bunch of district nurses they, they do help as well, on day to day lifestyle advice and we, they go to the nursing home and care homes and do health there directly with them, so, I think...

AW: 02:05 So, there is lots of different programmes?

GP5: 02:06 yeah, and then us all the time I mean yeah

AW: 02:08 the ones that we're looking at specifically are the ones that require a referral from a clinician so the exercise on prescription

GP5: 02:16 yeah

AW: 02:16 and do you refer to the LiveWell, programme?

GP5: 02:17 yes, I do yes

AW: 02:18 that’s fab. So, of, er cuz obviously the Swim for Health and the Walk for Health, that doesn't necessarily require a signature, that's just signposting

GP5: 02:26 no, signposting yeah

AW: 02:26 so the ones that you have to refer on to, out of them two, which one do you refer on to the most often?

GP5: 02:32, I think LiveWell, is quite erm, common because of the obesity and we do a form. I've got a form, I download it. We take the patient consent, patient signature and that's the way I refer them. The LiveWell, is more common for me, yeah

AW: 02:49 yep, the LiveWell, programme

GP5: 02:50 yeah

AW: 02:50 and the LiveWell, programme has er the information booklets and the referral forms. Is there anything else for you to give patients regarding the LiveWell, programme or is it a case of verbally communicating?

GP5: 03:00, I think verbal and then I give them a, because they have to read er, so they have to give their consent before they sign, or before we sign the referrals, so they have to understand what it involves. So, they read it and then I get their signature and then we sign it and consent so yeah

AW: 03:18 and what issues do patients typically present with when you feel you may initiate a referral? So, what do they come to you with?

GP5: 03:25, I think for stuff for LiveWell, it's mainly stuff with the obesity because we can't refer them beyond or like you know at least a BMI of over 45 or something. Er so you can't refer them below that BMI, so obesity is one of the things. And all whole range of health issues er in addition to er you know obviously it could be diabetes, general arthritis all around the joints, er heart problems. Er so, I think yeah, the, they maybe need to lose

the weight to really get them a bit more healthy in all respects so I would say that it is really useful and ...

AW: 04:07 so lots of different conditions. Does it typically, is it patients that come in and initiate referrals or does it tend to be you that initiates?

GP5: 04:15 us mainly., I think they don't know that what is LiveWell, programme is, but once we organise that A) they are overweight, and they are associated problem and they could be directly linked with the obesity and they will be definitely directly will be benefitted with the LiveWell, programme so that's where we initiate it from our side

AW: 04:34 so it's about you creating that awareness

GP5: 04:37 99% yeah, I think hardly anybody has commented unless they have heard from a patient, er friend or family that it could be useful, but otherwise mainly us yes

AW: 04:47 do you think it would help if patients were more knowledgeable about the programmes?

GP5: 04:51, I think yes. I mean they come to us, and they don't come to us unless they have a problem do you know what I mean? So, people could be obese, but they don't have any medical problem, so they never come to us. So, once they know that yes, there are some services of LiveWell, and if they come to us without having any medical problem just to for the future to become healthier or not to have those problems, it will definitely help us to er you know refer them and it will be really good, like it's a proactive approach so.

AW: 05:19 yeah, absolutely and sort of a preventive approach. Ok, so the next section is about the constraints of patient referral. So, do you personally experience any issues or constraints when referring patients?

GP5: 05:32 I mean some people maybe still working and er they may not be that keen cuz how they would take the time off. So, the employment is dependent on, and the motivation. Not many people are really motivated, but they really, erm they feel that they have done their best and they are not losing the weight so that, that, that motivation, that, that ambition gone to lose weight. But, once we talk to them, once we tell them the importance, and, I think they do understand, but it's still difficult to really identify how motivated they were after the talk. But most of them really accept the referral because once we tell them there's a direct link between your weight and a unhealthy lifestyle and your problems that you come with, so they, they really then become keen. So, so that's another thing and er, I think those are the main in my view, but yeah, a) motivation and employment. Yes, I mean they have be having some problems they just think that if they got the knee pain, how they are going to do the exercise. So, they start thinking in a worse way that is it really useful? Will that help them? How they going to do. What it involves? But, I think it do interest them that they do look after, ease all of your problems and they guide you according to your need and according to your situation they will then adjust like an exercise programme only, they don't just concentrate on one thing, it will be food otherwise it could be some other things.

AW: 06:55 so sometimes they are a little bit apprehensive, but as you say you tell them it is tailored to them

GP5: 06:59 yes, yeah

AW: 06:59 and you said that sometimes it is hard to see how motivated they are.

GP5: 07:03 yeah, yeah

AW: 07:04 how do you assess their motivation?

GP5: 07:05 I mean most of them say that they have done their best effort. They have never lost the weight. They don't see any point that they will lose it and sometimes they have that whether everybody like time and they may have them, they may not look good or other people will know that they have the problems as well. So, confidentiality, but I always tell them that this may help them. That people may have the same problems like them if they go to those groups and they may be a bit more motivated seeing other, other people in the same kind of basket you know.

AW: 07:40 yeah, yeah

GP5: 07:41 so yeah, I think that that's what they come with when we ask them the question are you happy for me to refer. Then they come out with some of the answers. I've done this this this, but it never helped and then I tell them this is more professional advice, there are more professionals involved so what you have done some time may not be doing the right thing. I know you've done the best effort, but whether those were enough or those were professionally guided so these services are more professionally guided so, I think that helps them to understand it more and accept it

AW: 08:12 ok. And to refer somebody you have to fill out a referral form. So, you said, that you had the one on the system

GP5: 08:19 yeah

AW: 08:19 do you print that out and then fill that in?

GP5: 08:19 yeah, I print it out immediately in front of them, discuss it with them, get their signature, consent, and then I finish it then and there within my ten minutes of consultation

AW: 08:27 and how do you find the measurements you've got to take. Do you find they are all appropriate on the form? I have an example...

GP5: 08:32 yeah, no, because they computer is linked with the hide, we always have that, so BMI calculations and then everything. So, I measure their weight then and there so once we have their weight, I calculate their BMI. I tell them that you are fit to be referred and this is what it involves. Give them the information, they read it, they sign it, and that's done

AW: 08:52 so in your opinion in ten minutes you have enough time to go through…?

GP5: 08:55 I won't say that it is perfect to make everybody understand everything, but at least then it, with experience you know how, how to judge people. I am not saying that I am perfect, but, I think given, given their condition, telling them how it involves and how it would benefit you, most of the people are happy to try it because they are almost fed up with everything with their pains and aches and most of them are willing to do anything. Yes, there is a motivational problem because once it comes to the weight issues not many people are really keen to listen or to do something about it because they feel that this is a disease, and I should do something for the disease. But if you make them understand somehow that there is a direct link what you are and what your disease is, and probably they are more, they can accept more, I think that's what I have felt so far.

AW: 09:44 yeah, so for you, it's really important to first of all make that link and then they will become more accepting of the programmes

GP5: 09:51 yeah

AW: 09:51 that makes sense. OK. Is there anything else in terms of constraints er of referral that you can think of or is it mainly patient motivation, er patient time because they might have to work.

GP5: 10:06 er I mean I don't know whether they could be disease related as well. If somebody is really breathless, they are like really house bound sometimes I mean they have done extra effort to come and see me and get some help, whether they have anybody at home. This could be another thing, who's going to take them to these clinics? Because they are immobile, aches and pains, so whether they have that support, er so that's another issue. Could be, erm, what else? (laughs) Normally, I think these are the main issues, I think that time, what there motivate is, whether they, somebody can bring them, whether they have any relatives, or whether they are in any employment, so, I think these are the main issues. The motivation

AW: 10:47 yeah, so the main issues are related to the patients really not necessarily to yourself?

GP5: 10:52 yeah. I don't think so I have any problems in referring anybody once they qualify the weight and the BMI and once, I think that yes, they will be benefitted definitely I offer them. I don't feel myself any problems.

AW: 11:04 are you using the online referral system or the paper referral?

GP5: 11:07 no, I normally still use the paper ones

AW: 11:08 the paper ones. Is that do you prefer the paper referrals?

GP5: 11:12 erm probably, I am satisfied that I send it you know, er I have never done the online one so far, so I don't know whether, how… it is, but I am happy with my paper ones at the moment yeah

AW: 11:24 absolutely. OK. And what information comes back to you about your patients from these programmes? Do you receive any sort of feedback?

GP5: 11:30 not much. I mean sometimes we do get that the patient has lost this much of weight, they are feeling better., I think very, not in a very clear way, not often. I am sorry.

AW: 11:43 OK that's ok. And what involvement would you like in terms of patient progress? Would you like more feedback?

GP5: 11:49 definitely. I mean that, that would help us to understand a bit more and it will, it will help us to be a bit more robust in the future. Like if I see that most of my patients are losing weight, it's a successful programme, they have been benefitted, that help me to increase more people and tell them the story that look I have referred them patients. I can give the data, the live data that yes, I offered ten patients out of them 7 had some success so that will increase once you give them more details and if you can tell them these stories that this has helped. And er, I think erm, it, patients will gain the confidence in us as well, that OK my doctor referred me and I've been benefitted with this and that gives us a bit more easy conversation probably next time. Erm, you know for future, any other illness or any other advice we give to them. So, it maybe that I have just sorted out their weight, it may be smoking next time. But they may feel wow I had benefits from what doctor told me, next time maybe smoking and then they will be more motivated probably

AW: 12:53 absolutely. So, as you say not only does it improve your confidence in the programmes, they may be more confident in you and your advice. So, is there anything in particular you would like to hear back from the programmes? So, you've mentioned weight. Is there any other indicators you would like to hear?

GP5: 13:09, I think, if you look into this, most of the obese patients, they have low self-motivation, low confidence levels, depression, they don't look at them very well, so it will be good if we know what had changed with their programmes. What changes they have noticed other than the disease of course. Say for example I am really looking, some knee pain is better since he has that amount of weight loss, his diabetes is better, but, I think we will be checking them anyways. But, how their personality had changed and how positively they have taken over, or whether their mood has been better, so that would be just by anybody. Like OK, when I saw the first day, patient was very low in mood, but when he left the programme, he was high in spirit and then he was willing to engage in the future as well. So, er, that sort of all-round holistic idea about what, how does it help. What our debate could be. Whether disease modifying, whether it's confidence, their personality, their overall, you know, for the future plans, what they want to do in the future. So, it, it would help us to really, next time when they come in, to catch on all these things that they have done good

AW: 14:24 as you say a complete holistic approach because you will probably be assessing the disease in practice. It's all these other things that you don't necessarily measure. That's all makes sense. And how would you like to receive this feedback?

GP5: 14:35 probably I don't know whether it could be in writing, that would be best way because we read mostly letters and er, er, if it will be, come to me then I will feel good as well. Well, I referred this patient look I have done something good in society or you know to one particular patient. Er, it's a good investment in a way you know? We can save thousands and thousands of pounds on diabetes, and all those other diseases if they really can change themselves. So, as I say it makes you a bit more confident in believing in these programmes, making patients more confident when you give them the data, the precise data. Look, I've done this, and we have referred the patient, patient can do it. You can force those points to the patient, and you can empower them to do a bit more. So, I think yep, written information is always good because it's more data and I don't know they can phone us as well. Oh, look we have done this good, but that may not be enough if they call us and do this. I feel...

AW: 15:35 OK so ideally erm in a written format. As you say you're not getting much feedback, but it's going to have so many other benefits if you're able to communicate that with your patients. You'll be more confident, so feedback is a big thing

GP5: 15:46 yeah, yeah, I think

AW: 15:49 that needs improving. OK er so the last sort of section is about support networks. So, do you have any support networks in this surgery to manage your patient load? Do you have any form of telephone triaging for example?

GP5: 16:02 yeah, I mean we work in a way, we have set number of appointment then we've got some telephone triage if patient just need the advice. And

we've got the task-based thing so my reception can send me the task if patient, if I don't need to speak to the patient directly, what they could do is they could send me the information the task way and then I look into this and I feedback them back. This is my decision. So, er, it's like 3 way, but it's sometimes as simple as patient is asking whether she can take the paracetamol for example. Is there any risk of taking the paracetamol? I say no! Patient can take the paracetamol after looking into their notes, so I don't necessarily need to speak to the patient

AW: 16:44 or see them yep, so it kind of cuts the patient coming in..

GP5: 16:47 exactly yes. So, er that helps us because sometimes you ring the patient they're not in the house or they're not picking the phone and then it becomes more difficult like how you want to contact the patient. That, that really saves time for us if it's this way information. And er yes, then we got the whole support in terms of, if I need for example, they have come to see me, but I feel the patient needs immediate dressings, some immediate blood tests, immediate ECGs, or they need to see the nurse for how to use the inhaler, so I go to the other people. People who takes the blood, people who can do the ECGs, or a nurse who know how to use the spray and asthma for their inhalers more, so I use that channel as well. So, telephone, face-to-face, task-based erm and we write to them as well, you know? When I say for example if I need to see a patient erm, for example I have seen a blood test and I see I need to speak to this patient or I need to, or they need to come and see us. Then we send a letter as well, so through the letter support base

AW: 17:55 yeah, so lots of different ways that you can help manage that workload.

GP5: 17:57 yeah, yeah

AW: 17:57 and how long have you been doing the telephone triage? Is that relatively new or have you done that for a long time?

GP5: 18:01 no, I think when I joined the practice this was the starting you know point. We already had the telephone triaging, but luckily with practice, somehow the way our receptionist works is fantastic, so we don't get that many telephone triage every day. Maximum six a day. So, we are managing well, in that respect. But we do everyday

AW: 18:23 yep, fantastic. So, that's sort of all the areas I wanted to talk about today. Is there anything else that you'd like to add that you think might be important about anything we've spoke about?

GP5: 18:33 no, I think it depends on what your research base is, but for me, yeah, with time you learn how to really you know, your workload how to manage it. How you really can help patients in many ways. They come to us for one disease, but then when we look at them again as a holistic approach, how your house is, can I sort out this? Can you do this? We have the opportunity to do something else. Can I check your blood pressure whilst you are here? So, for example they came for a very, very simple thing, ten minutes are too much for you, so you take the opportunity to, to deal with a couple of things. Can I look at my graph? Have we checked the blood pressure? Can I give them some advice? They may not have come for that particular thing, they may not be really obese, but there are some signs of that yes, they may

be more fitter in themselves so we can give them the advice then and there so have a look into this…

AW: 19:27 so...And how are you informed about, obviously with the social prescribing network there's so many different places you can refer on. How are you informed about the programmes? So, LiveWell, and Exercise Referral

GP5: 19:40, I think we, we, a) we have our own practice meetings erm so what anything new comes up, so these are the old problems we all know about these, at the moment you join the practice we know that in the meetings or when they come, sometimes they "I want to lose weight". So, say for example, if I am a very new GP and I don't know about there's something like LiveWell, and if someone says I want to lose weight so the first thing you would like to know is who knows about it? So, it could be a colleague, it could be like you go on the internet and find out what are the East Riding programmes are and erm and, I think any new programme happens then we do get the information through the leaflets, or the information. Sometimes they are representatives that come and tell us like we are starting this programme. Erm, and erm like, we have PTL days. So, PTL days we go out in much bigger, you know, all the practice are coming together so we have representatives there. We have the leaflets. Various ways

AW: 20:41 lots of different ways to do that. Fantastic

GP5: 20:41 so I would say sometimes face-to-face, it is leaflets, through the emails, through the task again, through the colleagues in the practice, they know sometimes. So, yeah…

AW: 20:56, but again if you had that feedback, you would have that confidence in where you refer to because you'll have experience?

GP5: 21:02 yeah, yeah

AW: 21:02 fantastic. Erm, is there anybody else in the practice that you think it would be useful to speak to. Does anybody else do the referrals?

GP5: 21:09 yeah, [PN's name] does that

AW: 21:12 [PN's name], is it?

GP5: 21:14 No [PN's name]

AW: 21:14 oh, [PN's name] I think I spoke to [PN's name] last time

GP5: 21:20 yeah, [PN's name] does that sometimes., I think nurses play quite an important role because they are the main health education in a way because they deal with time to time, on a daily basis. Because if someone comes with, like asthma nurse or diabetes nurse so they do really help with the lifestyle advice. You may speak to them as well, like what are the... because for a diabetic nurse it's the bread and bread that they have to detect

AW: 21:48 yeah, they've got to know all that! Fantastic. Well, thank you for allowing me to speak to you today

GP5: 21:50 no problem I hope that helps you

AW: 21:52 yeah, absolutely. I will type this transcript up and within 4 to 6 weeks, probably a bit earlier, I will send you your transcript

GP5: 22:00 sure, not a problem

AW: 22:01 thank you very much

GP5: 22:03 take care bye, bye

AW: Interviewer **Interview date:** 22.09.2017

GP6: Participant Interview **location**: Manor House Surgery, Bridlington

AW: 00:00 How old are you? If you don't mind me asking.

GP6: 00:02 46

AW: 00:03 46 and what is your role as a GP? Are you a partner? Salaried?

GP6: 00:08 partner

AW: 00:08 Partner. And do you have any additional roles? ... For example, do you do any out of hours work?

GP6: 00:16 no...no, just do here

AW: 00:16 OK. Are you full time or part time?

GP6: 00:19 full time

AW: 00:20 full time. Is that 8 sessions per week in general practice?

GP6: 00:24 er 8 clinical session over 5 days

AW: 00:29 and how long have you worked as a GP?

GP6: 00:32 sorry?

AW: 00:34 How long have you worked as a GP?

GP6: 00:34 17 years

AW: 00:35 17 years. Has that always been within the East Riding of Yorkshire?

GP6: 00:39 yes

AW: 00:39 Fantastic. Could I jot down your email address because I'll type your transcript up and sent it to yourself for verification?

GP6: 00:46 yes, ok er [GP's email]

AW: 00:50 Is that [GP's email]

GP6: 00:52 [GP's email]

AW: 00:53 [GP's email] sorry.

GP6: 00:57 [GP email]

AW: 01:04 brilliant. So, the first section of the interview is focused on the healthy lifestyle programmes

GP6: 01:12 yeah

AW: 01:12 so what healthy lifestyle programmes are available in this locality, Bridlington, for you to refer patients on to?

GP6: 01:18 you mean that I am aware of. (laughs)

AW: 01:19 yes, (laughs) that you're aware of

GP6: 01:21 so the LiveWell, the Exercise on Prescription,

AW: 01:25 yep...

GP6: 01:28 and I am aware that they are working on some health improvement optimisation scheme. You know, like pre-op type erm yeah

AW: 01:38 yep, so, I think that's the new programmes that's erm, not quite out yet, but, I think its next month

GP6: 01:43, but it's in development

AW: 01:43 yeah, absolutely for patients that are requiring non-urgent surgery. So, of the LiveWell, programme and the Exercise on prescription, which do you find that you refer patients onto the most often?

GP6: 01:56 myself on exercise on prescription

AW: 01:58 OK and why is that?

GP6: 02:00 it's more accessible...

AW: 02:03 ok... in terms of the criteria?

GP6: 02:06 yes

AW: 02:08 so do you find that more patients are eligible for the exercise on referral?

GP6: 02:13 yes

AW: 02:13 and how are you made aware of the programmes? ...So, how was you made aware of LiveWell?

GP6: 02:18 er, well, I've got that leaflet (laughs)

AW: 02:22 yeah, so, the healthy lifestyle...

GP6: 02:25 and then we've got one of the original leaflets on, scanned onto the computer as well

AW: 02:32 ah OK... so the LiveWell, and the Exercise on Prescription have referral forms and the referral resources. Is that something that you use with your patients?

GP6: 02:44 yes... So, most of the time we use to sort of have a chat and recommend exercise on prescription for example. And then would say could you make a nurse appointment and then we would have one or two allocated nurses who tend to do the checking. So, they were a bit more familiar with the inclusion criteria and exclusion criteria and then would just sort of do the up to date figures that they asked for like the BMI, blood pressure, erm, and you know, specifying a patient reason for wanting to participate. So, they would do that. Erm, more recently because of constraints in nursing time, I've just pulled the leaflet off here instead, printed one off and ticked the referral criteria myself

AW: 03:33 previously it was something that you would refer, delegate that to the nurses?

GP6: 03:36 yeah, delegate to the nurses which obviously then creates two barriers for the patient to come back. One the nurse appointment and then the leisure centres first appointment as well, so

AW: 03:47 so do you find by you making the referral, is that an easier process? Rather than booking a separate appointment for the nurse?

GP6: 03:54 well, make me run late again, doesn't it? So, it's not ideal at all

AW: 03:57 ok

GP6: 03:58, but it's one way of getting them there

AW: 03:59 yeah, so, it's still causing you time constraints because you're spending time filling out the referral?

GP6: 04:05 yes, yes, yes

AW: 04:05 how long does it take to fill out the referral? ...Are you using the paper format?

GP6: 04:10 at the moment yes

AW: 04:12 at the moment. And what are your experiences of using the paper format?

GP6: 04:19 erm, once a patient came back saying, that the letter, they had lost it (laughs). Could I do another one

AW: 04:28 (laughs) right OK

GP6: 04:28, but otherwise it seems fine.

AW: 04:32 OK. In terms of the measures that are on the form, do you think they are all appropriate? So, the BMI, the blood pressure? Or could it be refined?

GP6: 04:42 no, they're easy enough.

AW: 04:45 they're easy enough?

GP6: 04:45 often they have been recorded recently and otherwise it doesn't take that much to do them. But it is an extra couple of minutes isn't it to get people to take their shoes off, jump on the scales and check their blood pressure if that's not what they particularly came for

AW: 04:58 absolutely. So, when are you prompted to make a referral? So, you said, if that's not what they came for, what sort of symptoms do patients typically come with where you might think...

GP6: 05:11 actually, I think the majority of my referrals have been for minor mental health problems

AW: 05:18 right, ok

GP6: 05:18 breaks isolation or as a stress management thing to build routines, exercise for stress. So, I think that is probably the majority of my referrals have been from a mental health point of view, I think. Erm, pre-natal, post-natal...

AW: 05:39 depression?

GP6: 05:39 well, no, not necessarily depression, sort of you know optimising BMI for women needed you know, optimal BMIs for pregnancy planning

AW: 05:47 yep

GP6: 05:48 so a couple of those probably. Erm... couple of people with sort of chronic pain and joint problems. Maybe if you find it difficult to start exercising yourself, erm, you know would it be easier because maybe you could start exercising with water or on a sort of laying down bike rather than a sitting up bike with very little resistance, you know? The instructors may be able to tweak that to your constraints and see if that will work and encourage them to do it that way

AW: 06:21 yeah. So, it seems like there's quite a few...

GP6: 06:25 different indications not just weight alone

AW: 06:29 symptoms that come up. So, as you say it's not just weight, most of the time it's revolved around mental health or isolation. Getting them out of the house. So, when you first mention that to patients, are they aware of exercise on prescription?

GP6: 06:41 a lot of the time not necessarily no, [knock at door, Dr answers] [Dr returns] Sorry.

AW: 07:24 so most of the time when you first mention it, are they a little bit apprehensive because they don't know what it's about?

GP6: 07:30 erm, mixed probably. Some need, need the encouragement a couple of times. But yeah

AW: 07:38, but mainly, usually they are not very sure when you mentioned exercise on prescription. They are a little bit, like what's exercise on prescription?

GP6: 07:45 uh hu, yeah

AW: 07:46 OK and do you feel that they've been provided with enough information to help you decided where to direct your patients in terms of the healthy lifestyle programmes?

GP6: 07:57 erm, yes

AW: 08:00 OK

GP6: 08:02 we almost did do actually a GP self-directed learning programme and we did one evening on social prescribing

AW: 08:09 oh, fantastic

GP6: 08:10 including exercise on referral so I actually emailed the facilitator from the council to get some basic data and advice. So, we're probably sort of a blinkered population (laughs) as in we have sought the advice and spread it amongst our clinicians

AW: 08:26 yeah, I've not heard of that before

GP6: 08:27 I was hoping that would increase the uptake and that we could improve it over time so...

AW: 08:32 yep, and have you found that has...?

GP6: 08:33 I haven't asked the figures back yet

AW: 08:35 oh, right, ok that would be really useful to see er if it has improved that uptake. But as I say Bridlington are fantastic. I have been to practice 1 and practice 2, but every surgery I have been to, they are so enthusiastic about…

GP6: 08:49 so... there's an across town learning group as well, so it's that we have actually spent some time specific on these type of prescribing

AW: 08:59 oh, fantastic [telephone rings] You can get that if you like, I don't mind [Dr answers phone]

GP6: 09:53 sorry

AW: 09:55 no, it's ok. It's fine. So, that's sort of everything that I wanted to ask about the healthy lifestyle programmes. So, next, onto any issues or constraints that you face when you decide to refer a patient. So, do you personally experience any issues or constraints?

GP6: 10:12 (laughs) erm, time probably, you know? And like the motivation of the patient themselves. You have to have some buy in don't you to see if you get that click and they think that might be worth pursuing

AW: 10:27 absolutely... So, in terms of motivation, how do you access that motivation in a consultation?

GP6: 10:35 I point out that it has worked for some people erm and if they seem to take on to that I carry on and if not, then, I think then next time maybe

AW: 10:44 absolutely so if they are not interested there's always another time

GP6: 10:47 yeah

AW: 10:48 so you're quite confident approaching that at a later date if they're not interested?

GP6: 10:51 yeah, sure

AW: 10:52 and you mentioned time as well. So, can you give me, can you tell me a little bit more about time constraints?... Or give me an example?

GP6: 11:00 just what I said, there like erm just you know, the form filling. Obviously, if we are really running on time and the nurses seem to have a bit more capacity then it will be delegated so... yeah

AW: 11:12 so really it depends on how much, so if you've got time, you'll do it there and then. If not, you will pass that onto the nurses, and they will do that

GP6: 11:20 yes

AW: 11:20 fab. Ok, so in terms of constraints we've mentioned time and patient motivation. Does patient motivation tend to be quite often a barrier if you had to rate which ones the most prominent if that makes sense

GP6: 11:36 er it's difficult to say really because it's very individual, isn't it?

AW: 11:46 so it just depends. Sometimes it might be time other times it could be because the patient...

GP6: 11:52 I mean patient will sometimes look interested and then say I don't know if I can afford it either. So, that's a patient constraint rather than my constraint for the referral...

AW: 12:06 on the patients behalf. As you say patient's constraints. They sometimes experience financial barriers so they might say well, I can't afford to do them programmes. As you say, that is a barrier on their behalf, not necessarily yours.

GP6: 12:19 sure. No erm for the LiveWell, scheme that's slightly different because as far as I am aware there is no, charge for that one. So, that varies there less, but the patient motivation is harder there to push them to go and to commit to the scheme

AW: 12:35 yeah

GP6: 12:36 or they might feel that the pro, mobility is true barrier to even try to get there or social isolation for people who are very house bound or perceived house bound that don't want to get there. And sometimes their BMI is just that little bit too good or they have made a slight improvement themselves and they just don't fall into the BMI criteria... yeah

AW: 13:01 when you said, sometimes it's harder to get patients to commit to LiveWell, why do you think it's harder for the patient?

GP6: 13:09, I think because that's a very selective group with extreme BMI or significant co-morbidity. So, think of sort of the very overweight diabetics with complications. Erm, and they are not automatically qualifying for bariatric surgery, and they would have to do the LiveWell, to get to bariatric surgery. Erm, and that it's very hard to buy them in motivation wise

AW: 13:33 yeah, absolutely. How do you try to do that? …Is it a case of explaining that the programme is tailored? Do you have any tactics to try and get them on board?

GP6: 13:44 basically, saying, it's the best in terms of support that they can get. Looking at both exercise and nutrition and, and you know professional support, but that's always not enough because it's still strangers to them

AW: 13:59 absolutely so it's about telling them it's not just exercise, it's an holistic approach if you like, exercise, diet, support, and just hoping that they buy in that way

GP6: 14:09 yes

AW: 14:10 that makes sense. So, we spoke a little bit about the forms and in your opinion you're quite happy with the measures you've got to take. Obviously, it takes a little bit of time, but in terms of the content, you feel that it's quite easy enough to fill out. Is that right?

GP6: 14:26 yes, yes

AW: 14:27 OK so that's everything about the constraints. There's a tiny bit about facilitators. So, does anything help ease the process of referral that you can think of? ...Or anything in an ideal situation that would help that referral process?

GP6: 14:44 I mean maybe more posters and public awareness.

AW: 14:47 OK... so how would increasing that public awareness, how would that help?

GP6: 14:58 so if they could self-refer after knowing about it that would increase the access easier without us needed to point it out to the public., I think that's what I am sort of thinking about really

AW: 15:13 absolutely, yes. So, by increasing that awareness, if they could self-repair, repair? Refer. It would stop them coming to you in the first place and give them that accessibility

GP6: 15:22 yes, yes

AW: 15:24 is it ever the case....

GP6: 15:25 However, the other way around as well. Sometimes people do actively motivate themselves and sort of enquire at a gym and then they come back with the request, can you sign me a health letter that I am safe to go? And I am like no, I can't give you a blanket policy (laughs) you know? I'm not there to supervise you. So, why don't you go through exercise on prescription? That's set up specifically for it and I do it that way

AW: 15:50 ok so sometimes the patients do come

GP6: 15:54 so it's the gym responsibility to take you on and check you know yourself or go that way because that is set up you know for people with health conditions to go through.

AW: 16:07 absolutely...

GP6: 16:07 so I don't turn it round sometimes as well, you know I say if people do actually have the motivation themselves, but need my signature to make it safe in their opinion

AW: 16:16 right, ok

GP6: 16:17 and I don't want to give blank signatures for safety (laughs).

AW: 16:23 (laughs) that's good. So, not only are you getting that awareness out there, they are people that are coming to you an saying, am I safe to do exercise and that give you sort of the opportunity to say well, there is exercise on prescription…

GP6: 16:34 yeah

AW: 16:35 fantastic. In terms of patient progress, are you provided with any feedback in terms of a patients' progress?

GP6: 16:41 We definitely get letters back from the LiveWell, to see how they have engaged and what health measures have maybe improved. I do remember received feedback let. I don't actually recall seeing feedback from exercise on prescription.

AW: 16:56 OK in terms of the health measures provided from LiveWell, can you remember what they provide you with… off the top of your head?

GP6: 17:03 BMI, I am not sure if it's walking distance or not, or a six minute walking distance. It could be the cardiac. it could be me getting confused with the respiratory health team for the walking distance

AW: 17:18 ok

GP6: 17:19 erm, not sure I can recall any others

AW: 17:23 that's ok not a problem. And does the information that is provided, does that help you understand if a lifestyle change has been made?

GP6: 17:31 it's nice to know if you've actively encouraged something that it's working. Or you know that they have engaged, but they haven't been very successful on the other hand, The same really.

AW: 17:43 so no, matter the outcome it would be nice for you to receive feedback

GP6: 17:47 some feedback yes

AW: 17:47 so you're more aware of it is has been beneficial or if it hasn't. Is there anything that you would like specifically in terms of feedback to know.... So, you've mentioned that you get BMI. ... And you get whether they have

engaged with the programme. Is there anything else that you would prefer to know if they was able to provide that in feedback?

GP6: 18:09 sounds fair to keep it simple

AW: 18:10 yes

GP6: 18:11 yes

AW: 18:12 keep it as simple as possible?

GP6: 18:13 yeah

AW: 18:15 and how would you like to receive feedback? So, at the minute you're getting letter from LiveWell

GP6: 18:21 yes

AW: 18:21 are you happy receiving letters?

GP6: 18:23 yes, because we scan them in, and they go in the patient records. They are there to refer to for future reference as well

AW: 18:33 so using that system you are able to attach that to the patients records erm and then I guess when they come in next time you've got that to reflect back on. Would you like to receive any feedback from exercise on prescription?

GP6: 18:46, I think it might be useful yeah

AW: 18:48 same sort of thing?

GP6: 18:50 you can sort of, it's a reminder as well, that you know, they have engaged with that and to reflect back with the patient on what was useful. They tell you though

AW: 19:06 do they? I was going to ask...

GP6: 19:06 you know patients come back and tell you it was useful

AW: 19:09 what's the general feedback?

GP6: 19:11 I'd say certainly the people where we have done it for them, minor mental health problems, they have often given good feedback and it helped to reset routines and helped with stress management. Erm, so I can think of one patient that sort of had muscular-skeletal type of problems that clenched the courage to start exercising and enjoying it so...

AW: 19:36 aw fantastic

GP6: 19:36 so that's good

AW: 19:38 so it's nice to hear that the patients have enjoyed it and as you say they come back, and they tell you anyway. So, if you don't necessarily get formal feedback, you're getting it from the patient afterwards. Fantastic, so just sort of the last section is about support networks. So, what form of network do you have in this surgery to sort of manage your patient load or direct, delegate patients if that makes sense... Do you use any form of telephone triage in the morning?

GP6: 20:14 er I don't think this would come through that very often, but erm, yes. Little though actually. The receptionists mostly triage whether it's for appointments or telephone calls or for certain requests. And then there's a duty system so any overflow or urgent calls or anything like that gets triaged so...

AW: 20:37 ok

GP6: 20:41 not likely very relevant to this particular topic you know, because it never is an emergency, is it? (laughs)

AW: 20:47 no, no, not at all

GP6: 20:48 so this wouldn't particularly go to triage um yeah. Support network as I say the nurses, the main nurses are quite familiar with the referral criteria and

the existence of exercise on prescription. So, we've mentioned it before and patients specifically asked then we would have said, well, if you're thinking about it and you're not sure, you know such and such a nurse um will be able to do the referral for you. So, then hopefully they don't come back to me they go to the nurse (laughs). But yeah, so if it's not a one stage process then that would be possible for them to self-refer to the nurse to get that done.

AW: 21:30 yeah, rather than coming back to you

GP6: 21:33 back here yes

AW: 21:33 do the others, I don't know if you will be aware, but do the other GPs, do they refer straight to a practice nurse or do they sometimes also fill out the forms?

GP6: 21:41, I think the majority goes to the practice nurse

AW: 21:44 right, ok

GP6: 21:45 I don't think there's many form filling doctors here (laughs)

AW: 21:51 ok and…

GP6: 21:53 they are all aware that the schemes exists don't get me wrong in that one

AW: 21:56 yeah, so, they're all aware

GP6: 21:58 and they probably all refer, but indirectly through the nurse

AW: 22:00 yeah, that makes sense. so, you mentioned the role of the nurses, do you think there will be any nurses in this surgery that would be happy to answer these same questions to get their perspectives with them dealing with a lot of the referrals?

GP6: 22:15 I would think so

AW: 22:17 have you got any contact details or any way that I could approach them...

GP6: 22:19 I could yeah

AW: 22:21 that would be fantastic thank you. And is there anything we've spoke about today that you feel we could elaborate on further, or anything that you feel might be important?... So, we've discussed the constraints, what makes it easier, or anything in general about social prescribing.... or do you feel we have covered everything?

GP6: 22:41 probably pretty much covered

AW: 22:45 no problem thank you very much

GP6: 22:45 although I do refer a lot to the health trainers as well, so um, I'm not sure if they can directly refer themselves, but obviously sort of for motivational build up on weight, healthy eating, smoking etc., so all the lifestyle things I tend to give the card of the health trainers out a lot so. And I always presume that they all feed into the same system however.

AW: 23:13, I think, the health trainers are NHS run, but, I think the health trainers can also refer into the exercise on prescription as well.

GP6: 23:20 I hoped that they could, so they don't send them back to us

AW: 23:23 yeah, so, it's quite a nice system. So, if they do turn up to the health trainers and they think it might be more relevant, it's quite nice that they can refer in as well

GP6: 23:31 yeah, good

AW: 23:33 do you feel it's a lot easier to give a card for the health trainers and patients sort of doing the leg work is you like? In comparison to filling the forms out

GP6: 23:41 yeah, yes, sure yes

AW: 23:45 so it will be easier in the future if patients could self-refer

GP6: 23:48 yes, yes

AW: 23:48 ok no problem. Well, thank you for your time today and your perspective. If I could get some contact details of a practice nurse that will be really useful just to get their perceptions of the referral form

GP6: 24:03 yes, you have our email address contact details haven't you from the emails

AW: 24:05 er Amanda Robinson's? Yes, I have Amanda's yes

GP6: 24:09 I presume if they're in they are probably working if you haven't been pre-booked to speak to them because sometimes, I might be able to get Trish, but.

AW: Interviewer **Interview date** 09/11/17

GP7: Participant Interview **location**: Hedon, Church View Surgery

AW: 00:02 ah there we go!

GP7: 00:03 erm, so I, what do I describe it as? So, I am a member of the fed of feds, which you might not have heard of...

AW: 00:13 OK

GP7: 00:13 So, our group of four practices in Holderness are joining together, are merging to be one practice, but on that journey, we've called ourselves Holderness Health Alliance which is otherwise HHA. And erm, so as a group of practice, we've been working together so I've been part of the steering group for moving us forward together. So, it's been er, me from here and one from each practice and now there's going to be two GPs from each practice and the practice manager all working together. Because of that then I go to the erm, fed of feds meetings which is the federation of GP federations. So, because we're working together, we're called a federation and what they have done is taken key people from each federation in East Riding and put us in a room together to try and sort out best practice, how we are going to all work together, how we are going to iron out some of the differences between the patch that kind of thing. Erm, so we've got Bridlington, they are called Brid Inc., we've got Holderness Health Alliance, and YHP which is Yorkshire Health Partners and they've got the biggest group of practices working together and there's Driffield and Leven er, and those some unaligned practices, but they don't come at the moment, but hopefully they will in the

future. So, that's a role and then I'm also the GP rep for the whole of the East Riding CCG for the STP which is the strategic transformation partnership which is supposed to cover everything from sort of Whitby out to York and down to North West Linc. So, erm, and that involved going to other meetings. So, that's one role which is sort of, kind of your, I don't even know what you'd describe it. The voice of general practice role and then my other role here is as a tutor for HYMMs

AW: 02:16 right OK. So, not only as a GP, you're heavily involved also in the federation

GP7: 02:25 and I am also a GP appraiser

AW: 02:28 ok a bit of everything

GP7: 02:30 yeah

AW: 02:33 and are you considered full time or part time?

GP7: 02:38 I am part time

AW: 02:40 how do you do that part time? (laughs)

GP7: 02:42 (laughs) well!, I think part time in general practice is quite a loose term ha

AW: 02:48 and how many sessions on average do you deliver per week?

GP7: 02:50 so I'm paid to do three days a week

AW: 02:53 OK

GP7: 02:54 erm, at the practice and all the other stuff is extra

AW: 03:00 extra as well, as that?

GP7: 03:01 well, it's not really extra, but I do it as extra, but I do it as extra

AW: 03:04 yep, no, worries and how long have you been working as a GP?

GP7: 03:06 mmm 19 years

AW: 03:10 19 years and has that always been within the East Riding of Yorkshire?

GP7: 03:13 yep

AW: 03:14 yep, fantastic. OK, so the first sort of section of the interview will be focused on the healthy lifestyle programmes erm that are commissioned by the East Riding of Yorkshire Council. So, what programmes are available for you to refer patients on to in this locality?

GP7: 03:31 OK LiveWell, Exercise on prescription and the, now the health optimisation programme which is the newest one

AW: 03:43 so that's been, because as far as I was aware it was still under development. Has that been rolled out now?

GP7: 03:47 Yes, yes

AW: 03:51, I think in different localities they have been rolling it out at different sort of paces

GP7: 03:55 well, the East Riding have rolled it out because we are not allowed, we can't refer now to the hospitals for an operation unless people undergo that so it's out everywhere across the East Riding

AW: 04:06 so sort of a pre, pre-op sort of thing so they have to engage in the programmes prior to operations

GP7: 04:11 yeah, or they wait 6 months whichever way it happens

AW: 04:15 right OK. And which one do you find you refer patients to the most often, from the programmes you've mentioned?

GP7: 04:19 Well, the health optimisation one has only been going for a few weeks, so I haven't referred anybody to that. Erm, I can't remember the last time that I referred anybody to LiveWell, and I can't remember the last time that I referred anybody to exercise on prescription.

AW: 04:39 OK

GP7: 04:40 However, the other ones are the health trainers and I do refer people, probably twice a week to the health trainers

AW: 04:51 Yeah. So, of them, probably the most popular one is the health trainers

GP7: 04:52 yeah.

AW: 04:56, I think that is a NHS run sort of scheme. Er, so what sort of…

GP7: 05:02 Well, they were based in, yeah, they were based originally, in leisure centres so, I think, some of them are local authority and some of them were health, but then the health, they might be public health now

AW: 05:16 right, ok, no problem. And how are you sort of made aware of these programmes?

GP7: 05:23 so health trainers we were made aware of that through our locality meeting. This is going back some years now and we decided as Holderness that we wanted to. So, Holderness is like that little bit of, that sticks out at the top of Hull that everybody wants to cut off the map (laughs). So, that, that, that area is our four practices. Er so essentially, we wanted to access our patients better because we are semi-rural, there's terrible transport so erm, I think it was Humber who came with us with a proposal to have more health trainers and we commissioned that for two years as a group within Holderness to see if it would work to access our more rural patients so that they would actually, because we've got a lot of patients who live on caravan sites that aren't really supposed to live on caravan sites

AW: 06:19 right OK

GP7: 06:19 so they live in holiday homes and those sites aren't supposed to be permanent residencies, but they do live there, and they go on holiday two

week a year somewhere else and that fulfils all they need to do. But because of that, because they're not really supposed to be residential, there's sometimes an issue with post and things like that. They are not allowed to have a letter box and it's quite awkward for them so we can't access them for flu clinics and things like that very easily. It's a bit difficult so, we were going to get the health trainers to go out into the caravan sites and promote things like flu jabs and healthy lifestyles, and check blood pressures. And we did have health trainers at the branch surgeries, so they were into the villages. So, we had health trainers here and erm, so they were part -funded public health, part-funded health. And it worked really, really well, but because our CCG is very short term in its commissioning, it would only commission for short periods of time. Well, you've got people who are, you know, they're humans, they've got lives, they've got families, they've got mortgages to pay. You can't at Christmas have not told them if they've got a job in March and that was what was happening and however, much we felt that wasn't the right thing, that is what was happening, so they left. So, they had spent a lot of money training people and they left, and they didn't commission it anymore because you can't, it's very difficult isn't it as you will have known to prove preventable things are having an impact because the impact is so far down the line.

AW: 07:55 yeah, absolutely

GP7: 07:55 and so the CCG were struggling to see the outcomes, so they decided not to commission it anymore. So, we lost most of the health trainers, but we still have one that comes to Rosedale which is between Hedon and Preston.

AW: 08:09 oh, right OK

GP7: 08:11 so that's one that we tend to use

AW: 08:12 yep, so there's just one. So, health trainers was...

GP7: 08:15 so health trainers was much bigger than it is now, but because of that, I guess for me personally, I got use to using the health trainers and they are quite holistic, they look at the whole person, and they look at their mental health and the alcohol and smoking and weight and exercise. So, er, and now [Fitness Professional name] who is doing the health optimisation at Withernsea, she was one of our health trainers

AW: 08:40 ah right OK

GP7: 08:40 so I know that she knows what she is doing

AW: 08:44 yeah, yeah. So, your mind is at ease a little bit

GP7: 08:44 so I feel confident in her ability

AW: 08:47 yeah, that's good. So, as you say, using the health trainers was a way to reach those hard to reach populations

GP7: 08:54 hard to reach populations, our transport is awful, patients can't get to places very easily er and as I say they looked at the whole person. So, they didn't just

AW: 09:03 yeah, holistically not just, not just certain aspects of their health

GP7: 09:05 not just "you're fat, let's work on that", but "why are you, why are you carrying too much weight because you've got unhealthy eating, because you're unhappy? Because you're not exercising?" and so trying to build on everything really

AW: 09:17 all the different sorts of things

GP7: 09:20 yep

AW: 09:22 if we just bring it back to the LiveWell, programme and the Exercise on referral, it might be relevant for the health trainers, but what sort of resources or information sources are you able to give to patients or for your own sort of understanding?

GP7: 09:32 we've got leaflets. They're all little leaflets erm well, they're that size. I haven't got any here at the moment I don't think, but they're... So, we've got LiveWell, leaflets

AW: 09:43 yep, the LiveWell, ones

GP7: 09:43 erm and, I think the exercise on prescription, I refer to one of our nurses that sorts it all out

AW: 09:52 OK for exercise on referral. And how useful are the resources in your opinion?

GP7: 09:59 do you know it's so long since I have read them, I can't tell you (laughs). I mean I guess really, we've sold the benefits of it to the patient before they need the leaflet. If I'm going to say to somebody, do you know what your BMI's 48 you really need to do something about it, I would have already sat down and explained why it's really important so actually what's in the leaflet, by then I would hope would just back that up.

AW: 10:23 yeah, yeah, and just back up what you've already said

GP7: 10:24 and what they need to do

AW: 10:27 verbally said. Absolutely. And do you feel you've been provided with enough information to help you sort of choose which programme is most appropriate for your patients?

GP7: 10:36 only in the last week

AW: 10:40 OK why is that?

GP7: 10:40 because they actually came to talk to us from the health optimisation and from Withernsea.

AW: 10:44 ah OK

GP7: 10:47 so they came out to our practice meeting on Monday

AW: 10:48 OK so they attended one of your practice meetings here

GP7: 10:51 so that was [Fitness Professional name] who, and her manager whatever he is called from Withernsea leisure centre.

AW: 10:58 yep

GP7: 11:00 and, I think they're going round the practices so you might find that when you get to someone who has just had them round, they know more than people who haven't

AW: 11:10 haven't absolutely. What about the LiveWell, and the exercise on referral? Do you feel you've got enough information in order to sort of direct patients?

GP7: 11:17 yeah, but I haven't found the, the patients have to be so overweight to get onto the LiveWell, programme that we don't, I don't see that many patients with a BMI over 45 who, who. So, I think that's probably the limiting factor. I personally think that is too high

AW: 11:39 OK. So, in this area you don't have a particular problem?

GP7: 11:42 oh, we do have a problem with obesity, but they are just not to that extent!

AW: 11:45 that extent yeah

GP7: 11:46 and that's what patients have said, to me in the past is "ah well, I'll go and put on an extra stone then I'll be able to do it won't I?"

AW: 11:52 that's the reality

GP7: 11:56 that’s not really the answer, is it?

AW: 11:57 so in your opinion if they was able to sort of er budge that BMI criteria

GP7: 12:02 yes, down a bit yep

AW: 12:04 obviously more patients would be eligible, and we can utilise that a little bit more

GP7: 12:08, but I've got no, idea I couldn't tell you how many of our patients have been through the LiveWell, or erm, and I don't know if we get any information back from it.

AW: 12:18 OK. That's what I have found a lot actually throughout this. So, well, we will expand on that in a minute if that's OK I'll just wrap this little bit up. So, what are your expectations from referring onto those sorts of programmes?

GP7: 12:34 I expect them to come back a size 10. No, I would like to hope that their BMI would be erm less and that they would be more motivated to live a healthier lifestyle so that they would be more aware of their diet and more aware of their need to exercise

AW: 12:53 OK

GP7: 12:53, but also, I spend a lot of time telling patients that if they can't exercise because of health reasons, they still need to look at their diet and lose weight through their diet

AW: 13:03 so as well, as BMI as you say it’s about increasing that awareness

GP7: 13:06 it’s about lifestyle yeah

AW: 13:06 so they are aware of how that impacts on their health conditions as you say

GP7: 13:11 yes

AW: 13:14 OK and what sorts of issues do typically patients present with? So, when are you sort of prompted to refer on?

GP7: 13:20 when am I prompted? So, if we found them to be hypertensive, osteoarthritis, but more and more it's, it's just the fact that they have walked through the door, and I have thought you need to get on my scales. And I'm quite proactive. Even if they have come with something completely unrelated, I am one of these make every contact count people who will say "do you smoke?", "can you get on my scales?". And so many people will say "I don't want to know" and, and I am quite forceful to say well, I'm afraid I want to know so you don't have to look, but I want to know.

AW: 13:59 I was going to ask how do they respond to that obviously if they have a completely different agenda er, do they tend to sort of do as they're told.

GP7: 14:08 yeah, with a little bit of persuasion and the fact that, I think it's really important that we have a benchmark, and we know where we are now and, in the future, you may want to address it and so we can say well, OK this is where we were then, and this is where we are now.

AW: 14:26 so for you...

GP7: 14:27 it's an information gathering, even if they don't want to entertain doing anything about it. And I will walk them down the corridor and do their height and make sure that their BMI is documented.

AW: 14:37 OK so just to try and be proactive. Sowing that seed if you like

GP7: 14:40 proactive yeah

AW: 14:44 just in case in the future they decide to do something. OK. So, the next section, just sort of onto the constraints of referral. So, do you personally experience any issues or er constraints?

GP7: 14:57 I can never remember what I am supposed to do so I have to start again each time trying to work out where the form is, but luckily, our secretary are really good, and they can usually tell me what I have to do.

AW: 15:08 OK

GP7: 15:08 because I don't do it very often

AW: 15:11 it is just a case of locating the forms

GP7: 15:13 yeah, yeah

AW: 15:14 or is it actually what you have to do on the forms?

GP7: 15:15 no, no, just finding them

AW: 15:16 just finding them the forms

GP7: 15:17 is there a form and where is it and what do I need to, you know. Where in the building does it live?

AW: 15:23 yeah, (laughs) so they are not really easily accessible?

GP7: 15:26, but the secretary's know where they are so...

AW: 15:29 so they have got that under control and are able to organise all that OK.

GP7: 15:33 yes, yes, but how easy it would be for everybody to remember that there is a LiveWell, I don't know

AW: 15:38 OK. What is the referral process? Are you happy to fill in the referral form or do you sort of delegate that?

GP7: 15:46 no, just do it

AW: 15:46 ah so you do the referral forms? How long does it take?

GP7: 15:48 I'm a control freak so if I, I do it because then I know it's done.

AW: 15:53 right OK and do you find in a ten minute consultation, is that feasible?

GP7: 15:59 no, I wouldn't do it with a patient I would fill it out after afterwards and if they need to sign it, I think they maybe need to sign that one don't they? They have to pick it up and do their bit with it.

AW: 16:04 ah right OK so you will fill, you will discuss sort of that with a patient in a consultation er sort of send them away and then fill in the rest of that

GP7: 16:11 and just say when you're passing pick it up from reception

AW: 16:14 ah right for the next time they're in

GP7: 16:16 and they sort it out yeah

AW: 16:16 how do you find the measures on the referral form? Do you feel they're all appropriate?

GP7: 16:21 I can't remember (laughs)

AW: 16:23 OK

GP7: 16:23 It's so long since I've completed one. But I don't remember thinking it isn't whereas some of our referral forms are so long and annoying that I would be able to tell you that they were not OK so it must be alright

AW: 16:37 I was going to ask how it does, how does the referral form compare to other referral forms for other programmes that you might refer on to?

GP7: 16:42 it's not very long is it so it's fine

AW: 16:45 so that's fine, good

GP7: 16:45 shorts good

AW: 16:47 the shorter the better (laugh). And in terms of the patient signature, is that something that's quite common amongst other referral forms?

GP7: 16:54 no. That's the only one

AW: 16:56 ah right OK, is that a struggle?

GP7: 16:58 it’s a bit annoying yeah, because it would be much easier if we could just send it off. Er and I am not sure, quite sure if there's, is it because you think people will just refer people without telling them? I don't think we would ever refer, well, I wouldn't ever refer anybody to anything without talking about it with them first. So, I am not really sure what the point is? Unless it’s about commitment to engage, but I guess you would probably assess that the first time you speak to them. If they don't answer your telephone calls or the contact, or get back in touch with the programme then they're not committed.

AW: 17:34 absolutely I completely agree

GP7: 17:37 so, I think that is a pain

AW: 17:36, I think it is, as you say a measure of that commitment and that motivation to engage, but as you say why can't you get verbal consent

GP7: 17:45 it’s a barrier

AW: 17:46 yeah, exactly it’s something that

GP7: 17:49 you could have a box that says "I've discussed this with the patient" tick

AW: 17:54 absolutely and then you are able to send that off and it sort of stops that delay if you like

GP7: 17:56 yeah

AW: 17:58 and you've said, about assessing motivation, so how do you assess your patient’s motivation?

GP7: 18:02 erm, usually they, well, obviously the patients who come to you that sit down and say, "I want to lose weight", they are obviously one step nearer to being motivated. Sometimes they want you to give them a magic pill though that's going to make it all vanish overnight and obviously that's not going to

happen. So, they're one group of patients who are partially motivated, but otherwise assessing it really is about, it's usually finding out what, why it is. What's made them want to lose weight? And usually, it's because you've told them something so "you're borderline diabetic", "you've got high blood pressure", you know. "You're going to have more back pain if you don't lose weight", "you're going to have arthritis in your knees if you don't lose weight", "all your aches and pains are going to be getting worse". Erm, or "you're breathless because you are four stone overweight not because there's anything wrong with your lungs". So, I think usually it's about their condition and about explaining to them the benefits of losing weight and how that might improve their condition. And usually, you then motivate them. So, I think that, and quite often they come back and tell you. You know, they come back and say "oh, I've lost four stone" or whatever when they've come in for something else, they'll be quite keen to let you know

AW: 19:26 how they got on, yeah. Er so as you say quite often it's a health concern that prompts that referral if somethings happened to them. Occasionally you'll get the ones that sort of initiate that, so they come in and say I'd like to lose weight, other times as you say it's you that sources that motivation for them.

GP7: 19:42 and that obviously isn't going to work as well, as them doing that themselves, so, I think sometimes they go I'm quite, you know, I'll say go away and think about it. And if they come back then you know they are one step nearer to doing something. But I am quite, I do talk to them about apps and Fitbit and all those kind of things. Anything, and any sort of exercise is fine, so long as they're doing something, but people who come in and say, "I never stop all day and I can't possibly fit any exercise in", then you try to

persuade them well, actually that's what they're doing now and that's clearly not working so they need to add something else

AW: 20:21 so as you say if they are not necessarily interested in the referral, anything is better than nothing so if you just, it's, it's generic lifestyle advice, walking, anything just, just to try and encourage that

GP7: 20:30 and I try and give them a goal as well. So, I had somebody in this week, and I just said, look I really want you to be able to walk three miles by the end of the month. This is somebody who did use to run marathons so it shouldn't be a big ask. But by setting goals, if they are motivated, they come back because they want another goal. If they are not motivated, they just don't come back

AW: 20:52 is that something that you've used quite often with patients?

GP7: 20:54 yeah,

AW: 20:56 that's a good idea I've not heard of setting goals

GP7: 20:58 well, I need them so other people might

AW: 21:02 anything you can do to...

GP7: 21:03 yeah, even if it's very small. You know and they will come in and say I did get to the end of the street, or I did get up the road and round the corner. I did get that half mile, I did get to the shops or whatever. So, it's quite small to start with if they're, dependant on how fit they are. If they are a pretty fit person then I will be saying, you know, you need to be walking a mile and then you need to be walking it a little bit faster and taking, and seeing how long it takes you and make sure you, you know, you're doing it faster

AW: 21:31 so you're not only assessing their fitness, as you say what they've done in the past, if they've not done anything, small goals. If they are fitter...

GP7: 21:39 and trying to stretch them a bit further, a bit quicker.

AW: 21:44 yeah, absolutely. Is there any sort of, any other constraints in terms of referrals? Patient-referrals

GP7: 21:52, I think it's, erm, for them, it's time, they say I haven't got time and patients also say well, I work 9-5 Monday to Friday so I can't do it because it will be when I can't go because they want it to be evenings and weekends. Erm, and for us, it's the fact that they are at Withernsea, or they can use South Holderness, but it's a pretty grotty sort of gym really so it's about getting to places

AW: 22:22 ah right so there's South Holderness and Withernsea did you say?

GP7: 22:24 there the ones that our patients tend to use so erm, and, and it's cost for patients as well. So, even the one where they pay a small amount, is it £30 for 10 weeks or whatever it is?

AW: 22:41 yeah, the exercise on prescription

GP7: 22:41 even that can be prohibitive. And I know that Withernsea have told us now that for some people they will weaver that if they can and they use their budget to mitigate it. Probably put the prices up for swimming lessons, or something else so they will be able to balance it, but erm, it's still an issue. And, I think that for patients, if they are like over 60, they expect everything for nothing because they don't get prescription, they don't have to pay for their prescriptions, so they kind of expect that everything else the NHS is going to give them will be free. So, there is a bit of an issue there probably something you need to, we need to talk to them more about or somebody needs to talk to them more about that because you know, somebody has got to pay for it haven't they?

AW: 23:25 yeah

GP7: 23:26 three pounds a week is quite a bargain!

AW: 23:29, but as you say if they haven't got the money, they haven't got the money

GP7: 23:31 that's right

AW: 23:33 have they give you an indication of how many sort of free spaces if you like they are willing to offer?

GP7: 23:38 no

AW: 23:39 so again that's not something you can promise with your patients because you've got no, idea

GP7: 23:45 yeah, no

AW: 23:46 OK. So, in terms of constraints is there anything on your behalf that you find, so you've mentioned a little bit about the patients...

GP7: 23:55 remembering about it.

AW: 23:56 OK remembering

GP7: 24:01 so I probably go to the health trainer first, and let them, if they think it's appropriate, they I would expect them to refer on as well.

AW: 24:09 right OK

GP7: 24:11, but I don't actually know if they do

AW: 24:12 I'm not actually 100% sure. I'd hope they feed into the same system er, but it's something I need to find out because if they are not able to...

GP7: 24:23 then I am under a misapprehension and probably other people are too

AW: 24:26 yeah, so, I will definitely find that out. I am not too sure

GP7: 24:28 because they use to be part of the same system you see and now, they're not. I don't know.

AW: 24:31 yeah, because they are separate officially

GP7: 24:33 yeah.

AW: 24:36 I'll find that out. OK, so we've mentioned a lot of patient ben, sorry barriers on the patient's behalf. Time, er unemployment, transport, costs. On your behalf...

GP7: 24:48 and time. The times of it. So, the Monday to Friday thing as well, so they often say they are too busy, and they're obviously the people who aren't quite as motivated and they're not going to engage are they?

AW: 24:58 no, not at all. In terms of on the GPs behalf, the patient signature is a bit of a nuisance if you like.

GP7: 25:07 yes, yeah

AW: 25:07 and it's the remembering.

GP7: 25:09 yeah

AW: 25:09 erm, is there anything that we could perhaps create that would prompt you to remember or is there any way of getting around that?

GP7: 25:16 we've just got so much to remember, I think, you know, every single thing has got a referral form these days., I think probably having more on an emphasis on prevention generally and that will probably need to come from the CCG. That they actually accept that you can't prove everything in two years and that they need a change of philosophy and that they need to accept that you know, prevention is better than cure. And they need to invest and put their hands in their pockets and say OK we are going to pay for some of these schemes. And if they do that and prevention is on every agenda and meting that people go to and they push for every contact counts and that is something that everybody is doing everywhere, then it will become more of the norm

and then it will be there. And, I think really, really is important in schools. And, I think that schools get hung up on they haven't got enough money to have you know, to do hockey and they can't do this, and they can't do that, and it's about er sport, but actually, I think that schools should be focusing on activity. And you know, because lots of kids hate sport. They don't want to get into their P.E kit, but actually they could walk around the yard in their normal uniform or play a game of something that makes them run around. So, I think you know, a lot more needs to be done in schools that stops schools worrying about the costs of the activity and just makes them get on with encouraging moving

AW: 26:53 yeah, absolutely so as you say not focusing on sport as such and really trying to encourage that from a, from a young age as a preventive sort of measure. And then as you say the sort of flip side of that is encouraging the CCG to accept that in two years it's not possible to always prove the effectiveness within two years

GP7: 27:13 prove. That this is long term and that comes from the government because every time the government changes, all the goalposts move and that's just, you know, ultimately the NHS needs to be out of politics, but that's never going to happen, is it?

AW: 27:27 (laughs) so it's just increasing that awareness from a young age as well. A whole society sort of shift

GP7: 27:34 yeah, yeah. I'm getting very philosophical now, aren't I? (laughs)

AW: 27:38 That's alright. So, that's all to do with barriers. If you think of anything else, we can go back to this that's fine. Next, a little area on facilitators. So, is

there anything that sort of eases the process of referral or anything hypothetically that would sort of streamline that system?

GP7: 27:56, I think having the, if we could have like Withernsea have, they have an erm, they call them a navigator. They have a girl, a women called [CN's name] who is in their waiting rooms

AW: 28:07 the care navigators?

GP7: 28:07 yes. So, if we could have somebody who was sat in our waiting room who I could say to my person sitting there you know, so I've put you on the scales, your BMI's 38, I'm worried that in the next few years or in the next ten years that this is going to have an impact on your health., I think if we start tackling it now, we can avoid a lot of those issues and we've got this really lovely person who's just sat at the end of the corridor and she would walk you through it and say you know, and she will even go with you to the gym if you need her to go. You know, hold your hand and make sure that you can go to the classes and you're not going to pitch up on your own. Because there's a lot of that self-confidence and that's another barrier for patients, isn't it? That not wanting to go on their own, not having anybody to go with, having somebody who would be a befriender just temporarily to get them into the system so if you has somebody you could, and they could do the referral and, and do everything, but you've identified and started the ball rolling with the patient. And that's kind of how I am using the health trainers, but I don't think, I think they're a level too high and they actually need somebody before that probably. They might say "oh, you like the fresh air, I've got a rambling club" you know, why don't you do that? Or erm, a gardening club or some, you know,

Hedon in bloom or something like that which would just get people engaged and more active.

AW: 29:28 so as you say, not necessarily straight into that programme, but that whole sort of social prescribing agenda

GP7: 29:34 yeah

AW: 29:36 if you had somebody that was

GP7: 29:38 handy

AW: 29:39 so what, how come Withernsea have roles such as care navigation?

GP7: 29:42 that we haven't?

AW: 29:44 and other places don't

GP7: 29:47 er because they've got a very deprived population, so they have a lot more of the problems. So, they've got a lot more obesity, a lot more diabetes. So, therefore, they have already identified that there's an issue there so they've already had people working together across boundaries so they've already had local authorities working together with the GPs, working together with education to try and solve some of the issues that they have in their area in the hope that that would be able to be rolled out

AW: 30:15 so it might be something in the future...

GP7: 30:16 so they attracted the funding because they had the most deprivation essentially

AW: 30:19 yeah, because of their sort of demographics. I did wonder because I spoke to a care navigator in Withernsea and it just fascinated me that some surgeries obviously have that, and other surgeries are deprived of having that

GP7: 30:31 yes. So, hopefully, but that's the NHS, it's very patchwork now because of how it's funded and because there's so many private providers and different

bits and bobs, here and there and who's bid for which pot of money. It's a bit of a pickle

AW: 30:48, but if you was able to have someone

GP7: 30:52 somebody like that yep

AW: 30:53 as you say not necessarily a health trainer, but to look at that person holistically, just to see if they wanna go for a walk, to befriend them, just to ease them into that and alleviate some of...

GP7: 31:03 and you know, if somebody is lonely. So, that they could say to them, well, you know, you're sat at home eating a packet of biscuits because you're bored and you're lonely, so you'd actually be better off, I know another lady who's just as bored and lonely as you are. Or there's a knitting group or a cross-stitch group or a, you know, star gazing group, whatever and just you know, getting people to the right places.

AW: 31:27 is there any way that you can signpost patients to those sort of areas now?

GP7: 31:31, I think there's too many because obviously the voluntary services, what one area has, somebody else doesn't because it's always dependent on the interests of the local people. So, erm, that's what, we've got a community link worker now so that's what I hope that she will be able to do.

AW: 31:48 oh, right OK. Is that a new role?

GP7: 31:50 That's a new role in the last month

AW: 31:51 OK very, very new role

GP7: 31:56 very, very new role so erm and that's what these forms are. I don't know if you want one.

AW: 32:00 yeah, I will take one of those away great. So, hopefully she might be able to do some care navigation

GP7: 32:10 yeah, but she's not trained as a care navigator I don't think

AW: 32:13 OK

GP7: 32:16 They're literally there to say

AW: 32:16 there's this available

GP7: 32:16 yeah

AW: 32:18 sort of bridging that gap between...

GP7: 32:19 so if you've got someone who's lonely at home you might have a befriending telephone service or something so they're a bit more of a directory of what's out there

AW: 32:28 right OK. And sort of the fourth section is about patient progress. So, you've said, that the feedback that you are aware of comes from the patient directly not necessarily from them services

GP7: 32:42 yeah, I wasn't aware of any, apart from if they write to you to tell you they want some more sessions or something. I don't know, I think they send a letter

AW: 32:47 is that for re-referrals?

GP7: 32:48 yes, yeah

AW: 32:50 OK so they only feedback, well, any sort of communication

GP7: 32:54 that I am aware of. They may well, be feedback, but I don't remember it

AW: 32:59 what involvement would you like in terms of patient feedback?

GP7: 33:03 erm, I think it would be weight, height, blood pressure you know some measurable things that we can put into patient records so that in the future if they then slip back into their old habits you can say "at the end of the

LiveWell, you weighed this this and this and now you've stopped doing all those things that you've learned, you're here. Would it be worth going back again?"

AW: 33:29 OK another sort of benchmark?

GP7: 33:32 yeah, another benchmark so you can say this is where you were, and this is where you are now. Or it might be that you use it as encouragement to say you finished the LiveWell, programme, this is where you were and look how brilliantly you've done because you're now here and you've obviously carried on with everything, they've taught you and now you're off your blood pressure tablets and you're not anywhere near being diabetic so. Because, I think patients need positive feedback…

AW: 33:56 so you can focus on all the positives in the future when they come back

GP7: 33:59 yeah, yeah. You shouldn't just focus on the negatives because the positives keep people going don't, they?

AW: 34:02 absolutely yeah, absolutely. So, there's not really much in terms of feedback so in terms of feedback if, ideally, if you was given any, you'd like weight, height, blood pressure, any sort of changes from that programme. But at the minute it just tends to be the patients that come and tell you that... And does it tend to be positive feedback that they give you or?

GP7: 34:28 it's usually incidental. It's usually sort of, probably if I'm doing their blood pressure and I put them back on the scales or something like that

AW: 34:40 Yeah. OK so the final section is about support networks. You've said, you've got a new role at the minute, the

GP7: 34:49 community link worker

AW: 34:49 the link, community link worker. And what sort of support networks do you have in this surgery to manage your patient load? So, do you have any form of triaging?

GP7: 35:00 Well, that's only started this week

AW: 35:02 so that's a new thing as well? OK. Is that telephone triage?

GP7: 35:04 it's all change. Yes, yes, so that is because we are short of doctors, short of nurses, erm. So, at one point we had 10 GPs and now we've got 8 and we had more full time than part time ones that we've got now. We also had 2 nurse practitioners and we haven't got any and we've advertised, and we haven't had any applicants. So, it's not that, the people aren't, just aren't there. They don't want to come and live at this end of the M62. Erm, so we've had to kind of look at what we can do differently erm and so we were getting quite a lot of extras at the end of our morning surgeries and so this week, from this week, anyone who wants an appointment who we haven't got an appointment to give because they're all gone, then we're ringing them back and deciding whether or not they do need to be seen that day. So, it's not a complete triage, we are not ringing everybody, we're just ringing the over spill to think well, what's the best way of dealing with them and if they need to be seen, they need to be seen and they get an appointment.

AW: 36:10 yep, but if not...

GP7: 36:11 if not, we can give them advice, or we can tell them well, actually you've had this for five years and you can make a pre-bookable appointment even if it's in two weeks' time or something

AW: 36:19 OK so is it the receptionists that do that?

GP7: 36:20 it's us, GP's

AW: 36:23 so it's the GP's

GP7: 36:23 so the receptionists populate the triage surgery, or they triage phone call slots and then we ring them back

AW: 36:31 right OK so give advice or bring them in if need be

GP7: 36:34, but I've got no, idea if it's going to work or not. If it's any good or not

AW: 36:37 OK

GP7: 36:39 it was great for me on Tuesday because I didn't have anyone to ring (laughs)

AW: 36:41 perfect (laughs) and are you happy, are you happy consulting with patients in that sort of respect?

GP7: 36:48 yes, yes

AW: 36:51 and does, I saw in the waiting rooms, WebGP, is that a new thing you've started?

GP7: 36:56 yes, yes, that's erm, we've had that for quite a while now., I think our experience is reasonable in that quite a few patients do not end up needing to have an appointment because they've gone to the chemist or they've gone and bought something at the supermarket or whatever, erm, or rung 111 or done whatever they needed to do. We have had a few patients who are sort of cheating the system where, when it asked questions, they've said, no, I haven't got this, no, I haven't got that and then they've done a free text that basically, contradicts everything they've just said

AW: 37:28 right OK

GP7: 37:29, but you can't get around that really, I suppose if they're prepared to

AW: 37:35 there's nothing you can do to stop that

GP7: 37:35 you can't make them not lie on the form (laughs). Erm, so actually if they had answered honestly, they would have been directed to get more quick medical attention or advice, but actually they've obviously lied on it to make sure it comes to us, and they don't get sent off to 111 or something like that so I don't know what you can do about that really.

AW: 37:59 But apart from that it's been beneficial?

GP7: 37:58 on the whole it's been, yeah, yeah, but it's not massively popular.

AW: 38:02 right OK

GP7: 38:04 so a lot of our patients don't use the, wouldn't use the web

AW: 38:07 why do you think that is?

GP7: 38:08 er, probably the elderly ones aren't so IT you know, happy. They like to see people or speak to people

AW: 38:19 yeah

GP7: 38:20 in fact I had somebody this morning who said, "oh, I'm not sure about all this not face-to-face contact" because obviously it's been in the news quite a bit hasn't it recently? "I'm not going to like that"

AW: 38:33 you can't change some of them, can you?

GP7: 38:34 Some people really like it because they might be sat in front of EastEnders and they just think I'm a bit worried about this, I'll just ask my GP about it and er that it's very convenient in that sense

AW: 38:45 yeah, and it allows you to filter some of those patient away and

GP7: 38:50 and most of those won't come anywhere near us because it's nonsense

AW: 38:55 that's good, so they can be filtered before they come to you.

GP7: 39:00 yeah

AW: 39:00 Fantastic. That's sort of all the questions I wanted to ask today. Is there anything you'd like to add that you think is relevant or important about anything we've spoke about?

GP7: 39:07 no, I think, you know, broadly, I think that we have some good services there, I think that we don't, we don't often get reminded about things enough. That would be the other thing, just to keep prompting us that they are here sort of even if it's an email just to say, you know, don't forget that the Live Well's for this and some bullet points of the salient features of each service because you know, we know because we've just had the sort of visit to remind us, but actually if you'd had been asking me the same questions a week ago, I would have known BMI 45 for LiveWell, I would have known to send them to our nurses for Exercise on Prescription and they would sort it out, but I wouldn't have known that you could send children to that LiveWell

AW: 39:53 the young LiveWell

GP7: 39:54 yeah, yeah, so, I wouldn't have had a clue about that so that's something that I've learned over this week so, I think reminding people that that's there would be good

AW: 40:03 so as you say one of the appropriate ways to do that would be through email

GP7: 40:07 could be, couldn't it? Or actually, I think it's also, do you know how many people we have who come when it's been on Viking radio or something about "I've had a cough for three weeks, see your GP" so everybody comes in with a cough for three weeks and you're like oh, OK that's great. Erm, and, I think just having more, so the patients, they can read. So, if they're sat waiting somewhere, if you've got them sat in customer services at the council, or the

kids are having swimming lessons and they're losing the will to live in a hot cafe because it's too hot, you know, they're watching them go up and down for the six millionth time or, or they're sat in our waiting room, if you had something that went round that said, you know, have you thought about LiveWell, or exercise on prescription, talk to your doctor about it or your nurse or whatever, you know so people know about it so they come and ask us. They might ring up and say you know, what about this, can you refer me to that? So, I think if patients are aware of it, they would probably want to engage with it. If it was seen as a, something more, low key almost, more normal. If you normalise it, it's a bit like going to the gym or going to something that people do, it's part of life, that they could actually say well, this is there, and I'll go and see if I am entitled to that

AW: 41:34 yeah, yeah, so, it's really important that we...

GP7: 41:37 promotion! But promotion directly to the patients not just to the health professionals, but to actually say to patients this is there. Because when patients are told to come, so you know, might you be at risk of diabetes? Why not have a check for diabetes? You know, is your weight a problem? How about seeing if you're entitled to any of these services. It could be a leaflet drop or it could be in the Hull Daily Mail or on the radio.

AW: 42:05 just anything to increase public awareness?

GP7: 42:05 yeah, yeah, on the back of a bus is usually a good place

AW: 42:09 yeah, and then as you say if they're actually coming to you and asking about it then you're going to be reminded to, to refer

GP7: 42:18 yeah, they are going to tell us and if a patient comes in and says what about this then we do it usually

AW: 42:20 because it's on their agenda

GP7: 42:23 yeah, and it might be that they, or when you mention it to them it's not a "what on earth is that", they've actually heard of it

AW: 42:31 do they tend to be sort of a little bit resistant if you mention it first?

GP7: 42:34 hum yeah, well, most patients don't like you to tell them that they've got a weight problem because they know they have

AW: 42:41 yeah

GP7: 42:42 so they don't really like someone to tell them, but actually it's, if we tell them, it does have more of an impact...

AW: 42:49 as opposed to somebody that wasn't a medical professional?

GP7: 42:52 a bit like smoking, isn't it? If we say it then they do listen more.

AW: 42:59 absolutely er you mentioned that you send your exercise referrals to your practice nurse. How come you complete the LiveWell, but not the Exercise referrals?

GP7: 43:07 er because they use to do the assessments and they use to make them run around and do all sorts of things so I'm not quite sure if that's just something that anecdotal to us.

AW: 43:20 I've never heard of nurses doing assessment for that

GP7: 43:23 No? ah right OK

AW: 43:24 I know on the referral form it requires the, the blood pressure, the height, the weight, all those sort of measurements, but I wasn't aware...

GP7: 43:31I think that's probably to make sure all of that is done

AW: 43:33 OK

GP7: 43:36 so, I think it's probably just to make sure that that's all up to date for the patient

AW: 43:41 OK and do you think there's anybody else in this practice that would be happy to answer these questions? Anybody relevant? Maybe one of the practice nurses?

GP7: 43:49 yeah, maybe one the practice nurses probably would

AW: 43:52 I know obviously its restricted to exercise referral only, but what we're hoping to do, well, the hope is, I'm not sure if it's possible yet, but trying to integrate the forms with your clinical systems. Er, so these forms are pre-populated just to save that time. So, if we are able to link those systems erm, that's sort of the ultimate aim, but as I say it just depends on what you want.

GP7: 44:15 I mean we have, we can put forms on our system which are pre-populated so when we get a form from the hospital, we can put it on our system and then we can email it so that's a way of doing it so that it would pre-populate on here and then we would email it if we had an email to go to. We're not on system one so we are not the same

AW: 44:37 are you on EMIS then?

GP7: 44:39 hum

AW: 44:39 EMIS at the minute. So, am I right in thinking that practices that are on EMIS are able to integrate their own forms into the system?

GP7: 44:47 yep. I don't know about system one

AW: 44:50, I think system one is really restrictive

GP7: 44:52 yes, yes, and at the moment we are quite, we're, so in Holderness there's three practices that are on EMIS and one that's one system one, but the CCG want everybody to go onto system one as far as I know, but that's not happened so far, and they have been on about that ever since I became a GP

AW: 45:10 ah right so a long time

GP7: 45:11 so we will see

AW: 45:13 and is that something that would be easier for you if it was sort of on their rather than paper?

GP7: 45:17 yeah, and then we would do the exercise on prescription ones and see that actually they didn't really need to go and see the nurse because it was all already there anyways.

AW: 45:27 right OK so that stop that sort of delegation?

GP7: 45:28 so that would yeah, yeah. So, sending things by email would be miles better and with a tick box to say I have discussed this with the patient, or I have the patients consent to send this referral. Just a tick.

AW: 45:43 yep, so removing the signature

GP7: 45:47 signature

AW: 45:47 the need for the signature and ideally if it was electronic, you'd be able to send that erm paperless to wherever it needs to go. As you say it will be pre-populated because you're on the EMIS system. OK, that's sort of the gold standard., I think it will be a lot easier to change practices that are associated with EMIS rather than system one. It's just trying to work out how we can include that with other practices

GP7: 46:10 other doctors will make Withernsea change to EMIS in the end (laughs)

AW: 46:15 is that your plan? (laughs)

GP7: 46:17 well...

AW: 46:18 and have you got any contact details for your practice nurse? Or anyway....

GP7: 46:20 [PN's name], so there's [PN's name], there's [PN's name], and there's erm, [PN's name] would be the two. And [PN's name] is actually really interested in research, so she has time out for research within the practice.

AW: 46:34 ah fantastic

GP7: 46:36 so she might be

AW: 46:38 is she a practice nurse?

GP7: 46:40 she's a practice nurse yeah, and she does COPD and all those different things that might mean that those get referred to exercise on prescription so she would be a good person to...

AW: 46:49 OK have you perhaps got an email for [PN's name]?

GP7: 46:52, I think if you put in erm,

AW: 46:55 sometimes there's a dot before the NHS sometimes there isn't. I just don't want to guess

GP7: 46:55 erm let me just see...it's [PN's email]

AW: 47:31 brilliant thank you. yeah, we're just trying to get as many different perceptions and perspectives of the referral process as possible because there's no, point of creating something that's not going to work for everybody, so we need to make sure it's amenable for all roles and erm different programmes really

GP7: 47:53, I think erm, I've got your email somewhere, haven't I?

AW: 47:57 er yes

GP7: 47:58 because I've got your thing so I could even give them your details and just say if any of them are interested I'll send them your email

AW: 48:04 that would be great. That would be really great. Thank you very much. Well, thank you for your time today.

AW: Interviewer **Interview date**:07.03.2018

GP8: Participant **Interview location**: Practice 2 Bridlington

AW: 00:00 that's absolutely fine, no problem. So, as I say the first area is centred on the healthy lifestyle programmes. So, what programmes are available for you to refer patients on to in this locality? Those run by the council.

GP8: 00:13 er, what I know of really, the exercise referral and the erm, erm what's it called? That's the one I use the most and the other one is LiveWell.

AW: 00:29 LiveWell, as well

GP8: 00:30 yep

AW: 00:30 yep, fab. And so, you've said, you use the exercise referral the most, why is that?

GP8: 00:36 because it fits most criteria basically, I think obviously LiveWell, the BMI is the cut of criteria, so we have some patients that qualify and some patients that don't, but we have a lot of inactive patients with other health needs which fulfil the exercise criteria

AW: 00:52 ok so it's a case of what patient are eligible for which sort of programme

GP8: 00:55 yeah, basically, yep

AW: 00:56 and what's the process of referral in this surgery? Do you refer?

GP8: 01:01 yeah, yeah. Well, if the patient is here then I will do the referral myself. I know they are going to be seen. We do sometimes refer to the HCA's if we need a bit more information from them. If they need weighing and etc., etc., and they have got an appointment. We do not make a special appointment for them to do it that's just a waste of appointment that so usually I refer, but also the nurses refer directly as well, so we all

AW: 01:28 so practice nurses, as you say yourself, and sometimes you will delegate that to health, healthcare assistants if need be

GP8: 01:35 yeah

AW: 01:35 and how are you made aware of what programmes are available?

GP8: 01:38 I do not know via email usually

AW: 01:45 and do you feel that you have been provided with enough information for you to make an informed choice of where to signpost patients?

GP8: 01:52 for those programmes yes

AW: 01:58 and is there anything else you would like more information on? So, there the new, I don't know if you are aware the new health optimisation scheme

GP8: 02:03 right

AW: 02:13 that is a very, very new scheme so that's

GP8: 02:17, I think the HCA's are referring to that as well, I think that was one of the things they were doing because there was some schemes weren't they with the erm CCG criteria for surgery and things like that which was one of those stop smoking and the weight scheme

AW: 02:28 yep

GP8: 02:32 we also, to be fair, we also refer to the health trainers a lot

AW: 02:36 the NHS health trainers?

GP8: 02:36 yep, they have got a shop in town

AW: 02:40 perfect. Is it more convenient then to refer onto them?

GP8: 02:43 well, not necessarily again it depends on what, all the smoking cessation is done by the health trainers so from that point of view they will also do er for people will board line diabetes and things they will do the dietary advice and you know increase activity levels and things like that so again it depends on what the patients' needs. If they need smoking or something else, then usually I would send them to the health trainers, but

AW: 03:06 so it just depends on what the patients want really.

GP8: 03:07 yeah, yeah

AW: 03:08 perfect. The exercise on referral and the LiveWell, have information resources such as

GP8: 03:15 yeah, those

AW: 03:15 have you seen those?

GP8: 03:14 yeah, I've got those

AW: 03:18 how useful do you find these resources? Are they patient friendly?

GP8: 03:20 yeah, they're fine yeah, I normally with the LiveWell, one give the patient their half and tear the other half off, so they know what they have been signed up for essentially

AW: 03:31 yep, fab. And when are you prompted to refer patients onto these programmes? Is there anything in particular they come with?

GP8: 03:37 (laughs) they walk through the door, and they are usually overweight and need referring or they are inactive, or they are depressed, and they are not doing anything. They are not getting out the house. They are not doing anything really

AW: 03:51 yep. How do patients respond when you tell them about these programmes? Are they a bit taken back?

GP8: 03:56 no, most of them are fairly open yeah. Most of them are fairly er quite happy and quite glad of the support really.

AW: 04:05 yeah

GP8: 04:07, I think particularly the LiveWell, works well, because, I think a lot of them, when the patients are that heavy, they often do not want to go to the gym on their own so the fact they can take someone with them, I think works well.

AW: 04:19 and are they, do they know what LiveWell, is? Do they know what the programme is, and do they come asking for it?

GP8: 04:25 hm no, I haven't had a lot of people asking for it, so I don't know what their awareness is, but I have certainly referred a number of people to it and as I say the feedback, we get from people that have been referred tends to be you know useful, it’s a useful programme so and they do tend to lose a bit of weight

AW: 04:47 fantastic so you are given positive feedback about that, but as you say you're not really sure how aware patients are.

GP8: 04:52 yeah

AW: 04:52 would you say you're quite confident issuing a lifestyle prescription as opposed to a medical one

GP8: 04:58 yeah, from that point of view yeah, I mean I do both if you know particularly for depressed patients, obese patients things like that part of it is you need to go and exercise, we can refer you.

AW: 05:15 that makes sense. So, the next section is about any er issues or constraints in the referral process. Not necessarily just, could be in terms of patient motivation, it could be in terms of the referral forms. So, have you, or do you experience any challenges when referring a patient onto these programmes?

GP8: 05:32 nope

AW: 05:33 not necessarily, that's fine. Are you using the online system or the paper referral form?

GP8: 05:40 I use the paper referral forms just because I have them, but, I think the HCA's are doing the referrals online, particularly for this new one [Health optimisation scheme]

AW: 05:47 ok. Does paper suit you better?

GP8: 05:50 yeah, personally, I'm not really, (laughs), I'm not very IT savvy so if I've got a form that I can fill in and get them to sign whilst they're in front of me then it's easy, it's done, and we sent it off yeah

AW: 06:03 and the measurement that are required for a referral, do you feel that they're all appropriate?

GP8: 06:08 yeah, yeah, yeah, absolutely

AW: 06:11, I think it asks for BMI, for blood pressure, things like that,

GP8: 06:14 and other relevant drugs

AW: 06:14, but that's fine in terms of…

GP8: 06:15 yeah, that's appropriate

AW: 06:17 yeah? What we have found is that GPs in particular say well, in a ten-minute consultation we just do not have the time

GP8: 06:27 I mean, you know, stand on the scales it doesn't take that long, does it? They're right there

AW: 06:33 so in your opinion it is feasible in ten minutes?

GP8: 06:34 we should have, we should have a record of blood pressure I mean it, it takes 20 seconds to take a blood pressure and if we don't then we get the HCA to do it it's not hard, it, its basic very basic examination, statistics and if we haven't already got them recorded then you know, if they've got a BMI of over 45 then we should have that recorded anyways, shouldn't we?

AW: 06:57 so as you say most of that should already be recorded on your system

GP8: 06:58 yeah

AW: 07:00 I wish they were more GPs with your mind set (laughs). So, in terms of the referral forms, no, issues in terms of what you have to do. As you say, patients tend to be quite open to referral

GP8: 07:14 we offer it, and they are either interested or they are not really

AW: 07:17 exactly it's their choice

GP8: 07:17 it's their choice, isn't it? Most of them take it up, some say no, but most of them seem to take it up

AW: 07:25 anything else in terms of what might make it difficult or does?

GP8: 07:31 no, except we run out of forms occasionally

AW: 07:32 just a bit of admin issues

GP8: 07:37 yep

AW: 07:39 ok so onto patient progress feedback. So, you've said, that patients come back and sort of give you that feedback which tends to be positive

GP8: 07:48 yeah, of the feedback that I have had, yeah, it's mainly been probably from the LiveWell, programme and people have you know, have obviously lost weight from it erm

AW: 07:58 are you provided with any feedback from the leisure centres regarding a patient's progress?

GP8: 08:04 I don't think we are. Well, I don't know whether we are or not, but having said, that for things like that I might not see the letter because we have

the letters screened by the secretaries for things like, simple things like that we may not, the GP may not see necessarily

AW: 08:20 yeah, it may not necessarily go to you

GP8: 08:22 it will be filed and, on the system, but we may not see the letter directly

AW: 08:27 so if it is filed and put onto the system, are you able to access that information if need be

GP8: 08:32 oh, yeah, yeah. It is all scanned onto the patients notes and if there is anything that needs updating like coding like a new weight or anything like that, the secretaries will do all that, but we may not necessarily get the letter on our desk in front of us

AW: 08:47 yeah, that makes sense.

GP8: 08:50 so we do a letter, a screening programme where they take out things that are immediately relevant or if there is no, action that we need to take as such.

AW: 08:58 yeah, and would you prefer for it to bypass you or are you quite happy for that to go to the secretaries?

GP8: 09:03 no, that's fine I mean its useful information if they have lost weight then we need to update our records, BMI things like that. If blood pressure has

improved, then great! We need, you know, it's useful to have the information, but I don't necessarily need to see it as such

AW: 09:17 yeah, but it is there if you need it

GP8: 09:20 yeah, it's there if I need it

AW: 09:21 is there anything in particular that you would like to hear regarding patient progress? You've mentioned weight, perhaps BMI, blood pressure

GP8: 09:31 continuing it

AW: 09:31 yeah, so something regarding their adherence?

GP8: 09:32 yeah, if they are continuing it yeah

AW: 09:34 and how they are sustaining that

GP8: 09:38 yeah, actually I guess the only thing with the LiveWell, actually a couple of times I have been asked if they can be referred again for a second time. Thinking about it, when patients have done well, and want to continue, but obviously it's a six or twelve month whatever it is now

AW: 09:57 is this after they've completed the programme?

GP8: 09:59 yeah, can they go again, can we refer them again to revisit, to continue with the programme in that sense, but er I don't think that's available.

AW: 10:06 what information have you been given regarding re-referrals?

GP8: 10:11 [shakes head]

AW: 10:11 none?

GP8: 10:11 I don't know.

AW: 10:13 they can be referred more than once, but it is at the leisure centres discretion, so it does just depend on their situation, but what they do at the end of the LiveWell, programme, they try and encourage people to stay on, so they offered discounted memberships, it's a free scheme, but, I think they are allowed two referrals. There has been cases where patients have had a third referral, again it's just patient dependant.

GP8: 10:35 ah right well, it's useful to know that we can refer them again because I have had the odd patient ask.

AW: 10:41 I was going to ask do you have any information about if a patient has already been on the programme. Or is there any way of finding that out?

GP8: 10:51 well, if the referral has been done it should be on our system

AW: 10:53 ok

GP8: 10:53 we should have it on the system that we have referred them yeah

AW: 10:56 ah so you make a note on the system to say that you have done that

GP8: 11:00 yeah, there should be a copy of the referral on the system so you would know

AW: 11:07 so are the referral forms scanned on?

GP8: 11:08 yeah, usually all of our referrals are scanned on

AW: 11:16 ok and onto the last section, which is about support, networks. You mentioned you have healthcare assistants to sort of manage that load if it does get a bit overwhelming or you've got too many patients. Do you have any sort of triaging mechanisms?

GP8: 11:32 no

AW: 11:32 no, nothing like that. Is there any telephone triage by the receptionists or anything?

GP8: 11:37 not really telephone triage, we have, for appointments and thing no, we don't triage as such in that sense. We have telephone appointments for follow ups and things which we can book in to, but we don't we don't, we don't triage

AW: 11:49 don’t necessarily triage no

GP8: 11:51 we don't have formal triage system no

AW: 11:52 is that something you can see developing in the future?

GP8: 11:54 no

AW: 11:53 quite happy is it is?

GP8: 12:01 yeah, (laughs)

AW: 12:01 fantastic well, that was everything that I wanted to explore. As you say from your point of view, you are quite happy with the system

GP8: 12:08 it's a good system

AW: 12:08 you think it's fairly feasible within ten minutes

GP8: 12:12 it's easy

AW: 12:13 you've got healthcare assistants if need be

GP8: 12:13 yeah, it's easy it's no, more than filling out an x-ray form or something like that. It's only like filling in a patient for an x-ray

AW: 12:21 I was going to say is it a typical form, is it user friendly and typical of other referral forms

GP8: 12:26 yeah, just patient demographics and a bit of information about them, which is again the same if you are referring them for any scan or anything it's the same, similar information

AW: 12:36 why do you think there is a reluctance then amongst other sort of GPs?

GP8: 12:39 I don't know I don't know, but I guess, I think obviously Bridlington is quite different from quite a lot of the other areas in the county I guess in terms of the demographics, so we've got much more social problems, er probably much more obesity and ill health so I guess we are perhaps a bit more focused on that in a way. As I say [Dr's Name], we've been doing social prescribing and things. I don't know if he has talked about the EASYCare project and things

AW: 13:17 yeah, he did. Is that the health needs of the over 75's?

GP8: 13:20 yeah, and we had a MDT every fortnight which is now as and when if we need it, but for a time, we was doing it every fortnight, [name] was doing it with one of the receptionist who works as a navigator, a care navigator, has a role as a care navigator. Was doing that with a social worker coming ion, mental health workers coming in for any patients that needed extra input in any way obviously some of which may have been this sort of thing [HL programme support] so we kind of do it. It's everyday practice!

AW: 13:54 its everyday practice. it must just be because you're keen to improve the health of resident because honestly the other GPs are completely different, this is not part of my job remit, we delegate that, and they can make an appointment with the practice nurse for instance.

GP8: 14:09 well, we can make an appointment with the practice nurse, but if I have got the patient in front of me that's just a wasted appointment with the practice nurse, isn't it? And appointments are scarce, so I guess from that point of view we are under doctored in Bridlington significantly compared to other

areas in the county. We find it hard to recruit so why would I send a patient if I have got them in front of me and it takes two minutes to fill in a form, 30 seconds to fill in a form to go and have an appointment with someone else and take up another appointment. It's nonsense

AW: 14:37 well, thank you very much for your time today

GP8: 14:45 it's no problem

AW: 14:46 do they think there is anybody else in this practice that I should speak to give me a good insight. So, I have spoken to [Dr's Name]

GP8: 14:53 er a couple of the practice nurses would be maybe helpful

AW: 14:57 ok anybody in particular.

GP8: 14:57 erm [Nurse's Name] might be helpful and we've also got a nurse practitioner, but any of them erm, but when I say [Nurse's Name] because she does most of the diabetes stuff, so she does a lot of sort of exercise referrals and that sort of thing I mean because a lot of the diabetic patients are obese as well, so it does a long with it

AW: 15:19 absolutely, have you got any contact details for [Nurse's Name] by any chance?

GP8: 15:24 er she will have an email er or

AW: 15:27 we don't have access to NHS emails that's all

GP8: 15:31 yeah, or I can ask her. I can forward my email to her and get her to contact you

AW: 15:36 that would be brilliant

GP8: 15:37 I can forward the email that you sent yeah

AW: 15:39 brilliant thank you very much

GP8: 15:42, I think she does probably more. Although all the nurses are going to do it, she probably does more because she does all the diabetes stuff.

AW: 15:47 yeah, because that's sort of her specialist area. Fantastic well, thank you very much for your time I will just stop this recording.

GP8: 15:53 that is OK. I guess what we want is a single access point, single point of access. I guess this should be on tape [end of sentence missing as recorder turned off]

**Dr GP8 discussed how he would prefer a single point of access meaning all patients are referring to some sort of hub where they are then directly to the most appropriate service for them (whether that be the health trainers, HL programmes, other social prescribing programmes)

AW: Interviewer **Interview date**: 21.06.2018

GP9: Participant **Interview location:** Manor House Surgery, Beverley

AW: 00:01 others have care navigation, er care navigators, community link workers so it just depends obviously which surgery you are in, but it's just about finding out what happens in your surgery, how you operate and what you think of the forms and how we can improve referral. [HLO's name] said, you had some really good ideas in terms of the content and what necessarily doesn't need to be there and what could be improved. Erm, so yeah, speak as hypothetically as you like. There's no right or wrong answers, erm likewise, if there's anything you don't want to answer during the interview just say no, comment and your free to withdraw at any point

GP9: 00:35 ok yeah, yeah. All that yeah, that's fine and I've signed it as well

AW: 00:40 brilliant. So, I'll just scribble on the bottom of there.

GP9: 00:47 and I understand the information will be used anonymously, but with a suitable identifiable....

AW: 00:52 yes, so for instance, you might be GP 10 or GP 20, but no, other information pertaining to where you come from, there will be no, sort of attachment in terms of that and if you would like a copy of my thesis transcript, I can provide that for you.

GP9: 01:09 so you transcribe it? Word for word?

AW: 01:11 yes, so basically, we record the interview. Yep, so word for word I will type up that transcription and that's for my analysis and I will look back on that. It's just so I get an accurate recording of the conversation that we've had

GP9: 01:23 ok

AW: 01:23 and I may use some quote when I am trying to, say we report this back to the CCG and for instance, the patient signature doesn't need to be on, I'll have X amount of GPs that have said, that, and I may pick some compelling quotes, but again nothing will be identifiable to yourself. Happy?

GP9: 01:39 yeah, yeah

AW: 01:41 ok so the interview I centred on four key areas. First of all, the healthy lifestyle programmes that are available to you in this locality. So, what you can refer patents on to. Next the information and referral resources so whether you are provided with anything to give to your patients or any sort of resources to help you decide, or in your case it might be that you delegate that to someone else who makes those decisions. Any constraints that you face that you face with the referral process…

GP9: 02:13 any what?

AW: 02:13 constraints or challenges

GP9: 02:16 constraints

AW: 02:18 yes, or if you look at the referral form and you think that doesn't necessarily fit with the way that we work, any sort of recommendations on the back of that

GP9: 02:26 I have to admit that I cannot quite recall what the paper referral form looks like

AW: 02:29 that's fine I've got one in here

GP9: 02:34 and I cannot recall the online form. I've only glanced at the online referral form. Erm, yes, what, what struck me about the paper referral was that that, it had tick boxes for various conditions, and you could tick more than one. Can I have a look at it?

AW: 02:55 yes, of course you can. Is this the exercise referral form?

GP9: 03:00, I think that's the one yeah. I will have to just rattle it down

AW: 03:06 yes, not a problem

GP9: 03:13 er so one thing is that that, erm, the inactivity, I don't think is clear. There is no, clear definition of inactivity. If you use the NHS England criteria for recommended activity, it's 150 minutes per week and I don't manage to do that so I would class myself as inactive probably. So, I think, I think that's not a very useful criteria to be honest. Erm, diabetes, I am not clear why mediation or no, medication is required on that because I don't, I can't really see how it makes, well, I keep asking myself what difference it makes to what they do with it really, that medication. I'm not…

AW: 04:21 so you are unsure why they are requesting that information in the first place

GP9: 04:27 yes

AW: 04:27 absolutely and as you say the word inactivity, it's a bit of a relevant term if you like and as you say 150 minutes you don't necessarily reach that so is it necessarily important for them to know.

GP9: 04:39 yeah, well, somebody has defined, somebody has said, that the patients' needs to be inactive otherwise they don't need to be referred for activity I suppose but actually if you think more closely about it, that is not what reality is like. People have got, I mean most people say I do a lot of housework and housework can be anything from washing up to scrubbing floors and breaking out in a sweat I suppose so it's really difficult to define. And yes, I do think if you ask a question on the form, think if it is clear to the clinician or to whoever referring them has to complete it and why you need that information because you're more likely to get a sensible answer. Yeah?

AW: 05:26 yeah, absolutely.

GP9: 05:28 I've always found this when I did like an apprenticeship or something in the past and somebody said, er "give me those screws over there", and then you come back with a box of screws and it's "oh, no, not those ones, the other ones " and you come back with the other screws " oh, why did you bring me those!" If they explained, they want to do, I don't know the wall is about that thick and I need to have the right screw for that. I would have gone and looked for the right screw

AW: 05:54 absolutely yeah

GP9: 05.55 if I didn't know why I was doing something, there a high chance you're getting it wrong and it's really frustrating as well. Erm, the, the tick boxes otherwise themselves, I'm not quite sure whether that's actually a

comprehensive list of erm, of all conditions that are allowed for the referral. Erm, patients' blood pressure,

AW: 06:31 how often are the blood pressure, how often is that measured and documented in the patients record. Is it up to date?

GP9: 06:37 it's very variable it depends if the patients got high blood pressure, or if the last ones ok. It depends on how old they are, what comorbidities they have, so sometimes I am faced with the pain of, at the end of 10-15 minutes agreeing on exercise on referral and working really hard to actually come to a conclusion that that might be a good thing and then I try fill in this form, I remember that I don't do it anymore and I'm thinking I haven't checked his blood pressure, I haven't got time to check his blood pressure now so actually "ah can you go and see the nurse downstairs and have your blood pressure checked"? That's really silly because that's using an appointment for the nurse for blood pressure., I think it might be really useful if actually somebody at the leisure could check their blood pressure possibly, and say this is too high for us to be happy to exercise, but I have for example no, I don't know of any evidence what blood pressure is too high to exercise

AW: 07:42 so again it's about providing you the why, why is that a contra-indication to exercise

GP9: 07:46 It's about providing us with that information, why? yeah

AW: 07:49 and as you say the records are variable and if you haven't got time to do that, you are then delegation that to a nurse which is another appointment so it's not ideal again for you

GP9: 07:58 yeah, and there might not be an appointment on the same day that would mean that I would need to put the form away for a day until they have got the blood pressure or give it to the patient to take to the nurse so she can record it, but then the patient might accidently leave it at home, so it becomes really complex just because you need that bit of information which you haven't got. Erm, BMI well, actually, I think it might, I understand why that is needed because there is like a limitation. Obviously, there is the LiveWell, there is the exercise referral and there's also the H, is it the HOP?

AW: 08:37 yes, the new health optimisation scheme

GP9: 08:38, but actually it would, I think it would just be useful to have one referral form for all three conditions because you are asking the same information and just have three boxes to say HOP, or actually you could just, you could even just say I am referring this patient for health optimisation because they are needing surgery rather than HOP because not everyone knows what that means. There's exercise referral and there's LiveWell, and if you describe in brackets BMI of under 45, BMI of over 45 that would be absolutely fine

AW: 09:19 so really just simple reminders as you say the clinician, it's a prompt so they remember

GP9: 09:24 a prompt yeah, because I don't really want to then, apart from taking the blood pressure, weight the patient again so I get their BMI right, cuz the only, well, I think the relevance is, ok it's there because I want to lose weight, but again, I would hope that that could be checked at the recipients side (sighs). Actually, not only for the exercise referral, but I said, to you that it would be great if you could use your findings to actually enlighten everybody on what a

good referral would look like. A good form would look like and very often when I have to start putting peoples ethnicity, er, when they first registered, next of kin including address and telephone numbers and all of that on a form, er that then deters me from actually starting I have to say. You can use the clinical systems to pre-populate this information, some of the information is quite easy to populate, but actually developing these word documents that they are I system one and, I think in EMIS you know there are the two systems?

AW: 10:40 yeah, templates in the two clinical systems

GP9: 10:39 Whilst there is a lot of choice and you can extract, if you are good at it, almost anything and put it nicely into the form, it actually takes quite a bit of time to find the right field format it in the right way, erm, think about what happens when the field doesn't exist for example like allergies. There is actually an option that the computer, that the system will say non recorded or whatever you want it to say if there isn't anything in that field, but it takes time so somebody would need to develop that form and test it and that testing often doesn't happen. It's done half-heartedly and when you fill it in erm it's really difficult to complete and it goes over three pages, and the page breaks are in the wrong place because nobody has ever tried to use it before, but theoretically that works really well. We've got a set of forms at our surgery that I have sort of worked with and thought ah this this field doesn't work right or something like this and I've improved and now it's really the click of a, button and all the, all the information that I don't want to complete, have to complete is pre-populated and it works quite reliably.

AW: 12:01 are you more likely to refer if you have got a form that is pre-populated?

GP9: 12:03 yeah, oh, definitely yes, yes

AW: 12:07 and would that save the delegation if these forms where on the clinical system?

GP9: 12:11 yeah

AW: 12:12 and as you say it is time consuming, but once, if it's set up properly and tested as you say that's the important thing then actually these could work really well

GP9: 12:22 it could save loads of time for other people and for yourself yeah, so that's why it tend to invest my time because I get it the way I want it and it works. But yeah, it, well, actually, I think it might be sensible sometimes to use clinicians to do this sort of thing even though they are expensive, they know what's relevant, rather than using admin staff and not quite getting it right if that makes sense. That's why [name], sorry [name] you'll remember, he's from the CCG and they commission healthcare, but they are not clinicians and we've found that having a clinician involved in trying to develop new services, it's immensely helpful because GPs are more likely to accept something that a GP has developed. And there are aspects to implementing a service that are difficult for them to appreciate, they are also aspects for me where, I think there shouldn't be a problem, where they can say actually there are some regulations, but yeah, just getting the person you want to use the form involved and actually developing it is probably

AW: 13:37 absolutely that's why we are really keen to, in the post this has always been developed by leisure and they have always had problems and the information coming through is not always the right information that they need as you say because there's no, guidance which is why we are really keen to involve as many different surgeries that are willing to co-operate and then we will develop something hopefully to make your lives a lot easier, but as you say if there are wider implications, we can hopefully spread this out across all referral forms.

GP9: 14:08 yeah, just have a short paper that says the lesson learnt where... maybe you could consider that when you develop whatever. Right then just going through here, current medication relevant to exercise, you know, that, that could have, that could be pre-populated and actually I don't know what medication is relevant to exercise to be honest. Angina spray probably

AW: 14:35 absolutely another relevant term. What is relevant. Who knows?

GP9: 14:39 I'm expected as a GP to know what blood pressure is safe to exercise, what medication is relevant to exercise, er and actually I haven't had any training in that and I use to common sense to say if someone's blood pressure Is 250 over 150, I would be just intuitively a bit concerned about that, but if it’s 160 over 100 well, it’s likely that if they improve their general health it’s going to come down, and they are probably statistically at high risk of stroke and heart attack, but how likely is that to happen because the exercise and how much higher does the blood pressure go when they exercise? I don't know that! And, and people sometimes just say I've been running here my blood pressure will be really high and actually it isn’t, so I don't think there is

any evidence for that sort of thing. Well, I know your blood pressure goes up when you exercise, but

AW: 15:38 absolutely, but what is safe? How much higher does it go? There's no, evidence provided around that so again it's providing the why

GP9: 15:47 yeah, why is it needed and what wouldn't you be happy with because then what's the point in me filling it in if it's over 100 over 100, 80 over 100 or whatever

AW: 15:54 absolutely

GP9: 15:55 and they are going to say no, it needs to come down first

AW: 15:58 and then it comes straight back to you

GP9: 16:01 yeah, it's all sort of wasted work, isn't it? And then medical history, I always felt I was ticking the same flipping, sorry, the same boxes that I've already had a look at above because they are almost the same conditions and then please tick any relevant current or previous conditions, erm has only one leg is not on there, but that would be very relevant whilst high blood pressure, it's already up there so I, I think is it necessarily or should you leave it in the GPs remit to say well, actually, I think you should know about this. I don't think tick boxes are suitable for that sort of thing almost unless you can tell me why because I mean there's having one arm, having one leg, it's not on there. Erm, having MS, that would come under, well, I would have to think about what that comes under. OK so, and then I've completed that form and it says participant declaration "I've not withheld any relevant information" well, actually they didn't complete that form.

AW: 17:25 absolutely, that doesn't make sense at all

GP9: 17:28 I give consent to participant, what!?

AW: 17:34 do you have to complete the patients signature for any other referral form that you complete?

GP9: 17:40 no, I think until the GDPR implied consent, if I say I'm going to refer you to an orthopaedic surgeon was sufficient if the patient says yes, that's fine because that sort of implied that I needed to supply them with the relevant information. Since GDPR, we have to tell the patient that it will involve including their medical history things like this, but, I think verbal consent is sufficient. That's my understanding anyways.

AW: 18:13 as you say if the patient has gone it's getting them to fill in that field before you can process that referral

GP9: 18:20 I just always just, I think I put a cross on there. So, I hereby give my consent to participate on the exercise referral, that's ridiculous. Well, either you do it or you don't. They are not going to force you on the bike, well, they might do, but if you resist, they shouldn't.

AW: 18:37 no, they wouldn't at all

GP9: 18:37 I really don't think it makes sense for me to consent to participate, I don't think

AW: 18:47 I completely agree as well, and it says to the full scheme as well, and, I think that's bit of a big step for them to not really know about the programme to commit to the full scheme

GP9: 18:54 yeah, yeah, it's bizarre, isn't it?

AW: 18:54 the LiveWell, for instance, is 52 weeks long so that's a massive commitment

GP9: 19:02 yeah, and 'I understand what the scheme entails', that would mean me fulling explaining what it entails and actually I don't know!

AW: 19:15 what information are you given about the schemes? How did you...

GP9: 19:20 we've got the leaflets

AW: 19:24 is it the healthy lifestyle ones? I haven't actually got one

GP9: 19:30 do you do about other conditions as well. Other referrals or just…

AW: 19:33 that's just the protocol for the exercise on referral., I think you are referring to the healthy lifestyle leaflet and it's got all the programmes in

GP9: 19:40 it's about that shape. Oh, no, A6 or lower. This sort of format

AW: 19:45 oh, that's from the health trainers

GP9: 19:44, but it's that format. It's a leaflet like that

AW: 19:49 yeah, I think it is

GP9: 19:52 and we have had information, we've had it sent through, but that's a different topic. If you want GPs to read something, don't, don't make it a big pack. Put it on one A4 page and get the message across

AW: 20:06 bare minimum?

GP9: 20:07 not bare minimum, yeah, yeah, well, essential

AW: 20:09 essential yes

GP9: 20:09 because if you've got 3 points that are important, and you've got them on one page it's more likely to stick then 5 pages of small print

AW: 20:20 so what do you need to know if we are creating information resources?

GP9: 20:23 what do I?

AW: 20:26 what would you like to know. Not the bare minimum, but what is essential in terms of the criteria?

GP9: 20:35 I'd have to think about that. Yes, I think the current leaflet is not bad. It's got the three programmes on it, not quite sure I would have to see it, if it's got the cost on it because that's important for the patient

AW: 20:57 yeah, I don't think it does actually

GP9: 20:58 it needs to have the information on there that you would be eligible for a corporate membership afterwards, I only learned about that recently and that's a huge incentive, I think for patients

AW: 21:16 yeah, so being more clear, if there was more clear about the incentive to patients, the membership at the end of it and just communicating that and the costs I guess because patients might not be able to afford it so by having that information readily available that's going to help.

GP9: 21:32 and I still have a bug bare, half a bug bare, you know what I mean. Something that I find really that I understand, but in another way not is that if your BMI is over 45 you get it free and if it's under 45 you have to pay for it which has led to situations where I said, to patients look can you just continue over-eating for another month or so and I can refer you for free.

AW: 22:02 it's bizarre

GP9: 22:03 it's not good, is it? so I wonder if you should put a reasonable fee on all of these programmes and if you should have criteria so some people could

actually be exempt from it cuz I have had people who are on what's it called now... universal credit, have got two children, would really benefit from just looking after themselves a bit more, but they can't afford it and it's the inverse care law again, isn't it? The people who need our help the most, are the least likely to get it

AW: 22:57 yes, absolutely I know that they do offer a selection of free spaces, but I am not sure

GP9: 23:05 I only learned about that last week

AW: 23:05 yeah, but I am not sure

GP9: 23:06 ***the following has been removed at the participants request***

AW: 23:07 yeah,

GP9: 23:11 can you cut that bit out? [from the transcript]

AW: 23:11 yes, of course I will yeah. It's a bit of a funny situation because they tend to prioritise Bridlington, Withernsea, obviously because they have really high deprivation levels, but yeah, if they did communicate that more then it could be up to...

GP9: 23:26 yes, don't write it on the publicly available leaflets, but

AW: 23:32 if GPs had an understanding, then you can for special cases write those exemptions

GP9: 23:35 or you could recommend an exemption, I think maybe although that is open to abuse, isn't it? That, I don't, there could be situations where you're trying to persuade somebody to go, persuade, convince, and they say ah I

really can't afford it, I don't want to spend £33, and you say well, if you got it for free would you go? Oh, yeah, if it's free and that's not the point, is it?

AW: 24:07 it's a difficult one, isn't it? So, you said, you learned last week, is that when you met [HLO's name]? Did she do like a training day?

GP9: 24:12 no, we met with [name] CCG] and myself to discuss how we could work more proactively with patients with erm chronic knee pain, or lower knee or hip pain, arthritis, chronic back pain, and I also think chronic shoulder pain because that's quite a common thing and rather than referring for physiotherapy, because physiotherapy now offer exercise, well, group sessions, classes so they have some activity classes where you learn how to do the exercises and that's a group session not one-to-one. And then one theory session on the background on what we know about arthritis, but actually our idea was well, why do you do the exercises in the physiotherapy department when you need to keep doing them. Why don't you do them in the leisure centre and accompany this with education and also behavioural support that's the ideal scenario that I can think of that these are health classes rather than illness treatments type thing. And the leisure centres to me provides a more vibrant positive atmosphere than a physiotherapy department. Not because it's nasty, but because it's associated with hospital and not being well

AW: 25:34 and illness yeah, absolutely., I think with the leisure offering that discounted membership at the end, that subsidised membership, it gives them that incentive to carry on after their physiotherapy sessions as well

GP9: 25:46 and you know I'm sure that at about 50, well, I can't be sure, but I suspect that a large proportion of people who are given physiotherapy

exercises who know they should be doing them and know how to do them, still don't do them because it takes, it takes effort and, I think we are all guilty of not doing the things that we should be doing all the time let's put it that way. Online referral

AW: 26:21 yeah, so, the online referral form it's kind of broken down into three sections, so it's got the previous medical conditions, reason for referral and...

GP9: 26:37 have you got it?

AW: 26:39 I haven't, I haven't no

GP9: 26:39 and I don't know where to access it

AW: 26:43 ah yeah, so, it's previous medical history, current medical history, and reason for referral... now my argument for that is again there's that duplication so many have said, to me you're just ticking the same boxes over and over again

GP9: 26:57 and again I don't know if boxes make sense., I think yes, certainly having, having acute angina or stable angina might limit what people should do and can't do. Having had a stroke, does it really need to be on the form? Yes, probably should be on the form erm, but again the patient will generally know if they've had a stroke. My question again is why do you want to know this? Epilepsy, yes, that's important because if they have having a seizure in the middle of the gym you should have someone who knows how to deal with it. I mean they are all relevant I suppose, but again sometimes it's not obvious why they are relevant.

AW: 27:50 absolutely, I think they have tried to create the form, so they get the best understanding of the patient prior to seeing them, but as you say there's no, section to freehand so if someone does have one leg

GP9: 28:02 there is [referring to the form]

AW: 28:02 oh, yes, a tiny section yah, but the online doesn't have that and there needs to be that option, but again for you it's about providing that justification of why we need that because I agree a lot of these are not necessarily relevant at the point of referral

GP9: 28:23 well, maybe, maybe you could ask a more general question such as, well, for each of these, chest pain or heart trouble well, if someone's got like muscular chest pain that's not really relevant. Heart trouble, I think I would be more specific like have they got active angina. Like if they get tight chest when they exercise, should they maybe stop. Diabetes, I'm thinking why would you want to know about that if someone is on insulin and they are having a hypo yes, fair enough that's probably really important to know. If they have got type 2 diabetes and are on metformin or no, medication at all, that's important because one of the goals would be to try and loose that diagnosis or to optimise it, but it’s actually you would put that on there wouldn't you

AW: 29:19 that would be one of the reasons yes

GP9: 29:19 anxiety, might be relevant because they might not feel comfortable in that big gym because I don't. I wouldn't want to go into the gym. Erm, depression, yeah, again could be relevant, but, I think the question could be something like I don't know if that's helpful for your interview, but something

like are there any, any medical issues that you think would either limit or make exercise dangerous or where you would expect medical complications during exercise. Yeah, or that might affect which type of exercises the patient could take part in. OK I would have to think about that a bit more, but actually that's probably a good thing because you might then find that you've missed out that a patient is severely agoraphobic and wouldn't ever be able to actually go into the gym or into the leisure centre. That sort of thing because this, all I do if you've got a form with tick boxes you, I think it encourages people to switch their brains off and look for information

AW: 30:48 yeah, and there's a lot of duplication so if that was more general it might prompt GPs to think right, ok what might limit or make exercise dangerous. yeah, I think that's a good point

GP9: 30:58 yeah, that sort of thing and what we do I believe is we, when we refer patients, we print off a summary of their medical notes and give it to the patients to take with them to the leisure centre

AW: 31:12 right, ok

GP9: 31:14 that's not always the right thing because sometimes there are things on there that really, the leisure centres don't ned to know about, but the good thing is that you, well, you don't really need to get consent because you give them the information and say have a look at this, take it to the leisure centre and show them that because that's your medical history. But we have had one or two who have said, I don't want that on there. I don't want them to know that I've had this embarrassing condition a long while ago

AW: 31:44 yeah, so there's a bit of an issue with sending all that information across.

GP9: 31:45 yeah, and that's the problem with the self-populated forms, isn't it? It will just populate everything, but at least if you, if it's easy to refer to don't have to spend a lot of time on it. You can then, which I usually do, have a look through that medical history and think is that all relevant. Is there anything that is not relevant and sensitive that doesn't really need to be on there.

AW: 32:18 absolutely. Are you provided with any information back from the leisure centres regarding a patients progress? Any sort of feedback or communication?

GP9: 32:26 we use to get a A4 letter saying, this patient has now successfully completed exercise referral., I think we use to get a letter saying, we've contacted the patient, but they didn't feel they could do it this time. Not quite sure if we got a letter saying, they had completed so and so many sessions, but then disappeared or decided not to carry on. I have had the occasional message from the patient, and once or twice even, I think a phone call from the personal trainer saying, " I really think this patient would benefit from another referral" when on the other hand, I get information from the officials or from papers or from I don't know wherever they came from that you can only be referred once per condition. So, the last one, which wasn't long ago, I rang them and said, are you sure about this? Can I do this because I'm told I can't, and I was told yes, you can do it I am happy with that which is think is great cuz it was somebody who needed one-to-one supervision and they

would have stopped exercising had they not had a personal trainer for continuing support

AW: 33:38, but there was a mismatch in information because you was told yes, you can do it, no, you can't

GP9: 33:43 yeah, it was like a Chinese whisper, the patient said, well, the personal trainer who's name I can't remember said, that I should be re-referred so that's really difficult.

AW: 33:54 so again if they are really clear about how many referrals patients can have

GP9: 34:00 well, no, no, I don't think there should be a restriction, well, there should be a restriction on it, but, I think there should be the option for the leisure centre to say, I think it's appropriate for you to refer back

AW: 34:15 yeah, so at their discretion

GP9: 34:17 yes, their discretion because if it's at my discretion, well, actually, I think, I think for them it should be, it should be the directive should be no, you can only have it once per condition, mind you, you can refer for another condition apparently, erm, but they could have some sort of MDT approach if they felt that was essential or very useful for somebody that they agree to fund another session. Probably not endless, but then some people with chronic conditions who otherwise wouldn't be able to do this, there would have to be some other way of funding that because it's a bit like getting carers allowance, isn't it? You can have that for four weeks and after that you wipe your own.... they need ongoing support and if that means that erm, but that's, that's outside the scope of this, isn't it?

AW: 35:26 yeah, you said, you use to receive letters mainly about their attendance or whether they have completed, whether they dropped out, is there anything you would like from the leisure centres specifically? Any patient measures or anything that you would utilise or anything helpful for the patient records?

GP9: 35:45 erm, out of interest, I'm not quite sure if this is always clinically relevant, but sometimes you don't know when it might become relevant and that's not a good measure and a good way to collect information, but it would be interesting to see how well, they engaged. I'm not quite sure how you would measure that cuz some people can only make it once a week and some people can come every day and some people..., but, I think to have some feedback if somebody felt they were engaging well, with the programme or not. The reason why they said, or why it was perceived that they were engaging and what type of exercise they found that was useful to the patient that they enjoyed, what they could do and what they couldn't do. But that's, the information I said, I'm not quite sure what I would do with that. Sometimes it would enable you to say you know if you like that at the leisure centre, why don't you look at [pauses] to continue this afterwards. Just suggestions because I've got no, idea what they do there sometimes unless they tell me.

AW: 37:30 so that might help with your signposting to other services if, if you're aware for instance, there's a swimming group and you know at the leisure they went swimming, again it helps you bridge that gap

GP9: 37:40 and then also I am never quite sure how much lifestyle advice people receive as in weight loss, healthy eating and how well, they engage with that. Lifestyle. It would be useful if they could do that, but again that's maybe a bit

too much to have there. Discharging BMI to see if it has led to any weight loss

AW: 38:22 is that something you would update your system with that information?

GP9: 38:27 yes, BMI and sometimes you don't even need to do that, but at least you've got it. Erm, I mean, I think it would be good to have some sort of status report on, on like how they are doing even before discharge, but that, that's a lot of work and I understand if that's not possible and sometimes, sometimes people come to me and I say, "are you still doing the exercises" and they go "yeah", and you think well, how often are you doing it? When did you last go?

AW: 39:26 so again you've only got that feedback from the patients not necessarily from the programmes during...

GP9: 39:30 yeah, and there could be a mismatch between what the programme are recording they are engaging with and what the patient perceives that they are engaging with

AW: 39:42, I think leisure are documenting their data on Pharmoutcomes. Do you have access to Pharmoutcomes in this surgery?

GP9: 39:50 yeah, I think we have, we get print outs off the website basically.

AW: 39:55 right I'm just thinking how they can get that information back to you because obviously hey send letters at the moment and I wondered what the ideal would be because I'm not sure if with letter someone has to put that on your system

GP9: 40:06 yeah, they do, but that's something we commonly do. The Pharmoutcomes actually, in our surgery I don't know why, I usually get a

printout of the website which is like in very large print for five pages and then at the end it's probably the normal browser version where it's all on one page and that's the right size really, that's really good. So, I would be happy with either, maybe there might be a different way of accessing Pharmoutcomes er if it can be imported directly electronically, I'm not quite sure, but I would be quite happy with a letter, but, I think letters might be more work for the leisure centres to complete so if they can send it electronically and we just print it out or import it into our system that would be fine. That's probably cheaper

AW: 41:01 brilliant that's all the areas I wanted to explore today. Is there anything else you feel is relevant or important to add about anything we've discussed? Or about the process in general?

GP9: 41:17 no, I think I've mentioned everything that was on my, was on my mind when I thought about what to do. No that's, no, I think, I can't think of anything at the moment

AW: 41:27 Ok brilliant thank you and thank you for your time today. It's really nice to sit and dissect this form because of my interviews have been about oh, I don't have the time to do this, my workload is excessive, really generic, but it's been really good to sit and dissect what about what the problems are with the forms and how we can improve it. So, really insightful and valuable and I'll be sure to report this back and we can look at amending these. Would you be happy for continuing contact in the future when we do amend the process to get your views on that?

GP9: 41:55 yeah, sure yeah. I mean that's what I do, are you still recording this?

AW: 42:04 yeah, but I'll stop recording now

GP9: 42:07 erm

AW: Interviewer **Interview date:** 27.07.2017

NP1: Participant **Interview location**: Practice One, Bridlington

AW: 00:00 so how old are you [NP's name] if you don't mind me asking?

NP1: 00:04 43

AW: 00:04 43 and what's your surname? Have you recently been married?

NP1: 00:08 no, but I have changed my name

AW: 00:10 ah right, ok

NP1: 00:10 I got married about two years ago, but never changed my name, but I have done now

AW: 00:14 congratulations!

NP1: 00:14 so its erm [NP's name]

AW: 00:16 [NP's name] ?

NP1: 00:17 yep

AW: 00:18 yep, I did wonder on the door, and I thought [NP's name]

NP1: 00:20 no, because I just, I, I've only changed it because I needed a new passport

AW: 00:25 ah, ok. And what is your role at this surgery?

NP1: 00:28 I'm an advanced nurse practitioner

AW: 00:31 and do you have any other roles?

NP1: 00:33 erm, no

AW: 00:34 nope ok. Are you full time or part time?

NP1: 00:36 full time

AW: 00:37 full time. And how many sessions do you deliver in general practice in per week on average?

NP1: 00:42 eight

AW: 00:42 eight. And how long have you been working as an advanced nurse practitioner?

NP1: 00:47 about erm, it's more than 10 years I can't think really. Somewhere around there. Between ten and fifteen years somewhere around there

AW: 01:02 yeah, approximately 10-15 years. OK and has that always been within the East Riding of Yorkshire?

NP1: 01:06 no

AW: 01:08 OK

NP1: 01:08 previously North Lincolnshire, erm

AW: 01:12 if you had a give a rough estimation of how long you've been....

NP1: 01:13 East Riding? Erm, that is definitely ten years

AW: 01:18 definitely ten years, great. Fantastic, so the first section of the interview will be focused on the healthy lifestyle programmes that are run by the East Riding of Yorkshire Council. Erm, so what healthy lifestyle programmes are available for patients in this locality? In Bridlington.

NP1: 01:31 for us to refer to you mean?

AW: 01:33 yep

NP1: 01:34 so we've got the exercise on prescription thing. Erm, there's another one that's name I forget where, for people with a very high BMI

AW: 01:48 is it LiveWell?

NP1: 01:50 LiveWell, that's it

AW: 01:54 any more for patients? That's usually the main two.

NP1: 01:55 no, there the only two referral ones, I think that we physically refer into yeah

AW: 02:01 and how are you informed about these programmes?

NP1: 02:03, I think, I've only been aware of them, I think since I've worked here which is 18 months and, I think it was just obviously they were just part of the services that where available here, so I suppose it's from being in this role I haven't erm, they've always been there as far as I know since, since I've worked here. I don't think I was aware of them before that

AW: 02:31 ok so was it sort of word of mouth?

NP1: 02:34 yeah, I would say so from here yeah, and just profession, from other professionals really

AW: 02:40 yeah, and which ones do you find you refer patients to the most often?

NP1: 02:46 exercise on prescription

AW: 02:47 exercise on prescription. And why is that?

NP1: 02:50 erm, I think because, obviously the LiveWell, programme, the criteria are more erm, are more rigid because obviously your BMI has to be at a certain level before, so obviously we have less people I guess that we can refer to them because of the criteria. So, I think that's probably it just cuz the exercise on prescription is a broader, broader criteria really

AW: 03:14 so it's purely about who is eligible and as you say less people are eligible for LiveWell.

NP1: 03:18 yeah, yeah

AW: 03:20 and who else can refer in this surgery? Obviously, I spoke to [Dr's Name]

NP1: 03:24 [Dr's Name] I presume. [Dr's Name] refers as well

AW: 03:27 yeah. So, the doctors and the nurses

NP1: 03:29 I'm not aware that all the practice nurses do, but certainly I do, and [Nurse's Name] does. She's like the advanced, advanced practice nurse. She, I'm sure she does as well

AW: 03:38 right, ok. Erm, so LiveWell, and Exercise referral have information booklets and referral forms such as these ones. When I find them., I think I have left them in [Dr's Name] office actually. So, it's the referral forms- ah ha. Are you given anything else for patients or any information resources?

NP1: 04:08 see I haven't had any, but I've seen them so they must be around somewhere in the surgery. Obviously, we've got the posters in the, erm, public areas, but I don't think I've actually got any leaflets. No, I haven't

AW: 04:25 ok

NP1: 04:26 to be honest I wasn't aware that there was erm, a leaflet that I could give to a patient regarding the programme

AW: 04:34 ah right would that help if you had more leaflets?

NP1: 04:35 yeah, definitely, yes, because you find yourself sort of half trying to explain it, I guess, and you know a bit more information that they could take away would be much better., I think they are here somewhere, but I just don't know where- I should!

AW: 04:51 so how do you communicate at the minute the programme? It is kind of verbally telling them about it

NP1: 04:55 yeah, yeah. It would just be during a face to face consultation because that's where you would sort of have the thought to make the referral and then you just talk to them about what you think it does you know, and you know the process and what they have to do really, so yeah.

AW: 05:12 and do you feel you have provided with a satisfactory level of information about what each of the programmes entail to help you make an informed decision about where to refer your patients?

NP1: 05:22 yeah, I think there's sort of sufficient information on the referral form even for you to make a decision about whether they meet the criteria or not. Erm, other information would be useful. I'm sure we have got it. I'm sure it's more that I haven't looked for it rather than it not being available if you see what I mean

AW: 05:39 and erm, when are you prompted to refer onto the programmes? Is it sort of, do you initiate the referrals, or does the patient tend to ask for a referral?

NP1: 05:50 the patient very rarely asks., I think it's just your idea about what might be erm, you know suitable for them really., I think I've probably had 2 or 3 people actually physically ask me for them. Erm, it's more about people that you identify over the course of a consultation that would be suitable

AW: 06:12 yeah, so it's sort of your own clinical judgement and as you say you identify. And how do you identify who would be eligible?

NP1: 06:20, I think erm, obviously we've got a huge problem with this sort of demographically, locally with obesity, with chronic disease, with pain, chronic pain, and it's just trying to find different ways to manage that. Erm, often we are not seeing, people might not present because of that, but they might be presenting because of a manifestation of that. Do you see what I mean? So, you're trying to get to the root cause. Particularly around muscular-skeletal pain, erm, depression, massive, massive issue and just generally the

impact of obesity really on you know all the other long-term condition processes. So, I think it's just, it's...

AW: 07:10 a bit of everything! So, as you say usually, they will come erm with a completely different enquiry and as you say all these things kind of link with that and it's you that says ok that might not be the reason why you came, but you can see that they might be obese, have depression, erm all these different things that you can refer for. And you say pain can be a big one and that would prompt you to make that referral?

NP1: 07:34 yeah, I think if you've got a patient who is in pain, who everything else, you know, you've kind of made those exclusions really from your assessment and you're looking at chronic pain which is related to maybe obesity, the fact that they're completely inactive, the fact that they you know, erm, are also depressed, it kind of, it's really common picture, common presentation really. But they very rarely come asking for it.

AW: 08:03 ok so it, it's usually you that has to put them pieces of the jigsaw together

NP1: 08:09 yeah

AW: 08:09 and what are your expectations from referring patients onto these programmes?

NP1: 08:14 erm, I think, it's about lifestyle modification. It's about helping them to understand that's there's a different way to live which will help a lot of their physical symptoms and improve their various conditions whatever that is really. Erm, you know, and they come here for an answer for things erm, but they won't have thought that this is an option, but it's all about lifestyle adjusting. They just come in from a very inactive, very unhealthy sort of way

of living and it's just really to try and make any kind of change to that and any progress you can make towards a healthier lifestyle that's more, going to support you know good physical health and that's all we can do really. But that would be my expectation of the programme., I think the LiveWell, programme you know you're looking at morbid obesity, you're looking at, and especially for younger people, and, I think you're looking at big lifestyle change. You're looking at prevention for later on particularly with the younger ones. The people that I have referred into LiveWell, have been younger people and, I think that's, its, you're just looking forward. You're looking to the, you know, where what conversations you're going to be having in ten fifteen years if they don't do something about you know the way they are living really.

AW: 09:46 so it's all about, especially with the LiveWell, prevention. Do you refer directly into the Young LiveWell, or is it just younger adults?

NP1: 09:51 younger adults I would say yeah, yeah

AW: 09:54 and as you say it's about them learning lifestyle change so learning to modify their behaviour now which is going to help manage some of their conditions or even prevent

NP1: 10:06 or prevent, yeah, more importantly, I think actually making the prevention

AW: 10:10 so prevention is key

NP1: 10:13 yeah, more so for the LiveWell, I think. Well, I feel like that. Exercise on prescription, just for the people I have seen I guess it's just more about trying to make some improvements to an already, an existing situation you know

AW: 10:28 so that's perhaps for existing conditions and self-management whereas for you LiveWell, is more about prevention. Preventing them getting any worse especially for the younger participants

NP1: 10:39 the younger ones yeah

AW: 10:40 OK. So, the next section of the interview I'd like to focus on the constraints of patient referral. So, do you experience any issues or constraints when referring patients onto these programmes?

NP1: 10:52 erm no, I've not, I've never, I don't think I've ever come across erm, a difficultly making a referral or accessing the scheme. I've, I've recently been a little bit confused about how many times they can be referred in because particularly the exercise on prescription it's sort of a programme isn't it and I know I've had a couple of patients actually come back asking for it to be extended and to be fair I've just sent in another referral. I'm not sure if that's the right thing to do or not and I'm not sure how that's ended up, whether they have ended up getting another erm block or what's happened, but...

AW: 11:28 so perhaps more information around re-referrals

NP1: 11:29 yeah, I guess I could have found that out for myself, but, I think all I did was just re-refer them and just hope that they would be allowed again (laughs) and that someone would tell me if they weren't. So, I'm not sure exactly what's happened, but erm. I can't think of any other constraints because I mean the criteria are really clear so you're not going, well, personally I'm not going to be referring people that aren't, that don't fit the criteria so in that case there shouldn't be a constraint really. And certainly, from an admin point of view, I can't think of, we just send it off and it happens you know. I'm not aware that there are any problems with the actual process or…

AW: 12:07 ah right, ok. Are you using the paper referrals?

NP1: 12:10 I do yeah, yeah, yeah, and just fill it out obviously get the patient to sign it and then erm, the admin staff send it off, so I just give it to them really.

AW: 12:22 and I've not got an example, but in terms of the patient measures that you're expected to take, do you feel they are all appropriate?

NP1: 12:29 yeah, they're perfectly reasonable yeah

AW: 12:34 and if a patient shows no, interest in terms of referral, what happens to those patients?

NP1: 12.37 erm, well, I think, you know, beyond, if they're not going to consent to that referral and they are not interested in it, then you are a bit stuck really with trying to identify other ways of you know, all we can do, there aren't other erm pathways really, I don't think. It's a case of hoping that they'll just go for that and if they don't you sort of you just try and do what we did historically, I guess. Just our own advice about lifestyle management and stuff like that. There are the health trainers and things, aren't they?

AW: 13:20 yeah, so the health trainers are run by the NHS

NP1: 13:24 that's right yeah

AW: 13:24 is that an option that you sometimes use as well?

NP1: 13:28 yeah, I have used those before erm or just signposted really because I wouldn't put a referral in myself, but we've signposted to health trainers

AW: 13:39 yeah, because, I think they can self-refer onto, that's my understanding, the can self-refer onto health trainers, but erm these ones need a health professionals referral

NP1: 13:46 that's right yeah, they can definitely self-refer to health trainers erm and that would be the advice I would give because, I think that's probably the only

alternate in terms of looking at lifestyle modifications unless they've got a chronic disease in which case there are some specific ones. You know there's diab, diabetes, there's separate services and things like that, but if you, if they won't consent then there's nothing much else really!

AW: 14:15 erm so that's a little bit about the constraints. As you say erm, there's not many. The referral criteria is nice and clear for you. Erm, there's a little confusion surrounding re-referrals and you could perhaps do with a little more information about the services and even more leaflets to give the patients, but in terms of that everything, you're quite happy with everything?

NP1: 14:34 yeah, yeah, yeah

AW: 14:37 if it was paper or online, what would you prefer? Are you quite happy filling out paper or would you prefer it to be perhaps, I'm just thinking off the top of my head, if it was a link off system one

NP1: 14:47 yeah, that would be easier. We have lots of, lots of our referral forms are mail merged so we can just, because then they get populated, and you know, and you literally just have to fill in your bits that you need so that would be really useful if we could mail merge them.

AW: 14:59 yeah

NP1: 15:01 because that's, you can do that just as quick during your consultation and then print it off and get it signed. I guess the patient has to sign it, so it has to be something, so you see, you have to fill it out whilst they're with you. Do you see what I mean? So, it's as quick to do it probably on here and it is to do it paper in terms of filling it in because you've got to have filled it in before the patient has signed it

AW: 15:26 absolutely and it requires their signature, so you'd have to print it anyways

NP1: 15:28 it's not something that I can say I'll do it for you later type of thing so if, if it was mail merged it would be as easy as filling it out

AW: 15:37 and a bit quicker maybe

NP1: 15:37 yeah, and our copy on here, the form is rubbish the actual. Do you know because it has been scanned on

AW: 15:44 oh, right, ok

NP1: 15:46 so by the time you have printed it out again, it's tiny and you have to sort of read it to the patient to go through it so it would be better if it was nice clean form

AW: 15:57 so it maybe looks a little less tatty when it's printed out

NP1: 15:59 yeah, yeah, yeah

AW: 16:02 that is the hope because obviously erm a lot of service referrals are electronic now and they are pushing for electronic referrals. Erm, just so they can audit referrals and follow up on patients and things so that is the future hope. It is just working out where we are going to link it in, how was can integrate it. And if everything on the form is relevant, if it's all fine we can stick that one or we might need to make amendments. Erm, so that's why I'm sort of asking you about the different referral forms

NP1: 16:30 yeah, yeah

AW: 16:31 so that's a little bit about constraints. Is there anything that ease the process of patient referral?

NP1: 16:36, I think it is a really quick process. It's really quick and easy to do the form it's not a problem. Even when you printing out and filling it in it, you

know. It is quick, it is easy and, and as far as I am aware it goes off you know, and people are dealt with really quickly, so, I think it seems like it. The form itself, I think is good and adequate and easy to sort out. So, within your ten minute consultation you've got enough time to go over that and do everything that you need to do. So, I'd say there aren't, the form itself helps to you know make the process easier

AW: 17:22 yeah, and as you say it's nice and timely referrals. And in your opinion in a ten minute consultation, it's feasible to do?

NP1: 17:30 to do that yes

AW: 17:32 great. Erm, in terms of patient feedback, are you, are you provided with any information?

NP1: 17:38 not now we're not you see! Unless the patient actually comes back to tell us, we don't hear anything! LiveWell- I've had some bits and bobs back from LiveWell, before and definitely if people don't succeed on the LiveWell, or don't turn up or whatever we get feedback about that, but I haven't ever had feedback from exercise on prescription except for patients coming back to tell me. You know, that would be useful I suppose it would be useful I suppose, just from your own point or view, or your own audit to see whether, because it's an intervention that I don't have any control over once it's gone do I, but it would be interesting to see.

AW: 18:25 whether it's been worthwhile for the patient

NP1: 18:25 yeah, yeah, and when patients have had positive experiences which they do they come back and tell you which is great, but you don't necessarily hear officially you know from the service itself

AW: 18:35 and how have you received feedback from LiveWell? Has it been emailed or letters?

NP1: 18:39 letters

AW: 18:40 letters and as you say it's regarding mainly the attendance...

NP1: 18:47 yeah, mainly the ones I've seen

AW: 18:48 ok so not the positive things that you want to hear?

NP1: 18:50 no, no, but then, I think it's hard for them because, I think the LiveWell, programme it is, you know their task is much more difficult and, I think it's a much, you know, you maybe haven't got as receptive audience either you know your clients are you know there's a high DNA (did not attend) rate., I think a lot of people don't go and, I think a lot of people don't complete the programme which is a real shame, and you know it's a, but you know they are kind of up against it from the start, aren't they? Delivering that service to that, to that sort of population

AW: 19:25 yeah, so you said, having some sort of feedback would be useful. What, what specifically would you like to hear in an ideal world?

NP1: 19:32 I suppose just to say that somebody had completed a programme or that they have had some progress. Also, if there is anything else, any recommendation on the back of it really or anything else that they felt would be supportive. I guess they would probably tell the patient and they would come back and tell us, but you know I don't know. That sort of stuff really, I would think

AW: 19:55 yeah, but it would be nice to have something that you can look at

NP1: 19:59 yeah, yeah

AW: 20:00 and would it be appropriate to send it through letter or would you prefer email?

NP1: 20:05 yeah, either doesn't matter really yeah

AW: 20:08 and would you like any indicator of lifestyle change? Would that be of any use to you?

NP1: 20:14 yeah, that sort of thing I mean really

AW: 20:18 anything in particular? Because obviously they take a lot of measures, but we don't want to bombard you

NP1: 20:26 no, you wouldn't want to be bombarded with everything. I suppose where somebody has been successful in increasing their activity level, erm, weight management., I think as well, I suppose, I don't know what measures they do in order to assess mood and so on, but I do refer a lot of people with depression so it would be interesting to, and to be fair I suppose I see them anyways because they are coming back with regard to mood, but it would be interesting to see how that is be measured. Because obviously if they were referred on that criteria, at some point, somebody must be monitoring that. It would just be interesting to see how that's changed

AW: 21:13 I'm not too sure., I think, I think it's questionnaire based, but I'm not sure

NP1: 21:16 yeah, I think it is

AW: 21:18, but yeah, it would be nice if you got some sort of

NP1: 21:21 you see it helps with our monitoring of their mood and so on doesn't it because what somebody comes here to tell me might not be actually what's been experienced elsewhere

AW: 21:32 absolutely and as you say maybe not for everybody, but the people you have referred specifically for depression, that would be really relevant to know for your systems

NP1: 21:42 exactly yeah

AW: 21:44 ok so that's sort of everything I wanted to ask about patient feedback. So, from, in your opinion, you would quite like some more feedback not just from the patient when they come back to see you, but it would be nice to hear particularly in terms of what you've referred them for, if there has been an improvement in that specific reason why you've referred them. Again, if they completed and a little bit about recommendations or any further support would be useful for you.

NP1: 22:12 yeah

AW: 22:13 so in terms of support networks, what support networks do you have in this surgery to manage patient load? So, in terms of triaging, do you have any triaging systems to help signpost patients in the right direction? Do you use any form of telephone triage?

NP1: 22:29 not really no, no

AW: 22:33 OK. And is there anything else that we have spoken about in general that you feel we could expand on or anything else that you think might be important?

NP1: 22:43 no, no, I don't think so, not really., I think we've covered you know the main issues that I've had with it we've already talked about so. yeah, I don't think there's anything else that I can think of

AW: 22:56 OK. Erm, and you mentioned earlier on, I think her name was [PN's name] the other nurse practitioner. Do you think she would be happy to let me ask her these same questions and give her insight?

NP1: 23:08 yeah, you would have to double check that she does do the referral here I'm presuming she does, but I am not absolutely sure. She does a lot, well, she does pretty much all the diabetic long term condition management. I don't know if she makes referrals in for those patients you know so you would have to double check, but I am sure she wouldn't mind you asking the questions if she is a referrer

AW: 23:29 Fantastic! Have you got any contact details for [PN's name]? Or is there any way I could pop in to ask her?

NP1: 23:36 I'll have a look... Shall I just ask her?

AW: 23:47 erm yeah, you can do thank you

NP1: 24:55 she does and she doesn't mind. Would you like to do it now?

AW: 25:00 erm yes, if she's got time yes

NP1: 25:02 she has about twenty minutes she said, if...

AW: 25:03 yeah, that would be great fantastic. Thank for you allowing me, I know you've been busy.

AW: Interviewer **Interview date:** 18.01.2018

NP2: Participant **Interview location:** Walkergate Surgery, Beverley

AW: 00:00 how old are you? If you don't mind me asking [PN's name].

NP2: 00:06 oh!

AW: 00:08 just to start things off (laughs)

NP2: 00:09 I had to stop and think then... 58

AW: 00:11 58

NP2: 00:13 yeah

AW: 00:14 and are you a practice nurse?

NP2: 00:15 I'm a nurse practitioner yeah

AW: 00:17 nurse practitioner. Do you have any other roles within the surgery?

NP2: 00:23 no. Just do the practice nursing, minor illness. No, no, no.

AW: 00:27 OK and do you work full time or part time?

NP2: 00:28 part-time

AW: 00:30 part time. How many sessions is that per week?

NP2: 00:33 two

AW: 00:34 two sessions per week. And how long have you worked as a nurse practitioner?

NP2: 00:39 oh, a long time. Erm, about 18 years I would think

AW: 00:45 18 and has that always been within the East Riding of Yorkshire?

NP2: 00:49 yes

AW: 00:50 OK and I have an email address for you. So, basically, once your interview has been transcribed, I'll send you a copy for you to verify that it's an accurate account of what we've spoken about today

NP2: 01:03 yes

AW: 01:05 ok so the first section of the interview is focused on the healthy lifestyle programme. So, what programmes are available in this locality for you to refer patients on to?

NP2: 01:13 er the exercise on prescrib, urgh, you know, prescription. Living well

AW: 01:20 yep

NP2: 01:21 and this community links one that's just started. Have you got that one down?

AW: 01:24 the community link workers?

NP2: 01:26 hmm yeah

AW: 01:28 yeah, so are they within this surgery because it varies surgery by surgery

NP2: 01:31 hmm [nods head]

AW: 01:33 OK is it, [CLW's name]?

NP2: 01:37 yes, [CLW's name]

AW: 01:38 yes, I have met [CLW's name], I met him last week he's lovely.

NP2: 01:39 yeah

AW: 01:42 ah fantastic. So, do you refer onto [CLW's name] to complete the referrals or is it something that you do as well?

NP2: 01:48 we do that as well.

AW: 01:50 ok

NP2: 01:50 I've only actually done one so at because I only met him last week.

AW: 01:54 yeah

NP2: 01:55 I invited him to come and tell me about it

AW: 01:57 Ok fantastic., I think they are trying to implement them within all surgeries eventually.

NP2: 02:02 that's the idea

AW: 02:04, but there's only a selected few at the minute

NP2: 02:04 yeah, yeah, pilots or something he said.

AW: 02:06 and how are you made aware of the programmes that are available?

NP2: 02:14 I'm trying to, hearsay more than anything! Oh, I mean, this was a prime example. I saw it at the protected time for learning, erm, that they had at the race course, and I thought this is really good! Came back here and said, to the practice manager this is good I like this idea and she said, oh, I've got a meeting with them on Tuesday. Oh, fair enough, left it at that. I was on holiday for a week, couple of weeks after that. When I came back, I opened my emails and there was a newsletter from [CLW's name] . Nobody had told me that he was, they were doing it. So, I learnt from him that he was doing it, or they were doing it doing it. So, I emailed him, tasked him and said, hi this is who I am, this is what I do, do you fancy coming and telling me what you do?

AW: 03:10 so you had to make that connection yourself?

NP2: 03:11 yes, yes,

AW: 03:16 is that typical of primary care?

NP2: 03:17going back to exercise, yeah! Going back to exercise on prescription and that sort of thing, it's so long, because that's been around a while, and I actually can't remember how I found out about that. I can't remember whether there was a formal introduction to it or whatever. I actually can't remember so

if I did, I'd be fibbing really. Whereas this one [community link workers], yeah

AW: 03:41 ok so is there any sort of ongoing training if you like to keep you informed about the programmes or any amendments

NP2: 03:48 no, or there wasn't, but interestingly in the last month maybe just before Christmas, I was invited if you wanted to go and learn how to stop smoking, you know, make every contact count. I could initiate stopping smoking. But then that was…

AW: 04:13 ok do you think community link workers are better placed then to do them sort of referrals?

NP2: 04:17 more continuity and like he said, he knows who to tap into. Erm, so in some ways he's there answering some of your questions in that they are going to be more streamlined, and they are all together. He I mean, he said, to me if you got any, if there's any issue that you think we can help with, let him know, he'll find an answer he said.

AW: 04:47 fair enough so he's got that sort of wider range of knowledge if you like?

NP2: 04:53 yeah, yeah, yeah

AW: 04:53 and of the two programmes you've mentioned so the exercise on referral and the live well, which one do you refer to the most often?

NP2: 05:01 exercise

AW: 05:00 why is that?

NP2: 05:04 because that's what they ask for, I think more than anything else. I've been a big, I've been a big health trainer pusher because they would look that the whole, their diet, the whole shebang rather than them just going to the

gym and doing you know, just doing exercise so I've been a bit of a health trainer user. Erm, but patients ask for the exercise on prescription. Now whether that is economically lead because they only have to pay so much, erm I don't know, but they do, that's what they do ask for

AW: 05:49 ok so clearly patients do have an awareness of exercise on referral?

NP2: 05:54 yes, yes, yes

AW: 05:59 OK and do you have any information resources about the programmes? Anything that you can give to patients or that helps you keep informed of what the eligibility criteria?

NP2: 06:10 yes. I mean we've obviously got that for them. yeah, I've got these, them, so yeah, oops just wreck the place. yeah, so in answer to your question yes

AW: 06:25 ok and is it something you give....

NP2: 06:27 I give them out. I give them out. I can't speak for anybody else, but I give them out

AW: 06:32 are they useful resources to have handy?

NP2: 06:34 yeah, cuz you're informing the patient, aren't you? You're making them aware er, and then allow them to go home and make the choice. You're empowering them and then it's their choice, isn't it? You can't make them do it.

AW: 06:46 absolutely so as you say you're just trying to make them aware of what they're condition is, and give them that choice. As you say it's not something you can force upon them. At the end of the day, it's their choice

NP2: 06:54 no, not at all, not at all, exactly

AW: 06:59 so do you personally feel that you've been given a satisfactory amount of information about what each of the programmes entail?

NP2: 07:05 no

AW: 07:09 ok

NP2: 07:11 I do this [CLW], but, I think that's the enthusiasm of the people that are involved with it. With the health trainers, no, not really, I don't think so. It's a long time since I've looked at it.

AW: 07:33 yeah, the health trainers are slightly different because they're commissioned by the NHS, so they are not location specific

NP2: 07:40 no, maybe not

AW: 07: 44 ok what would you like to see? Would you like to see more leaflets? More advertisement?

NP2: 07:48 yeah...

AW: 07:52 for both....

NP2: 07:54, but you see, I think it's a two Way Street, isn't it? We've got to advertise as well

AW: 07:58 ok

NP2: 07:59 and I know that there has been posters of this [CLW], but they're still not up in our surgery.

AW: 08:04 ok

NP2: 08:06 so...

AW: 08:08 so a lack of advertisement is actually quite a big issue

NP2: 08:10, I think so, I think so

AW: 08:14 ok and what issues do patients typically come in with or present with that makes you think actually you might benefit from increasing your physical

activity for instance. Would you be interested in exercise on referral?? What sort of things do they come in with?

NP2: 08:29 I'm on this diet. I can't shift the weight. And they might be on a diet, but they are not doing any exercise

AW: 08:39 so a lot of it is centred on their weight?

NP2: 08:41 a lot of it is centred on the weight. Mood, mood, erm its beneficial to get them moving and then social, but you're hitting into social isolation and things like that and that's often somewhat related which is where this comes in, I think [care navigation]. They will take them, they will go with them to get them going, but they are the main ones really. Erm, weight, exercise and mood really. They are all often linked anyway

AW: 09:12 absolutely yes. And as you say social isolation as well, so getting, particularly the elderly people out and amongst one another

NP2: 09:24 absolutely

AW: 09:24 ok so in terms of the constraint of patient referral so the next section of the interview, do you personally experience any constraints when referring patients onto any of the programmes?

NP2: 09:35 no, I don't think so just the initial thing, the computer thing was just that really. Apart from that I just sent paper ones and then it had been fine.

AW: 09:46 ok so you're using both the paper and the

NP2: 09:48 well, yeah, I do the online now. Erm, but I've got my paper one if I need it. If it decides it doesn't like me on a particular day which this computer can do, then I'll send a paper one

AW: 09:59 and how long have you been able to access the online referral. Is that new in this surgery or something you've been able to do for a while?

NP2: 10:05 oh, it's been a while now, it's been a while. A good long while

AW: 10:08 just because some surgeries are a bit behind, and they use the paper

NP2: 10:13 you lose track of time really. You do lose track, a while, a good year!

AW: 10:19 and do you prefer using the paper or do you prefer using the online system?

NP2: 10:20 it's easy because you can liaise with the patient. Erm, but either or, either or, either or. I mean with the paper one,

AW: 10:37 I've got an example if you'd like to see one?

NP2: 10:38 no, I've got one there, the patients sign it to say that they are aware that they have to commit to 20 sessions or whatever it is and obviously on the computer one it doesn't, but by the time they catch up with them they probably get them to sign that

AW: 10:53 do you think that's something that's useful the patient signature?

NP2: 10:54, I think, I think commitment because you're giving up so much of your time to them and it's very disheartening if they're just sat listening to you and then they're not going to do it. They will find some kind of way of not doing it and at least, I think if you put your name to it, I think that they're a little bit more inclined to attend. Not always.

AW: 11:21, but sometimes. So, just having that signature there for you is sort of...

NP2: 11:26 well, it's their responsibility. It shows that they are committed really to changing their lifestyle which is what it's really all about, isn't it?

AW: 11:35 yeah, absolutely. And if you are communicating with a patient and they absolutely have no, interest in any of the programmes or changing their lifestyle, what happens to them patients?

NP2: 11:48 I always give them information. I always make them aware of what is available and often you can plant a seed and they go home, and they think about it and then they will get in touch with you and say well, I thought about what you had said, or I have read what you have given me, and they change their mind, or they think oh, maybe I will give this a go. Those that you sort of lose in the ether because you've just given them the information and they have left the room invariably they tip up somewhere else because they've probably got diabetes or something so somebody else is following them up a lot of the time. And even GPs will be following, they'll see maybe one of the GPs regularly, so they are never really lost and, and, and you've documented that you have given it. It's their choice, isn't it?

AW: 12:35 absolutely which again shows the importance of these advertisements because as you say even if it is just to plant that seed in their mind and give them that time to reflect

NP2: 12:48 that's it! Absolutely, absolutely

AW: 12:48 so in your opinion would it help if we provided more advertisements or thing that you could give to your patients?

NP2: 12:53 yes

AW: 12:53 OK

NP2: 12:55 not too busy, ones that are easily understood, I think.

AW: 13:05 absolutely and when you're filling out the paper referral form in particular, it requires you to take some patient measures, so

NP2: 13:18, I think they ask on the computer as well

AW: 13:20 do you feel like all those measures are feasible? Is it something you can do in your ten minute consultation?

NP2: 13:26 yeah, yeah, yeah

AW: 13:28 no, issues in terms of using the paper form? [NP2 shakes head] Nope. OK so what is your overall, impression of the current referral process? Is there anything you feel could be tidied up a little bit because I know the paper and the online referral are slightly different in terms of what they ask?

NP2: 13:49 no, I think its fine. I can't see any problem with it. Erm…

AW: 13:57 and is it common practice to have paper referrals?

NP2: 14:04 depends where and what I suppose. I don't do many paper referrals

AW: 14:16 right, ok, but you've got no, issues with doing them when you need to?

NP2: 14:18 no, no,

AW: 14:22 ok and the next section is on facilitators of patient referral so anything that sort of makes that process easier. So, earlier you mentioned a little bit about patients coming in and asking for it, can you tell me a little bit about how that eases that process?

NP2: 14:36 does it ease the process? I'm not bothered about raising it with patients either. I don't know. They've already half made the decision if they are coming in to ask for it then they are half way there and you haven't got to persuade them, so I suppose in that respect it's easier. You're probably more likely to get a compliant and motivation patient if they have come in and asked for it.

AW: 15:04, but otherwise you're quite happy breaching that topic regardless. And how do they, do patients expect it? Are they a little bit taken back? In your opinion.

NP2: 15:17 depends how you say it. I'm always very, very, I am very nice when I say it. I just, you know, if, a lot of the time they will say something about their

weight or on most of these, I just have to keep my computer awake otherwise it logs off and throw me out. It's gone off already! Erm, they will, how can I put this? On most of the reviews that we do, whether it's diabetes, well, I don't do diabetes, but any of them, asthma, any of the chronic disease reviews, anything, looks at your BMI, your weight, and the amount of exercise that you do. So, that is a way of asking about the exercise and "oh, I don't do anything I just watch the tele", "have you thought about doing this?", "oh, no, oh, well". so that's, there are ways of getting to it, but often they will say it themselves

AW: 16:36 and if not, as you say during their reviews, it's a good way to make that link

NP2: 16:39 yes, yes, yes

AW: 16:41 ok that makes sense. And are you provided with any information regarding a patient's progress on any of the programmes?

NP2: 16:47 no, no, not, not, not unless I make the conscious effort to keep a log of every patient that I ever refer, and I haven't got time for that, I haven't got time to be going into the computer apart from which it's not very good, is it? you just, oh, I'll just go and have a look at Jo Blogs notes to see if they have been to the... whereas if someone was to task me and say or write and say we've seen so and so today. They are making good progress, lost half a stone, whatever. yeah, it's quite nice.

AW: 17:20 is that something you would like to see in the future?

NP2: 17:21 yes, yes

AW: 17:24 anything in particular?

NP2: 17:26 no, just progress, just a progress report!

AW: 17:31 and what would be the best way to sort of receive that information? So, would it be best received via email for instance? By post? Ideally would it be something that goes straight into the patient records?

NP2: 17:42 erm, I think you need an alert that it is there. Erm, because they are trying to go paperless anyways, aren't they? You see with this because they are part of the surgery, they just cut and paste it straight into the patients note and they just task you to say right I've seen them, this is the progress, have a look at so, so and so, so. So, that's, so they will be a way around it.
Because you want to go paperless the ideal, I suppose is straight into the patient's notes, but then it's alerting the referrer that you've actually done something

AW: 18:19 yeah, done that and they can check it if need be

NP2: 18:20 yeah

AW: 18:21 ok and the final section is on support networks, so this differs between each surgery. So, in this surgery you've said, you've got community link workers that can make the referrals, yourself can make referrals. Do GPs engage with the referral process do you know? Or do they tend to sort of signpost

NP2: 18:39 go and see Helen, she will refer you onto exercise on prescription

AW: 18:42 right, ok, ok. So, within their ten minutes, it's easier for them to just say book an appointment with our practice nurse

NP2: 18:50 yeah, yeah, which I potentially I suppose you could lose the contact with the patient. Not always, not always because otherwise I wouldn't know that the GP had referred them, would I? So, they are coming, but I just wonder

how many get lost. They've [GPs] mentioned it and they've [patient] said, oh, yes, oh, yes, doctor I'll make an appointment and then don't

AW: 19:12 no, OK. Would you like to see GPs, if we made this process absolutely as quick as possible, would you like to see the GPs making these referrals to stop patients...?

NP2: 19:22 well, I think so because, I think you know a one stop shop would be quite a good idea. So, if they raised it and they're happy, then yeah, I don't see why they can't press a button or two

AW: 19:33 OK

NP2: 19:35 so that everybody does it

AW: 19:37 so it's about making that referral process open to as many different people

NP2: 19:41 yes

AW: 19:44 and would you ever push that onto the community link workers or do you tend to try and....

NP2: 19:49 well, he actually said, to me, he would do it. He said, no, send them to me and I will do it, I'll sort it. There's another girl as well, erm, if they want to do it, yeah.

AW: 20:03 absolutely I'll have to see if I can get in to speak to [CLW's name] because we're trying to get as many different perspectives as possible because obviously GPs have different constraints to your constraints in your consultations. [CLW's name], I am guessing has longer with patients?

NP2: 20:15 I don't know how long he didn't say., I think it's just as long as he is needed, I suppose. I don't know. It was interesting, very interesting

AW: 20:24 is [CLW's name] in the surgery today?

NP2: 20:25 I don't know where he is. They are based at Greenwood not here

AW: 20:31 ah right, ok. I've got his email I'll see

NP2: 20:32 he's trying to get in. He is trying to come here, but they're in Greenwood because it's a bigger place

AW: 20:35 right, ok am I right in thinking they sit within the waiting rooms, don't they?

NP2: 20:38 yeah, they have got an office just off, they have a big waiting room, and they have an office just to the right, but yeah, they are there so to speak

AW: 20:48 it will be nice to see when they are all, in all the surgeries.

NP2: 20:50 yeah

AW: 20:51 OK, I was going to ask, I was going to ask who do you think is best placed to refer? Is there anyone in particular who you think is best suited to refer? Is that person [CLW's name] and the community link workers?

NP2: 21:07, I think it's the person at the time, every, everybody. Healthcare assistants, you know phlebotomists, because they form, if they get regular bloods, they form quite a good relationship with some of these patients and they could, they are in as good as a position to make a referral.

AW: 21:23 do you think it helps when the patient has that relationship, a good relationship with...

NP2: 21:28, I think it's positive, always positive in that situation, but, I think anybody. Not necessarily, I think if you have a suspicion that there is more to it and there's more that they [care navigators] can help with, then go that way, but, I think it depends on, yeah, I think everybody should have the facility to do it

AW: 21:45 yeah, but again its patient dependant

NP2: 21:48 situation dependent absolutely

AW: 21:51 going by your own judgement

NP2: 21:53 yeah, absolutely yeah

AW: 21:53 perfect so that's sort off all the areas that I wanted to speak about today. Is there anything you feel you could add that's relevant to anything we've spoken about?

NP2: 22:01 no, I don't think so we've covered everything

AW: 22:03 ok no problem and do you think there would be anyone else in this practice would may be interested in sharing their perspective? Perhaps any GPs?

NP2: 22:12 [scoffs] erm

AW: 22:16 or any other practice nurses that are referring to these programmes?

NP2: 22:25 [Name], the clinical practitioner might, [Name]

AW: 22:28 ok do you have any contact details for [Name]? Perhaps an email address?

NP2: 22:36 I don't off the top of my head erm, I'll see her next week. I've got your details here, haven't I?

AW: 22:44 yes, my email address is on there

NP2: 22:47 right ill speak to [Name] next week

AW: 22:49 brilliant thank you

NP2: 22:49 I don't know, because we just task one another you see. Erm, but I will, I'll see [Name]. I'll speak to [Name] and ask her if she will contact you

AW: 22:59 not a worry so is she situated in another practice?

NP2: 23:01 she does all over. She does here, she does Greenwood.

AW: 23:06 so in Beverley, do they all work amongst each other. I get confused with who is merged

NP2: 23:10 Greengates medical group is us, Greenwood Avenue, Ministergate, Cottingham medical centre, Molescroft, and Salmon Road

AW: 23:23 right OK. There's so many different ones. So, Dr Mixer and Partners is that the fire station surgery?

NP2: 23:27 it's too big. I have no, idea, that's the fire station

AW: 23:29 they're not in....

NP2: 23:29 no

AW: 23:31 right, OK

NP2: 23:33 we don't want any more, well, I don't want any more! It's just ridiculous now. It's just redic, every time we have a practice meeting, or nurse meeting there's another nurse!

AW: 23:41 I did, I am interviewing the whole East Riding of Yorkshire and I can never understand which surgeries collaborate and which ones are separate. I'm just like, I have no, idea!

NP2: 23:53 it's probably the best way, but ill speak to [name] and I'll let her, well, it won't be til next, it's either Wednesday or Thursday next week so don't expect anything before then

AW: 24:01 no problem. Well, I am interviewing until March and then we are cutting off recruitment so…

NP2: 24:03 and then ill erm, ill point her in your direction.

AW: 24:07 fantastic. Thank you very much for your time today

NP2: 24:10 no, worries, no, worries at all

AW: Interviewer **Interview date:** 31.01.2018

NP3: Participant **Interview location:** Walkergate Surgery, Beverley

AW: 00:01 I'll pop that on there. Right, so just before I begin, I just need to, we've spoke about the purpose of the study and you're happy that you understand?

NP3: 00:10 yeah

AW: 00:12 just a little note about your rights as a participant and confidentiality. So, you are free to withdraw from the study at any time and if there's anything you don't want to answer just say no, comment and we will move on. Likewise, anything that you do say today will remain strictly confidential so you will not be identifiable by name at any point

NP3: 00:31 ok

AW: 00:32 it might be that I choose something that you've said, in my thesis, but again you will not be identifiable

NP3: 00:37 yep

AW: 00:36 does that all make sense? Fantastic. So, the interview is based on five key areas the first one being the ERYC healthy lifestyle programmes that you know about, and also the information resources that are given to you to advocate those programmes to your patients. There's a section on barriers to referral or constraints, whether that's on your behalf, perhaps on the patients behalf. They may not be interested in example. So, anything that sort of gets in the way of making that referral

NP3: 01:05 yep

AW: 01:06 and finally what makes referral easier or what hypothetically would make that process more streamline

NP3: 01:13 yep

AW: 01:15 ok so before we begin is it ok if I take some demographics? So, how old are you if you don't mind me asking?

NP3: 01:20 37

AW: 01:21 37 and what's your role within this surgery?

NP3: 01:24 clinical practitioner

AW: 01:27 can you just remind me what a clinical practitioner is please?

NP3: 01:32 advance nurse practitioner

AW: 01:33 ok so the roles are the exact same just names differently

NP3: 01:37 yes, it's, just justifiable [laughs]

AW: 01:38 ok id just not come across that before er, Helen was saying, and I was like what is a, what is a clinical practitioner. OK, and are you full time or part time?

NP3: 01:49 full time

AW: 01:48 full time how many sessions is that per week in general practice?

NP3: 01:53 er... its 9 I should be 10, but I have one long day, so I do a shorter day so it's classed, its 9 sessions, but its 10 effectively

AW: 02:07 in theory yep, that's makes sense and how long have you worked as a clinical practitioner?

NP3: 02:12 er 2 years

AW: 02:14 2 years has that always been within the east riding of Yorkshire?

NP3: 02:17 yes

AW: 02:18 fantastic. Did you have any roles in primary care prior to...?

NP3: 02:24 I was a practice nurse a few years ago and then my previous job to this was erm in the east riding er, I was the team later for the integrated hospital team

AW: 02:33 ah right fantastic and how long was you a practice nurse for?

NP3: 02:35 3 years

AW: 02:39 3 years so you will have still done this sort of stuff as a practice nurse?

NP3: 02:42 yes

AW: 02:44 no problem so first of all as I said, the first area is about the healthy lifestyle programmes. So, what healthy lifestyle programmes run by the council are available for patients in this locality?

NP3: 02:57 exercise on prescription

AW: 03:01 yep

NP3: 03:02 the weight loss one that I can't remember the name of, but you have to have a BMI of over 50. Healthy lifestyles?

AW: 03:10 is it the LiveWell, programme?

NP3: 03:12 LiveWell! Thank you.

AW: 03:12 no problem

NP3: 03:15 erm, and then we've got the new health optimisation

AW: 03:22 ok

NP3: 03:23 for people who want to be referred for surgery

AW: 03:29 yeah, that's not been running that long the scheme

NP3: 03:31 no

AW: 03:32 ok and how are you made aware of these programmes... was you offered any training?

NP3: 03:39 nope

AW: 03:39 ok so how did you come about knowing about them?

NP3: 03:43 er patients ask for them so I went and found the forms

AW: 03:51 so you're not actually given any information about what's out there it's a case of patients come to you and then it's your responsibility to learn...

NP3: 03:58 yeah, or you find random forms in draws and things and think I'll find out what that is!

AW: 04:05 ok is it useful in that sense?

NP3: 04:07 the information?

AW: 04:11 would you prefer someone to come and tell you about the programmes?

NP3: 04:14 it would be easier, maybe not coming to tell us because, I think we would be really time constrained for that, but to have like a crib sheet of these are the things we've got, we know what we can offer

AW: 04:30 so some kind of sheet so you can say ok these are what are available, these perhaps are the eligibility criteria

NP3: 04:37 yeah

AW: 04:37 just so you know that you can refer onto them. Er, and from my understanding, do you work across surgeries?

NP3: 04:46 yes

AW: 04:46 so this isn't your only surgery ok. And what's the, er who's responsibility is it to refer?

NP3: 04:49 me, mine

AW: 04:54 ok so, I mean do the GPs refer?

NP3: 04:56 the GP's they do, they tend to task the secretaries to do it.

AW: 05:02 ah right, ok

NP3: 05:04 er, but the practice nurses also refer

AW: 05:08 so the GPs sort of delegate that away to their secretaries and then as you say the practice nurses refer to

NP3: 05:15 yep, yep

AW: 05:18 ok and is it the same across all the surgeries you work at? Is it the same sort of protocol?

NP3: 05:23 yes

AW: 05:23 ok so you've mentioned the LiveWell, programme and the exercise on prescription. So, of them two programmes, which one do you personally refer to the most often?

NP3: 05:31 exercise on prescription

AW: 05:34 ok why is that?

NP3: 05:34 erm, for the elig, er the eligibility criteria is slightly wider

AW: 05:43 ok so does that invite more people obviously that are eligible?

NP3: 05:45 yes

AW: 05:46 and do patients tend to ask for that one or do patients ask for LiveWell?

NP3: 05:52 er I don't think I've ever had anyone ask for live well

AW: 05:53 ok, but there is an awareness of the exercise on prescription?

NP3: 05:58 yep

AW: 06:00 and what resources are you given to hand out to patients or for you for your own sort of understanding

NP3: 06:09, I think there's some, there were some leaflets, but we've not had any for ages

AW: 06:14 right, ok

NP3: 06:15 we tend to just do a verbal discussion with the patient

AW: 06:22 ah ha, how easy is that

NP3: 06:22 relatively. It depends on the patient. Some patients want to know absolutely every detail and we haven't got that level of understanding. You know? What will happen? Will I get this? How long will it be? They've want that level of detail

AW: 06:40 ok would you like more information so you can provide that?

NP3: 06:44 generally with those I tend to say you need to have that discussion, it's a personalised thing so you need to have that discussion when you go and have your initial appointment and, I think that's a reasonable

AW: 07:00 absolutely so you're informing them that is it tailored to them and that they can go on and if they want that information they can go and get that. Ok and what sort of issues present with. If they are not coming in asking for it, is there a type of condition they present with where you think they might benefit from those programmes?

NP3: 07:21 erm I tend to use it for patients with high blood pressure and I don't see a lot of diabetics because it's not really my area, er and I try to encourage a lot of people who have got things like depression and anxiety to utilise them.

AW: 07:46 and how do the patients respond when you first talk about the programmes?

NP3: 07:54 it's probably a 50:50 split between yes, that's definitely something I'd be interested in or absolutely I'm not interested

AW: 08:04 yeah, so how do you bring that up with them? Do you have a go-to phrase?

NP3: 08:12 it depends on the patient. Depends on the age of the patient and what I am seeing them for. But the go to spiel certainly for anxiety and depression is

about you know we know that exercise produces endorphins, and you know it helps your mood and also it gets you out. It gives you some routine and purpose, so it just tends to be, but you tailor it to each patient and their level on understanding and things, so it tends to be quite personalised

AW: 08:40 yeah, so you often make that link between what they are coming in with and how exercise can benefit that

NP3: 08:48 yeah, yeah

AW: 08:49 that makes sense. And what are your expectations of referring patients onto these programmes? What do you expect of the patient and likewise, of the programme?

NP3: 08:59 er I expect of the patient that they will go or at least try. From the programme I expect that they get an initial appointment to discuss what their needs are and then have that tailored supported programme and give them the skills and the confidence to then maybe carry on after the programme has finished to allow them to have the confidence to continue

AW: 09:36 so trying to encourage them to sustain these changes long term not just something in the short term?

NP3: 09:42 yes, yes

AW: 09:43 ok erm so next a little bit about what perhaps could get in the way of making a referral or what makes that referral a little bit difficult? Er so have you ever experienced any issues or constraints that deters a referral?

NP3: 10:02 er filling in the form because you've got to get the patient to sign it so you have to do it within your appointment time is quite constraining because for other referrals you can say I'll do this, and you can do this in your gap at the end of your surgery. You can do your other, but because you need your

patient to sign it, it has to be done with them. Erm, and they tend to get lost quite a lot because they have to be posted

AW: 10:34 ok so not many benefits of the paper referral really

NP3: 10:36 no

AW: 10:37 ok so is this surgery on the online referral system yet? Or is it purely done by paper referrals?

NP3: 10:47 it's purely paper at the moment. I understand we are getting the online system, but don't think, I think I've been briefly shown it once and I've forgotten how to do it. Oh, no, that was health optimisation... it's only for health optimisation we've got online...sorry

AW: 11:04 no, no problem, not at all. It's different in each surgery that's all and I'm really glad you mentioned it because it is one of the things we would like to change. Is it, is it common practice to send paper referrals anywhere else?

NP3: 11:16 they are switching them all off for all the other hospitals and things like that. There's very few paper referrals now

AW: 11:24 and do you ever have to get the patient signature for anything else you refer them on to? [NP3 shakes head] OK that's interesting.so do you find, because you've only got your appointment time, has there ever been a case where you have thought I haven't got the time to go through that, so I won't mentioned it

NP3: 11:47 yes, or you have to try and bring the patient back because obviously they have come, they've come with their medical issue that they want dealing with. Very rarely do they come just to have an appointment to get referred on so actually you've got to deal with that first because that's the priority and

because we're suggesting something as an add on, you can't not deal with what they need dealing with to and do the referral if you see what I mean

AW: 12:18 yeah, yeah, that makes sense yeah

NP3: 12:19 that was really badly worded [laughs]

AW: 12:21 it makes sense. So, sort of they come in with their own agenda if you like. So, I have this problem and I need you to sort it out and as you say a lot of the time the programmes are just an add on suggestion.

NP3: 12:36 yeah, yeah

AW: 12:36 and do they tend to come back, or do they get lost once you've said, oh, will you come back and make an appointment?

NP3: 12:39 they don't tend to come back

AW: 12:41 OK, why do you think that is?

NP3: 12:42 erm, patent perception that they don't understand or see the benefit of it and it's not a prescription, it's not a medication...

AW: 13:06 ok so do you think there's a sort of assumption that I'm going to see my, my practice nurse, my general practitioner and I will be given a prescription?

NP3: 13:12 oh, yeah!

AW: 13:15 they think exercise. What are prescribing exercise for?

NP3: 13:17 yeah

AW: 13:20 ok so we've spoke about time constraints within a consultation, and touched upon what the patient perceives, so they think perhaps they are not going to benefit. Is there anything else in terms of constraints or difficulties? Anything that sort of makes that process a little bit more difficult?

NP3: 13:37 I don't think so, I think it is very difficult to get the patients to understand that actually it could be really, really positive especially if you're not referring to something like HOP where it's like actually you have to go through this process before you can get to the point where you want to be at which is your surgery. They just sort of think well.... and it's, whilst there's an evidence base, you can't sit with the patient and say yes, but look at all this evidence that I've got that, because it isn't part of the culture yet. It isn't part of health culture yet

AW: 14:26 that's interesting about culture. As you say with the HOP scheme they are forced, not forced, but there's more of an obligation to go on that if they want the surgery, but the rest of the programmes, it is personal choice.

NP3: 14:41 yeah

AW: 14:42 which I guess if that culture isn't present, they are not going to opt for that option.

NP3: 14:47 yeah

AW: 14:47 ok I've got an example of the exercise on referral form and the live well, form and I wanted to talk to you really briefly about the measures that it is asking for you to fill in. for instance, the exercise on referral form, do you feel that all the measures it is asking for, are they appropriate to take? Do you think they are all relevant? Is there anything in terms of structure that we can improve on?

NP3: 15:23 for me, I think BMI on its own, as much as I don't want to fill in any more, but obviously to get the BMI you have to do the height and weight and actually the height and weight are probably more informative than just a BMI.

Because you can get fit, massively fit burley rugby players who haven't got an ounce of fat on them who have got a really high BMI

AW: 15:46 absolutely yeah

NP3: 15:48 so actually for me that doesn't necessarily give you the information that you need. Er, but and, I think the current medication relevant to exercise is actually really difficult because any medication could be relevant to exercise. So, it's kind of a you either ask them for all as a printout or none. Because, I think that's a very difficult decision to make because for me it could be anything. Two paracetamol could be relevant to exercise if they haven't taken them

AW: 16:27 absolutely if they are in pain. I understand completely where you are going with that

NP3: 16:29 so for me, I think the relevant to exercise bit it is a bit....

AW: 16:34 so for you to make that decision it's difficult. As you say what is, what is relevant to exercise? And all or nothing you'd like to see so either a print out of every single medication they're on or don't ask for anything on the form

NP3: 16:49 yeah

AW: 16:52 ok and as you say BMI is not a very good indication of the way someone is presented. Anything else? So, we've spoken a little bit about the signature, so that's a bit of a nuisance if you like

NP3: 17:04 yeah

AW: 17:05 anything else in terms of the form?

NP3: 17:08 not particularly I don't think it's sort of standard form really

AW: 17:14 yeah, similar to other referral forms?

NP3: 17:18 yeah, yeah

AW: 17:18 OK no problem as I say we are trying to move away from the paper forms anyways, but anything we can take forward from that onto the online system to try and improve that er, not a problem. So, that's everything to do with constraints, but if you think of anything else we can revisit. Is there anything that makes it easier or eases that process of referral? Any specific examples or anything hypothetical that we could do to streamline or make it easier for you. I know that's quite a big question

NP3: 17:50 that is a big question., I think to be honest to make things easier and, I think to probably help us create more engagement with patient is shifting the culture so more marketing, marketing is not quite the right word, but more publicly available, in the mainstream media, information about the benefits of these things, I think because you're more likely to get patients to engage and as much as it pains more to say it, probably something like celebrity endorsement would really help because we know like with Jade Goody with the smears, you know the cervical screening uptake went up massively you know it pains me to say it, but...

AW: 18:50 absolutely so beyond what we're doing in surgeries as you say there needs to be more public awareness if you like just to try and shift that culture from a patient perspective

NP3: 19:01 patients come to us expecting a prescription not expecting a referral to go to the gym and them almost, the culture at the minute is they always feel a little bit hard done by and fobbed off if that’s what they get instead of a more traditional medical intervention

AW: 19:26 are you ever quite ever, not persistent, but I'm trying to say are you ever quite strict and say no, you don't need XYZ medication, what you do need is this

NP3: 19:36 I would never prescribe anyway if I didn't feel it was beneficial. I will really try and encourage patients to go down that route first and say you know if you're getting no, benefit from these methods lets then look at something else.

AW: 20:01, but that's always something you try to encourage first

NP3: 20:02 yeah

AW: 20:04 and as you say then you can explore other avenues if that, if that doesn't work

NP3: 20:10 and sometimes you do it as an add on as well, so it's like ok yes, you do need traditional medical intervention, but actually if we do this alongside,

AW: 20:19 then that helps?

NP3: 20:22 yes

AW: 20:22 and there is a slight financial cost with the exercise on prescription, how is that received by patients?

NP3: 20:28 they just don't go. If they decide they can't afford it, they just don't go.

AW: 20:30 right, ok

NP3: 20:32 I don't talk to them about financial cost because I don't know what it is and well, I think it's even harder to get people through the door.

AW: 20:46 absolutely if the first thing you talk about is how much it costs. OK and onto the last section, sorry second to last section, do you receive any feedback

from any of them programmes you refer to? [NP3 shakes head] Not at all? Regarding a patient's progress?

NP3: 21:03 nope

AW: 21:03 is it something you would like to see?

NP3: 21:04 it would be useful

AW: 21:09 anything in particular that you'd like to hear about?

NP3: 21:10 just if they attended more than anything. I don't think we need to know the ins and outs necessarily, but actually did they come and did they complete the course. Because unfortunately, patients will say oh, yes, I definitely went, and you think did you? Did you really? I don't think you did, but I can't say you didn't, but for all other referrals if you get a did not attend, we get a letter, a communication to say patient didn't come

AW: 21:45 right, ok and how do you receive a did not attend? For instance, is it a letter, electronically?

NP3: 21:52 er if its hospital referrals it tends to be by post, but we get some by email as well

AW: 22:00 ok what would be the ideal?

NP3: 22:01 email

AW: 22:03 emails the ideal ok. I'm just thinking in the future because this has been highlighted as a quite a big issue that's there no, particularly for re-referrals so if someone if trying to refer somebody onto a programme and they are not aware that they have had it before, that poses a problem as well

NP3: 22:24 and you get the people that didn't go and then you try to refer them back and they don't go again. But we don't know that you know actually this is the fourth time that we have done the referral, but they are just not turning up

whereas if we can see that you can say well, actually we are not going to do that again

AW: 22:44 yes, you've got an audit that they haven't been there. And on to support networks. So, do you have any support networks in this surgery to sort of manage your patient load? If that makes sense. So, any form of triage or.... So, you said, earlier on doctors, if they've got someone coming in, they will pass that onto their secretaries

NP3: 23:07 the doctors, I don't think the doctors would see people again just for a referral although I did have one lady yesterday actually who did come and see me just for that. Er, but I don't think she met the criteria, but we trying to wang it. Er, so tend not to because it's really difficult. With the nurses the patients are asked a brief what are you booking in for because they have different time slots, but we have ten or fifteen minute appointments and that's just blanket and actually all the patient feedback is "I don't want to tell the receptionist what's wrong with me"

AW: 23:51 right, ok so at least with the practice nurses they have an idea of who is coming in, but as you say you've got a blanket, you've got no, idea

NP3: 23:59 yeah, we've just got a list of names and you wait and see what they say

AW: 24:05 and do you have community link workers in this surgery?

NP3: 24:07 yes, we do

AW: 24:08 ok so do they do any of the referrals?

NP3: 24:11 I believe they are just starting to. I understand that now there is a possibility that we can send a task to them via system one and they will do it with the patient which would be brilliant

AW: 24:26 I was going to ask what would be the benefit of having a community link worker who is able to process them referrals for you?

NP3: 24:33 time and also the community link workers, I make quite a lot of referrals to them for their social prescribing element and actually if we are sending the referrals, they are speaking to the patient and actually they can unpick and uncover things that we don't have time to do within our consultation so actually, I think it gives the patient a much more holistic approach

AW: 25:02 absolutely so they have got a lot longer with their patients as you say compared to yourself. And are they based across all the surgeries?

NP3: 25:11 yeah

AW: 25:11 yeah, OK.

NP3: 25:15 well, they cover all the surgeries, but their base is at Greenwood

AW: 25:18 ah, ok so they are based at one surgery, but cover all of them. So, if you had a referral today you could task that

NP3: 25:25 yeah, I could just task him

AW: 25:25 ok so does the patient have to then go to their surgery?

NP3: 25:28 no, they can, they can be even at whichever surgery. They are based there [Greenwood Surgery] purely for space issues because we've only got three clinical rooms here which are always full of clinicians, and we've only got three clinical rooms at our other site whereas greenwood is much bigger so they've got something that they can be based

AW: 25:48 ok so would they visit the patients to visit all this and go through...

NP3: 25:50 yeah

AW: 25:51 yeah, ok that's really useful. Fantastic so that covers everything that I would like to talk about today. Is there anything you feel is relevant about anything we've spoken about?

NP3: 26:02 I don't think so. If anything, its culture. We need to change the culture

AW: 26:05 yeah, absolutely I agree completely. So, just to summarise we've spoke quite a lot about time being one of the main issues and more than that on the patient's behalf, they expect to come in and get prescriptions. One of the biggest things that we could do is to provide a list for you guys so you can see exactly what is available

NP3: 26:31 yep

AW: 26:31 and that will help facilitate referrals onto those programmes

NP3: 26:35 yeah

AW: 26:37 fantastic. Is there anybody else that you're aware of who might be interested in sharing their perspective?

NP3: 26:44 [PN's name] probably at greenwood because she is our specialise nurse who has a specialist interest in diabetes. Er and she will see a lot of the pre-diabetic patients and she really obviously encourages weight loss and those sort of things and she does a lot of these referrals

AW: 27:03 right, ok do you by any chance have an email address for [PN's name]?

NP3: 27:06 you're better off ringing her.

AW: 27:07 ok have you got a contact number

NP3: 27:09 [PN's contact number]

AW: 27:11 [PN's contact number] brilliant 01482?

NP3: 27:13 yep, she will be there tomorrow afternoon or tomorrow morning, is it thruway tomorrow morning, it is, she will be on [PN's contact number] no, she won't [PN's contact number]

AW: 27:33 [PN's contact number] is that in the afternoon or morning?

NP3: 27:36 that's morning

AW: 27:39 and otherwise evening [PN's contact number]

NP3: 27:42 yes

AW: 27:42 brilliant thank you very much for that

NP3: 27:42 that's alright. All our numbers have got too many 8's in!

AW: 27:45 year know I was like 8, 8. I had three numbers for [PN's name] not it was for you

NP3: 27:53 yeah, for me because I'm based all over!

AW: 27:53 I was ringing everybody, and they was like she's not in today, she's not in today and I was like I don't know which one I have rang and which one I haven't rang

NP3: 27:56 it's because I'm based all over so I'm really difficult and I don't have, were about to go to set sessions, but I haven't had set sessions so I can't say on a Wednesday I will be here

AW: 28:08 oh, so have absolutely no, idea where you are?

NP3: 28:11 no, you've, I just have to look the night before and thing right this is where I need to go tomorrow. So, that's why I couldn't say to you this is where I will be, I don't know

AW: 28:22 because when you sent me you're contact details I thought oh, there three I thought I'll just ring them all

NP3: 28:27, I think you rang a Friday afternoon, and I don't work a Friday afternoon [laughs]

AW: 28:30 it's not a problem at all.

AW: Interviewer **Interview date:** 16.04.2018

NP4: Participant **Interview location:** Eastgate Surgery, Hornsea

AW: 00:00 I won't be a second, I'll just set this up. Scribble on the bottom, ah here you go. There's two there for some reason. You don't have to sign that one, it has just printed twice. So, that's for you to keep for if you want to refer back to it at any point or you can pop it in the bin. It is completely up to you.

NP4: 00:27 so is this part of you degree or?

AW: 00:29 yeah, so I'm doing my PhD. Basically, it's a collaborative research project between the East Riding of Yorkshire, Public Health, and the university. We've been commissioned to investigate the referral process onto the East Riding of Yorkshire healthy lifestyle programmes. so, programmes such as the LiveWell, scheme and the Exercise referral scheme and what we are hoping to do is streamline that process so it's as quick as possible for you guys. Tighten up everything and make it as seamless as possible which is going to be quicker for yourself and for patients. Currently it has been developed by the leisure centres, but not necessarily for you guys, so it's not working as well, as intended in practice

NP4: 01:06 hmm

AW: 01:07 er so that's the rationale for that. I will keep that [consent form]. Really quickly before we begin, confidentiality, so anything you do say today will remain completely confidential and it won't be shared with anybody else outside the research team. You have got several rights throughout this study.

So, your participation is completely voluntary, but if there is anything that I ask and you don't want to answer, your free to comment, er no, comment and we will just move on from there, that's fine. Likewise, if you want to be withdrawn from the study, that is absolutely fine and the minute you tell me you want to do that, we can destroy all data that we've collected so far. Does that all make sense?

NP4: 01:44 that's fine

AW: 01:46 brilliant so the interview will be centred around four key areas- the healthy lifestyle programmes that you can refer onto that are available in this locality, any information or referral resources that you are provided with or hat you use to make that referral, if you receive any feedback from the programmes, and any constraints that you face, or anything you feel can be challenging, or prevent that's referral. So, just before we begin, can I take some simple demographics from yourself?

NP4: 02:16 ah ha

AW: 02:16 how old are you if you don't mind me asking [NP's name]?

NP4: 02:18 60

AW: 02:20 60 and what is your role within the surgery?

NP4: 02:21 nurse practitioner

AW: 02:24 nurse practitioner. Do you have any other roles?

NP4: 02:28 within the practice?

AW: 02:30 yes, in addition to...

NP4: 02:30 no, just nurse practitioner

AW: 02:31 that's fine and are you considered full time or part time?

NP4: 02:34 part time

AW: 02:33 part time. How many sessions approximately do you deliver per week in general practice

NP4: 02:38 six

AW: 02:39 six and how long have you worked as a nurse practitioner?

NP4: 02:42 20 years

AW: 02:45 20 years. Has that always been within the East Riding of Yorkshire?

NP4: 02:46 yep. Always at this practice

AW: 02:49 always at this practice too! And I have your email so that's fine. Yep, just checking that's recording. So, can we start by exploring what programmes are available I this locality? So, what can you refer patients on to?

NP4: 03:04 erm, the exercise programme at the leisure centre for adults and then I've got the living well, for the 16-18 year olds

AW: 03:15 yep, the young live well

NP4: 03:15 and ten erm health trainers, we refer to them. Those are the ones I use most.

AW: 03:22 of them ones, so the LiveWell, scheme, the Exercise Referral scheme, and the Health Trainers, which one do you refer to the most often?

NP4: 03:29 the exercise referral

AW: 03:32 ok why is that?

NP4: 03:33 erm because our patient population have, is mostly elderly with erm long term conditions

AW: 03:44 so do you find they fit that criteria better than other populations?

NP4: 03:46 yeah, yeah, and you tend to find that the younger ones don't actually, they are probably not aware. The only ones that I have referred to with the living well, the obese children that the parents have brought in or who have

had health problems, so I don't know whether they know, whether the people are aware that the service is available

AW: 04:12 and what's the process of referral in this surgery? Are patients sort of signposted to you from the GP or does everybody refer?

NP4: 04:20 no, they can come in, you can just pick it up on a normal consultation. The GPs refer their own patients. I refer my own patients. The nurses refer their own patients.

AW: 04:33 ok so there's a shared responsibility amongst everybody to do it. It's not sort of...

NP4: 04:39 one person

AW: 04:38 that's fine. Do you find, is anybody best placed to refer, or do you think it should be shared?

NP4: 04:44 no, I think it should be shared really cuz otherwise it makes extra work having to refer them onto another, or somebody else, or somebody else whereas we can all do it ourselves

AW: 04:54 exactly. It saves that sort of delegation to somebody. So, you've said, you've got the health trainers as well, who are commissioned by the NHS and the LiveWell, and the exercise on referral is the East Riding of Yorkshire council. So, how do you decide where to refer patients?

NP4: 05:09 I suppose it depends on the patient, but for those with the long-term conditions, I meanly use the exercise referral and the LiveWell, obviously for the younger ones. And health trainers are for those in-between really who could be 20,30,40,50 that haven't particularly got health problems, but either just want to get a bit fitter or want to know what they can do to improve their lifestyle.

AW: 05:32 so it depends on what issues they are sort of coming in with, as you say if they tend to be obese and younger it's the Young LiveWell. Erm, long-term conditions, exercise on referral, but anything else sort of under 50, just for generic lifestyle advice to tend to send them to health trainers

NP4: 05:45 start off with the health trainers

AW: 05:49 and how are you made aware of the programmes that are available?

NP4: 05:53 erm the Living Well, I had to find out about myself because the patient that I had wanted to have some exercise, so I rang the council offices at Beverley and they were able to give me, I'm sure it was the Council, yeah, gave me all the information and sent me lots of leaflets. And the exercise on prescription has always been part of what we do. We've always had referral forms available.

AW: 06:20 yes, so the exercise on referral has always been embedded, but you had to seek the advice for LiveWell

NP4: 06:28 yes, and the health trainers, they came to give us a talk when they first started in Hornsea, which is going back a few years, about what they did and what they didn't do. So, we've got all their leaflets

AW: 06:39 so lots of leaflets as you say from the LiveWell, now and the health trainers and exercise on referral is something you've always done as well. Fab, so the lady that came in, or the child, sorry about obesity. Did she come in asking for the LiveWell?

NP4: 06:51 her mum did

AW: 06:53 ok so she knew

NP4: 06:55, but she has medical problems as well. Erm, and also, she had slight learning difficulties so didn't understand the conception of heathy eating and

things at school, so she was getting a bit of, not bullying, but her mum was concerned. Erm, so we looked at what we can do, and she been going there, or she was going there maybe last year now, and she did enjoy it. But I haven't had any feedback from any of those services. It was the mum that keeps in touch

AW: 07:28 ah, ok so that feedback is provided by the younger girls mum as opposed to the programmes

NP4: 07:32 yeah

AW: 07:33 is it something you would like from the programmes? Feedback.

NP4: 07:36 yeah, I think so because you don't to keep referring people if, either they are not turning up you know. You don't know whether they turned up, whether they attended.

AW: 07:50 so in terms of feedback, is there anything specifically you'd like to hear so you've said, whether they've turned up...

NP4: 07:56 just whether they have turned up and erm, the outcome really

AW: 08:03 and what would be the best way to receive that feedback? Would it be via email?

NP4: 08:07 just email or letters. Emails are a bit quicker for them because they are very busy, aren't they?

AW: 08:14 fantastic. So, is there anything else that you would like more information on regarding the programmes or do you feel satisfied that you have got enough information?

NP4: 08:23 erm, it's just erm the price, do you know when they alter the prices and there's then recessions because we always don't always get to know that and

sometimes the patients think it is free and they are quite annoyed when they get there and they have to pay erm,

AW: 08:41 is the cost a concern to some patients?

NP4: 08:42 to come patients it is yeah, but the Living Well, one I free isn't it for the youngsters so

AW: 08:51 yeah, there's an adult LiveWell, scheme as well, and that's also free, er, but they have got very specific criteria, so you've got to meet that criteria to get on the programme.

NP4: 08:59 ah right I didn't know there was one of those

AW: 09:01 yeah, so the adult LiveWell, that's for adults with a BMI of over 45 so it's a very specific patient group. But if they don't quite meet that target, its exercise on referral which they have to pay for so its swings and roundabouts and it can be difficult if they are sort of the borderline. I can get you some more information if you'd like

NP4: 09:19 oh, can you? Yeah!

AW: 09:18 yeah, the Adult LiveWell. Yes sure

NP4: 09:23 because we do have patients, we do believe that are that big

AW: 09:27, I think I might, I'll get some

NP4: 09:37 yeah, just send them in the post

AW: 09:40 I'll get some ordered from [HLO's name]. Brilliant, so in terms of the leaflets that you are given, how useful are those leaflets. Is it something that you give to the patients?

NP4: 09:51 yep, erm, cuz they have got to fill in a bit of it anyways for the referral to go ahead then yeah, it's to read and things. I also give them additional healthy eating leaflets and advice

AW: 10:09 is that something you've created within the surgery

NP4: 10:11 yeah, we've got leaflets and things from all over and especially diabetes, but they are not specific for diabetics, but we can get them from there so

AW: 10:22 right, ok. So, diabetes is obviously something, one condition that might prompt a referral. Is there a particular, particular condition that they come in with that might prompt you to refer?

NP4: 10:34 just long term conditions, we put it under that umbrella, so its overweight, high blood pressures, diabetics, respiratory

AW: 10:46 so a lot of conditions that could

NP4: 10:48 yeah, that you think might benefit from some exercise and some structure

AW: 10:52 and for the exercise on referral, obviously with the LiveWell, you are referring via the paper format, is it the same for the exercise on referral?

NP4: 11:02 yeah, we can print it off and then we make sure it's filled in correctly and get the patient to sign it and send it although we do have some paper ones, but they're

AW: 11:13 ah right so you've got the paper versions

NP4: 11:15 there is the health trainer ones. We do have some paper ones, but we can download it now so it’s a bit easier

AW: 11:22 ok. Is that a template that's on your system?

NP4: 11:30, but the patient has the sign them, so you have to...

AW: 11:33 ok so there's the issue of that. With it being on the system, is it, does it auto populate, pre-populate or is it just a template that you print off?

NP4: 11:42 no, it’s auto populated

AW: 11:44 ah right, ok is that easier

NP4: 11:50 I'm sure it is, let me check.

AW: 11:56 cuz that really useful a lot of practices don't

NP4: 11:59 yeah, we call it exercise on prescription

AW: 12:03 ah it will be interesting to see how that was set up because a lot of practices struggle time wise because they are having to fill it all in

NP4: 12:09 no, it all populates it with the information. I shouldn't be showing you really. Confidentiality, but yeah, the patients name, address, then you er, it will print out like it, you know BMI, BP and things, then you just have to fill in what the medical history is and the reasons for referral and then just print it off and send it to the leisure centres

AW: 12:30 so that saves a lot of time there.

NP4: 12:32 yep

AW: 12:33 that's brilliant. So, in terms of the referral form, do you find that all the measures that is it asking you, do you find them all appropriate, so it asks for things like the patient blood pressure, the BMI, things like that.

NP4: 12:43 that's fine and then there's the, so you can add in there

AW: 12:49 just anything else you feel is important

NP4: 12:50 yeah, yeah, and it’s quite simple and its quick so

AW: 12:55 is there any improvements that you would like to see to the referral forms or referral process as a whole?

NP4: 13:01 no, no problem no

AW: 13:04 so you mentioned earlier on about sort of the awareness of patients. What could we do to raise that awareness? Would it help if patients were coming in asking for it?

NP4: 13:15 yeah, and I suppose posters, posters in the surgery to get patients to ask. The only thing is though sometimes if they don't meet the criteria when you've actually got them in to assess them, you've got to explain haven't you?

AW: 13:30 absolutely, yes. So, do you typically. Have you got longer than 10 minutes with patients?

NP4: 13:35 yeah, we do. For the long term conditions, we have 20 minutes per patient

AW: 13:41 ah right, ok

NP4: 13:43, but my normal appointments are 15 whereas the GPs are 10

AW: 13:45 yeah, so you've got as little bit longer to explain that process

NP4: 13:48 and the diabetic nurses have, they get 20 minutes, and their job really is to work with the long term conditions patients, so they get longer

AW: 13:58 right, ok. So, that everything in terms of constraints. Is there anything else that makes it difficult to refer? or any challenges that you have experienced previously

NP4: 14:08 no, not really.

AW: 14:08 that is fine, fantastic. Er, the next section is about facilitators, so anything that will make it easier. It’s a little bit difficult because obviously you have said, you don't face many barriers so you've said, the cost can be an issue to patients, but that's sort of on the patients behalf. Same with the awareness, you said, it would help perhaps if there was more posters

NP4: 14:33 yes, yes. Or even in the leisure centres. I don't know whether they have posters up saying, they can be referred

AW: 14:41 yeah, so maybe if there was posters, not just here, all over

NP4: 14:42 they could signpost them, yeah

AW: 14:46 and you mentioned about the patient's signature, is it an issue having the signature on the form?

NP4: 14:52 it sometimes is because if you are busy or you are running late and say to the patient right,

I'll do that referral when we come to the end of the surgery when we've got admin time. So, you let them go, you go to print the form off in your admin time, and you haven't got their signature.

AW: 15:14 oh, no. What do you do in that case?

NP4: 15:15 so I just usually either PP it or explain that the patient had left the surgery before.

AW: 15:20 ah right, ok so it's not a case of inviting them back in

NP4: 15:22 no, no

AW: 15:24 right

NP4: 15:24 if anything I would send it in the post to them and ask them to take it to the leisure centre once they have signed it

AW: 15:28 ah right, ok so that gets around that

NP4: 15:31 yeah, we don't want to ask them to come back in

AW: 15:33 ideally would it be easier if the patient signature was scrapped altogether?

NP4: 15:35 yeah, cuz I mean, I think just being referred form a healthcare professional is enough really.

AW: 15:43 yeah, absolutely I agree. We are looking at how we can amend these form so if, if quite a lot of people are saying, well, actually it's a bit of a nuisance then we can actually scrap that signature from there to make it easier

NP4: 15:56 yeah, if you've seen them and you've talked about it with the patient and you've both decided that's the way forwards, the healthcare professional signature should be enough really

AW: 16:05 absolutely. Is there any other forms, is that common in general practice to take a signature for anywhere else you refer onto?

NP4: 16:16 no, I don't think so

AW: 16:16 no, no, ok

NP4: 16:19 no, we don't do that anywhere, no, [mumbles]

AW: 16:19 okay dokey so it's a little bit of a, a nuance really if it's not something that's common. Ok, er and the last section is about progress feedback, so we've touched on feedback and said, that actually the only feedback you do get, from the LiveWell, programme has been from the child's mother. The exercise on referral, do you receive any feedback from that scheme?

NP4: 16:43 no, or if, erm whether it comes to the practice generically and then it might go straight to the patients GP. It wouldn't necessarily come to the nurses that have referred them. So, that's sometimes what happens you know, it goes back to their GP, not necessarily who has referred them

AW: 17:01 yeah, so you could be receiving that feedback, but you're not going to necessarily see that if it does go straight to the GP

NP4: 17:08 yeah, unless we see the patient again

AW: 17:10 that makes sense. And if it does go back to the GP, is it then attached to the patients records for you to see if you want to see

NP4: 17:17 yep. they probably wouldn't let me know that they have received any, but it will be scanned so if you were looking for something in that patients records at a later date, you'd see it

AW: 17:26 yes, so there is that option to see. Anything else you'd like to hear about? So, you said, just really generically their attendance, the outcome, anything specific in terms of the outcome? So, would you like to hear about weight loss for instance?

NP4: 17:40 yeah. Compliance whether they did comply. Whether they are continuing because sometimes they can go on, pay for it themselves, and they finish the course, and keep going to the gym. But we do, we follow the patients up anyways so we will be seeing them maybe six monthly so...

AW: 18:00 yeah, and is it something you discuss when they come back?

NP4: 18:02 yeah

AW: 18:08 brilliant. And does this surgery have any healthcare assistants or anybody in place to do the referrals. So, the GPs obviously do them, the nurses do them, do you have

NP4: 18:17 we have healthcare technicians, but they don't do the referrals

AW: 18:18 they don't do that yeah, so it's just GPs and Practice Nurses?

NP4: 18:22 yes

AW: 18:25 fantastic so that's all the areas I wanted to speak about today. Is there anything you would like to add that you think is relevant or interesting? Or anything we can expand on?

NP4: 18:33 I mean them services, is it a well-attended service? cuz you don't

AW: 18:37 yeah, the LiveWell, is, the LiveWell, is really popular and they have just realised a new programme called the Health Optimisation Scheme. I'm not sure if you've heard about that one. Basically, it’s for a patient that is requiring non-urgent surgery. So, it might be a hip replacement, a knee replacement. If they have a BMI over 35 or over, or they are a smoker, they

have to show some commitment or willingness to change their lifestyle prior to the surgery. So, the council are proposing a new programme called health optimisation. That can range from 4 weeks to 12 weeks, but they have to go on one of those schemes and show willing to change their lifestyle

NP4: 19:16 oh, that's good

AW: 19:15 so that's a new sort of scheme that's going on at the minute. I can make sure that you get a lot more leaflets especially for the LiveWell, schemes. Is there anything else you need? Do you need any more referral forms or anything like that?

NP4: 19:28 no, we are fine, absolutely fine

AW: 19:32 ok I'll make sure there's some new leaflets and then we can go from there. OK thank you very much. I'll just turn this recorder off.... Have you got a busy day today?

AW: Interviewer **Interview date:** 17/05/17

PN1: Participant **Interview location:** Gilberdyke Health Centre

AW: So, just before we begin, so you're a nurse within this surgery? 00:11

PN1: Yes. 00:11

AW: Are you full time or part time? 00:12

PN1: Part time. 00:12

AW: Part time. And how many sessions do you do in general practice per week? 00:15

PN1: I work 3 days, so, I suppose it's not sessions as the GPs done. 00:23

AW: It's more days, yep. And how long have you been working as a nurse? 00:28

PN1: Erm, erm, 34 years. 00:37

AW: 34 years. 00:37

PN1: Yes. 00:38

AW: Has that always been within the East Riding of Yorkshire? 00:40

PN1: Mostly, Hull and East Riding. 00:44

AW: Right OK. If you had to give a rough estimate of how many years you've worked specifically within the East Riding, what would you say? 00:52

PN1: Erm, I think, it's just about 7. 7 or 9 years. 00:57

AW: Yep, 7 to 9 years. OK, so the first section of the interview will be on the East Riding of Yorkshire healthy lifestyle programmes. So, what's available for patients in this locality? In terms of the East Riding of Yorkshire healthy lifestyle programmes? 01:11

PN1: Erm, there's the LiveWell, programme, and the exercise referral. 01:17

AW: So, the LiveWell, and the exercise referral, so are they the two specifically available in this locality? 01:23

PN1: Erm, well, we also refer patients to the living with diabetes programme which has got a lot of elements of erm, that's, partly, well, I suppose that's partly, I don't quite understand how it works, but we can still refer into that so… 01:42

AW: Yep, 01:42

PN1: That's sometimes an option obviously for our diabetics which they can get some good information regarding healthy lifestyles. Erm, there's also the junior, is it the junior LiveWell? I've never actually referred. 01:55

AW: Ah yes, the young LiveWell. 01:55

PN1: Anybody to it. yeah, the young LiveWell, should I say. Yeah. 01:58

AW: Yeah, so you've mentioned young LiveWell, adult LiveWell, exercise referral and erm, the diabetes. 02:04

PN1: There's a smokers cessation service as well. 02:06

AW: Yep, and smoking cessation. So, of them programmes, do you find that you refer patients to one more than the other? 02:13

PN1: Generally, the living with diabetes programmes. 02:17

AW: The living with diabetes. 02:17

PN1: The most yes. 02:19

AW: And why is that? 02:20

PN1: Well, I deal with a lot with diabetics, and it tends to fit them pretty well, because erm, erm, I also I try and encourage the exercise referral more recently actually. 02:32

AW: OK. 02:33

PN1: Erm, just because it has been brought to my attention a little bit more recently, but we have had a few problems with that because the referral process has changed quite a lot. 02:42

AW: Ok. 02:43

PN1: Over the years we've had paper referrals, online referrals, back to paper and now were in the process of going back to online so it doesn't help. 02:53

AW: yeah, so that kind of confusion of flitting between… 02:56

PN1: It does, erm yeah. 02:57

AW: Does that sort of put you off a little bit? 02:59

PN1: It does a little bit yes. 03:02

AW: And when you say that recently you've become more aware of exercise referral, how did that come about? 03:07

PN1: Well, I've been in touch with [HLO's name] and I'm trying to sort of use these resources a little bit more because erm, they're there for patients and, I think they need it really. 03:23

AW: yeah, so when you say resources, what are you given for your patients? Is it a, it is a leaflet or is it something that is communicated through email? 03:32

PN1: With regards, I don't think we, I haven't got a leaflet for the exercise referral. 03:40

AW: Right ok. 03:40

PN1: And that would be useful actually. 03:43

AW: Uh huh. 03:42

PN1: So, you're not necessarily having to deal with people on the spot, you can send people away with something to return if they, erm, I think that might be thinking about it, part of the problem because we do have that with the living

with diabetes. If they're not interested in talking about it there and then, give them leaflet and ask them to get back to me which does often work. 04:06

AW: Yes absolutely. 04:09

PN1: I don't always have time to deal with it in a consultation, so… 04:13

AW: yeah, 04:13

PN1: It gets left unfortunately. 04:14

AW: so, for you… 04:15

PN1: If I haven't got anything to give them then they don't get back to me. 04:17

AW: yeah, that makes sense, so for you, having something that you can give to the patients, that would really help. 04:25

PN1: Absolutely. 04:25

AW: That makes sense. 04:27

PN1: Yeah. 04:28

AW: In terms of live well, do you have any leaflets or anything for live well? 04:31

PN1: Yes, we have stuff in the waiting room we have stuff about the smoking cessation. 04:35

AW: Ah, right so the other programmes have information resources. 04:39

PN1: Other lifestyle programmes yes. 04:39

AW: But just none for exercise referral? 04:42

PN1: No, we don’t. 04:45

AW: That's interesting, OK. Erm, so what are your sort of expectations from referring patients onto these different programmes? 04:51

PN1: Erm, really that they'll get the, the information to help them get motivated themselves, they get information and support. 05:02

AW: Yep, ... so, for you it's, erm, helping them to get that support so they can motivated themselves? 05:09

PN1: Getting into a good routine and trying to get into better habits really, over a period of time. Erm, patients sometimes like to come here and get weighed once a week or have a chat about their diet and it's not a very effective I find. 05:26

AW: OK. 05:26

PN1: Because it, it very often doesn't work and erm it's not a very good use of resources at all I don't think, that's not what we're qualified to do. 05:36

AW: Yeah. 05:38

PN1: Erm, patients perceive that it's going to help because erm, they get the view that they're going to be motivated because they're coming in once a week or every fortnight, whatever it is, but (laughs). 05:48

AW: But you feel you can use the resources better? 05:49

PN1: Absolutely, we can support them with their health and medications, and referring them to the right programmes, but not necessarily, I don't necessarily think doing the lifestyle changers job for, what we should be doing really. [Answers phone regarding a patient and cannot disclose this information]. Sorry. 08:23

AW: That's ok, it's fine. So, when are you typically prompted to refer patients onto these programmes? 08:30

PN1: Erm, 08:34

AW: Do they tend to ask specifically for it or? 08:36

PN1: Sometimes, but more often than not its brought to light because they've got some kind of health concern like raising blood glucose, or er, some condition that might be associated with an unhealthy lifestyle. 08:49

AW: Yep, so most of the time it's their presenting symptoms? 08:52

PN1: It could be their blood pressure, erm, er, weight-related issue, so it could be something that we would go through the causes is impossible. 09:05

AW: Yep, and that kind of leads on nicely to the referral? 09:08

PN1: Sometimes. 09:11

AW: So, the next section we're going to talk about is the constraints of patient referral. So, you spoke a little bit about the referral process changing from paper format to electronic format… 09:22

PN1: And back again! 09:22

AW: Yep, back again! Er, so do you experience any other sort of issues or constraints when trying to refer or initiate a referral with a patient? 09:33

PN1: Erm, well, time, time is an issue., I think when we get use to the online system, hopefully this will stay, stay with us, but when we get use to the online system, I think us all knowing what to do and being able to refer patients at the time is a good thing really. Er, I think, I think having to research how to do it, ring people up, it just makes it difficult, and it often doesn't happen. 10:08

AW: Yeah. 10:10

PN1: So, that's the main thing really. It's time and er, yeah. 10:12

AW: And sort of knowing the process? 10:14

PN1: Knowing the process yeah, and having it on your desktop. 10:20

AW: Can you tell me a little bit about your experiences of using the paper form, electric form, er, paper form? 10:28

PN1: Erm, I was quite unclear about where the forms were going. Sometimes the patients took them with them to the, it seems to always work out, but sometimes they took them with them to the er, to the health centre sometimes they were sent, and it didn't seem, we were getting conflicting advice about what to do with them. 10:47

AW: Right OK. 10:48

PN1: Er, there was a lot of information on a very small form. On the surface, although we're not use to it, the online forms seems a lot better. 11.00

AW: Yeah, and the measurement that are required for the forms, did, do you feel like they're appropriate? I do have an example one...11:07

PN1: There aren't any on the online form though, are they? 11:08

AW: I've not seen the online one to be honest, we are trying to push everything, all the programmes referrals online. 11:14

PN1: Yeah. I didn't think they were appropriate. 11:17

AW: I'll just get some examples out, so the paper formats, erm, here's the exercise referral ones. 11:21

PN1: That's right yeah. 11:23

AW: So, in terms of er, what it's asking you to fill in, what do you think is perhaps not appropriate? Or do you not think it needs to be assessed in general practice? 11:33

PN1: Erm... I don't know why a lot of these things are here. I suppose it, it's a useful, it it's useful for... it's useful to know that someone has been referred

isn't it, that.... Erm...The fact that participants must be inactive is er, it's a bit of a relevant term, isn't it? 12:06

AW: Yeah... absolutely because there's no, definition of what is meant by active. 12:12

PN1: No. 12:12

AW: Do you use any measure to determine how active they are? 12:15

PN1: We do on screen yes, but even there, the, the I mean, what my patients say they're very active can mean that they do the housework. 12:24

AW: yeah, absolutely. 12:25

PN1: Er, it it's, erm, participants who are, you might, you might not describe as inactive, but they could still do with some structured, some structured exercise programme really, you know? 12:45

AW: Yeah. 12:45

PN1: They're not inactive because they're doing their shopping and their housework, but they really could do with getting out of breath occasionally and erm. So, I don't know if that's helpful, I know that they're erm, the gyms were we referring to they're not very strict with that from what I understand. 13:02

AW: Ah right, ok. 13:02

PN1: But er, I don't think that's on the new forms so I'm quite pleased about that. 13:09

AW: yeah, so I'll have to update myself with the online version. 13:13

PN1: I've never really thought about this, why it's all relevant. I suppose certain things would need to be known wouldn't they if someone had epilepsy, but it doesn't actually ask if someone is taking insulin or, if they might be at risk of

a low blood glucose, which is more important than the fact their diabetic really, I think. 13:34

AW: Because er, a lot of people that I've been speaking to as well, have mentioned that there's not a lot of room because it is handwritten. 13:39

PN1: No. 13:40

AW: Er, not much room to elaborate on anything really… 13:43

PN1: No. 13:43

AW: So, this is why we're trying to move away from this format to online. 13:50

PN1: Yes, I can see that's not a really good form. 13:53

AW: And if you want to speak to a patient about a referral and they are quite resistant to the idea of being referred, what happens then? 14.00

PN1: I wouldn't refer somebody who wasn't, erm, keen to do it because I don't, I don't think they would engage. They wouldn't engage, go once and then not, I don't think it's a good use of resources to refer who aren't keen and it's the same with the living with diabetes programme. I make sure that patients ask ultimately, and I give them the form and then say let me know if you want me to refer then, me to refer you and they'll either say yes, please do it now or they'll come back a week later and say I've had a look and I've had a chat with my wife and, I'd like you to do it. Cuz, I would get a lot of patients not attending. 14:41

AW: Uh huh. 14:41

PN1: Which then doesn't help when...14:43

AW: Doesn't make the programme look good? 14:44

PN1: No, it doesn't make the programme look good and then we've got a waiting list for patient who aren't keen. 14:48

AW: So, for you it's having that information resources to give to patients so they can make that decision in their own time? 14:56

PN1: That's right so you can refer them more appropriately really. 14:58

AW: Or if they're really interested then they can take it away and at least have a think about it. 15:02

PN1: Absolutely, yes. 15:03

AW: That makes sense. So, we've mentioned the referral process, er a little bit about time and er, about there not being a clear structure to the referral process… 15:13

PN1: Hum, 15:13

AW: Is there anything else that you find difficult, or any constraints when referring patients? Or are they your main?...15:23

PN1: They are, the erm. I don't, there's some referral criteria and I'm not always very clear on that for the different programmes. 15:30

AW: Ah right, ok. 15:33

PN1: Erm, I think there's BMI, there's a criteria for BMI isn't there for the two programmes? Is it 30 for the...? 15:43

AW: LiveWell? 15:44

PN1: Living with, the exercise referral is it 30 or above?

AW: Thirty and above yes. 15:52

PN1: Thirty and above. 15:54

AW: It is really confusing. So, do you think it would help if...?

PN1: But if you got a very skinny, hypertensive patient who could really benefit from doing…. 16:03

AW: Yeah. 16:04

PN1: Sorry I interrupted you there… 16:05

AW: No, it's fine I was just thinking. 16:06

PN1: And then is it the LiveWell, programme its 40 and above right? 16:13

AW: Ah yeah, the higher BMI for the live well, that's right. So, for you it would quite good if you was to get more information about the different referral criteria and...? 16:21

PN1: Yeah. 16:21

AW: And more information about...16:23

PN1: And why really because I can't actually see, 16:25

AW: And how would you like to receive this information? Do you think it would be useful for scheme coordinators to come to the surgery or? 16:35

PN1: Erm, possibly? Er… 16:43

AW: Or perhaps online training? 16:43

PN1: Flowchart, some sort of flowchart. 16:48

AW: yeah, just something so you can clearly…. 16:52

PN1: And BMI is not always a very accurate measure of somebody's needs is it really? No and it's quite, it seems quite strict really that, I don't know whether patients would be turned away if the BMI was… 17:07

AW: Yeah. So, you think it will be useful just to have some kind of criteria just so you can refer to it and think OK this is the criteria for this programme, this is the criteria for the next programme. 17:17

PN1: Yeah. So, we know what the options are for different groups really. 17:23

AW: That makes sense. OK, so we spoke about what makes it hard to refer patients. Er, the next section is about what facilitates referral so what kind of eases the process of referral to one of these programmes? 17:36

PN1: Er, I think being able, to make, with the new online system, being able to make an appointment at the time is useful. 17:48

AW: Uh huh. 17:49

PN1: I wish that was possible with the living with diabetes programmes. It's not it's just a referral and then er, patients get a letter and it can be a long time til they, sometimes they're lost, lost interest or feel that they've sorted the problem themselves, or feel that it's not going to be useful anymore. It's just getting there half the time, they get their appointment sometimes. 18:13

AW: Is that why you think it's important to initiate that referral there and then? 18:18

PN1: Referring them there and then and actually even making an appointment, so two weeks on Saturday you're going and discussing when they're going. That helps as well. 18:27

AW: yeah, so they have a clear focus point. Is there anything else that sort of helps, any patient characteristics that help er, aid referral, like I'm just thinking of the top of my head, if a patient really keen to get onto the programme or? 18:46

PN1: Well, yeah, of course er, yes, if they're willing to be flexible about, and they need to be able to pay don't they for the exercise referral, not for the LiveWell? 19:06

AW: No. Do you think that poses a barrier to some patients? 19:13

PN1: It has posed a barrier to a patient. So, yeah, I think it can, but erm, generally not because it's a modest amount with regards to what… 19:28

AW: yeah, I think they're subsided. 19:28

PN1: It's £32 or something for… 19:33

AW: I'm not too sure, I know it's subsided compared to a usual membership. 19:36

PN1: Of course, yeah, it's a lot less! 19:38

AW: yeah, a lot less, brilliant. So, they next section is just a little bit about the feedback you receive from the programmes in terms of the patients you've referred on. So, what information comes back to you about your patients in terms of the programmes you've referred them on? Do you receive any kind of feedback? 19:57

PN1: I get er, a standard tick box letter from the living with diabetes programme to say either they've completed, or they haven't. 20:07

AW: OK. 20:08

PN1: Or they haven't attended, or they didn't, so I could do an audit on there to see how many of mine have done, it would be useful thinking about it. I don't get anything from exercise referral as far as I'm aware. I don't get any information apart from maybe what the patients will tell me… 20:30

AW: OK, so the feedback that you do receive if any is if a patient kind of comes back and tells you something. 20:36

PN1: Then again, there might be something on record, but I have never seen anything, so it is never brought to my attention. 20:42

AW: OK, so with the living with diabetes, you just find out whether a patient completed, and you find out…? 20:50

PN1: I don't, yeah, if I come across the letter and I do see those, but I don't see anything. The, er, exercise referral 21:00

AW: OK what sort of involvement do you think you should have after a patient has been referred? Would you like feedback? 21:05

PN1: I suppose I would, but whether that's any help for the patient I don't know really. 21:12

AW: OK. 21:13

PN1: Erm, we're all on different computer systems aren't we? So, er, and I don't expect you know, health centres to be on the same computer systems as a doctors practice at all. But we, even with er, with, er, clinics, hospital clinics, we don't see what's happening so it's very difficult to expect that we know what's happening in a health centre. 21:39

AW: Yeah. 21:41

PN1: Er without letters, I suppose letters, letters are the way, aren't they? But, erm… 21:48

AW: So, let's suppose that a letter was sent from the programme. So, say LiveWell, started providing feedback… 21:53

PN1: Hum… 21:53

AW: What would you like to receive? Is there anything specifically you'd like to know about or anything that would help you understand if a, if a change has been made in their lifestyle? 22:01

PN1: yeah, it would be, it would be er, it would be good just to have a paragraph of the completed, they enjoyed it, er, they're planning, what their plans are, whether they're achieved any goals. I suppose even just a couple of sentences would be good, so we know whether it's actually effective. 22:21

AW: Ah ha 22:24

PN1: Because we've no, idea really! 22:25

AW: yeah, I guess if your referring patients...22:28

PN1: We don't know if we're referring patients and it's not doing any good or if it's actually a great thing! 22:35

AW: So, it'll be good for you to kind of erm, so you've got that confidence in that programme and you can say well, actually it has helped? 22:41

PN1: Absolutely yes. I've never really considered it, but it would be good. It would be good to audit what we're doing really and see if it's actually, or see if we should be doing something different. 22:53

AW: Absolutely, er, is there, would you like any medical feedback come back to you in terms of feedback so any indicators of lifestyle change? For instance, if there's been a change in blood glucose, would that be useful to you or would you prefer to know if they're completed, if they've enjoyed it, as you say if they've reached their goals? 23:16

PN1: yeah, I think that would probably be enough. Er, if the blood glucose is erm, if they've been referred because they're blood glucose is a problem then after we would be monit, monitoring that anyway and then discussing with the patient as they come back. Ah, I see you've lost weight and it's had a positive effect on your blood glucose. that's really, you know…23:36

AW: Yeah… 23:36

PN1: That type of thing, but erm... not to say it's not useful if somebody else does it. It can be can't it for the patient, but it probably wouldn't help us because, if, if it's been a problem we're probably monitoring it anyways and discussing it. 23:50

AW: yeah, so as you say your monitoring that anyways 23:53

PN1: yeah, 23:54

AW: That makes sense. Erm, that's that whole section. So, just the final section really is about support networks. Er, now I understand this is more relevant to GPs so if, if the question doesn't make sense or you want to pass on that's fine.

However, I kind of wanting to know what support networks you have in this surgery to help monitor patient load so you can preserve consultation time for high-risk patients. So, do you have any er, triage system or anything similar in this surgery? 24:24

PN1: Yes, we do we have er, a, a nurse triage, telephone triage, in the morning. 24:30

AW: Oh, right OK. And how does that work briefly? 24:34

PN1: Patients , er, who may want an appointment on the day or speak to somebody, speak to the triage nurse , she'll either speak to one of the nurses, speak to a doctor, make an appointment, refer them to another service, or give them simple advice. 24:50

AW: Ah right, so before they reach their GP you can triage them off into the most appropriate area for them. 24:58

PN1: yeah, 24:59

AW: And do you think that's successful? 25:01

PN1: Yeah, definitely yeah, 25:03

AW: And how long have you been triaging is that something relatively new? 25:08

PN1: It’s difficult to say, maybe four years, 5 years maybe. The GPs will do that sometimes as well, but we have a nurse employed just to do that 25:19

AW: yeah, fantastic, er, so that's wraps up the interview. Is there anything else you feel is appropriate to add about anything we've spoke about today that might be important? 25:30

PN1: I don't think so… 25:36

AW: Quite happy? 25:36

PN1: I think the leaflet thing is a big thing really and posters perhaps as well. 25:43

AW: yeah, so kind of some sort of advertisement so… 25:47

PN1: More information yeah. 25:47

AW: So, the patients can get more info, as you say you can get more information if you're` not sure. 25:53

PN1: I mean you can copy and send newsletters just so patients know it's available really. 25:57

AW: Yeah, so do you think it would help if patients were better educated on the different programmes that are available? 26:02

PN1: Definitely, yeah! I know we don't use it enough! I know we don't use it enough because we don't always have the opportunity to actually just sell it really. But, I think if, if patients knew about it more they would ask about it more and we would have to use it more and it would be to everybody's benefit in the long term. You could [unclear] it then! (Laughs) 26:32

AW: Absolutely, I agree. 26:34

PN1: There's lot of resources out there that we don't use enough, I think really and because we are general practice, we try and deal with everything and it's not the way forward I don't think. 26:46

AW: It's hard to keep on top of everything that's going on I guess. 26:49

PN1: it is, yeah, yeah. And I've got a book of passwords there that I really shouldn't have, but I have to because it's all referring to different services, using different systems… 27:01

AW: It's hard to remember them all. 27:01

PN1: It is, but its erm, it's vital that we do really cuz its, its, general practice has changed such a lot we've got to be able to refer to everybody haven't we? 27:13

AW: Absolutely. [Phone rings] Do you want to get that? 27:14

PN1: [answers phone] 27:25

AW: I just have one more question to ask, er, I just wondered if they was anyone else in this practice er, who you think it would be useful to speak to who refers on and the best sort of way to contact them. 27:37

PN1: Er, I've got, we've got two other nurses we've got [PN's name]. 27:44

AW: [PN's name]? 27:45

PN1: And I've got a new, we've got a new, well, I say she's new she's been here a few months now, but she's sort of getting to know about services and you may find her useful to interview. 27:54

AW: What's her name? 27:56

PN1: [PN's name] 27:57

AW: [PN's name]? 27:58

PN1: [PN's name] 27:59

AW: Oh, [PN's name] sorry. We're just trying to talk to as many different people as possible so, obviously the more evidence we can collect, were going to create something better that's going to help streamline patients. Erm, what do you think it the best...28:13

PN1: Do you want their email address? 28:13

AW: I was going to ask if you, what was the best way to contact them? 28:17

PN1: Erm, right so if I, [turns to computer] if I copy in that might be the best way. 28:34

AW: yeah, absolutely. 28:37

PN1: [PN's name]... [clicks mouse] This may be... Oops can't spell. 29:04

AW: Neither can I! I'm so glad theirs auto correct (laughs). 29:07

PN1: Yep, I've just put maybe [PN's name] would be happy to participate and just copied them into it. Is that all right? 29:13

AW: Yeah, brilliant! Thank you very much that's really useful, thank you. In terms of GPs do you think they will be any GPs in the surgery that, because I remember you saying, it's going to be really difficult to try and persuade GPs because obviously we're not offering any…29:28

PN1: They don't actually do any referring they would just ask us to do it. 29:32

AW: Ah right OK that's useful so as part of your triage system they would? 29:36

PN1: I suppose they would, they might mentioned it and then they would make an appointment with one of us, which isn't very, it isn't very good! I was thinking I might, when I get to grips with it a little bit more myself I might er, kind of chat in one of the meetings and just go through how easy it is! 29:55

AW: Mm, so they can do that without kind of 29:58

PN1: So, they can just do it yeah, because it saves time for everybody. Or even er, it doesn't really have to be somebody medical does it I suppose? 30:05

AW: No it doesn't, erm, typically practice nurses and GPs do, do the referring, but even the receptionist at some places can, the, the doctors kind of say OK we've not got much time, but if you'd like to go and see our dedicated health nurse or the receptionist and they will be able to initiate the referral. So, I think there's only one that doesn't require a health professional. I don't know if it's, I don't know it's, it's live well, or if they just fill in obviously the medication and things and then the receptionist can do the rest of it. 30:36

PN1: Right OK. 30:38

AW: But yeah. 30:40

PN1: Is, is the LiveWell, that they can refer themselves? 30:43

AW: No not the live well, it does require a health professional. 30:45

PN1: Ah, I see, right, ok. 30:48

AW: OK. 30:51

PN1: Health trainers they can refer themselves. 30:51

AW: The health trainers ring them within 24 hours of the referral and then they are referred to the closest leisure centre and meet the health trainers. 30:58

PN1: But they can just ring up themselves to refer themselves can they patients? 31:03

AW: I'll double check. I will double check. 31:05

PN1: There's a from with a slip on the back… 31:10

AW: Maybe, I thought it had to be initiated first by a GP I may be wrong, but I will double check because there's that many I can't remember myself never mind… 31:19

PN1: I, I think so. Er, like the stop smoking service, patients can just ring up can't they to get, to get access. 31:25

AW: Yeah, yeah, yep. 31:27

PN1: yeah, OK. (Laughs) this is how confusing it is! 31:30

AW: I know god knows how you remember it all because I can't remember it all. Well, thank you for your time today I really appreciate it! 31:37

PN1: You're very welcome and good luck with it! 31:40

AW: Thank you. Well, you are my first participant actually today, so I was really excited that somebody got back to me! 31:45

AW: Interviewer **Interview date:** 27.07.2017

PN2: Participant **Interview location:** Practice One Bridlington

AW: 00:01 so I'm just going to start with some simple demographics. What's your last name [PN's name]?

PN2: 00:06 [PN's name]

AW: 00:08 [PN's name] and how old are you if you don't mind me asking?

PN2: 00:11 erm 44

AW: 00:12 44 and are you an advanced nurse practitioner as well?

PN2: 00:16 erm advanced practice nurse, kind of junior nurse practitioner if that makes sense?

AW: 00:21 yep, sort of

PN2: 00:23 sort of

AW: 00:24 and is that your only role within this surgery?

PN2: 00:27 yes

AW: 00:28 and are you full time or part time?

PN2: 00:29 full time

AW: 00:31 so do you deliver 8 sessions in general practice per week?

PN2: 00:34 erm, yeah, I do 32 hours over 4 days

AW: 00:39 and how long have you been working as an advanced practice nurse?

PN2: 00:44 quite a while erm

AW: 00:47 if you had to give a rough estimation

PN2: 00:49 probably 5 years

AW: 00:53 5 years. Has that always been within the East Riding of Yorkshire?

PN2: 00:56 yes

AW: 00:57 brilliant 5 years in the East Riding of Yorkshire

PN2: 01:01 and ten years before that as a practice nurse sort of working up. So, 15 years in total in practice

AW: 01:05 ah right, ok. So, the first section of the interview is based on the healthy lifestyle programmes that are run by the East Riding of Yorkshire Council. So, what healthy lifestyle programmes are available for patients in this locality?

PN2: 01:20 erm there's the LiveWell. Erm, there's the exercise referral. Erm, we can utilise the health trainers

AW: 01:33 ok, I think they are NHS run

PN2: 01:38 I'm never quite sure who runs what. Erm, and then if we're at the extreme end of the scale, we potentially, erm again, I think it's NHS, with the erm, weight management, the tier three

AW: 02:03 OK tier three weight management services?

PN2: 02:03 yeah

AW: 02:06 ok so in terms of the East Riding of Yorkshire ones we've got LiveWell, and exercise on prescription, exercise referral. Which ones do you refer patients onto the most often?

PN2: 02:13 probably the exercise on referral

AW: 02:17 ok and why is that?

PN2: 02:17 why is that? Because they, the LiveWell, you've got the criteria of the BMI and if they are under the BMI. Although having seen the erm, results of the LiveWell, you get much better, you get much better. I wish the BMI was almost a little bit lower

AW: 02:38 yep, does that have implications for how many patients you can refer on?

PN2: 02:43 yeah, yeah

AW: 02:45 do you have many patients with a, I think it's a 45 BMI

PN2: 02:48 yeah, yeah, there's a few, there's a few erm, but, it's trying to engage people on. A lot more of them, we refer to the exercise on referral and that's because often there BMI has not got to that point, but we know the benefits of exercise. I see a lot of diabetic patients and of course that's, it's massive. Exercise is a huge thing with diabetes.

AW: 03:16 so for you it would be quite useful if the BMI was a little, but lower as you say then you could refer onto LiveWell, more

PN2: 03:22 yeah, yeah. Because they get more input...

AW: 03:27 I've left my examples in [Dr's Name] office, but LiveWell, and exercise referral have information booklets and referrals forms. Are you given any more information to give to your patients regarding the programmes?

PN2: 03:40 no, I would generally just do the, quite often it's verbal. Verbal information. Tell them what it involves erm whether there is any cost implications to it. Erm, fill the referral forms out and send them off

AW: 03:58 ok so in this surgery it's more about verbally communicating the programmes?

PN2: 04:02 yeah

AW: 04:02 are you quite confident in doing that or would it help having…

PN2: 04:06 it certainly won't do any harm to have written information in front of us because sometimes there are time constraints and you know it would be useful to actually say you know go and read this

AW: 04:18 so again if you had something you could give out the patient could take that away and they have that with them. So, do you find that you have been provided with a satisfactory level of information about what each of the programmes entail to help you make an informed decision about what to refer onto?

PN2: 04:33, I think so., I think that's mainly because I've been doing it quite a while

AW: 04:39 ok and how are you informed about these services

PN2: 04:42 often you will be literature round, or if there is a new service it will come via, usually come via the practice manager

AW: 04:50 ah right, ok. So, the practice manager will inform you about what's available?

PN2: 04:54 yeah, and if there is any changes yeah

AW: 04:59 and what are your expectations of referring patients on to these programmes?

PN2: 05:04 erm, hopefully that they will get the support that they need. Appropriate guidance within the service, erm, and ultimately to encourage them to continue with the lifestyle changes.

AW: 05:21 so it’s not just short term. It’s about them being able to make these changes and sustain them?

PN2: 05:25 yeah

AW: 05:27 and what issues do patients typically present with that would make you, prompt you to make a referral?

PN2: 05:34 erm, oh, goodness me it could be all sorts. Erm, diabetes, erm ,weight management, erm blood pressure management, anxiety and depression you

know? Sometimes it's a social factor that are influencing, so there's quite a range really!

AW: 06:03 and does it tend to be, is it ever the patients who initiate that conversation, or is it you using your clinical judgement?

PN2: 06:10 no, no, patients come in and say I've heard about this, will you refer me?

AW: 06:15 oh, great!

PN2: 06:16 so we do, we do, not as many as we initiate, but we do get them that say I've done this, or my friends done this, and I would like to do it as well

AW: 06:23 so again there is an awareness amongst patients as well. Do you think that helps with you, obviously you have to communicate with them, do you think that helps with your time constraints?

PN2: 06:32, I think it does because they are much more aware of what the programmes entail

AW: 06:41 ok so the next section is going to be about constraints of patient referral. So, do you experience any constraints or issues when referring patients onto these programmes?

PN2: 06:50 no., I think, only with the refer, the referral criteria. Erm,

AW: 07:01 and that was for the LiveWell, particularly?

PN2: 07:03 Particularly the LiveWell. Erm, but we do occasionally get, erm, get them onto the exercise referral that actually haven't got any specific health issues that really would benefit from exercise and we can't always refer them on

AW: 07:27 you mentioned a little bit earlier about time constraints. Does that ever influence or make it difficult to refer?

PN2: 07:34 no, because we make time. Even if we give the information and kind of get them to sign on the dotted line, we fill the rest of it in later you know. It's just, it depends on the patient. Some patients are really easy erm, and some patients have every question under the sun and in ten minutes, we haven't got time. But we generally get around it. And if needs be, we will bring them back again and say you know " this is what it's going to do, but actually I'm going to have to bring you back to complete all the documentation".

AW: 08:12 so because you need their signature sometimes it's just a case of giving them that information

PN2: 08:18 yeah

AW: 08:18 so again it might be useful if you had a leaflet so they could take that away with them and kind of think about that. OK, in terms of the referral form, what are your experience of using the referral form?

PN2: 08:32 it's a referral form. yeah, it's fairly straight forwards. Erm, I've got a copy up there somewhere. What have I done with it?

AW: 08:48 and in terms of the patient measures, do you feel they are all appropriate?

PN2: 08:50 yeah, it's easy enough and then I've got LiveWell, somewhere. As forms go it's probably one of the simpler ones

AW: 09:02 oh, ok. So, no, issues or constraints in terms of the measures or the form at all

PN2: 09:09 no

AW: 09:10 great. And is there anything that eases the process of referral to the programme. You said, sometimes you get easy patients...

PN2: 09:22 yeah, I think those that are a little more willing to engage in lifestyle changes. Erm, sometimes you will refer people they will agree to it and then you find out down the line they have never turned up. Erm, but you know those that want to make changes

AW: 09:43 and how do you assess their willingness to engage?

PN2: 09:48 it's pretty much questioning whether they want to do something like that. Whether they want to go forwards with activity, exercise. If they think it's going to benefit them. Again, sometimes there's a cost implication with the exercise referral and best intentions we live in an area that is, we have a number of very low sort of socio-economic demographics around the area that just can't afford it. Even for, you know at that reduced rate, they just can't afford it.

AW: 10:26, but you communicate the cost implications to them, so they are very much aware of that

PN2: 10:31 I mean it's you know, essentially it's a bit of a bargain, but you know if you haven't got the money, you haven't got the money!

AW: 10:36 exactly and as you say if you're in a low socioeconomic area sometimes there's nothing you can do

PN2: 10:44 yeah, it's quite a high, I think Bridlington is probably one of the highest areas of erm, social deprivation on a similar par to Hull, but of course you don't get the funding that obviously the inner city's do in this area

AW: 11:00 so the fundings different?

PN2: 10:59 yeah

AW: 11:01 and do you find that many patients struggle with the cost? Is that a frequent issue?

PN2: 11:09 some of them do yeah. Some of them can, you know they will step back and look, and they will go away and think about it. Erm, but you know those that are willing to pay for it, they are quite happy to pay for it

AW: 11:25 erm, so the next section is about patient feedback, so do you receive any information about your patient's progress from any of the services you refer on to?

PN2: 11:36 oh, goodness I've not had any sort of major feedback for quite some time. Certainly not from the exercise referral erm, LiveWell, I think they do feedback. But to be honest it's been a while since I've actually had to refer onto the LiveWell, programme, so I've not seen anything come back for a little while.

AW: 12:03 ok and is feedback...

PN2: 12:04 I'm almost, I'm almost sure the last one I did though, I think we did get feedback and, I think it was quite positive so

AW: 12:13 ah that's good. And did it help you understand if a lifestyle change had been made?

PN2: 12:17 yeah, yeah, you know certainly if there has been weight loss and improved activity and erm, improved fitness

AW: 12:25 ok. So, they informed you about how much weight the patient had lost, if they had increased their physical activity and fitness

PN2: 12:30 yeah

AW: 12:31 is there anything else, any other indicators you would like to know about? Or are you quite happy with what they provide back to you?

PN2: 12:38 no, I think any, any feedback is useful whether they feel that the patient has benefitted, actually whether the patient has any plans to continue, you know with those changes

AW: 12:54 and in terms of, I'm just thinking off the top of my head, their plans to continue, how is that beneficial to you, knowing, say the programme has finished and you get feedback saying, they would like to continue...

PN2: 13:07 sometimes erm, we can refer back into the service again. So, we can make a second referral and sometimes its erm, helping them to decide which pathway they would like to go down, whether they would actually going to do that or whether they are actually going to go and get a gym membership of some description or whether they are going to continue off their own back. And it's useful, particularly for, erm, for like I say mainly for diabetics because diet and activity is quite a big...

AW: 13:46 and as you say it's all about, not just on the programme, but it's about sustaining that lifestyle change. So, for you...

PN2: 13:52 it's the sustainability of it. If they can't sustain it it's absolutely pointless

AW: 13:59 yeah, absolutely. And do you ever get any feedback from the patient. Do the patients ever come back in....?

PN2: 14:05 occasionally yeah, occasionally. Erm, they will say you referring me to exercise on referral or wherever or I've been down to health trainers or you know, signposted to whichever programme that has been most suitable for them. Erm, sometimes, occasionally you do get those who come back and say oh, it was a complete waste of time, erm others come back and they are really

positive and actually it has been really beneficial, and we will do the bloods and we will see the benefits as well

AW: 14:34 and how does that influence your referral in the future?

PN2: 14:37 it's certainly encouraging, isn't it?

AW: 14:42 especially if you hear...

PN2: 14:43 if it's been successful yeah, yeah, definitely

AW: 14:47 ok. Just on the last section. Sorry I'm trying to be as fast as I can.

PN2: 14:50 no, you're OK

AW: 14:52 In terms of support networks, do you have any support networks in this surgery to help manage patient load? So, what I mean by that, do you have any form of triaging system to help?

PN2: 15:03 erm not structured. But they, the guys on reception try to erm, allocate the most appropriate clinician for the tasks that there are

AW: 15:20 ah, ok is that telephone triage?

PN2: 15:23 it's mainly, it's mainly when the patient phones and you, they will say you know who they want to have an appointment with, and they will ask then well, you know this is something that the nurse practitioner or the practice nurse can deal with

AW: 15:39 ah, ok is it ever the case where if someone phones up and said, "I'm really wanting to do something about my weight" can they sort of signpost patient to programmes or would they make an appointment with the nurse?

PN2: 15:51 they would probably make an appointment with one of us

AW: 15:56 and does this practice engage with WebGP?

PN2: 16:00 No idea

AW: 16:01 it's called e-consult some people call it

PN2: 16:04 don’t think so

AW: 16:05 not all people do that's fine. It’s like an online tool where patients can pop in their symptoms and it kind of triaging them, but not all practices are involved with that

PN2: 16:16 not that I am aware of at the moment. However, erm, anything could happen with [Dr’s Name] because he is very keen to move forward with erm, alternative consultation availability really because the workload is just getting bigger and bigger so we've got to do something with it so I suspect it’s something that may come up in the future

AW: 16:42 yeah, something you can see maybe developing

PN2: 16:44 yeah

AW: 16:45 fab so that's kind of all the different areas I wanted to speak about. Is there anything that you'd like to add that you think is important about anything, anything to do with the referral process or feedback or constraints? Anything off the top of your head or anything you would like to support you in the future?

PN2: 17:02 erm, I don't think there's anything other than what I've already, what I've already said., I think it pretty much covers it.

AW: 17:12 Brilliant that's fab. What we are hoping to do in the future is develop as I say some kind of tool that's going to, because obviously there is so many different services and you need to remember all the criteria and it’s almost impossible. So, if we can create some kind of screening or referral tool so you can perhaps help erm, navigate patients to the most appropriate service for them, that's the hope. Erm, we are trying to push it to go online because

obviously there's a huge push for service referrals online now and so you can audit and look at referrals. Is that something that you think...?

PN2: 17:46 definitely I mean you know system one is pretty, pretty good, but you know even if it was an external link through a weight management or exercise management template where you could go on, click on the external link and it would take you to a website to actually you know. It's almost like the cardiovascular risk tools that you can go on and you put in all the information and then it spits out you know your answers. That would be really helpful because that will, if that includes all of the criteria that are required, it does take away a lot of needing to remember. It sounds really lazy doesn't it?

AW: 18:31 no, not at all

PN2: 18:32 trying to remember all this information

AW: 18:33 there's loads, there's loads of different ones. That was one of our, because obviously some people are using system one in the East Riding of Yorkshire, some people are using the, is it EMIS?

PN2: 18:42 EMIS yes

AW: 18:42 Erm, so if we can do, because it's obviously going to be really difficult to get it integrated into system one, if there is as you say some kind of external link, erm, we're hoping we can even pre-populate the form to save you spending time writing. Obviously, the patient consent signature will still be on this so it might need printing, erm, but we are making amendments all the time to referral forms so we might event take it off if need be, but that's sort of...

PN2: 19:11 that's certainly you know. And as well, what I would, what I would suggest is one form rather than having a LiveWell, form and an exercise

referral form, and whatever form, just put it on one form and send to the appropriate service

AW: 19:30 absolutely so some kind of system where you fill out all the details and then that system

PN2: 19:33 hit print off it goes!

AW: 19:33 decides this is the most appropriate, we are going to send them to LiveWell, or we are going to send them, yeah

PN2: 19:37 yeah

AW: 19:41 that's a really good point actually because you won't have to determine which one is more appropriate because the form will already do so

PN2: 19:48 yeah

AW: 19:51 brilliant thank you. Well, I'll leave you to crack back on now

AW: Interviewer Interview date: 06.12.2017

PN3: Participant Interview location: Willerby Surgery

AW: 00:01 is it ok if I take some demographics just before we begin?

PN3: 00:01 yeah

AW: 00:03 so what's your last name [PN's name]?

PN3: 00:04 its [PN's name]

AW: 00:08 u e r, and how do you spell [PN's name]?

PN3: 00:11 just like that [points to her badge]

AW: 00:14 yep

PN3: 00:15 [PN's name]

AW: 00:16 fantastic and how old are you if you don't mind me asking?

PN3: 00:17 oh, 54!

AW: 00:20 54 and you're a practice nurse?

PN3: 00:24 yes

AW: 00:24 do you have any additional roles within this surgery?

PN3: 00:26 no, just practice nurse, practitioner. General dogsbody

AW: 00:29 yep, and are you full time or part time?

PN3: 00:32 part-time

AW: 00:33 part-time. How many sessions do you deliver in general practice per week on average?

PN3: 00:39 it's three days. Er, so that will be erm two sessions a day

AW: 00:47 ok and how long have you worked as a practice nurse?

PN3: 00:48 7, coming up to 7 and a half years

AW: 00:52 has that always been within the East Riding of Yorkshire?

PN3: 00:55 yes, always here

AW: 00:58 fantastic and can I jot down an email address so I can send you your transcript?

PN3: 01:02 yeah, it's the same name. It's [PN's email]

AW: 01:13 fantastic. So, as I say the first section of the interview is focused on the healthy lifestyle programmes that are provided by the East Riding of Yorkshire. So, what programmes are available for patients in this locality that you can refer on to?

PN3: 01:28 we've got the LiveWell, and then the exercise on prescription which is the one we use the most

AW: 01:33 OK… So, you say you use exercise on prescription the most…

PN3: 01:39 yes

AW: 01:39 why is that?

PN3: 01:39 erm, we have got some very large patients, but quite often they're just, er, just not interested. I have referred on that, but they defaulted their appointments, didn't pitch up. Erm, and that might, time issue. Other ques... The LiveWell, programme is actually, on the paperwork it says that it has to be signed by the doctor.

AW: 02:07 OK

PN3: 02:08 so I then have to refer them to the doctors which they often don't do. It's not the doctors who doesn't do it, it's the patient who doesn't pitch up, you know? Sometimes I'll just, erm, hand the paperwork over to the doctor, you know? If it makes it easier, but I just really can't see a reason why I can't refer on that.

AW: 02:27 OK so for the LiveWell, programme, because you're a practice nurse, you're not able to do that referral?

PN3: 02:31 erm, I think there's one here somewhere

AW: 02:36 Do you think that should be something that's spread out amongst all clinicians? Should all clinicians be able to refer?

PN3: 02:42 well, there's only the practice nurse or the doctors, but on here it says quite clearly "name of the GP" which to me should be healthcare professional.

AW: 02:52 yep, on the LiveWell, form....OK and who do you think is best placed to refer in the surgery in your opinion?

PN3: 03:01 to be, in my opinion it doesn't matter who refers as long as the patient gets referred, and does the programme, and benefits from it. But the chances are, they are seeing either the nurse or the doctor here because there aren't really any other clinicians. I mean there's a phlebotomist, er, who's not in that sense a clinician as such. She just does bloods, nothing else. So, if she's got any concerns, she would see me, but generally speaking the ones she sees are already known to the GP or to me if that makes sense.

AW: 03:37 yeah, yeah. So, if any healthcare professional was able to refer, it would stop you from having to pass that on to the GP and make it a bit easier.

PN3: 03:43 yeah, yeah. Easier for the patient more than anything as well.

AW: 03:49 yeah, and do you feel you've been provided with enough information about the different programmes and what you can refer your patients to?

PN3: 03:55 erm, yeah, it's a case of getting the leaflets out, and read through, and find out what the body mass index requirement and all that. Er, we haven't got that much. Erm, exercise...., I think it would be useful if in the broacher, alright the LiveWell, one for the high BMI they are free, but like the exercise on prescription isn't free so it would be quite useful to have the price actually on the information.

AW: 04:29 ok so you can communicate that with your patient?

PN3: 04:31 yeah, at the moment I say well, it's round about, you know?

AW: 04:37 does that pose a problem to some patients?

PN3: 04:39 y, it has been mentioned yeah, yeah. But quite often they're the ones, I mean if you think about it logically, without being awful, they are spending a lot of money on food., I think majority of them living in this area could afford it, you know? Obviously, I am not sure about out of these boundaries where there is a bit more poverty and all that., I think generally speaking, this area...

AW: 05:08 in this area they, they can manage that cost?

PN3: 05:09 yeah, yeah.

AW: 05:09 so do you think it's more of a choice to spend their money on food rather than the programmes?

PN3: 05:14 yeah

AW: 05:14 OK and what issues do typically patients present with, that might prompt you to make a referral or to discuss the programmes with them?

PN3: 05:25 er, new patient medicals when we do the height and the weight. Erm, when they come for their annual review if they've got some chronic diseases. Erm, anything really! You can see you know when they're just a little bit overweight or whether they are seriously obese. It's visible, isn't it?

AW: 05:56 so there's plenty of opportunities?

PN3: 05:57 there's plenty of opportunity, yes.

AW: 06:01 OK so if we talk a little bit about constraints of referral. So, you've said, a little bit about patients sometimes struggle with the cost. The leaflets are not

really clear in terms of how much the programme costs either. Do you experience any other issues or constraints when referring patients?

PN3: 06:19 erm, let me just get this form out. I don't find this very user friendly at all.

AW: 06:25 Ok. Which form is that one?

PN3: 06:27 this is the exercise on prescription. This is the one that we do use the most and I understand from talking to er, Sue at Haltemprice that our surgery has got quite a high referral rate compared to some others and, I think that's why she put you in touch with us hasn't she?

AW: 06:44 absolutely yes

PN3: 06:46 so we do try really hard. Erm…

AW: 06:51 you are one of the top referrers which is fantastic and obviously we know that you really do engage with the exercise referral. But we know that the process can be improved. So, when you say it's not user friendly, what about it isn't user friendly?

PN3: 07:04 well, reason for referral. I find it quite offensive that it says patients got to be inactive before they ought to be referred.

AW: 07:15 Ok. Why is that?

PN3: 07:19 because there is quite a few obese people who are not inactive. You know?

AW: 07:27 that could still benefit?

PN3: 07:26 yet they would still benefit wouldn't they? Erm, I mean there are some, yeah. I mean what is inactive these days, you know? Is it sitting in a chair all day, but you're still out and about isn't it. People still go out to work. That doesn't make them inactive, isn't it? They just don't do any sport, they don't look after themselves. So, this is always a bit..., I think the reason for referral and the medical history, it's almost double, isn't it? You're putting the same thing in both boxes....

AW: 08:02 Ok. So, in terms of duplication, can you identify any duplication where it's sort of similar thing, or the same sort of thing that the forms asking? Anything in specific that we can improve?

PN3: 08:21 for example, the blood pressure for starters. I mean, I think that should be checked at the time when they get their induction because I might check it today, I give them the form to take in, I mean they might not take it in for three or four weeks, you know? So, therefore it's not up to date anymore., I think medical, reasons for referral think they tie in with the same things, isn't it?, I think if you would put another box with heart trouble or stroke, erm, this could all be one box. And it's not very clear who is supposed to hand the form in

AW: 09:08 ok

PN3: 09:09 once the form is completed, send to the instructor. Is it the patients' role? Is it our role? I always think well, if they're inactive and they want to lose weight, they can walk there themselves and hand it in (laughs). But it's not very clear, is it?

AW: 09:22 so there needs to be clarity in terms of er, who takes the form in. Clarity in terms of, what is inactive? What does that mean? And also you say the reason for referral and the medical history, a lot of that is duplicated.

PN3: 09:36 well, yeah, if you look here, depression, depression, hypertension, high blood pressure, diabetes, diabetes. You know?

AW: 09:46 yeah, all the same things. How does this form compare to some of the other referral forms that you, that you send for different places? ... Is it sort of similar layout?

PN3: 09:58 I don't tend to use any others really because all the other referrals the secretary tends to do electronically so there's very few referrals these days that still get done pen and paper.

AW: 10:10 does that pose a barrier because it is pen and paper?

PN3: 10:13 not to me, but I could imagine to some of them do. I mean I am still old school and I'm quite happy with pen and paper, but, I think the younger people would probably prefer electronic referrals. And then of course if you're doing it electronically, it leaves like an audit trial as well, doesn't it?

AW: 10:31 absolutely

PN3: 10:33 which pen and paper is a little bit more difficult

AW: 10:35 is that useful to audit the referrals you're making?

PN3: 10:40 yeah, yeah. Anything that leave the premises, there should be some kind of a trial where it's gone, isn't it? I mean yes, I put on the record, you

know er passed referral to patients to hand in sort of thing, but er it looks a little bit don't know, like I haven't done my job properly sort of thing (laughs). Sorry I'm just muddling this up while...

AW: 11:03 that's fine. In terms of the info, I see you've got a LiveWell, information leaflet there, what's your overall, sort of opinion of that leaflet? Is it helpful? Is it something that you give to your patients?

PN3: 11:18 yeah, yeah, absolutely, yeah, yeah. I discuss it with the patients, I give it to them. I take that off and I give that to the GP [referral form] then to be signed.

AW: 11:31 so in your opinion, is the LiveWell, referral form, is it better than the exercise referral form?

PN3: 11:37 yeah, I think it is apart from that the GP has got to sign it. Think I remember that Jim [practice manager] has had a few issues with it hasn't he?

AW: 11:50 yeah, a few. Unfortunately, because he's a practice manager, I've not been able to use that data. However, I have recently made amendments to my ethics so I can now, if he was willing to, I can go back and use his data, with his consent obviously.

PN3: 12:06 yeah, yeah.

AW: 12:09 and do you feel that patients are educated enough on the programmes, or is it a surprise when you first mention it?

PN3: 12:19 yeah, yeah, seems to be a surprise., I think what I've, what I've find, what happens a few times in the past is either haven't told me, and I've had

that before. They haven't told me that they have accessed that programme before so I then got a message back to say they have done it once, they can't do it again. Or I've done a referral and then it comes through in the discussion when I am right at the end, oh, I've done it before once I remember, you know? And they only entitled once and, I think for people who have got low self-esteem issues, when they are so obese, I think everyone deserves a second chance

AW: 13:06 ok

PN3: 13:06 if they then haven't done on the second chance by all means you know, two strikes you're out sort of thing, but, I think just on one chance, erm you know? If the weight has crept back up again, I think they should be able to have one more chance or if they've stopped half, I mean I've had one lady which fortunately Sue, er was very good about it. She actually was half way through the course when she had done herself an injury and she couldn't physically do the exercises anymore so she dropped out. So, then after that problem has healed, I think she hurt her shoulder or leg or whatever it was, she came back for me to be re-referred and officially they weren't allowed to accept her which, I think its

AW: 14:01 so you think it’s a little bit harsh that they can only have sort of one go

PN3: 14:05 yeah

AW: 14:06 and why do you think some people complete the programme and come for another referral?

PN3: 14:10, I think it's because they, they, they have been in a bit of a cloud really., I think they thought one session would, you know, be the answer to it all and weren't prepared to keep the work up sort of thing., I think the idea is that they would maintain it. That they would then join the gym and carry on, but some of them just don't, do they? The course finishes and that's it. I do believe, but then again, that's only something I have found out by talking to other people, there's no, no, guidance that they do get some support after., I think they get a phone call about 6 months down the line or something, but that's not something which was made available to us, that information.

AW: 14:53 so that's just information that you have found out by talking to people?

PN3: 14:54 yeah, yeah., I think it was a letter actually when I picked up that somebody had been referred and erm, sort of, I must have been looking for something in somebody's notes, another letter, and found out that they were offering referral, follow up visit

AW: 15:16 so how are you informed about the different programmes?

PN3: 15:16 sorry say that again

AW: 15:19 how are you informed about the different programmes?

PN3: 15:23, I think, well, it's difficult to answer that because you don't know what I should have been told and what other people get told. I just literally got this letter

AW: 15:35 right, ok

PN3: 15:36 actually says on there, £33 to the patient, but that was 2015

AW: 15:41 right, ok is that feedback? Or was that just general…

PN3: 15:41 no, that was a letter for the referral

AW: 15:49 ah right, ok so a little bit of an information letter?

PN3: 15:49 yeah, so that's it that's all I got and all the pamphlets and all the leaflets

AW: 15:55 and as you say that was in 2015 so quite a significant time ago

PN3: 15:59 that's right and I've not had an update about the prices or anything and before the 2015, I didn't even have that price

AW: 16:10 right, ok. And how would you like to receive more information if they were able to provide that?

PN3: 16:18 well, official way should be via email shouldn't it, but I don't check my emails every day at work. A letter to me would be, I'd be quite happy about.

AW: 16:26 yeah, OK. Is there anything else in terms of constraints that makes referral difficult? So, we've mentioned passing it onto a GP, that's sort of a constraint because you can't fill it out yourself. Some of the measures that you've got to take, blood pressure for instance, you don't think is entirely relevant. Is there anything else that sort of, anything else that can be improved with the=at process?

PN3: 16:48 hmm, I can't think of anything at the moment.

AW: 16:54 OK

PN3: 16:56 I mean we only get ten minutes to do the referral you know? So, they like to talk about their problems of course so ten minutes sometimes isn't enough. So, if we could keep it to the minimum, what is required, to be able for them to access. I mean that would be better for us because you know what it is like in GP land, there's hardly any appointments spare anyways. So

AW: 17:22 the less you have to do on the form the better?

PN3: 17:24 yes

AW: 17:24 as you say within ten minutes you're quite constrained

PN3: 17:29 yes, because they will tell you about all the excuses. Why they haven't been able to exercise. Why they've got to the weight they are, you know?

AW: 17:37 as you say a lot of them don't really know about the programmes so you've got to sort of explain that

PN3: 17:41 that's right yeah

AW: 17:43 do you think it would help if patients were better educated on what's out there?

PN3: 17:44 I don't think it would make much difference, no.

AW: 17:46 OK. So, onto the next section a little bit about facilitators. So, is there anything that would make the referral process more smoother or more streamline?

PN3: 17:58, I think I've covered that, what we've just been saying, isn't it? Sorry if I'm not giving you the right answers [laughs]

AW: 18:06 no, no. It's fine you are absolutely

PN3: 18:09 it's keeping an eye on the time as well, because I've got my babies coming at 2 o clock

AW: 18:13 how long have we got? Have we...

PN3: 18:15 we've got ten minutes left

AW: 18:15 that's fine

PN3: 18:15 will that be enough?

AW: 18:16 yeah, yeah, absolutely so I'll move onto feedback. Do you receive any feedback in terms of your patient's progress on any programmes?

PN3: 18:25 not really no. Not me personally. I believe there is sometimes a letter going into the patients notes, but erm unless I see it by chance, er then no

AW: 18:37 ok so it's not something that is brought to your attention?

PN3: 18:39 no

AW: 18:40 and what involvement would you like in terms of patient feedback?

PN3: 18:43 it would be quite nice to find out if people are erm, you know, how they're doing or if, if they have found it beneficial when they completed the course.

AW: 18:54 is there anything in specific that you'd like to hear in terms of feedback?

PN3: 19:02 it would be nice. I suppose, at the end of the day it doesn't really matter as long as the patient loses the weight, isn't it? And gets more erm, you know, gets the joints moving better, do the exercise sort of thing, you know?

AW: 19:19 so it's about them being able to, as you say, lose the weight and improve conditions that they already have

PN3: 19:28 yes. Yes it would be nice, but I am always mindful that, you know, everybody's busy. That would mean that somebody has to type up a letter to address to me to say you know Mr Block has lost ten kilo and can walk a little bit better now sort of thing you know? But. But if they do a letter to the GPs, you know, if they could maybe just copy me into it or something like that, you know, and they would pass it round. But if it just says to [Dr's Name] then it wouldn't get passed onto me, isn't it?

AW: 19:56 right, ok so if it was electronic and in the patient record, you would be able to sort of access that if you needed to?

PN3: 20:03 yeah

AW: 20:05 and what do you think about it being electronic? If the full process was online, would that be something that would be easier do you think?

PN3: 20:12 if the software is easy enough to use, yes!

AW: 20:15 OK. What would make the software useable? What's the ideal?... In an ideal situation, would it something that had to be compatible with your systems?

PN3: 20:26 well, it would have to be compatible with EMIS yes.

AW: 20:35 fantastic. That's all the different areas I wanted to cover. Is there anything else that you would like to add that you feel is relevant or important? Anything about referral, what makes it easier, what makes it difficult, or any improvements, or do you feel we've pretty much covered everything?

PN3: 20:51, I think we've covered everything really.

AW: 20:54 yeah

PN3: 20:54 yeah, I mean out of it all, it works, you know? I just think it's just the form it's a little bit, 'oh, I've ticked that before, and now I'm ticking it again' and yes, why do I need to have a GP to decide that this person is severely obese sort of thing, you know? I mean if there's any health concerns that, I think that the client would be at risk by doing the exercise, then I would run it past the GP anyways

AW: 21:20 OK. And why do you think this area, well, this surgery in particular, why do you think you've got such good referral rates?

PN3: 21:31 because we're just good (laughs)

AW: 21:31 because you're just good? (laughs)

PN3: 21:35, I think it's because we are perceptive of it, you know? It is there, it is available. If you don't use it, you lose it and if it helps people then then the better, isn't it?

AW: 21:48 have you found that it has been successful for many patients?

PN3: 21:50 well, patients do like it, but they don't often keep it up after

AW: 21:55 ok so there's is that problem sustaining that. As you say if they are able to be referred again, then they've got that second chance to see if they can really sort of change themselves

PN3: 22:05, but there has got to be a cut-off point, you can't keep referring, referring, referring you know, but, I think one more chance would be…

AW: 22:14 yeah, just give them that benefit of doubt sort of thing. So, is it something, it's obviously very valuable to you because you use it quite a lot. Is it stressed amongst all the clinicians that you need to use it? Are you all sort of positive about it?

PN3: 22:27 yeah, I think pretty positive about it yeah

AW: 22:31 fantastic and in terms of this surgery, do you have any support networks to help manage your patient load? So, do you use any form of triaging or the WebGP, the online sort of consultancy?

PN3: 22:47 we don't use WebGP here, no. Erm, triage not for the nurse's appointments as such. The receptionists use it for GP appointments, but not for nurses no. If they're in doubt then they just come and ask me

AW: 23:03 right no problem. Fantastic. Well, that wraps up the end of the interview. What I will do is type this up in a transcript and send you it through email for you to verify that. Thank you for your time today

PN3: 23:15 well, I don't know how much use that has been for you really because you know...

AW: 23:17 no, it has! My concern was when I spoke to you and Jim last week, you was telling me such fantastic things, but because it was, because it was sort of a focus group because there was more than two people, I couldn't use the data which was really frustrating because I really wanted to put some of these really important points across

PN3: 00:19 well, Jim is looking, he is a manager, isn't it? He looks at it from a completely different angle

AW: 00:25 yeah, absolutely, you're a user

PN3: 00:27 you know I just look at it from the patients, you know? He looks at it from the clinical governance point of view and everything, isn't it? So, he will look at it from a complete different way

AW: 00:43 it was just really useful because what I have found is quite a lot of the practice nurses I have spoken to, I think they are a little bit complacent so they will say oh, it's fine because they have to do that so that's their job, but they are not very critical of it. Obviously, when I spoke to you and you said, well, "what is the point of taking blood pressure!?" It makes us think well, what is the point? Why have they put it on there? So, it's something that's useful for us and if we can take that off, then it's going to be better. I meant to ask you, I forgot, about the patient signature, do you think that's sort of useful?

PN3: 01:18, I think it's good because it brings it home to the patient that they have got responsibilities. I mean, if I wanted to be really awful about it, why can't the patients self-refer to that?

AW: 01:37 ok, yeah.

PN3: 01:37 why does it need to be a health professional? Why does it need to take ten minutes of a GP surgery when we are so, we've got little available appointments available. I mean at the moment I am the only nurse out of three working. So, if I was have somebody, a person popping who doesn't even get a chance to get an appointment with me at the moment, and if I do get somebody on an exercise on prescription at the moment then you think right, ok, is this something really urgent that you needed to book this appointment when somebody maybe needs a dressing changing or an injection and can't get in because you've booked exercise on prescription, you know?

AW: 02:24 absolutely yes. So, if it could be self-referral....

PN3: 02:27 yeah, I mean I really can't see why, you know, it can't be self-refer... I mean smoking cessation is now self-referral

AW: 02:36 absolutely yes. Did that use to be GP referral or has it always been self-referral?

PN3: 02:40 it's been self-referral for a while now yes, definitely

AW: 02:44 and is it easier to signpost rather than...?

PN3: 02:46 yeah, we just give them the leaflet

AW: 02:48 yeah, so there's no, referral forms

PN3: 02:51 so I really didn't see why this could not be done self-referral. You know, that we give them a leaflet, you know, that East Riding would supply us with a card or whatever and you know it could have all the details you know if your BMI is above 45, this is your pathway, you can do that. Below, exercise on prescription yeah, it's available, you're entitled to it, there's a telephone number, book an appointment.

AW: 03:17 patient books that appointment yeah. I will have to obviously bring it up. I don't actually know why it's not self-referral. I don't know if it's because of some of the medication they are on. I don't know why.

PN3: 03:29, but if they are on medication then they should all have a repeat prescription list for medication. They could just bring that along to the appointment couldn't they?

AW: 03:36 absolutely yeah

PN3: 03:38 and this is you know, we need to do the height, the weight, and the blood pressure erm like I say I have got no, control, I'll check it today, but I have got no, control when they go and book that appointment. They could have lost 3 kilos, they could have put half a stone on by the time they get there so that measurement is not really up to date any more

AW: 03:59 absolutely so if anything it's pointless, pointless doing that in the first place

PN3: 04:03 yeah, it is.

AW: 04:05 ok fantastic well, I'll let you go because you've got your babies coming in

PN3: 04:09 I can't hear them yet, but they'll be on route!

AW: Interviewer Interview date: 16.04.2018

PN4: Participant Interview location: Eastgate Surgery, Hornsea

AW: 00:02 brilliant thank you very much and I'll just scribble on my side. April already! Where is this year going?

PN4: 00:25 I was listening to the radio coming in this morning and Chris Evans said, in 7 weeks it will start getting darker again and you think shhh!

AW: 00:35 I know as soon as its 6am, I'm wide-awake. The sun comes up and it drives me insane. So, just before we begin, just a few introductory comments. So, the purpose of this study in to gain a rich insight into people who are referring onto the East Riding of Yorkshire healthy lifestyle programmes so programmes such as the LiveWell, scheme, exercise on referral, health optimisation. So, this insight will help sort of highlight what the gaps are, or the constraints in the current referral process and we are looking at making that process as streamline as possible, so it is as easy as possible for you to refer to try and preserve some of your consultation time. So, just a note on confidentiality, anything that you do say today will remain strictly confidential, and only myself and the research team will have access to your transcript. You have several rights as a participant, so your participation is completely voluntary and if you have got any questions at all during the interview, feel free to ask. And if there's a point where you don't want to comment on a question, just say no, comment and we will move on if you find it too uncomfortable, but I assure you it won't be uncomfortable (laughs)

PN4: 01:43 Oh, my god (laughs)

AW: 01:45 likewise, if you want to be withdrawn from the study at any point, let me know and we will destroy any data that we have collected from yourself. Does that all sort of make sense?

PN4: 01:53 absolutely

AW: 01:52 brilliant. So, the interview is going to be centred on five key areas. So, the healthy lifestyle programmes that are available in this locality for you to refer patients onto, the information resources that you are provided with, or the referral resources, any issues or constraints or challenges that you have faced in the past as opposed to issuing a referral so that could be on the patients behalf if, for instance, they have no, motivation. It could be a problem that you've experienced with the forms, anything in terms of the whole referral process. Fourth is the feedback that you received from the programmes so whether you do receive feedback or not, and in an ideal world what you would like to hear back from the schemes. Finally, if there's any support networks in this surgery so if you use any healthcare assistants or community link workers to make the referrals or it might be that yourself and the GPs refer. So, that depends, varies from surgery to surgery.

PN4: 02:49 yeah

AW: 02:51 so they are the four, five key areas sorry. Do you mind if I take some really demographics before we begin?

PN4: 02:58 no, that's absolutely fine

AW: 02:58 fab. How old are you if you don't mind me asking?

PN4: 03:01 59

AW: 03:02 59 and what is your role within this surgery?

PN4: 03:06 erm practice nurse

AW: 03:08 practice nurse. Do you have any additional roles?

PN4: 03:09 nope

AW: 03:11 brilliant. And are you considered full time or part time?

PN4: 03:13 part time

AW: 03:14 part time. How many sessions do you do ion general practice per week?

PN4: 03:18 erm, 5 yeah, it's 4 and a half days

AW: 03:26 yeah, 4 and a half days. And is it just this surgery in which you work?

PN4: 03:31 no, it's also Aldborough and Hastings in the mornings

AW: 03:38 Aldborough and Hastings. Is that far from here?

PN4: 03:40 Hastings is Calvert Lane and Aldborough is obviously

AW: 03:47 ah Calvert Lane, Hull?

PN4: 03:48 yeah, outside the Hastings pub

AW: 03:49 right, okay dokey and how long have you worked as a practice nurse?

PN4: 03:53 for, 2013, so for 4 plus years

AW: 04:01 yep, and has that always been within the East Riding of Yorkshire?

PN4: 04:02 erm, for that particular practice yeah

AW: 04:06 brilliant I have your email

PN4: 04:08 I have been a practice nurse for a lot longer, but erm.

AW: 04:12 Outside of the East Riding of Yorkshire? Where did you work previously?

PN4: 04:13 I was in Bridlington

AW: 04:17 ah right, ok

PN4: 04:17 Manor House Surgery for about 12 years and then I worked in Dublin as a nurse manager for the out of hours.

AW: 04:27 ah fantastic. I went to Manor House the other week actually. I was interviewing somebody there.

PN4: 04:29 oh, did you?

AW: 04:32 yeah, because the research in targeting the whole East Riding of Yorkshire so we trying to get into every single surgery

PN4: 04:37 each practice

AW: 04:37 or at least from each area. That's why I was really keen to get into Hornsea because I hadn't spoken to anyone from Hornsea

PN4: 04:41 Manor House was the first practice to start doing exercise on prescription in Bridlington

AW: 04:47 ah was they really!

PN4: 04:48, I think Withernsea were the first practice to take it on board altogether and then we were the first one in Bridlington

AW: 04:54 god and you're the highest referrers, well, Bridlington are the highest referrers onto the schemes.

PN4: 04:59 yeah, yeah

AW: 04:57 so they are very keen to push everybody through. Fantastic so can we start off by exploring what programmes are available for you to refer patients on to in this area

PN4: 05:11 so I suppose exercise on prescription would be the most common one. Erm, living well, I have seen the referrals, but don't refer myself

AW: 05:23 yep

PN4: 05:23 erm, there would be the two really

AW: 05:29 yeah, they are the main ones?

PN4: 05:29 and then health trainers were the other thing that I use an awful lot.

AW: 05:31 yep, so you've said, you use exercise on referral, that's the most common one. Why is that the most common?

PN4: 05:41 erm I suppose that's the one I know the most of and particularly, I, I deal with most of the diabetics in the practice, so they are the ones that benefit the most from going onto exercise on prescription

AW: 05:57 so the patient, patient group you see are more eligible for the exercise on referral

PN4: 06:01 yes. And from a diet point of view, if we are looking for that, then I would be referring them, well, I do automatically, they all get automatic referral onto the Living with Diabetes course you see so

AW: 06:12 ok. Is that something like available within the East Riding of Yorkshire?

PN4: 06:17 no, no. It's in hull as well

AW: 06:19 ah it's in Hull as well

PN4: 06:27 so everybody who has diabetes within Hull and East Riding, when they are diagnosed they are referred onto...

AW: 06:40 oh, that's really good. Is that to increase their understanding of...?

PN4: 06:43 understanding and awareness of food and how it impacts on diabetes. They actually take a huge box full of plastic food and actually show people

AW: 06:52 do they really?

PN4: 06:51 yeah. It's absolutely fantastic

AW: 06:55 that's fantastic. Am I ok to keep this? [Leaflet for living with diabetes]

PN4: 06:56 yes, I have a whole pile of them over there

AW: 07:00 so they are automatically given that scheme

PN4: 07:01 yes

AW: 07:01 and how do they respond if you suggest exercise on prescription?

PN4: 07:05 erm, it would be the ones that actually want it that are, you know, so they respond really positively. I always talk about exercise, but a lot of people will say no. So, in that case you would be looking at what they could do. So, walking would be the majority of the things that we would you know, sort of recommend to people that they start and that they can always come back to us if they want to do exercise [on prescription]. They can actually come back to us, erm, here.

AW: 07:42 yeah, so you give them that sort of option so this is what's available, and if they are not interested, ok let's explore some other ways that we can manage that.

PN4: 07:50 that's it. I mean recently they have started chair aerobics on a Monday at the floret hall and that is really, really popular. About 70 people do it at the moment

AW: 08:03 oh, wow chair aerobics. That's really cool

PN4: 08:07 because when you think people retire to the coast, so they are not 100% wanting to do the gym so

AW: 08:15 so are they typically an older population?

PN4: 08:16 it's a typically older population yes

AW: 08:21 that's a really good point. If they retired here, they are not going to want to do a lot of exercise. They want to be relaxing!

PN4: 08:27 and I know years ago in Brid [lington], we actually use to, Wednesday mornings was over 50's. Erm, and erm it turned out it was mainly over 70's that attended, but it was called the over 50 and they use to do things like table

tennis erm, walking football before it ever existed and sort of a bit of chair aerobics then and sort of couples could go together which was really nice

AW: 08:53 they have always been very keen to get everyone active

PN4: 08:55 yeah. Honestly, the old sports hall was absolutely brilliant for that. We worked really closely with them

AW: 09:04 are they as keen in this area do you find?

PN4: 09:07 erm, I think they are. I don't know them as well, over here

AW: 09:12 ah right, ok. Is that the leisure centre staff?

PN4: 09:16 that's the leisure centre staff. I probably do know them as patients [laughs], but...

AW: 09:22, but not as leisure centre staff [laughs]

PN4: 09:25 not as leisure centre staff

AW: 09:26 do you think it would help if there was more of a collaboration between the leisure centres and general practice?

PN4: 09:29 yeah, I feel that would be lovely

AW: 09:34 so how are you made aware of the programmes? You said, you are really knowledgeable of the exercise on referral, but not so much so the LiveWell. So, how are you made aware of what's available?

PN4: 09:44 erm, it would come from erm, [Practice Manager], or from the GPs

AW: 09:53 OK. So, not necessarily from the leisure centres themselves. It will be from your practice manager or the GPs

PN4: 09:58 yes, yes

AW: 10:00 and what's the process of referral in this surgery? So, do the GPs sort of delegate patients to you or are they also referring?

PN4: 10:09 no, GPs will also refer cuz they will just send automatically, send to the typist, you know, fill in the forms, send them off so that's why, and not as much comes our way so

AW: 10:25 that's good because that's saving your consultation time

PN4: 10:27 yes

AW: 10:27 and obviously you refer yourself

PN4: 10:32 yes, and that's how I become aware of the Living Well, because I've seen other patients who have been referred. Hang on, what's that?

AW: 10:40 what is that programme? [Laughs] Do you feel that you've been provided with enough information or is there anything you'd like more information on?

PN4: 10:46, I think the other programmes that are around, you know? To be aware of everything that's out there for patients er is excellent. Like the health trainers, the health trainers actually came in one day and spoke to us all so that was really good

AW: 11:05 is that something you would like to see arrange from leisure if possible?

PN4: 11:09 yeah, that would be great!

AW: 11:14 brilliant. Is there any other way you would like to receive that information? So, if it's not possible for them to do a training day, how else would you like to receive the information?

PN4: 11:23 I suppose in leaflets and things like that I mean, usually, someone been typing, I've always got a handful of leaflets so

AW: 11:37 so they are always handy for you to use

PN4: 11:38 yeah, and, I think that you can, whilst you've got somebody in and they are motivated, erm, particularly with a new diagnosis, it's great to be able to

give them something and say just give them a ring up! Shall I just send a referral for you?

AW: 11:51 absolutely, yeah. So, as you say it's important to judge their motivation, but it's easier to get them just as they have been diagnosed.

PN4: 11:58 that's right!

AW: 11:58 why do you think they are more motivated if you get them in that early stage of diagnosis?

PN4: 12:01, I think, it balances off the negativity of the diagnosis. So, you go in, I'm really sorry to tell you, you know, you've been diagnosed with diabetes, or you know, pre-diabetes, because we do see an awful lot of those as well. And they want to do something about it because they don't, they don't want to end up on insulin. They are always convinced that the moment they are diagnosed, they think 'oh, I don't want insulin, so I'll do something about it'. So, I think they are, and I would say a good 60 % are motivated to change their lifestyles at that moment.

AW: 12:47 yeah, so a good proportion, probably as you say because of that fear factor cuz they don't want to go on insulin for the rest of their life

PN4: 12:54 yeah

AW: 12:54 er we have some LiveWell, booklets. I can arrange for [HLO's name], so she's the programme co-ordinator to have some delivered

PN4: 13:03 that would be brilliant

AW: 13:04 yes, I will speak to [HLO's name] cuz erm they are a lot of leaflets and it would be great if we could share them and then obviously then you'll know more about them as well

PN4: 13:13 that's it

AW: 13:12 so yeah, I will get that arranged. So, are you as confident issuing lifestyle referrals as you are medical referrals?

PN4: 13:24 I'm more confident doing a lifestyle referral than a medical referral. If it was for a medical referral, I would actually pass that on for a GP to do

AW: 13:33 right, ok

PN4: 13:35 so I suppose sort of my training is doing lifestyle

AW: 13:44 yeah, so because of that training you're a lot more confident issuing lifestyle referrals

PN4: 13:45 and from that, it's not just diabetes. I suppose when looking at COPD, when looking at, sort of, we refer regularly into pulmonary rehab for, for respiratory problems so

AW: 14:03 so we've talked a lot about diabetes, and about respiratory problems such as COPD, is the, what sort of issues do patients present with where you find well, actually a lifestyle referral might be beneficial? So, you've said, a lot of it is diabetes because you're obviously the diabetes nurse

PN4: 14:18 that's it yes

AW: 14:20 is there anything else?

PN4: 14:23, I think some of it is opportunistic as well, because they will be coming in probably for a blood test or a blood pressure check and so at that stage you take any opportunity that you can to sort of suggest lifestyle changes that, you know? Even, even probably patients new to the practice who are coming in, to be able to refer them to exercise, erm, or into community activities, it can bring them into a community. You know? If you have just retired here having spent 40 odd years of your life in the same community and suddenly you move to the coast, and you are suddenly out on a limb because you don't know

your neighbours, your family are probably are still all over there. It's lonely and so leisure activities in particular are a way of getting people into a community.

AW: 15:28 yeah, absolutely. So, it's not just, as you say it's opportunistic. It's not just when they are diagnosed, and you make a really good point that actually, it's not just about the physical benefits, it's also psychological, getting them into...

PN4: 15:42 it's psychological absolutely

AW: 15:44 the community and I guess one of the big issues with over 75's, and the elderly is loneliness. It's one of the key issues

PN4: 15:52 it is, it is

AW: 15:54 that it's going to help combat as well. That's really interesting. Brilliant. So, that's everything in terms of the healthy lifestyle programmes that are available. Next, I'd like to speak about any challenges or constraints or any improvements that you would like to see to that process. So, have you ever experienced any challenging when attempting to refer somebody onto any of the programmes?

PN4: 16:15 some people might not want to participate, but I don't think that's a challenge., I think you can then give them the information, let them take it away and say look come back to me if you change your mind and we can sort something out for you. Or like in the case of the health trainers, we can give you the free phone number and then it's, so you're not putting up a barrier. It might not be the right moment for them to do that change, but you can facilitate it. I don't think there are many challenges as such. Occasionally, probably, I suppose the only challenge would be finding something that will

suit certain people. So, if you are riddled with arthritis, your mobility is poor, two gym session a week is not going to do anything for you so it's looking at sort of, is there anything? And probably something like that maybe doing aqua walking. So, are they going into the pool and doing aqua jog or whatever and they are actually moving in water. So, it, it's suiting the activity to the person as well. Or like in Brid[lington], they have just had all the bikes on the seafront so that it doesn't matter what state of physical ability you've got, you can now hire a bike and ride all around the sea front. You know, they have got the three-wheelers and all sorts now so, it is, it's' things like that that change and it's looking at the individual. It's tailoring it to that particular person

AW: 18:09 absolutely so even if patients are not necessarily committed at that time, in your opinion that's not a barrier, that's an opportunity to increase their awareness, let them know what is out there, and then it's their choice if they want to come back. One of the issues perhaps could be if they have a condition that limits their ability, but as you say, it's knowing what's available.

PN4: 18:31 it's knowing what's available. There should be no, for me, physical activity, there should be nothing that prevents you from doing it, but its finding what suits you.

AW: 18:42 absolutely, yes, and I guess if the leisure centres were able to communicate what they offer the you'd have more of an understanding of what they can do. Because I know, they have got, for instance, people with amputations and they are able to put them in the swimming pool. For the LiveWell, programme, you have to have a BMI of over 45 so that population have a lot of associated medical problems and I know a lot of the time they get them in the pool. So, they don't necessarily do a gym class, it's more sort

of aqua aerobics, but again if that's not sort of communicated to you guys, you're not able to tell patents

PN4: 19:15 how can we tell them?

AW: 19:17 absolutely so there definitely needs to be that bridge of a gap, I think. And again, if they were able to communicate more than they are going to get

PN4: 19:26 they will get more referrals

AW: 19:29 absolutely. So, when you are referring somebody onto exercise on referral for instance, are you using the paper referrals or the online referral system?

PN4: 19:39 well, it's a paper referral. We do it online, but we give it then... The two ways it works within this practice is that I would give the paper referral to the patient because it's something for them to sign, and then they take that off. Again, it's giving them that, they have got to, you know, they have got to want to do it so I can give them a paper referral, they've signed it, I've signed it, but it's up to them then to take that physical piece of paper onto East Riding

AW: 20:14 absolutely and I guess that shows their commitment. If they want to do it, them patients are going to be the ones who take it to there.

PN4: 20:18 yeah, that's it

AW: 20:21 so what's the second way? You've got your sort of physical paper form that you hand to them. How does it work on the system?

PN4: 20:26 the GPs will actually, I think it just automatically goes through electronically. So, they will just erm, send a message upstairs, this person needs a referral, and the secretaries would produce that referral and send it off so that's not really as such a contract with you and the patients. That's then

going to come, I would think, I don't know, East Riding will then get in touch with them and say, we have received a referral from your GP.

AW: 21:00 yeah, yeah.

PN4: 21:02 how would you like to go about it

AW: 21:02 fantastic. So, the electronic one, I'm not sure if you'll be aware, is it a separate online system that they log on to or is it a form integrated into the system?

PN4: 21:12 I presume it's the form, but..., I think so anyways

AW: 21:16 and are you using EMIS or Systm1?

PN4: 21:16 EMIS

AW: 21:19 EMIS fab. Brilliant, so in terms of the paper referral form, in terms of what it is asking you, do you find it's all appropriate?

PN4: 21:30 yeah

AW: 21:30 I have an example one

PN4: 21:30 yeah, yeah, no, yeah

AW: 21:33 no problem, that's fine.

PN4: 21:40 [someone walks into the room]...

AW: 21:55 sorry I forgot what I was going to ask you. My minds gone blank. So, in terms of the patient signature, is that something that's common practice? Is it something that you...?

PN4: 22:06 I like that because as I say you are picking up on their commitment, so they need to want to go and do that

AW: 22:17 so for you a tool for you to measure that and you don't mind collecting...

PN4: 22:20 that's it

AW: 22:20 fab. So, a little bit on the facilitators of referral. So, we've not actually mentioned that many problems as such. It's' quite nice that when you are faced with what some people might call a problem, you flip it on its side and say well, actually it's not a problem because x y z. But is there any improvements generically that you would like to see to the referral process?

PN4: 22:46, I think it would be nice to have feedback. To be able, you know, that they actually tell us that people have completed the programmes. I mean I know there is a confidentiality thing, but, I think they should be able to just let us know that so and so is on a particular programme, whichever the programme is. Because then we are aware, you know? And at times it's nice to say, "well, done you've been on that" so it, it can be positive. It can also be, I suppose from the patients point of view, negative if they didn't take it up for whatever reason. The next time they come into clinic, because I see them on a fairly regular basis, I will be able to see oh, so, not sort of blaming them, but saying, what was it, why couldn't you attend? So, it would be nice to have that sort of feedback.

AW: 23:44 are you provided with any feedback whatsoever from any of the programme

PN4: 23:48 no, not as far as I am know. I have never seen any anyway

AW: 23:51 right, okay dokey and is there anything in particular you would like to hear? So, we have said, about their attendance, whether they have completed. Is there anything else you would like to hear if there was able to provide a communication loop?

PN4: 24:02 erm, no, because, I think it would go into that, whether they are, whether it is the right sort of programme for them so have we taken them down the right channel so to speak.

AW: 24:24 absolutely so some feedback about are we actually making the most appropriate referral

PN4: 24:29 absolutely that would be lovely.

AW: 24:32 brilliant and it's nice that you said, feedback can be used as encouragement so if they do come back and you can see that feedback you can say oh, well, done I can see that you completes this programme, and we've just taken your blood pressure for instance, and it has dropped by this. So, you can use that as a tool to sort of motivate them further. And again, you said, if they don't actually enrol on the programme you can, not blame them, but sort of delve in a little deeper as to why

PN4: 24:55 as to why they didn't go. I mean it could be something as simple as It's financial, that they can't afford it. And in which case we can say that's ok there's health trainers because that's free of charge so it's not the same thing, but we can refer you through there so not, you're looking at...

AW: 25:14 and it just gives you a little bit more of an idea about that patient and as you say if it is financial for instance, there are other options that you can explore with them

PN4: 25:23 yeah

AW: 25:23 does it tend to be an issue? The cost. The exercise on prescription is £33 for 10 weeks

PN4: 25:27 is it 33 now, erm, it can be. It can be. and that can be just expectation wise so there is a certain group of community that don't want to pay for

anything, but that's in every single thing and you know there, so you wouldn't even think of putting them on an exercise prescription because you'd know they're not going, whereas you'd be surprised how many people don't mind paying. They can see that it, it, it's done for as reason

AW: 26:08 is there, when you say the people, the community that don't want to do it, is that a typical patient group or, is it?

PN4: 26:18 I don't think there is a typical patient group without putting a

AW: 26:20 a label on it

PN4: 26:22 a label yes. There is a group of people who do not want to pay for anything in society and there are one or two of those

AW: 26:31 erm, I think that's sort of all the areas I wanted to explore today. Is there anything else that you would like to add that you think is relevant or important?

PN4: 26:39 erm no, I think just the feedback would be the main thing and knowing how they have done sort of thing I suppose. Erm, and for us to have all the different sources of information because it’s not just me as a nurse, I have a colleague who's a healthcare assistant and we do, in pre-diabetes we would be giving them both the exercise and the dietary advice so for her to have the information would be excellent

AW: 27:16 so does the healthcare assistant refer as well?

PN4: 27:16 er she could do. There's no, reason, potentially she could

AW: 27:23 again if there was more information supplied to refer on

PN4: 27:27 yeah,

AW: 27:28 absolutely. yeah, I will speak to [HLO's name] and get some of the LiveWell, ones and we are looking at how we can increase that awareness so not just for the general practices, but for the patients as well

PN4: 27:40 yeah,

AW: 27:40 would it, in your opinion, would it help if the patients were coming in asking for it as opposed to you probing?

PN4: 27:46 it would be great if I'm honest. It would be brilliant

AW: 27:50 that's the aim if we can sort of increase their awareness it saves you having to explain all the programmes as well, and again it's just time saving. The less you've got to remember

PN4: 27:58 it's like they were doing those health checks and I don't know how many patients actually took them up on the health checks that they were doing at the leisure entre., I think we all got an advert through the door saying, are you between 50 and 74 and would you like a health check. We had a lot of patients who actually brought them back in and said, can you do that for us. You know and it was in, so you know, it was interesting to see whether they were taking them up or not

AW: 28:27 absolutely, I think there's an expectation as well, if I'm getting a health check I go and see somebody within general practice

PN4: 28:31 my doctor exactly that's it

AW: 28:34 not necessarily leisure. I wasn't actually aware that the leisure were doing health checks are well

PN4: 28:39 yeah, they were. I presume they still are, but yeah,

AW: 28:41 yeah, but it would be interesting to see, from a patients perspective, I think there's as well, as overreliance on medical professionals

PN4: 28:52, I think we are coming to the stage where that is going to change, and you can go elsewhere. You can go to a pharmacy and get advice, but you've also got a very, here you've got a very traditional community erm, who if I've got something wrong with me, I will go and see a doctor. And probably those in the minor injuries it that will be interesting to see. Hornsea suffers from people not wanting to do things, here. Erm,

AW: 29:27 in terms of lifestyle change?

PN4: 29:28 yeah, but not for the people its people providing the services. So, like Living with Diabetes doesn't happen here. It happens in Bridlington. It happens in Beverley. It happens at Hedon, but they do not run a course here

AW: 29:47 ah, ok

PN4: 29:48 and you've got people who haven't got transport. There's no, bus service. There's no, trains. So, again, I know that I've got pressures at the HEART course through in at the leisure centres in Brid, but they had the heart attack in Hull, so Bridlington is the nearest place, but there's nothing here so it, it's transport

AW: 30:22 it seems a little fragmented

PN4: 30:21 it is, and, I think having more for the people of Hornsea

AW: 30:30 so you said, they are automatically enrolled onto Living with Diabetes, so do you then say to them although you're automatically eligible for this, you've got to travel to Bridlington

PN4: 30:43 and that's why a lot of people won't actually take up the course in the end

AW: 30:48 and is there a leisure centre close to here?

PN4: 30:53 yes, it’s not too far. if you stand at the bottom of the drive, if you go, erm, left and then first right then you are on a road called cliff road and then you just turn left again by the, there's a, instead of turning into town centre just go left again and the leisure centre is

AW: 31:18 ah so that's not so much of an issue

PN4: 31:18 no, no. not at all

AW: 31:21, but it’s more of the other services

PN4: 31:24 the leisure centre is very handy and is fairly central for most people

AW: 31:28 that's good, but not necessarily the other programmes.

PN4: 31:30 no, and the hall is just left and left

AW: 31:35 so you're in quite a good location in terms of those programmes

PN4: 31:38 yes, we've got the building it’s just we haven't got the people facilitating

AW: 31:44 yeah, absolutely. Do you think there would be any GPs who would be willing to speak with me to share their perspectives? If they are using the online system?

PN4: 31:53 I don't knower I can go and ask

AW: 31:57 yes, that would be brilliant if you can fantastic. I’ll type everything we've talked about in a transcript and send that to you within 4 to 6 weeks because it takes ages to type up.

PN4: 32:07 actually thinking, no, they won’t today because they have got a practice meeting today

AW: 32:11 no problem no problem.

PN4: 32:11, but what I can do is I can ask them, but it would mean you coming back in I'm afraid

AW: 32:18 that's fine I am only in Hull. To be honest I travel from Bridlington all the time for interviews that's why I was so happy today that I was seeing two people because that has never happened. It’s always like I'll see you on Thursday and I’ll see you on Tuesday

PN4: 32:27 oh, no

AW: 32:29, but yeah, brilliant if you could ask around and you can pass my email to anyone who may be interested

PN4: 32:37 I will do

AW: 32:37, but yeah, I will send you your transcript in 4-6 weeks for you to verify that.

AW: Interviewer **Interview date:** 23.04.2018

PN5: Participant **Interview location:** Practice 2 Bridlington

PN5: 00:11 have you come over from Hull?

AW: 00:10 yeah, from Hull today and then I am going straight to Goole from here

PN5: 00:14 oh, are you?

AW: 00:13 so I'm little bit here there and everywhere today

PN5: 00:17 what's the traffic like?

AW: 00:17 it was good. It was good all the way here actually. Usually, I am caught behind a tractor, but no, today it was really clear

PN5: 00:24 here you go

AW: 00:24 thank you. It was a little bit busy trying to park so I had to circulate you know this area

PN5: 00:31 ah if I'd of thought you could have come in our erm, I never thought, you could have come into our car park

AW: 00:35 oh, it’s ok I parked on the front, but it was only an hour, so I thought I best park on you know the curb., I think it’s three hours I've got

PN5: 00:43 yeah, it is if your round this side yeah

AW: 00:44 er yeah, I thought if I do the hour one, I am pushing it a little bit

PN5: 00:47 yeah, because they're a bit...

AW: 00:49 keen

PN5: 00:49 yes, I mean as you pull into our car park, there's the wall there and there's the entrance there, and there's a wall there and here behind the wall there is some grass and a few years ago one of the practice nurses from next door, because the parking in our car park is terrible, we just double park and

we move if somebody wants to be out. This girl parked on the grass, so she was within the ground of our carpark, she went out at lunchtime and there's a parking ticket on it. Anyways the practice manager sent a rather curt letter off to the council and they rescinded it, but its private property!

AW: 01:23 they can't do that! You know what they're like

PN5: 01:23 so anyway and then I went, we went, we go to leisure world on a Monday and a Wednesday night to do shebang and on Wednesday night I went and you can't always get in even though you've got virtual parking so I thought I'll just park down the road and as I pulled up, it was about ten to six and I thought, and I just out the corner of my eye saw this traffic warden and I thought, what do I do? And he was sort of coming towards me, I am watching him in my mirror, so I thought ah! So, I drove round the block. It was about two minutes to six and I thought if you dare nab me now, but yeah,

AW: 01:58 that's ridiculous (laughs)

PN5: 01:59 anyways

AW: 02:00 this is for you to keep so your copy of the study

JB 02.02 ok

AW 02:02 for you to refer back to if you want to at any point. So, just a quick talk about confidentiality before we begin. Anything that you do say today will not be shared with anyone else outside the research team er and will not reveal your identity in any way. You've got several right as a participant so your participation is completely voluntary, but if at any point you would like to withdraw from this study, if you let me know we can destroy any data that we have collected

PN5: 02:29 yeah, yeah

AW: 02:28 so that's not problem at all. If you've got any questions at all during the interview, please feel free to ask. And the interview is going to be sectioned on four key areas. So, the healthy lifestyle programmes that are run by the Eat Riding of Yorkshire council that you can refer to, the information and referral resources that you are provided with, we will then focus on any challenges or constraints that you have faced or anything that makes it difficult to refer, and then finally any feedback that you receive from the programmes, if any. Does that all make sense?

PN5: 02:59 yep, that's fine

AW: 03:02 brilliant so it is ok if I take some simple demographics before we begin?

PN5: 03:05 yep, yep

AW: 03:07 so how old are you if you don't mind me asking?

PN5: 03:08 53

AW: 03:09 53 and what's your role within this practice?

PN5: 03:12 practice nurse

AW: 03:16 do you have any additional roles?

PN5: 03:18 you name it, we do it as practice nurses (laughs)

AW: 03:21 everything (laughs)

PN5: 03:22 oh, give it to the practice nurses. I, I, I am the lead for the diabetes

AW: 03:30 and are you considered full time or part time?

PN5: 03:33 erm part time

AW: 03:34 how many sessions do you do per week on average?

PN5: 03:36 so I do 8 I do 4 days

AW: 03:41 and how long have you worked as a practice nurse?

PN5: 03:41 16 and a half years

AW: 03:46 has that always been within the East Riding of Yorkshire?

PN5: 03:47 yep

AW: 03:50 brilliant and I have your email so that's fine. So, can you start by telling me a little bit about what programmes are available for you to refer onto? Those that are run by the East Riding of Yorkshire Council

PN5: 04:03 so we've got the exercise referral scheme and we've got the LiveWell., I think there the two that we use mainly er

AW: 04:13 and out of the LiveWell, and the Exercise on Referral, which one do you tend to refer patients to the most often?

PN5: 04:18 the exercise referral cuz the LiveWell, has got the BMI restrictions so er, but yeah, the exercise on referral

AW: 04:27 yep. Do you find more patients are eligible for the Exercise on Referral?

PN5: 04:27 yeah, yeah

AW: 04:30 and what's the process of referral in this surgery?

PN5: 04:33 right we use to do paper and send it off, but now we can do it electronically so its great cuz if the patients ask one of the GPs about it, or they mention it to us at a consultation, we can say, like I had a diabetic in this morning. I said, "oh, have you heard about the exercise referral scheme?" No. Explained it to her and said, would you like me to book you an appointment? And she, she's declined it, but some say oh, yeah. It's great now because we can do it cuz we use to do paper referrals, send them off and then you'd get a letter weeks later saying, your patient has not contacted us, or has turned up for one session. Whereas now, you go on, you book their initial appointment, and they go out of here with it in their hand saying, you've chosen that time

and that date to go and have your induction and then take it from there erm so it's great yeah. That has been running, how long have we had it online? Maybe going on a year. There was a few initial er problems at first, but, I think it was the computer systems more than anything else, but it works well, now yeah, yeah

AW: 05:44 so do the GPs, do they use the online referral system? Or do they delegate that to you?

PN5: 05:49 they delegate it. They have got it on their desktops, but, I think they prefer to just... practice nurses or healthcare assistants they do it as well

AW: 05:57 ok so practice nurses, healthcare assistants. Do you feel anybody is best placed to refer if that makes sense or should it be shared in your opinion?

PN5: 06:04, I think it shared, yeah, shared yes

AW: 06:11 and how are you made aware of the programmes that are available?

PN5: 06:12, I think initially, because it's been going a long while the exercise on referral before they even updated the East Riding, it's not leisure world anymore is it, we've got to call it East Riding Leisure. Erm, we, I think, initially, I think they did do a talk because as I say I have been here 16 years and I can remember when I first started, I use to go two afternoons a week to encourage some of our patients and I use to do it with them.

AW: 06:39 oh, right, ok the exercise?

PN5: 06:43 yeah, but it has progressed since then into, you know, it's more tailored to them now., I think when I use to do it, it was just like, it was the instructor with a big room of them doing you know exercise or what have yeah, but now they get a tailored programme.

AW: 06:58 yeah, so it has developed from there

PN5: 06:58 yeah, it has developed. It’s great

AW: 07:01 what about the LiveWell, programme? How did that come about?

PN5: 07:03, I think again, we just got a programme. We've got some literature. We have got a big thing that tell us what's available and we've got some leaflets we're referring with, I mean with that we tend to still fill the form in because it has to have a GP signature.

AW: 07:18 right, ok

PN5: 07:19 and then we fax it off. Erm, they are quite strict about the BMI. I mean I had one patient that, bless them, had lost, I think they had lost something like 10 pound of their own so it took them under the BMI, but they were actually eligible before that. They were so motivated and wanted to do it and they turned them down.

AW: 07:43 because they didn't quite meet the BMI crit...

PN5: 07:45 yeah, and that's about a year ago now and I felt gutted for the person because she was so motivated, but obviously there's constraints with finance and they have got to have a criteria I suppose but it was a shame.

AW: 08:00 what would help would you think in the future if somebody was sort of really close?

PN5: 08:06, I think if they could have some leeway. If they look, because we did write on the form that this person has done this on their own, so she's motivated, she was motivated. Erm, whereas I can think of someone who we suggested, oh, yeah, referred them on and didn't take up the offer. And it's a fantastic offer because they get six months of 1:1 and they can take somebody with them. I've just had somebody else actually that I referred, she came in a couple of weeks ago, and I said, "have you heard anything”? and she said,

"yeah, it is fantastic, I love it!" She said, erm "I can't believe that I am getting this for free!"

AW: 08:43 it's a really good scheme

PN5: 08:44 it's a really good scheme, yeah, it is

AW: 08:46 so you for if there was just that little bit of leeway with the criteria....

PN5: 08:47 yeah, yeah

AW: 08:49 cuz LiveWell, they actually get 12 month on the LiveWell, so it's a long time, and as you say if there was that little bit more leeway then more people would be eligible for that.

PN5: 09:01 yeah, yeah, yeah

AW: 09:00 do you feel that some of the programmes are better publicised than others?

PN5: 09:04 yeah, I think the exercise referral is definitely well, publicised. The LiveWell, maybe not as much. It's something that we tend to know about, so we say look you know. And I suppose it's a difficult one to broach with people because they are obviously very overweight, and nobody likes to be told they're overweight do they? And their self-esteem and everything when they are that size can be quite you know? So, you've got to be careful with them. You don't want to sort of, you've got to address it, but you've got to be tactful how you address it I suppose is what I am...They are going to feel self-conscious to go to the gym aren't they or whatever, you know? But as I say to them, no-body is actually looking at you. As I say we go to shebang on a Monday night and a Wednesday

AW: 09:53 what is shebang

PN5: 09:54 it's brilliant. It, it's, it's like dance class, but it's Latin, it's a bit of all sorts, it it's erm, Les Mils it's, look at it, you can look at it on YouTube, Les Mils is the one that's done it.

AW: 10:08 ah right, ok. I have heard of Les Mils, just not shebang before

PN5: 10:10 yeah, erm you get a cardiac, it's cardiac workout plus burn calories yeah.

AW: 10:17 fantastic

PN5: 10:17 and nobody, you know, nobody is watching anybody else because you're too busy watching the instructor (laughs)

AW: 10:23 and making sure you're doing it right (laughs). So, do you find it difficult to sort of address... If someone comes in and they have perhaps a little bit less self-esteem and they are rather large, do you find it difficult to approach that subject without offending them?

PN5: 10:36 yeah, sometimes yeah, my tact usually is you know, do you do any exercise? Is there anything that you incorporate into your day like a brisk walk, you know? Especially with the diabetics, you know because you know we do it from a glucose control, you know? It will help with that if you can incorporate you know, twenty minutes brisk walking or erm, Cuz somebody that I had this morning, I was speaking about the exercise referral and well, you know, "I am busy, I work full time, I'm busy in my job". And I said, yeah, I appreciate you are, but actually it's not that exertion that, you know? We can all walk. Yes walking is good for you, but you need to actually need to work your heart a little bit you know? Erm, so yeah, yeah., I think you've just to learn to be tactful, but the beauty of this job is you get to know your patients because you're seeing them regularly yeah

AW: 11:32 does it help having that sort of relationship with them?

PN5: 11:34 yeah, yeah

AW: 11:36 and how do patient respond? Do they tend to be informed about the programmes or is the first they have heard of them?

PN5: 11:41 most of them, it's the first they have heard of it. Occas, you'll get the occasional one, I had somebody last week who came in and said, oh, my friends told me about this, can I do it? And I said, yes, certainly, and we got him an appointment and off he went, he was delighted! So, yeah, yeah

AW: 11:56 so sometimes they are coming in and they have heard about it before, but as a rule it's the first time

PN5: 12:01 yeah, because, I think unless they go, cuz, I think when you go into the leisure centres, it's very well, publicised they have got all the posters up, they have got all the screens up with it all on, but unless they are actually looking for it, I don't think they are aware of it.

AW: 12:16 is it publicised in this surgery? In terms of do you have posters up?

PN5: 12:19 I don't think we do actually saying, that. We should have, shouldn't we?

AW: 12:22 do you think that might help put awareness out there?

PN5: 12:26 yeah, yeah, yeah

AW: 12:28 ok and what information resources are you provided with for the programmes?

PN5: 12:32 basically, it's just... [looks for forms] we get these to give

AW: 12:52 ah the healthy lifestyle programme booklets

PN5: 12:54 and that's the er, oh, that's just a protocol for the Exercise Referral., I think, to be honest, I think we have got so use to doing it now we just sort of know it, but yeah, we've got those to give to the patients, yeah.

AW: 13:10 and how useful is this, I think this has all the different, yeah, the Exercise Referral, the LiveWell...Are these useful to have

PN5: 13:16 yeah, I do yeah, yeah,

AW: 13:20 ok is there anything you'd like more information on?

PN5: 13:21, I think the young ones, the young LiveWell. I mean we don't get many of the young LiveWell, because again that's a sensitive area because you don't want to make them too aware of their weight because we are all aware of anorexia and bulimia and that sort of thing and self-image and things, but erm, I think I know of one that's done that and done well, with it.

AW: 13:44 is it completely different to approach that because the Young LiveWell, [chokes], it's under 16's [coughs] so I'm guessing they've got the parents with them

PN5: 13:56 are you alright?

AW: 13:56 yeah, I don't know what I've got in my throat [coughs]

PN5: 13:59 yeah, it's usually, I think the one as I say I haven't done many., I think the one that I dealt with had come via the GP first. They had obviously gone through the GP. I don't know if they had gone for something else and it had been addressed. I don't know if parents had brought it up or the GPs had and they had, they'd er, sent us to do the erm, to do the referral, erm, yeah

AW: 14:23 yeah, so that was sort of delegated

PN5: 14:26 delegated yeah, yeah.

AW: 14:27 and you've mentioned that you deal with a lot of the diabetics, but is the, is there a particular patient profile that comes in that might prompt you to refer on? Do patients present with something and you think actually exercise might be really good for you?

PN5: 14:42 yeah, some of the hypertensive patients, and even some of the asthma patients really cuz, I think a lot of the asthma patients still have that thing in their mind that they can't exercise, but getting across to them that actually there is exercise that you know asthmatics and as long as your asthma is well, controlled then you know there's no, reason why you can't do it so yeah

AW: 15:08 so it's sort of explaining how it can improve their condition?

PN5: 15:10 yeah, yeah,

AW: 15:12 to sort of get that buy in. So, that's all in terms of the healthy lifestyle programmes. Next, I would like to focus a little bit about challenges that you've faced either previously or anything that can be sort of tightened up cuz we're looking at improving and streamlining this process so it's as quick as possible for you in primary care and to preserve some of that consultation time cuz er we know that there has been a lot of changes and quite often it has been created by the leisure centres, but not necessarily for you guys if that makes sense. So, we are trying to speak to as many people as possible to find out what we can tighten up on. So, have you ever experienced any challenges or do experience any challenges? Or anything you feel could be sort of tightened up on?

PN5: 15:56 I don't think so, I think, I think now since it's gone electronic, I think it's made it a lot easier for us erm,

AW: 16:06 yeah, so as you say before wasn't so easy

PN5: 16:08 no, cuz we sort of, we'd fill a form in, we'd send it off erm, then we might get a phone call from a patient saying, I haven't heard anything and we'd say you know well, go to the centre yourself because we have sent your referral form down just ask them where you are on the, on the waiting list

erm,. We do have some patients that would like to repeat it and I am not sure what the protocol actually is whether that, that might be, if we could have a protocol or some guidance as to can a patient do it more than once. erm,

AW: 16:43 in terms of the exercise referral...?

PN5: 16:44 scheme I mean I suppose their aim at the leisure centre perhaps is to then move them onto a membership and, but still, erm, my own husband did a cardiac rehab, which he did, and then he did like a step on from that with them and then he went to a membership of the gym with the staff being aware of his you know past medical history erm, but I, I think some patients just, and I know they can always ask the instructors, they're brilliant the staff are great, I think they maybe just feel that erm, protection if you like, that security if they know they are under a scheme

AW: 17:27 yes, they have that support

PN5: 17:27 that safety net sort of thing

AW: 17:30 absolutely

PN5: 17:31 I appreciate they can't keep doing it and keep doing it because then nobody else would get the opportunity to do it, but erm, if there is any you know

AW: 17:39 protocol around that yes. It's a bit of a funny one. From my understanding, they are allowed 2 referrals under exercise on referral, but it has to be referred on the system under something different. So, you can select so many different referral reasons

PN5: 17:53 yep

AW: 17:54, but you have to change one of those to something else erm then they are happy to accept the patient for a second time

PN5: 17:58 right yeah

AW: 17:59 occasionally they have accepted them for a third time, but, I think that's on a 1:1 basis so tis a case of speaking to the leisure centre, discussing the patient, and seeing if they can, if they have a spare place for that patient

PN5: 18:13 yeah, yeah, yeah, yeah

AW: 18:15 do patients get free places in this area?

PN5: 18:18 I haven't heard anything for a while. We used to occasionally get a letter saying, there's funding and there's a limited amount of free places, please refer anybody, but I haven't heard anything this year erm, again I suppose it's budgets, isn't it?

AW: 18:35 absolutely and in terms of availability on the online system, are you finding it easy enough to book patients in on a day that suits them?

PN5: 18:39 yeah, yeah, yeah, yeah, yeah, cuz when you go on, the guy that I did last week, I think it was a Wednesday or Thursday when I did him and there was right the way through all this week, all this coming weekend you know? So, you can pick whatever day you want its fine you know there was plenty there

AW: 18:55 and you prefer that so you can see the different...

PN5: 18:57 yeah, yeah, yeah, yeah

AW: 18:59 and do you have an audit trial of referrals? Cuz obviously it's a separate system

PN5: 19:06 yeah, no, we haven't erm, and the other thing, I don't know if they do any feedback I don't know whether they, you know. It would be quite good to know who has completed it. I mean I presume they will do them a succession questionnaire or something I would have guessed to see

AW: 19:25, I think they're on Pharmoutcomes. I'm not sure. Do you have access to Pharmoutcomes?

PN5: 19:27 no, I don't think so

AW: 19:30 ok yeah, there has been a few issues around feedback because many surgeries do not receive any communication loop, erm so we are looking at how we can get feedback from the leisure centres to erm the practice and I guess the trouble is because it's a separate online system, it's hard to get that information back

PN5: 19:49 yeah, yeah, yeah, yeah, yeah

AW: 19:52 what would be the ideal way to receive feedback?

PN5: 19:55 I mean if we are not on the same system, which yeah, it's difficult, isn't it because they're the Council and we're health. Erm, I mean even if it was just erm a letter just to say your patient has completed it. It's just so we know then cuz we could scan it on to the notes and we could look and say oh, yeah, they've done this. I mean we get, we'll get patients come back and say yeah, I've completed it and I've enjoyed it, but erm it just sometimes, it's like I refer onto something called Living with Diabetes which they, for the erm, newly, well, mostly newly diagnosed, but we can refer on patients that have had diabetes for a while, and we get a letter saying, they've completed it which is quite nice to know because sometimes we need to address. Again you'll get letters, yes, you've referred, but they have not taken up the place

AW: 20:48 yeah

PN5: 20:49 and then you'll get them coming in and saying, oh, my diabetes and you'll say well, actually we referred you to the Living with Diabetes, but you didn't attend. It's just so that we've got that information

AW: 21:01 just so you're a bit more informed

PN5: 21:04 yeah, yeah

AW: 21:05 so sometimes patients are providing that feedback if you see them, but for you if would be quite nice if the schemes providing that as well

PN5: 21:13 yeah

AW: 21:13 is there any examples of erm, any other sort of online, good examples of online referral systems?

PN5: 21:19 erm, I'm trying to think, that's the only one that we do really

AW: 21:26 ok

PN5: 21:28 yeah, as nurses I mean cuz we have an administrator that does a lot of our referrals for us erm, like retinal screening or erm, the even the living with diabetes or the pulmonary rehabilitation erm, we have a girl that does that, I mean we get them to check, but she does it all for us erm

AW: 21:52 are you happy doing these [ER] referrals yourself?

PN5: 21:53, I think we need to do these with them yeah, because we can say you know would you like to go here would you yeah

AW: 22:02 so you've said, in terms of feedback it would be really useful to have some sort of record of their attendance

PN5: 22:08 yeah

AW: 22:10 is there anything else that you would like to hear about?

PN5: 22:11 no, I think just whether they have gone on to do anything else really erm, but it just means that we can encourage them when we see them you know. I can see that you have completed this, well, done, you're going on to do this, how, and it’s conversation when they come in that you can ask them. You know? How are you getting on with it? You know? And also, we can say

to them look at, look, like the diabetes, you know your HBA1C is, you're obviously doing something, and it will encourage them, you know, it's a whole package sort of thing. You can see look the effect this is having on your diabetes or whatever. Your blood pressure has come down nicely, you know? Erm, cuz if they can see something and you can show them physically yeah, that's your blood pressure now that's what it was before or this is, it then encourages them to continue

AW: 23:04 absolutely so if you are giving a little bit more information about what they do after the programme as you say you can use that as encouragement and if you actually show what benefits it's having on their health, that's going to further sustain them changes that they are making. Erm, that's everything in terms of feedback, is there anything else in terms of the whole process that you would like to be improved, I said, that completely wrong

PN5: 23:35 er no, I don't think there is really I just

AW: 23:38 quite happy?

PN5: 23:37 yeah, as I say it use to be a bit of a mine field when it was the paper forms and we was sending them off and we didn't know whether they had got offered a place or, or anything which was no, fault of the leisure centres, they're as busy as we are, but when it went electronic is was great

AW: 23:56 and did you have to take the patient signature before with the paper referral?

PN5: 23:59 yeah

AW: 24:00 was that an issue?

PN5: 24:02 they use to come in for an appointment, we use to explain the scheme to them as we still do you know that there's a payment and it's 20 sessions over

10 weeks and you have to be committed to the 20 sessions, do you understand that? And they use to sign to say that they understood that, and they was giving us permission to give their medical history to them. And that's the same now. We print, when we print the form off that's got their appointment on it, they sign it to say that they have understood the scheme, that they give their permission, and we sign to say that we are referring them erm so they've got that

AW: 24:33 so you've still kept that element of the signature

PN5: 24:36 yeah, yeah, yeah., I think it's important to just have that record

AW: 24:40 yeah

PN5: 24:41 and then we save that to their notes

AW: 24:43 ah right so you are making your own sort of audit trial by doing that?

PN5: 24:47 I suppose we are in a way yeah

AW: 24:49 aw brilliant, fantastic. That sort of all the areas that I wanted to speak about today. The final section was about support networks, but you said, that you've got your healthcare assistants and you've got the administration staff that do the sort of referrals.

PN5: 25:05 yeah

AW: 25:05 do you have any form of triage in this surgery?

PN5: 25:06 erm, as a general do you mean?

AW: 25:12 yes, in terms of getting patients into the right sort of

PN5: 25:14 yeah, I mean when, the girls on reception are very good. When they ring up and ask for appointments, you know, can you tell me a little bit more about the appointment and then they direct them to either the Nurse Practitioner or the GPs. They changed the appointment system a good few

months ago now and appointments only open up for the day in the morning, and then they open up again at 2 o clock in the afternoon. These are for emergency appointments so when the patients are ringing up it's got to be an emergency that they go into those slots. There is still advance booking for appointments, but it's, they have limited that to, I think it's three weeks because you had some patients that where booking appointments weeks in advance because they wanted to see a particular GP and then somebody who needed an appointment on the day couldn't get one so that taken a lot of work, And the girls on the reception still get a lot of stick you know? They are having to say we are only acting on the direction of the GPs. And we are trying to erm channel into minor ailments more, so they go to the pharmacies. We've got a lot of posters in the waiting room here that tells them [patients] about how they can deal with certain things like sickness and diarrhoea and sore throats and things. Erm, and [NP's name] our Nurse Practitioner was just saying, last week that there's a list now, sorry I've just got, can I just?

AW: 26:42 yeah, of course you can

PN5: 26:51 erm, I'll just take that out a minute

AW: 26:54 yeah, not a problem its fine

PN5: 26:55 it's for the samples, they're early

AW: 26:55 it's ok

PN5: 27:57 they don't usually come while 12

AW: 27:57 are they a bit early today?

PN5: 28:01 yeah, so [NP's name] was saying, erm there's a, there's a list coming out from the erm, Department of Health of medications that they are no, longer going to be able to prescribe. If it's, somebody's got a long term condition,

erm they can, so if someone has got long standing pain, they can prescribe paracetamol, but if it's an acute problem, they can't. So, that's going to make a big difference to a lot of the things that go to [NP's name]. So, in a way, patients aren't probably going to like this because they are going to be, as we've been trying to direct them to the pharmacies through the minor ailments, but it needs to be addressed really. I mean she had someone a few weeks ago, and the appointment was booked at something like 8.30 in the morning, came in, either morning or afternoon can't remember. "What's your problem?". "Sore throat". "How long have you had the sore throat?". "I woke up this morning with it". So, there's a lot of, there's a lot of work going on around that so yes, they are trying to triage so that people that need to see somebody

AW: 29:16 yeah, are going to get the appointment. Do you think there's an overreliance on healthcare practitioners?

PN5: 29:20 yeah, yeah, yeah, yeah, yeah, definitely.

AW: 29:29 I agree and if you can encourage them to sort of use the pharmacy then hopefully it will take some of the pressures off general practice

PN5: 29:35, I think they need some more education in the pharmacies, and I also think there needs to be some education in the 111 service because the times we get, you'll get someone put, go to, they will go to the out of hours for instance, and they will be given an antibiotic for, I don't know, a chest infection. So, they are given a course of antibiotics. Two days later when they are still on the antibiotics, they'll come in to see [NP's name] particularly because it's [NP's name] who gets them, erm, what can I do for you? I aren't any better. Well, you've not completed the course. So, there needs to be, oh,

well, the pharmacy told me that, or the out of hours told me if I wasn't any better in 48 hours go to my GP practice. We get a lot of that. If you're not better, particularly the out of hours, if you're not any better in 48 hours. What it needs to be is there's a course of five days, complete it and then see. And the pharmacies do a lot of it as well. You know, go to your GP surgery

AW: 30:41 why do you think there is that discrepancy in that information?

PN5: 30:43 I don't know if it's fear of mitigation, but as long as you are following a protocol and you're following guidelines then you've got the back up, you know if there was something come of it. You haven't done anything, so, I think maybe confidence issues. I don't know, but...

AW: 31:06, but it would help if there were a bit more training...

PN5: 31:06 yeah, yeah, yeah

AW: 31:08 because that's just increasing your workload

PN5: 31:10 coming in with inappropriate things, taking appointments you know with GPs and Nurse Practitioners erm.

AW: 31:17 is there a typical patient group? So, does it tend to be sort of the older generation? The younger generation?

PN5: 31:23 erm, bit of both, I think really yeah, yeah. Maybe the younger ones. I don't know A bit of everybody yeah

AW: 31:36 brilliant. So, that's everything I wanted to speak about today. Is there anything you feel we could expand on or you think is relevant to add

PN5: 31:46 I don't think so no

AW: 31:47 that's fine. I'll type your interview transcript up in a word format between 4 and 6 weeks and I'll send it to you via email just for you for verify that it's an accurate representation of our conversation today

PN5: 31:59 that's fine

AW: 31:59 brilliant. Well, thank you for allowing me to talk to you today

AW: Interviewer **Interview date:** 31.07.2017

PN6: Participant **Interview location:** Dr Mixer and Partners Beverley

AW: 00:04 how old are you if you don't mind me asking [Nurse's Name]?

PN6: 00:07 oft 50

AW: 00:09 50 and what is your role at this surgery?

PN6: 00:11 I'm the senior practice nurse

AW: 00:14 do you have any other roles in this surgery?

PN6: 00:18 erm no, that's it

AW: 00:19 ok and are you full time or part time?

PN6: 00:21 part time

AW: 00:23 part time. And how many sessions do you deliver in general practice per week?

PN6: 00:26 erm, I do, erm, erm, (laughs), erm, well, I do three days so yeah, and I suppose it's classed as morning and afternoon so that would be six sessions yeah.

AW: 00:40 and how long have you worked as a senior practice nurse?

PN6: 00:43 erm 16 years

AW: 00:45 16 years. Has that always been within the East Riding of Yorkshire?

PN6: 00:48 yeah, yeah

AW: 00:50 fantastic. Have you always been at this surgery?

PN6: 00:52 yeah,

AW: 00:53 wow

PN6: 00:55 I know yeah

AW: 00:55 ok so the first section of the interview will be based around the East Riding of Yorkshire healthy lifestyle programmes. So, what East Riding of Yorkshire healthy lifestyle programmes are available in this locality for your patients?

PN6: 01:05 erm, the exercise referral programme, erm, the living well, one, erm, I think there is one for erm, is living well, the one where they have a BMI over 40?

AW: 01:20 yep

PN6: 01:21 yeah, erm, and is there a children's one now? Who have got a high BMI? I don't know what it's called

AW: 01:23 the young LiveWell,

PN6: 01:27 yeah, sorry (laughs)

AW: 01:27 it's ok yep, the young LiveWell

PN6: 01:29 yep, yep, erm, that's all I know actually. Just those

AW: 01:33 yeah. So, you use the LiveWell, the young LiveWell, and the exercise referral

PN6: 01:37 exercise referral that's the ones we use yeah

AW: 01:39 and which one do you find you refer patients onto the most often?

PN6: 01:42 exercise referral

AW: 01:42 ok why is that?

PN6: 01:45, I think that's the one that we tend to talk about more. I mean, yeah, we always talk about exercise referral for chronic disease patients, obese patients, but, and obviously the LiveWell, one we have, you know, anyone who's got a high BMI we've referred through that, but generally it's the exercise referral one.

AW: 02:04 yeah, ok and who else can refer in this surgery?

PN6: 02:08 erm, we, all the nurses can and obviously the GPs. erm, I think that's it within this surgery yeah.

AW: 02:19 GPs and nurses. Who do you think is best placed to refer? Is it shared amongst?

PN6: 02:23 erm, I think it's shared., I think you know, equally GPs and nurses see, yeah, do an equal amount of referrals really I would say yeah

AW: 02:33 and when you say it's talked about more, the exercise on referral, why do you think it's....

PN6: 02:36 erm, I think when we do erm, chronic disease clinics, diabetic clinics, and things like that and obviously we try and promote healthy lifestyles, then erm, it's something that we use to try and help people to look at losing weight and doing more exercise. And it's, you know, they say I can't afford to join the gym etc., so then you talk, you know you discuss it and they will either say yes, I will give it a try or not you know.

AW: 03:06 yeah, and LiveWell, and exercise referral have erm, information booklets such as these ones, I think I have a spare in here, actually I haven't. I don't know where they have gone. Is there any other information... ah here's a LiveWell, one

PN6: 03:21 yeah

AW: 03:22 do you have any other documents to give patients? Any other resources?

PN6: 03:27 no, we just have the leaflets. yeah, we just, yeah, we just do, have the leaflets for exercise referral and LiveWell, and the young LiveWell

AW: 03:36 and is it something you go through with the patient or do you give them that to take away?

PN6: 03:39 no, go through it and then give them the leaflet. Generally we erm, we do, we do the referral form and then give them the leaflet and talk to them a bit about the scheme and that they have to commit to attending and it's you know how many weeks it is, how much it costs etc., so we go through all of that and they have to obviously sign the form to agree to the commitment to it

AW: 04:04 and how do you find out about the services? How are you informed?

PN6: 04:08 erm, we, we usually get quite a lot of information from East Riding. Yeah, they usually send us all, every now and then they will send us some new leaflets and things yeah, and we ask if we need, you know, the new referral forms. We ask when we need some more of them. But generally they send it to us yeah, and via email as well, I think yeah

AW: 04:29 ok do they tend to come in and speak about the programmes?

PN6: 04:31 no, no, they have never come in to speak about it, not to my knowledge no

AW: 04:37 would that be useful if someone did perhaps come in?

PN6: 04:40 yeah, it might be something that would be worth doing yes, yeah.

AW: 04:44 and do you feel you have been provided with a satisfactory amount of information about what each of the programmes sort of entail?

PN6: 04:51 erm, yeah, yeah, yeah, I do yeah, and, I think it, you know, we give, we give them enough information for them to think about it and then obviously I would assume they get more information once they go on the scheme

[colleague comes in room]

AW: 05:17 and what are your expectations from referring patients onto these programmes?

PN6: 05:23 what are my expectations? Erm, hopefully that they will enjoy it and erm, lose weight, feel healthier, feel fitter, and that they continue with exercise

AW: 05:36 ok so it's not just the short term it's about

PN6: 05:38 no, it is that, but, I think, I, I feel my one thing about it that is that obviously they have so many weeks and then that's it and that if they would then offer a discounted membership for people to carry on because they, a lot of people complete it, but then they can't afford the gym membership so then it all, it's all wasted all that good work. So, I think it would be good if they could offer you know a continuing sort of scheme you know alright I'm not saying, at the reduced rate, but perhaps a bit discounted

AW: 06:11 yeah, so do you find

PN6: 06:14 to try and keep people engaged

AW: 06:16 yeah. Do you find after the programme patients tend to revert back to old ways?

PN6: 06:19 yeah, yes, and you know we do see people who have done it and a couple of years later they've well, I did do that, but then obviously I got to the end of it and then you know they didn't carry on with exercise yeah, which is a shame so I don't know the figures I mean some do some really enjoy it and will, will then go on to full gym membership, but obviously financially some people can't and so then that becomes a bit of an issue.

AW: 06:46 so in your opinion it would help if...

PN6: 06:47 yeah, I think it would help if they got a discounted membership to continue after their initial weeks on the referral scheme yes

AW: 06:56 absolutely and when are you prompted to refer patients onto the programmes? What sort of issues....

PN6: 07:01 erm it's usually erm, usually from the nursing point of view, it's generally within, you know if we see someone who's got high blood pressure who you know when they're overweight you know if we were in a well, woman clinic and we were, you know, generally it's people who have high blood pressure, overweight, diabetic patients who we feel would benefit from doing you know, doing some form of exercise

AW: 07:28 and when you mention it to the patients is that usually the first time they've heard of the programmes? Are they quite responsive?

PN6: 07:34 erm actually yeah, yeah, some it is, I would say a lot now have heard about it and a lot will ask, will come in and make an appointment for it. Not many I would say actually, but mainly I would say 70% we mention it to them for the first time and there are a small amount 30% say who do already know about it through friends or through you know whatever and they are aware of it

AW: 07:59 ok so some of them do have an awareness before you mention that

PN6: 08:02 yeah, some people do have an awareness before we talk about it, but not many I would say

AW: 08:05 yeah, ok. And then the next sort of section will be focused on the constraints of referral. So, do you personally experience any, any issues or constraints when initiating a referral?

PN6: 08:15 erm, sometimes because the form as it is now you have to have so many reasons to refer, and erm sometimes you can't always tick enough reasons.

AW: 08:32 is that for the exercise on referral?

PN6: 08:34 referral that's the one that I do majority is exercise of referral. So, yeah, like I say so yeah, so like reasons for referral there must be two yeah, so I could have some who's diabetic erm and that's it, yeah? They might just be diabetic and overweight. So, I suppose I could tick weight loss couldn't I yeah? Erm, but yeah, there are sometimes where you can't always find two, two reasons

AW: 09:01 ok and what do you do in that instance?

PN6: 09:02 ah well, I put it's usually a tick other to cover then why, you know. There was somebody, I think he had like a muscle wasting condition it was something that didn't come up on any of this at all so anyways we sent it off, I send it off and just put a reason why so… Generally, you can always find two I will be honest erm, but sometimes you know you can't. But no, other than that, I think it's, there's no, constraints really

AW: 09:32 ok and what, if we could add that sort of thing in, what do you think it could be called?

PN6: 09:37 erm, will I suppose it is classed, it's other isn't it. You have got it you know other please state yeah. What was the one I got... erm, recently was a lady, a patient who had had a stroke what was being referred, but he wouldn't go anywhere without his wife and erm she wanted to be referred as well, under the scheme. And so I put down other as in carer and, I think the, I think they got on yeah, they did get on, but she obviously clearly had nothing, no, medical underlying medical conditions

AW: 10:19 ah so she wasn't eligible?

PN6: 10:19 no, it was just that he wouldn't go without her because it was just a confidence thing, so I did fill a form out for both of them. He obviously fitted the criteria, but she didn't other than she was his carer, and he wouldn't go without her, and I said, that she may have to pay proper membership. And I did follow up and, I think in the end they did let her go yeah, they did yeah, so that's quite good, yeah. So, I think they are quite flexible yeah, yeah, but yeah. That's the only thing where I thought oh, I'm not sure if I would be able to get her on it because she, there wasn't an issue with her really, but he wouldn't go without her so...

AW: 10:59 so he would have missed out if she hadn't of done

PN6: 11:02 yeah, yeah, so I did think they let her go on it in the end

AW: 11:02 normally on the LiveWell, scheme you can bring somebody extra

PN6: 11:07 ah right yeah

AW: 11:09 and that's obviously one of the benefits of LiveWell, but I wasn't too sure about exercise on referral

PN6: 11:11 yeah, yeah, anyways I do think they let her go on it yeah

AW: 11:14 that's good. In terms of the other patient measures that you're expected to take, do you think they are all relevant and appropriate?

PN6: 11:20 yeah, yeah, definitely yes, yes, yes, yeah

AW: 11:24 and can you tell me a little bit about your experiences of using that form as a whole

PN6: 11:29 yeah, erm, as in any problems with it?

AW: 11:33 yeah, or as in erm maybe how long it takes, how confident you are using it....

PN6: 11:36 ah right erm no, I think it's quite easy really, I think it, you know, I think it's easy to fill out with the patient obviously we would do the blood pressure and record the BMI yeah, I think the medication thing use to be an issue erm, but now they have put relevant to exercise haven't they because you know you never had enough room on the form for all the list of medications, but now, I think they have altered it so it's only really relevant to the medications and everything yeah. But no, I think it's quite an easy form to fill out with the patient and obviously you fill it out together and then you know discuss it as you go along so yeah, I think it's quite a good form really.

AW: 12:13 and typically how long does it take to fill the form out?

PN6: 12:15 not long, 10-15 minutes

AW: 12:20 10 15 minutes and do you think you are more suited to go through that with a patient as opposed to a GP who has ten minutes?

PN6: 12:30 yeah, no, I think it's better that we go through it yeah, yeah

AW: 12:35 ok so earlier on we mentioned erm an issue or constraint if you like which was more on the patient side of things. So, you mentioned a little bit about their financial situation and how that might affect if they stay on...

PN6: 12:49 yeah

AW: 12:49 is that a quite a frequent issue?

PN6: 12:53 yeah, I would say it is yeah, yeah, yeah, because obviously it's a discounted scheme isn't it and then, but then when you get to the end of the scheme it then, you know there's, they'll erm we have had people come back for a second referral, you know I do know that and they have managed to get on for a second time yeah, but I'm not quite sure what, what the ultimate aim is. Is it that they do the, the initial weeks and then hopefully the aim is that

they will join the gym? You know, because that obviously would be great, but not everybody will, will they?

AW: 13:28 no, no, not at all

PN6: 13:30 well, because of the financial thing yeah, so then some do come along and get a second referral done

AW: 13:37 so one of the options is to be re-referred, but as you say it would be really useful if actually they could...

PN6: 13:42 they could follow on to a discounted rate yeah, yeah

AW: 13:46 and if a patient shows no, interest at all, erm to do with referral, what happens to those patients?

PN6: 13:53 erm well, we talk, obviously we discuss it and we try, we promote it. Particularly with anyone who is, erm we feel would benefit. If they were overweight, and they do no, exercise whatsoever erm, but erm some people just don't want to do it. So, then you try and discuss other forms of exercise that may be more amenable to them yeah. So, you know walking that sort of thing. You look at, some people just don't like a structured thing which is fair enough so. We always discuss that first yeah

AW: 14:30 ok so that's kind of all to do with the constraints, is there anything that makes referral easy or easier? Anything that eases that process?

PN6: 14:39 erm, well, it’s fairly easy., I think it’s an easy process anyways because you just have your referral form, you talk to the patient about it. Erm, I think there, there was a point when there was a really long waiting list, but, I think that is much better now than it was, but, I think that, that tends to be an issue that people were waiting a long time, but I feel now that has improved quite a bit. Erm, I think the other thing perhaps in terms of why it may, or does put

people off, sorry this is going back to your other bit, is that, that they feel oh, it's a gym environment, there is going to be lots of slim people there. yeah, and they will feel out of place and feel uncomfortable. There's quite a few, I would say that's a comment that is made quite a lot. You know quite obese people who really need to go, but they feel that they would be out of place and would feel self-conscious and I don't know whether that would be addressed by doing more sort of, not segregated sessions, but sessions where it is just people who are doing exercise on prescription. See what I mean? Rather than going into the normal gym with everybody else yeah, that has been mentioned a lot by people who don't want to do it and that and then you're saying, "why do you not want to do it"? It's because you know we're going to be in, you know we are going to feel out of place and self-conscious you know with everybody in their Lycra and etc. who are skinny so yeah

AW: 16:15 so it can seem quite intimidating...

PN6: 16:15 yeah, so, I think, yeah, that's a lot of the reasons why people you know decline it yeah

AW: 16:21 and what do you say to them when they are a bit apprehensive?

PN6: 16:23 well, you know try and say it is, there is a mix of people and that you know because you know there's cardiac rehab scheme there are other people who are within the gym at the times when they go who are not all super fit erm and there is a mix of sizes, ages etc. and to give it a try and just see you know and then they will see that there are other, it's not all skinny young people that are there.

AW: 16:48, I think sometimes as well, when I've been to other surgeries, the GPs are not really sure what it is so sometimes it's put across as boot camp

PN6: 16:57 yeah, yeah, yeah, no, that's it we just tend to say that it's tailored to you and that you know, you know they will do you a programme and it's your own pace. We do tend to try and say it's not going in there and you know running on a treadmill for a hour yeah, no, we do try and say that it is tailored to them yeah, so...

AW: 17:19 ok and do you receive any information about your patients progress from any of the programmes?

PN6: 17:25 no, I don't feel I, not that I've seen. I must admit it may be that it comes in via a letter and it just gets scanned on. But not certainly, that I have seen

AW: 17:36 and what involvement would you like in terms of patient progress?

PN6: 17:37 erm, I think if you know the people that we refer, it would be erm, nice... I don't know, I think if it has been beneficial, and you know, which would be more from the patient I suppose hearing from them really. But we only sort of see people in clinics particularly like chronic disease clinics every six months or every year so you don't always get that follow up to see if they did enjoy it or not. So, yeah, I suppose it would be nice to know, yes, they enjoyed it, yes, it was beneficial and that they lost weight and feel fitter, but I'm not sure how that could be, how that process could be done really

AW: 18:19 so if you do get any feedback it's from the patient during these clinics?

PN6: 18:23 yeah, generally yeah, yeah, I've not seen anything from the East Riding to say you know your patient has completed... Sometimes they did use to send letters through that I have seen that says your patient has completed x amount of weeks and the starting weight and the finishing weight things like that. I did seen, I have seen letter like that, but because we don't see all the letters that come through you see

AW: 18:47 and how does that sort of feedback make you feel if you have heard that your patient has successfully...

PN6: 18:51 no, no, it's good you know, I think if people have enjoyed it they may you know, I think if you know you have referred somebody and then you do know you are going to see them again in two- three months later then you know we always mention it, always, like we talk about lifestyle. So, some people, some patients will say yes, I did it and I really enjoyed it and I'd like to do it again so they would do a referral or yes, I enjoyed it and I am still going sort of thing, joined the gym. So, yeah, it's good no, it's good to get positive feedback that they have enjoyed it

AW: 19:23 and if you could get, hypothetically, feedback whether it was a letter, an email, what would you like to hear? So, you said, you would like first of all know whether they completed

PN6: 19:34 yeah, no, yeah, I think it would perhaps just something to say they completed the weeks that they, this is their blood pressure, their weight when they started and what it was when they finished and I suppose whether they are going to continue with it or not perhaps yeah

AW: 19:52 so blood pressure, if they have lost weight, whether they enjoyed it

PN6: 19:57 so sometimes we do it for depression so it's a mood thing as well

AW: 20:00 ok

PN6: 20:01 in terms of whether it has improve their mood

AW: 20:03 so I guess it depends on....

PN6: 20:05 what's the reason the referral is yeah

AW: 20:08 and why would be important to find out if they want to continue?

PN6: 20:15 because it's about life long, isn't it? It's not just about a short burst you know. So, you would like them to adopt it as a lifestyle measure in the long term not just a quick fix. I've done that and that's that! And then go back to their old ways

AW: 20:30 and I guess it helps you see if there's anything else that you can signpost them to

PN6: 20:36 yeah, yeah, yeah

AW: 20:38 ok erm and I'm terms of support networks do you have any form of triaging in this surgery to direct patients to the right place if that makes sense?

PN6: 20:51 no, yeah, it does make sense. Erm, no, not really, I think it's all done on an individual basis you know in a GP consultation, they, you know, if a patient goes to them and they think oh, you might benefit from exercise on prescription so then they then refer them onto us for us to do the assessment for them. Erm, so there isn't any form of triage it's just done an individual basis really

AW: 21:13 ok so the GPs tend to send the...

PN6: 21:16 yeah, so they may see a patient during a consultation and feel that they may benefit from it so they either fill out the form themselves or they send them through to us for an appointment and we will complete the referral form and do the blood pressure, BMI etc., and all of that.

AW: 21:35 is it often that the GP will do that himself?

PN6: 21:37 not very often I would say probably 9 out of ten times we complete the referral form

AW: 21:44 and why do you think, is that time thing?

PN6: 21:47 time thing really yeah, yeah, they will, yeah, it's a time thing really

AW: 21:52 so do you have any telephone triage system with the receptionists or anything like that or is it purely just the GP decides where...

PN6: 22:01 no, we don't, it's not, I don't think it's something that we advertise in the surgery as in we have a poster up saying, there is an exercise referral scheme that is run, you know, East Riding. we don't, you know it's all done via a consultation, you know, to, either with a GP or a GP patient, nurse patient, when you start to discuss healthy living, diet, lifestyle. Erm, so yeah, so it's not something that we actively, we don't actively advertise it

AW: 22:36 ok do you think it would help if it was advertised?

PN6: 22:38 yeah, I think, I suppose if we did have a poster up saying, because you know, a lot of people don't know about it you know, yeah. But it's the capacity to have enough appointments to deal with everyone who may want to do it.

AW: 22:52 yeah, absolutely that's the flip side

PN6: 22:54 that's the issue

AW: 22:57 so on one hand it would increase that awareness, but on the other hand,...

PN6: 23:00 yeah, it would increase awareness, but then it shaving enough capacity of appointments and staff to fill out the referral form and you know everything

AW: 23:08 and...

PN6: 23:11 and equally I don't know if they want to be inundated at Beverley leisure centre with like I don't know, you know how much they accommodate in their appointments because

AW: 23:22 so patients usually go to bev...

PN6: 23:22 yeah, usually go to Beverley to be honest yeah, they do usually go to Beverley yeah. And obviously they must only have a certain capacity of places to accommodate people because then it's in danger of becoming a victim of its own success, isn't it? If it's really popular, but there's not enough places., I think that was the situation a few years ago when there was a very long waiting list, but I do think it's a bit better now than it was yeah

AW: 23:50 with the exercise on referral

PN6: 23:55 well, it use to be called exercise on prescription that was when it was, yeah, exercise on prescription was erm it was busy then, there was a long waiting list and then they changed their name

AW: 24:06 and you have said, that it has improved in many different ways

PN6: 24:08 oh, yeah, yeah, yeah, and generally it's positive feedback from patients who have done it and yeah, the only negative thing is they wish they could have carried on yeah

AW: 24:20 I guess the aftercare is quite a big issue

PN6: 24:25 yeah, follow up yeah

AW: 24:25 ok so that all the questions that I wanted to ask. Is there anything that you think is important that you would like to add about anything we've spoke about?

PN6: 24:32 erm, well, erm, and no, I don't think so no.

AW: 24:36 ok and do you think there is anybody in this surgery that would be able to answer these questions who may be relevant?

PN6: 24:43 erm the only, I mean the two of us who do it, well, three of us are just other nurses yeah, because we do the majority yeah, my colleagues. There

aren’t many as I say, there aren’t many GPs who, who will do, sit and fill out this referral form. Generally they direct them to us

AW: 25:02 do you not think any GPs would want to

PN6: 25:09 (laughs) probably not Amy no, I doubt it because they will say it’s a good scheme, but we, we you know, they will just say we don't really do this form we just refer them to the nurses to do it

AW: 25:20 so it wouldn’t be really relevant anyways if they pass it on

PN6: 25:23 yeah, yeah, yeah

AW: 25:23 no problem. Well, thank you for your time today

PN6: 25:26 no, no, you're welcome!

AW: 25:27 I’ll be in touch in about four weeks’ time so I will type this transcript up erm and then I will send it to you so you can verify whether it is an accurate reflection or not

PN6: 25:35 yeah, yeah, ok that's fine

AW: Interviewer Interview date: 06.04.2018

PM1: Participant Interview location: The Riding Medical Group, Brough Surgery

PM1: 00:01 so erm, so basically, what we were just saying, the, the East Riding have set this up because they are thinking that GPs will go on and do the referral, but in fact a lot of GP practices are trying to take the workload off GPs for doing these and they will generally, yes, they will do the referral, erm, but they will just signpost. They will then either dictate or they might fill in the form that's on our computer system, in our clinical system and then it will be up to the secretaries to complete that referral and send that off. So, with the referrals we are always looking at ways to reduce GP workload and with our referrals we have created a lot of our forms we fill in paper wise that east riding would have had in the past and other services and we have created them electronically on our system. And what we want to be able to do is just email them and put the admin burden on someone else to actually implement that and erm, enter all that information into a record. Because their system isn't compatible with system one and our clinical systems, there's no, way of bringing it in demographically. The systems that work, like even e-referral, choose and book as it used to be, that links with our clinical system and it can bring the demographics in of the patients so it's a lot easier, so they don't have to fill, because by the time they have filled in patient name, date of birth, contact details, it's quite a lot of information and typing, even for our secretaries to do. It's a lot of information. Systm1, if we are doing it on a form, we can mail-merge it from the patients record, it pre-populates the form and all they are then doing is populating it with the patient or single, button,

populating in the patients information, and then just sending it off, email fax, whatever through the post, or giving it to the patient to actually take. One of the big issues we have got with using an online portal, obviously with the new GBPR rules coming in, there's massive concerns about IG, and recording information on other systems, and also transferring of information. You'd hope that the conversation that the patient and the GP are having is "I am referring to you this service because, I think you would benefit from exercise " or "further interventions" so in essence they are getting the consent off them and then at that point. and we, since we have done health optimisation, with the CCG, we created our own form electronically and our GPs will just mail merge it and the secretary will send it .so we actually haven't had the problem of actually consenting and getting people on board with it. That hasn't necessarily been a problem from our point of view, but GPs, the big thing with the GP forward view that you might hear about is about looking at er, reducing GP workload in all different areas. So, we are looking at document processing, we are looking at referrals, we are looking at working smarter. And more often than not, because of IG and other things, and because our clinical system is such a powerful tool, all of that revolves around our clinical systems making our lives easier and how we produce things rather than going onto some template. In an ideal world, this would be like e-referrals, yes, you would go look at the appointment online with the patient and say right you've got all these choices of appointments, but we don't, realistically we don't do that. What about giving the actual link to the patient to go and book. Do a referral, give the referral form, we will send the referral form through from the GP, but then there could be a tear off slip or

some form that we could give the patient for themselves to book into these appointments if they want an appointment, or it could be that you guys would ring them to say, well, not yourself, but East Riding would ring to say this is the appointment. I can see from their point of view, it's easier, it's safer if we enter all the information, but from a practical point of view, you're not going to get the GP to do it. We haven't got any admin time available to support another system of entering information because we just haven't got any spare staff. NHS as an entity is at saturation workwise. It has never been so busy. I have been here 11 years and I don't just mean our practice, I mean everywhere! It's never been so busy and what is happening is a lot of the admin functions that we had support in, like the movement of medical records, and other things, a lot of that admin has come back to the practice, and it means, it's basically, putting a lot of restrain on resources. Secretaries, they are having to do more and more referrals than they ever did because they have got to send everything electronically. With an e-referral system, so the, we want to basically, do everything in a single system because it makes it easier, but in other, lots of other services, we are getting "oh, just use this website". So, Humber mental health want us to use a website for referral

AW: 04:47 yeah, I have heard about the Humber e-referral

PM1: 04:48 then the other one we have been asked to do is individual funding request for patients, that's a new one that the CCG has asked us to fill in., I think that has come from ember where there's another form, where you have to use another system. None of it is linked. None of it brings in the demographics, but we know that some systems can bring in demographics if they are set up right. So, we have got erm, we do INR [international

normalised ratio] star which is INR warfarin [blood thinner] monitoring. Erm, obviously e-referrals can pull in the information, but it's about working with the clinical system providers to sort of facilitate that and sometimes they will say yeah, we can link, we can get that system to work with Systm1, but it's going to cost you. You know, there will probably be money exchanges and East Riding won't want to do that, a single council. We've got the other problem that we, you know, we have for East Riding, we have to use Pharmoutcomes for our NHS health checks and any services that are funded under the local authority and this is just another thing that you're asking us to do. So, unless it becomes contractual, I will be very, well, we won't be doing it as a practice! Erm, and we would say as far as we are concerned, we don't want to be entering our information into there

AW: 06:01 involved with that. Absolutely. As you say, there's so many different fragmented services and you've got these fantastic clinical systems that can auto-populate and mail-merge so as you say, what is the point in having all these systems which is increasing the admin burden

PM1: 06:17 well, our GPs, we've done a referrals template within Systm1, so they just literally go down to the, the just literally go down the referrals template [GP walks in room, PM and GP have separate conversation. GP leaves]

AW: 07:44 you said, you have done a form within Systm1\. How did you go about doing that?

PM1: 07:49 erm I can't remember if we asked you for it in word format because it won't work in PDF. Erm, if we haven't, we've just copied it. We've just basically, re-typed it all in word and you just put mail merge fields in. Systm1 is quite clever

AW: 08:03 ah so whatever you tell Systm1 to do in a particular field it will just transfer it from the records?

PM1: 08:07 Yeah. Yeah. So, it will transfer all demographics, it will even put the referring GP in, and you can put in when they were seen. There's loads of different bits of information it will pick out from a patients record, but for the referral for East Riding, it just needs to be the demographic information

AW: 08:20 yeah, within that. And are you on Systm1?

PM1: 08:24 yes

AW: 08:24 can that be done within EMIS?

PM1: 08:24 yeah. They just create it themselves, but whenever you guys set up new forms, I mean a single form for all these services would be better and then you can tick what service you want to do it to. So, if it's Health Op, or if it's Exercise on Prescription, or whatever. A single form would be better for us. But we, we just then, pull it in as a word document and we just have to set the mail merge fields up

AW: 08:49 right, ok. [HLO's name] did ask me to ask you if you wanted three separate forms or if we could create a singular form

PM1: 08:56 oh, no, do it as one. I will show you

AW: 09:01 because that would be easier for East Riding as well, if it was a singular form

PM1: 09:03 oh, yeah, and we would then just have to tick which service it is or that you know, we are referring to. Or we could have it so it's three forms on our template and you just pick, go down a list. Is it exercise on prescription?

AW: 09:18 yeah, which one is appropriate

PM1: 09:18 the information that coming back, I had asked about how it comes back and on Pharmoutcomes

AW: 09:26 is this in terms of the feedback?

PM1: 09:26 yeah, the feedback from, no, I don't mean feedback from this. I mean back when they've had their consultation, they are not very detailed what comes back. And it's not nec, I said, to her, it's not very clear that they have necessarily gone through health optimisation and there was some feedback and we said, that we would like to know, the whole point in them going to health optimisation is they have to get their BMI under that amount or it's the stop smoking service, isn't it? And they have to be seen to stop smoking. What would be really good on the outcomes of the information that comes back to us is this patient has completed and they have come below their BMI target, or they have stopped smoking. And whether they still, it would be good if the trainer or whoever speaks to them could decide or could ask the question "do you still want referring for that appointment" because then it would be "make sure you go back to your GP and ask to be referred"

AW: 10:15 as in for the surgery that they are wanting?

PM1: 10:19 yeah

AW: 10:20 right, ok

PM1: 10:21 yeah, so like orthopaedic stuff, they might want their knee or hip replacement and if their BMI is over 35 then they have got this 6 month gap or they go through health optimisation, get their weight within range, get it under the 35 and then the GP can refer. It doesn't obviously have to be the six months if they get it under within that time, but it would be really good, you know, rather than us... You'd hope, you'd hope that the patient would go in

and think well, actually I've got it down I need to go back to my GP now, but it would actually be a prompt to say. And they don't necessarily need a GP appointment it could just be a call the practice and speak to the secretaries and say you know need referring

AW: 11:04 and go from there, yeah.

PM1: 11:05 and we could send a message to the GPs. It's just about working a bit more smarter with those referrals

AW: 11:10 so what information comes back to you currently?

PM1: 11:12 er we get it [feedback] through Pharmoutcomes and I am presuming it's just a summary of what has gone on, but from the ones that we have seen, there's not a lot of detail. It's just like they've had a session, I think it will probably have the height and weight on there, but it would just be good if it was really clear

AW: 11:28 just to have the key thing. As you say BMI....

PM1: 11:31 yeah, completed

AW: 11:32 yeah, whether they have completed, stopped smoking and if they want the referral appointment with the GP

PM1: 11:39 yeah, if that surgery is still required or not or, because in some cases if they get their BMI right down, get within, below the amount they need to be, then you would hope that erm, some of the health problems they had as a result of them being overweight, and if it was impacting on them, it might have gone. But as I say, we have got a template, er, that all our GPs use. I'll go this way, it looks longer than it is [PM is showing referral templates] so they all have this referrals template and off here we've got loads and loads of different services and we've got a load of the community services. I will have

some of the Eat Ridings on here, but I can't remember where they are exactly. Er... is it on there

AW: 12:26, I think this is perfect. When speaking with the GPs and Practice Nurses, they are talking about time, auto-populate, the fact that they are doing duplicate form whereas this could solve all of that if they all had a form integrated in their system.

PM1: 12:39 yeah, it needs to be... I maybe don't have one for Eat Riding because, I think I asked for it and I don't know if you could provide it, actually it might be under a different template. I've got health optimisation template. Ah yeah, it's done it here. So, I've basically, got a template, which we record all the, at the point of doing our appointment, we've got to record health optimisation information about whether we can refer them or not. We record that in there and we say what signposting we are doing so it's re-coded in the patients record because we can then search upon that to look at where we refer the I've got a single click, button which is, we've already got it prepopulate with where it is going to. We actually email them through Systm1, but what we do, is we would write it now...

AW: 13:28 that's perfect so you've got that trail in the patients records

PM1: 13:30 yeah, audit trail because when you are doing it on an independent system, where's your fall back that you have actually sent it?

AW: 13:34 exactly yes

PM1: 13:37 the website, the problem is websites generally in the NHS , they are so slow, usually this is a bit quicker it’s just going a bit slow at the minute. But because I've already, so yeah, I think, I think we, I think we recreated this because you wouldn't give us it in word because you said, oh, no, you've got

to use to portal so we populate information and they will cross in what conditions a patient has got. It pre-populates the date of referral and then they can fill those bits in or we

AW: 14:07 perfect and this is much better than consent [referring to a tick box rather than a signature]

PM1: 14:12 yeah, we automatically put consent in and just put verbal consent. We agreed that with CCG at the time and then the secretaries if necessary will put in the signature. But what would be better is just the referring clinicians name going in. You don't need signatures on stuff nowadays

AW: 14:26 no, you don't for anything else do you?

PM1: 14:25 no

AW: 14:28 would you mind if I had a printout of this so I can show [HLO's name] what you've actually created. Because she actually I met with [HLO's name] and she said, it's a really good idea, can you ask her if we need three separate forms, or one form.

PM1: 14:42 you just could do it as a, you could just do it as a, but if you took a load of this out

AW: 14:48 ok so what would you like on the form? If you could start from scratch, what would you like to see? What is essential for your coding?

PM1: 14:54 shall I just edit it for you to show you what I want?

AW: 14:56 yeah, that would be perf, you tell me exactly how you want it (laughs)

PM1: 14:59 I mean I wouldn't put that on there I would put East Riding referral form, do it as one.

AW: 15:10 yeah, for all the programmes

PM1: 15:12 and then you'd probably take that bit off... erm, probably take that bit off because we already know all of that

AW: 15:22 yep

PM1: 15:23 you'd put medical conditions. I refer this patient onto er, the East Riding erm, I don't know if you would have to put Council there. And then, and then you would probably put erm for...

AW: 15:49 and can you edit these so you can type which one you want it for? Or is it a case of a list?

PM1: 15:52 I'd do this... do a little table

AW: 15:59 yep, and then indicate which one through tick boxes?

PM1: 16:02 I mean that's got date of referral on there, date of referral change that, if you wanted to, I mean does it actually matter which clinician has referred? Do you need to record that? You'd maybe put GP somewhere and then you'd probably just have a little table there.

AW: 16:15 yeah

PM1: 16:16 which would be...er...and the you'd just have a box

AW: 16:25 for which programme it is yeah. Thank you, this is really useful. It's amazing how you've created this template. Nobody else has...

PM1: 16:35 oh, we do it for everything because I know I can save secretaries loads of time and I know that I can save any clinician a load of time, but the problem is where you've got a load of paper referral forms in draws in GPs rooms which you do have in some surgeries. It's updating them all the time and getting rid of all the old ones. Then somebody will do a referral on an old form and it will be rejected because it's no, longer the...

AW: 16:58 yeah. And it's the same with the new online system I have found that a lot of surgeries are filling them in for the..

PM1: 17:02 have you seen how lengthy it is through online?

AW: 17:02 I've got, I've seen that there's three sections

PM1: 17:06 it's really lengthy! She [HLO's name] was doing it in the demonstration which, really enthusiastic about it, but I was looking at how much, and she said, oh, you don't have to fill all this in, but looking at all those blumming boxes and I just thought my god she's not going to get sold in.

AW: 17:19 yeah.

PM1: 17:23 and then you can obviously do the others just list it the

AW: 17:28 it's annoying because we know what the problems are, but until we have got people voicing it themselves

PM1: 17:35 they are really, we found this with the erm, when we were looking at NHS health checks, erm, because it's associated with the local authority and this portal of outcomes for health that you have to record everything into because that's the only facility they have got because they can't get Systm1. So, when we do a NHS health check in house, because we also are commissioned to do that service, we have to put it on our own clinical system, but to get payment through the local authority, we have to put in on their webpage as well

AW: 18:06 so it's just duplicating work?

PM1: 18:05 it's just duplicating it! And we are saying, but this is stupid that we are having to duplicate it, but it is the only way it will initialise payment. It then sends, we get an email with any stuff that's done through Pharmoutcomes, so

health op, the trainers , er anything that's done in the local pharmacies, NHS health checks. We also get our NHS checks back via email because it's how the system works. It can't filter out which ones are ours and which ones have been done elsewhere. It's just ridiculous because we have to tell it which practice it has been done at. So, you would just basically, do it like that [completes template] that's gone a bit skewwhiff I don't know why it's probably my erm margins. There we go

AW: 18:50 perfect yeah, so as little as possible

PM1: 18:50 yeah, but you don't wanna, you don't wanna be printing that off and then signing it. You want to save that in the patient records, the secretaries do the final save it and they can actually email it off via email on, erm, through the patient's record. That is saved in the patient record. You have got a record of the referral. You have got a record of the content that was sent off and then your audit trail is that the email has been sent

AW: 19:14 yeah, absolutely

PM1: 19:14, but you're not having to exit our clinical system to do all of that. It's all in the patient's record, maintained in that audit trail and keeping it all neat

AW: 19:24 yeah, absolutely. It's there it's pre-populated, no, patient signature, no, booking on and as you say you can ping that across and you've got that audit trail

PM1: 19:32 that's it! I'll save it. I'll just log into my emails

AW: 19:36 yeah, thank you. Do you receive any feedback from the programmes at the minute regarding a patient's progress from any of the programmes?

PM1: 19:41 I don't know because I don't see enough of them to come back to be perfectly honest. Erm, so this is, I questioned it in our meeting to say what are

you actually sending back to us? Does it state whether the patient has completed? Are they happy with the outcomes? You know and all this sort of thing erm. So, then we are not having to check back with the patient because it doesn't seem, it just seems a bit disjointed really. We don't seem to be getting told the full feedback and also we don't necessarily need progress updates on a patient, we probably need it at the point they are discharged we need the whole information at that point. You don't really want to be getting every contact because that's a waste

AW: 20:23 absolutely, it will burden...

PM1: 20:23 as well. It would be better to send it at the point that they have, obviously, because every time we get feedback into our clinical system, we have to erm record all those instances, every time we get the BMI and everything we have to record it all at every single instance. I mean they are not with you for a great deal of time are they?

AW: 20:42 no, no, unless it's LiveWell

PM1: 20:44 yeah

AW: 20:45, but as you say if it is just at the end then you don't have to, I didn't know you had to record every interval

PM1: 20:49 I don't know, yeah, we want it at the end, but it would be useful to know from our, from their side how the structure works and how they do communicate with us and say, because then we can say well, actually, as I say, just give us it at the end of the first instance and then at the point of discharge. You don't necessarily need it all because we have recorded that we have referred them to you. As far as we are concerned, they are under your

service. Some of the services, we get like updates all the time as it's like do we need it all the time?

AW: 21:18 yeah, it's just extra workload especially if you have got to keep updating the BMI

PM1: 21:23 is this your email address?

AW: 21:24 erm yes, that's the one fantastic thank you

PM1: 21:27 I'll put draft

AW: 21:30 so how do you, I've heard of Pharmoutcomes, but I don't actually know, is it a separate website you've got to log on to?

PM1: 21:35 yeah, yeah, it's erm, I can find it on here actually

AW: 21:42 I'm just thinking, is there any alternate where we can sort of link...

PM1: 21:48 Systm1 would be ace, but it's just not going to happen, is it?, I think we call it outcomes for health... outcomes... so this is another one where they were expecting GPs to log on when they did like coil fits for certain conditions, but they basically, just asked an administrator to enter it all. Erm, you've got the services, and you basically, I haven't got any patient information on there, so you basically, go into the different services that you are offering

AW: 22:45 yep

PM1: 22:46 er I've got a... so it has lots of validation on it and rightly so because its erm got information on it. Its suppose to anonymise all of our data so you can't identify the patients, but you have to go and you have to record masses and masses and masses and masses of information

AW: 23:06 wow

PM1: 23:07 the good thing the if, so when you are recording all of that

AW: 23:13 and they expect GPs to do this?

PM1: 23:13 this is our healthcare system, this is a NHS health check this one. If you go through you have to put all of the, there's load of boxes that you have to fill in for a health check. When we do it on our clinical system which our staff are used to using because it's what they are using every day, we've just got our own template that we use for NHS health check which is probably, erm, there. Which is detailed, but then we can then print this out as a summary to give to the patient and it's got loads of information on, saved in the patient's record.

AW: 23:45 it's just organised better, isn't it?

PM1: 23:46 saved in the patients record and we

AW: 23:49 and again can all this be pre-populated from the patient's record?

PM1: 23:52 er well, when we come to print it out it will pre-populate, but they would generally fill all this in, but its little tick boxes and its ting things in. But we have put explanations next to each thing so that when that patient gets that print out, they know what cholesterol means, they know what the blood pressure range should be and it gives them a bit more information. And then it says that we, we, we suggest you go to stopping smoking service

AW: 24:17 that's so much better and gives the patient much more of an awareness of what actually

PM1: 24:21 it's about patient education. If you print out, the one that you get from here, its dia [bolical]... it's basically, an online form

AW: 24:33 it's just page after page

PM1: 24:32 yes, it's really lengthy

AW: 24:35 that's not good to anybody!

PM1: 24:38 so and it's not always very reliant either the Pharmoutcomes

AW: 24:46 ok so we've spoken about sort of if we can move away from that online system, you've used your own integrated template for a long time, it's obviously working really well, so if we could provide you with sort of one singular form, with all the programmes on it will save you a lot of time

PM1: 25:00 yep, all we might do is, so the GP doesn't have to decide to tick the form, we might just put the form on four times, to save the form and have it on four times so it pre-populates and that will save time as well.

AW: 25:13 yeah, and save time that way

PM1: 25:15 yeah, when we refer we will have to put a different referral header for each one

AW: 25:20 yeah, er anything else in terms of what we've spoken about that you feel...

PM1: 25:22 no, I think there needs to be a bit of engagement really between the services. It was, to be fair to the East Riding it was set up in a mad major rush. CCG were just told that they had to go with it and it was late coming out, and the information was late coming out erm I don't know how well, it has been adhered to at the minute, particularly with the...

AW: 25:42 the online system?

PM1: 25:43 I mean the actual referrals and sending patients through health optimisation before going on... maybe this is about looking at how many patients would actually qualify for it to you know, I , I think it's quite hard to decide how many patients need to be seen for this service erm cuz it's a bit of an unknown, isn't it?

AW: 26:01 yeah

PM1: 26:01 it’s like how many referrals are you going to make

AW: 26:03 you don't know do you until...

PM1: 26:04 no, but I don't think it’s probably been utilised as much as erm, it was originally, sort of thought

AW: 26:10 yeah, as anticipated. Do you think there is anyone else in this surgery who wouldn't mind speaking to me who perhaps refers onto these services? I don't know if you use a secretary or healthcare assistant anyone like that?

PM1: 26:22 I can see if one of the secretaries are free?

AW: 26:24 yeah, brilliant thank you

PM1: 26:30 Hi Justin, sorry to bother you. I don't suppose you've got just two minutes, just downstairs. I’ve got somebody who’s looking into East Riding, you know the health optimisation, the referrals going to the services, and I am just explaining some of the problems with referring onto them because they are wanting us to use like an online portal. yeah, have you just got two minutes? Thank you, bye.

AW: 27:01 thank you, and can I really quickly take some demographics from you before I forget? is that alright?

PM1: 27:07 from me yeah, female, er 36

AW: 27:12 you're good at reading upside down!

PM1: 27:11 am I 36?

AW: 27:14 and you’re a practice manager?

PM1: 27:14 yep

AW: 27:14 any other roles within the surgery?

PM1: 27:16 erm, I'm, I'm involved with the CCG from an IT point of view, which is why I am on their R&T strategy group

AW: 27:25 that's why you're so good at templates then! And are you considered full time or part time?

PM1: 27:29 full time

AW: 27:30 full time. And how long have you worked as a practice manager?

PM1: 27:33 11 years

AW: 27:35 yep, has that always been within the East Riding of Yorkshire?

PM1: 27:37 yes

AW: 27:37 fab and I have your email

PM1: 27:40 yeah, yeah

AW: 27:41 brilliant thank you for talking to me today

PM1: 27:45 that's fine

AW: 27:47 yeah, if you could ping, you've sent that email yeah?

PM1: 27:48 yeah

AW: 27:49 because I can give that to [HLO's name], I think they are looking at quite soon, you know getting it integrated within all the systems.

PM1: 27:55 you just need to send it out to us because once you've got that form done, just send it word not PDF cuz the amount of times it gets sent in PDF and we just can't do anything with it, it won't go on there.

AW: 28:07 how long does it take you to set that up? Is it relatively quickly?

PM1: 28:10 yeah, if you guys give us it in this format

AW: Interviewer Interview date: 23.04.2018

CLW1: Participant Interview location: The Bartholomew Medical Group, Goole

AW: 00:02 am I ok to take some simple demographics from you before we begin?

CLW1: 00:05 yeah, of course you can

AW: 00:08 how old are you if you don't mind me asking [CLW's name]?

CLW1: 00:10 38

AW: 00:12 38 and what's your role within this surgery?

CLW1: 00:16 erm I'm classed as the community link stroke social prescriber

AW: 00:20 yep, are you considered full time or part-time?

CLW1: 00:24 full time

AW: 00:25 is that 8 sessions per week in general practice?

CLW1: 00:28 hm yeah

AW: 00:32 and how long have you worked as a community link worker?

CLW1: 00:33 since October

AW: 00:37 yep, 2017?

CLW1: 00:36 17 yes

AW: 00:41 I always forget what year we are in. And you've always worked within the East Riding of Yorkshire?

CLW1: 00:43 yeah

AW: 00:43 so it's always been within that surgery?

CLW1: 00:45 yeah

AW: 00:46 no problem and I have your email so that's fine. So, could you start by telling me a little bit about your role so what a community link worker is?

CLW1: 00:53 right, basically, what we do is we work alongside the doctors, the nurses, the health visitors, basically, anybody who is under the umbrella of the GP surgery. Erm, anybody who, who goes to see the doctor's if they feel it's more social, so erm, and if it's not medical so if it's not treated through medication and things like that, if it's more social, to do with housing rest bite, finances, benefits, erm, rest bite and carers support. Basically, anything that the doctors can't help you with (laughs). So, they will refer to us. They will send us a task, we will basically, find out what it is that they are wanting. We will contact the patient asking them to come in, do an assessment with them and then refer onto the appropriate people.

AW: 01:54 ok so for anything, as you say, that cannot be fixed my medical intervention. So, anything outside of that which can included finances, benefits, a whole host of things. So, then, do the patients see you on a 1:1 basis?

CLW1: 02:04 they do yes

AW: 02:07 how long do you have typically with them?

CLW1: 02:07 an initial assessment takes a good hour, a good hour because we go through quite a lot, quite an in-depth assessment with them cuz basically, they might come in regarding one thing and it might be that actually we can help them with half a dozen things

AW: 02:23 right, ok so how do you do your assessments to enable you to signpost them?

CLW1: 02:31 well, basically, we follow the assessment protocol and then it will go on to ask about erm, basically, their type of housing, whether it be council or mortgage, erm if they have any financial difficulties then it basically, carries through a process. It will ask about their exercise, it will ask about erm, their diet and things like that. So, again, that's where we can see if they are overweight, or you know things like that and that's when we would refer on to the weight management team or the LiveWell, programme or whatever is appropriate

AW: 03:11 so that assessments covers all different areas

CLW1: 03:13 it covers absolutely everything yeah

AW: 03:16 and can patients self-refer to you or is it always via delegation?

CLW1: 03:19 not at the moment they can't

AW: 03:25 Is that something set to change in the future?

CLW1: 03:25 as far as I am aware potentially it could be happening

AW: 03:29 ok and are you just based in Bartholomew?

CLW1: 03:35 Bartholomew on a Wednesday and Fridays, no, sorry Monday, Wednesday and Thursday, Montague (Montague Medical Practice) on a Tuesday and Howden on a Friday

AW: 03:46 where is Montague?

CLW1: 03:49 Montague is Fifth Av

AW: 03:49 ah right, ok so still within Goole?

CLW1: 03:53 yeah

AW: 03:55 and why might you refer onto the healthy lifestyle programmes?

CLW1: 03:56 the, basically, the, the leisure services you mean?

AW: 04:05 yes

CLW1: 04:05 basically, if they are referred through the doctors and they have a BMI of over 40 we would refer, and if they wanted to get into exercise, we would refer to the LiveWell, programme or the Exercise on prescription. I usually give them the option, if they want weight management as well. We can potentially refer onto the health trainers

AW: 04:31 ok

CLW1: 04:33 just depending on if they want that bit of exercise as well, you know some people don't, some people do so...

AW: 04:38 yes. So, it's looking at their preferences and seeing what is most suited to them?

CLW1: 04:43 yes, of course

AW: 04:43 of the LiveWell, and the Exercise on Referral, which one do you find you refer to the most often?

CLW1: 04:51 erm, it's about the same at the moment actually. A lot of people are reluctant for the Exercise on Prescription one when they find out there is a charge. They will say "oh, no, I will just go for the weight management option" which is do the health trainers erm so erm

AW: 05:15 so the weight management offered by the health trainers, is that free of charge?

CLW1: 05:18 yes

AW: 05:19 yes, ok

CLW1: 05:21 so erm

AW: 05:24 is cost an issue to patients in this area?

CLW1: 05:25 yes, especially like I say, especially if they have got financial difficulties erm, yeah, because it can be quite expensive. It's £33 for 10 sessions

AW: 05:37 yes

CLW1: 05:38 so...

AW: 05:41 how are you made aware of the programmes that are available, that are run by the council?

CLW1: 05:42 erm, basically, the leisure services got in touch with us when we started working for the health trainers, for the community link. Basically, we had some training erm and we knew we were going to be based in surgeries, so they, it's actually done online, all online now so we can refer straight away to the leisure services.

AW: 06:05 ok the online referral system?

CLW1: 06:12 yeah, yeah.

AW: 06:11 and do you feel that you've been provided with enough information regarding what the different programmes entail?

CLW1: 06:18 yes

AW: 06:18 is there anything you would like more information on?

CLW1: 06:19 erm, no, not at present it's not that long ago that [HLO's name] I want to say, he came to do some training for us all and he keeps us up to date quite a lot actually on different things that are going on so

AW: 06:36 so you are well, informed about the different things going on. Brilliant. Are you given any information resources to perhaps hand to patients?

CLW1: 06:43 yeah, we've got leaflets, erm posters up and things like that in the surgery so...

AW: 06:50 ok so lots of advertisements for patients

CLW1: 06:54 yep

AW: 06:56 do patients tend to be well, informed when you mention the programmes, or does it tend to be the first they have heard?

CLW1: 07:00 er no, I wouldn't say they are well, informed. It can basically, be the GP, or the Nurse or whoever has just said, oh, you, what's the word? You fit the criteria for the LiveWell, I'll refer you to [CLW's name], the Community Link

AW: 07:16 ah, ok and then is it your responsibility to inform them about the scheme?

CLW1: 07:20 yeah

AW: 07:23 how do you remember, because obviously you refer to so many different things, how do you retain all that?

CLW1: 07:28 (laughs) I don't. I get the booklet out and it tells me how each one differs

AW: 07:33 ah so you've created you're own sort of resource

CLW1: 07:36 erm, I think it was [HLO's name] actually who did a leaflet, a handout for us where you know, it tells us basically, the HOP, the LiveWell, the Exercise on Prescription, the one for the younger age

AW: 07:48 ah the Young LiveWell

CLW1: 07:49 and how they differ and things like that

AW: 07:53 you, you have all that criteria there

CLW1: 07:55 yeah

AW: 07:55 have you ever used the paper referral or have you always engaged with the online referral system?

CLW1: 07:59 no, no, I have used the paper one because I have to erm, get the patient to sign it and although I do it online and say that they have given their consent, I still have to get it scanned and put it onto their notes.

AW: 08:15 oh, right, ok

CLW1: 08:17 through Systm1

AW: 08:18 ok so you have to print it out and ask them to physically sign the paper as well,

CLW1 08:20 yeah

AW 08:19 ok how do you feel about having to....

CLW1: 08:24 well, it's duplicating isn't it really?

AW: 08:29 absolutely I wonder why you have you take the signature. I was under the impression the online

CLW1: 08:34 to save time basically

AW: 08:38 would it help if you didn't need to take that signature? [CLW1 nods] Do you have to take a signature for anything else you refer on to?

CLW1: 08:43 for what sorry?

AW: 08:45 for anywhere else you refer on to? Is it common practice?

CLW1: 08:48 no, no, it's just the leisure services basically

AW: 08:55 so in an ideal world it would be quite nice o scrap that. As you say nobody else, you don't need that for anywhere else

CLW1: 09:02 no, no

AW: 09:01 ok and have you ever experienced any other challenges when referring patients, or anything perhaps that makes the process a bit longer, or makes it difficult to refer?

CLW1: 09:13 see the only difficultly I would say I have had is when erm, cuz like the LiveWell, programme, usually they are only allowed it twice, so er if someone has already had it, they have to go through a process of explaining why they wasn't successful before and things like that to see whether they actually qualify again for it. Erm, so I would say that's the only difficulty, but it's not me who deals with that. I say I'll refer you, but I don't know if you will be accepted or not so...

AW: 09:52 yeah. So, who decides whether [CLW1 shrugs shoulders] you're not sure?

CLW1: 09:58 not sure, I think it's the leisure services. They will look and see why they wasn't successful before

AW: 10:06 so it's at their discretion

CLW1: 10:07 I believe so yes

AW: 10:07 do you find that many patients are not successful on the LiveWell, scheme?

CLW1: 10:12 to be honest because I've only started in October I haven't got any feedback or anything yet so erm, but as far as I am aware most of them that I have referred have seen quite keen so hopefully, hopefully, you know they have been successful.

AW: 10:32 it seems they have got that motivation, they are keen to do it

CLW1: 10:38 oh, yeah, yeah, yeah, yeah

AW: 10:38 anything else in terms of the referral process? So, what's your overall, opinion of the online system you are using at the minute? Do you find the measurement appropriate that you are required to take?

CLW1: 10:49 erm I would say that the downfall of it is that we have to book, we have to go onto Goole and then we have to book them in whereas it would be better if we could just send their details and the leisure services book them in rather than us actually you know what I mean, book them. Because we, we will book a slot with the patient, the client, whoever and then the leisure services get in touch with them to make sure that it's an appropriate time whereas really they could just do that, they are booking them in anyways

AW: 11:35 again there's a duplication so if you're are booking the appointment, and they are ringing them anyways to check it's ok, that's sort of a

duplication there. OK, are patients willing there and then to book an appointment or do they need a bit of time to...

CLW1: 11:50 no, no, usually they, if they are keen to get on with it, they want to make an appointment and know they have got it

AW: 12:00 ok, but for you it would be quite nice if that was taken from you

CLW1: 12:03 yeah, it we could just send the referral and they ring them and book them in

AW: 12:09 so the next section address patient feedback. I know you've said, you've had limited feedback at the moment. Do you get any feedback from patients? Do you tend to see patients again or are you completely in the dark?

CLW1: 12:20 no, completely in the dark. It would be nice to get some feedback, you know. You know if they have been successful

AW: 12:33 so what feedback would you like specifically? So, if they have been successful in terms of if they have completed the course?

CLW1: 12:38 yeah, if they have completed the course, erm how much weight they have lost or if they are going to continue and do the monthly membership. Erm, I suppose we will find out if they haven't been because they will come back later to see if they can do it again

AW: 12:59 absolutely. So, in an idea world, whether they have completed the programme, something referring to weight loss if they have been referred for their weight, but also if they are continuing with that change. So, have

they joined the gym? If they are taking exercise up on their own account. Fab, and if you received that feedback in general practice, do you then attach it to the patients notes?

CLW1: 13:22 not as far as I am aware, but me personally I would task the relevant doctor who had referred them or the nurse, whoever had referred them and just put a little note on to say they have been successful or you know things like that

AW: 13:42 and what would be the best way to send that feedback to you., I think the leisure centres are using Pharmoutcomes

CLW1: 13:48 that could be a potential because we use Pharmoutcomes

AW: 13:52 ah right so can the surgery use, have access to Pharmoutcomes?

CLW1: 13:56 the surgery don't, but us as a community link do

AW: 14:00 ah right so you can go unto Pharmoutcomes and see..

CLW1: 14:02 yeah

AW: 14:02 I'm just trying to think of how we can get it back to the surgery, that communication loop as not all surgeries have community link worker so I'm just cautious of...

CLW1: 14:12, I think they are going to

AW: 14:14 yeah, I think that's the hope in the future. Do you know the timing for that? When they hope to have them in every surgery?

CLW1: 14:18 well, we won the tender so erm it’s just a matter of time

AW: 14:24 just when ah brilliant. Fantastic. The last section is more relevant to general practice so it's how that surgery manages their patient load in terms of how they delegate their patients.

CLW1: 14:38 right

AW: 14:39, but I guess you are that support network in surgeries because you free up consultation time and patients are delegated to you.

CLW1: 14:49 yes

AW: 14:50 well, that's everything that I wanted to talk about today. Is there anything we've spoken about that you would like you expand on or anything that's relevant to add?

CLW1: 14:59 erm no, I don't think so as I say it would just be nice to have that feedback on the clients that you have referred

AW: 15:09 so feedback would be really good. If they could remove that online signature, and also if there wasn't that expectation for you to book that first appointment and then the only other thing we have mentioned that could pose a challenge is on the patient's behalf so sometimes the cot can be off putting, but as you say they have got that option of the health trainers if that is an issue

CLW1: 15:30 yeah

AW: 15:31 brilliant as I say I will type this up and send you your transcript within four to six weeks, but thank you for speaking to me today and I am sorry for all the messing about we've had

CLW1: 15:42 that's fine it's not your fault it was me. You went to see[CLW's name] didn't you?

AW: 15:48 yeah, so [CLW's name] is the community link workers at...

CLW1: 15:50 Hornsea

AW: 15:49 Hornsea that's the one so I spoke to [CLW's name] the other week

CLW1: 15:55 because [CLW's superior name] was just saying, is [CLW's superior name] aware that

AW: 15:57 yeah, we had a meeting with [CLW's superior name] during the Brid Inc

CLW1: 16:00 I was like I don't know

AW: 16:02 oh, no, she is fine. She is heavily involved with the Brid Inc group and we presented to Brid the other week erm yeah, because we know obviously the health trainers work really closely alongside the leisure centres so if we can bridge that gap and all work together then we can signpost our patients that say they have mentioned about smoking, we can signpost them to you and vice versa you sent them to us

CLW1: 16:26 yeah, definitely

AW: 16:26 yeah, I think if there is more of a collaboration...

CLW1: 16:30 at the end of the day that is what we are trying to do, isn't it? Everybody working together

AW: 16:34 yeah, because it is really fragmented so it would be good if people could fuse together

CLW1: 16:52 yeah, that's fine

AW: Interviewer **Interview date:** 10.04.2018

CLW2: Participant **Interview location:** Beckside Surgery, Pocklington

AW: 00:02 can I take some simple demographics before we begin?

CLW2: 00:03 yes

AW: 00:05 how old are you if you don't mind me asking?

CLW2: 00:06 21

AW: 00:07 21 and what is your role within this surgery?

CLW2: 00:10 a community link worker

AW: 00:14 is that full time or part time?

CLW2: 00:15 erm it's a full time job, but I only do Pocklington two days a week and Market Weighton the other three

AW: 00:22 ok so Market Weighton and Pocklington

CLW2: 00:27 yeah

AW: 00:28 and how long have you been working as a community link worker?

CLW2: 00:31 since October what's that like…

AW: 00:36 2016? Oh, 2017 sorry I'm behind a year! And that's always been within the East Riding of Yorkshire?

CLW2: 00:44 yes

AW: 00:46 I have your email so that is fine. OK so can you tell me a little bit about your role as a care navigator?

CLW2: 00:53 yeah, so erm, we are based in GP practices and we get referrals from, it started off just referrals from doctors for people who, maybe they had issues that were kind of non-medical so it might have been loneliness and

isolation, or they needed help with fiancé and benefits. Things that a doctor doesn't have time to deal with and we also help people with mental health problems to arrange counselling and support and things like that. It's now kind of expanded. The pilot has gone on and we accept referrals from some admin staff, hospital discharge and social care teams as well, so it can be anyone kind of anyone in the areas we're working. It doesn't just have to be the practice people anymore.

AW: 01:34 ok so as you say it started just been the GPs sort of referring to you, but now it's widened to social care, the admin staff...

CLW2: 01:42 yeah

AW: 01:42 so what's a typical day for you? Do you ever approach patients or are patients always signposted to you?

CLW2: 01:48 yeah, sometimes if they have, say if they already have a GP appointment, the GP will say to them in that appointment, oh, we have Eloise and she does this, would you like to see her? And if they say yes, especially at Market Weighton, they will book them directly in with me. Otherwise, they will send me a task on our system with the patients contact details, brief description of what it is about, and I will contact the patient and invite them to come in for an appointment

AW: 02:13 ok and is it the same at Market Weighton? Do you have your own room within the surgery?

CLW2: 02:16 yeah

AW: 02:20 so what can you refer patients on to? So, you've mentioned a few things that you can refer for, but can you refer onto?

CLW2: 02:27 so I can refer to mental health counselling, erm like cruise bereavement counselling, the East Riding leisure programme, and, I think that's it for referring onto, the rest is signposting people, oh, I can refer people to the council for AIDS and adaptation assessment as well, and the carer assessments and the rest is kind of signposting them to services rather than referring them

AW: 02:54 yeah, rather than a direct referral

CLW2: 02:55 yeah

AW: 02:57 how do you remember all the different services you can refer on to?

CLW2: 03:00 we've got, we kind of had to set up an excel spreadsheet so I've got a excel spreadsheet for Pocklington and one for Market Weighton because even though they are like six miles apart, cuz of the geography of it, Pocklington patients aren't entitled to what Market Weighton patients are entitled to so we've got two separate spreadsheets with everything because otherwise it would just be a nightmare!

AW: 03:22 so because of where they live they are not entitled to...

CLW2: 03:24 it's because Pocklington is more York and Market Weighton is more East Riding. It's mainly only really for the mental health so what Market Weighton can get, Pocklington cant. So, it's just remembering which services for which days they can go to

AW: 03:42 that makes sense. Does that influence the East Riding leisure programmes or can Pocklington patients be referred on

CLW2: 03:48 they can be referred on, yes

AW: 03:52 no problem. So, why might you refer onto the East Riding leisure programmes?

CLW2: 03:55 er so I've had quite a lot of people, well, in Market Weighton actually, not last week the week before, we ran an event. Erm, leisure centre staff came into the reception and had like a display set up just to try and promote it because I don't think that many people are actually aware of what they can get unless the doctor says to them do you want this. Erm, so each day we had staff from the leisure centre in with all the leaflets and all the information and we targeted the Beverley leisure centre and the Francis Scaife one because of where Market Weighton is. And I sent a text out to all the patients, and people just came in to get a bit more information and that actually generated quite a lot of referrals. Because, I think people came and told the gym instructor about their problems and say you know I've got a bad back, what can you do? And they kind of said, well, if you did exercise on referral we could help you strengthen your back, go and see Eloise and she can refer you. So, they were signposting people to me rather than to the GP because we are trying to save the GPs time. So, then, yeah, so that was good for getting referrals onto the programmes that generated quite a lot actually. Erm, another one is when the doctor has maybe mentioned that they need to lose weight, or if someone just comes to me and says I want to lose weight, I have tried everything, what can I do? I can say oh, well, have you heard of the things that the leisure centre are offering, and they will consider whether they want to be referred onto it or not.

AW: 05:10 yeah. So, as you say there's quite a lot of advertisement at the minute. There's the leisure centres coming in to try and get patient awareness up a

little bit and then you've also been also to text all patients which you've said, has brought a lot of attentions

CLW2: 05:25 yeah

AW: 05:25 have you found in terms of workload, are you managing with referrals? Is it manageable?

CLW2: 05:31, I think it's been more the last week, because of the event that we did, erm, I think once we get set up online it might not be as bad, but the paper ones at the moment, it seems like a lot of work, yeah.

AW: 05:43 ok well, we've more on to the paper forms. I have actually got a spare one here. So, is this the form you are using? That's obviously four separate ones, but is that the same form you are using for the exercise on referral?

CLW2: 06:00 yeah.

AW: 06:03 and then the back is the LiveWell, form. Is that the same one as well?

CLW2: 06:06 yeah, that's the right one yeah

AW: 06:09 so when you say it takes quite a long time to fill in the form, what is it about the form that takes so long?

CLW2: 06:12 it's because I don't have a scanner, so I have to do everything on, you know those interactive PDFs? Or edit it on the laptop and then email it. But the interactive PDFs aren't that interactive. They do take quite a while to make sure you get it, like especially cuz all these lines are so close together, so trying to get the writing in the right places is just, seems to take much longer than it should.

AW: 06:36 so someone has put this template sort of on your system?

CLW2: 06:38 yeah, [HLO's name] sent me an email online versions of all of these so I just fill them in on my computer then send them across to the leisure centres.

AW: 06:47 right, ok, but it's not necessarily the online portal where there the three sections. It's just this form?

CLW2: 06:52 yeah, I don't have any access to the online one yet it's not set up

AW: 06:54 ok and in terms of what it is asking you to fill in, do you think everything is appropriate?

CLW2: 07:01 yeah, I think so, I think maybe, I don't know, cuz I have to update their doctors notes to say kind of what they came in for and what we've talked about, I feel like maybe it would be nice to be able to give a bit more information on these because you can't actually tell that much. Especially cuz like if you're just ticking a box. I had one the other day er that was just depression and all you do is tick a box where actually we had a half an hour conversation about why she, why her depression is and why she thinks exercise is going to help that. But then she is probably going to have to relay that whole conversation to somebody else again even though it was quite upsetting for her whereas if they had just been like a bit more information I could have put in, I could have put you know this lady came in da, da, da....

AW: 07:42 so perhaps if there was a section, just a plain box for additional note, and you can say well, we had this conversation, and I guess that gives the trainers a little bit more of an insight about who is coming in

CLW2: 07:53 of course when they turn up they won't get a big shock if someone starts having a breakdown, it would be nice to know exactly what they are

going to get., I think one of them does, doesn't it? It has like a , like that one the LiveWell, has any other relevant information you should know about, but because of the way that I am filling it out I can't make that box any bigger so I can literally fit like a line in and the exercise referral ones don't have anything.

AW: 08:20 yeah, so perhaps if on all the forms there was just that option, as you say, if there's a little section so if there's anything that you think is relevant

CLW2: 08:26 exactly yeah

AW: 08:26 you can pop that in

CLW2: 08:29 not the whole life history, but anything to do with

AW: 08:31 yeah, just in case it is upsetting for her to relive that, it's not something she's going to want to do with every single person she speaks to

CLW2: 08:41 yeah, of course

AW: 08:41 and I know you are not set up on the online yet, but you have attended the online training

CLW2: 08:45 yeah

AW: 08:45 what's your overall, well, first opinion of the online system if any?

CLW2: 08:49, I think it looks quite straightforward. I don't know if it will be when I try it, but it seems to look quite simple in how you do everything.

AW: 08:56 ok and I don't think the online has a section either so that will be quite interesting to see if we can add something on there for you

CLW2: 09:08 right yeah

AW: 09:10 and the online allows you to book the patients' first appointment. What do you think about that?

CLW2: 09:14, I think for some people that will be quite good actually because a lot of people are quite keen to get started and they are asking me like you know, oh, when will I hear back and I'm kind of saying, to them once I've sent the referral it's not really anything to do with me so I can't guarantee that they will be in touch with you in two days, a week, because I don't, I don't know. So, I am telling them you know maybe wait a week and if they haven't got in touch with you then maybe give them a ring cuz I, I am not in control of their times.

AW: 09:41 no, no, you're not at all

CLW2: 09:41 and a lot of people are quite keen to know right when can I get started so maybe saying, to them oh, well, we can book your appointment in, that, I think, that would work quite well, actually for the people I have spoken to

AW: 09:51 yeah, and then you can give a definite appointment time for them. They will not be wondering

CLW2: 09:55 exactly and then it's kind of out of my hands. They either go to their appointment or they don't. It's not to do with me anymore. Because I can't make promises on behalf of the leisure staff because it's me, they will ring and be like oh, you've not been in touch

AW: 10:07 yeah, and that's not something within your control. Ok what information resources are you provided with? Are you provided with any sort of leaflets or...?

CLW2: 10:16 yeah, we've been given a copy of the leaflets for the LiveWell, Exercise on referrals, and the young LiveWell. We also got given a sheet a few weeks ago that kind of had a breakdown of erm what you needed to be

for each one. So, like with the LiveWell, what your BMI needs to be, that type of thing

AW: 10:36 and was it more difficult to do the referrals before you had that sort of eligibility criteria

CLW2: 10:41 yeah, because I wasn't quite sure about all the different little catches. Like I wasn't 100% sure that you had to pay for the 10 week one so now I know I can actually say to people and yeah

AW: 10:50 that's a sheet you've got., I think that's relatively new the sort of eligibility sheet to show the different programmes, but if it is working then that's good practice and we can look at doing some information resources

CLW2: 11:03 it's just nice to have something to reference rather than trying to remember everything all the time and being able to say right well, you need this for this, and that for that, and not having to just be like "oh, my god, what?"

AW: 11:11 what is that. As well, as everything else you've got to remember (laughs)

CLW2: 11:12 yeah, (laughs)

AW: 11:14 is there anything else you would like more information on?

CLW2: 11:18 erm I don't think so. No I don't think so

AW: 11:23 no. no problem. OK so in terms of anything that's made it more challenging or harder to refer. Have you ever experienced anything that has made it difficult to process a referral?

CLW2: 11:38, I think, it's just the kind of, the way that I am set up at the moment it's just a bit messy, I think cuz like we had for the event two people came , erm and [HLO's name] sent them upstairs to speak to me to refer them on,

but he hadn't given me the forms so I had nothing to do so I had to just kind of take all their details and then email them to [HLO's name] for him to send on, but then somewhere in translation they got referred to the wrong thing and then they rang me up saying, why have you done this? And I, it wasn't me, erm, but yeah, it just seems like if anything kind of goes wrong, the patients are ringing me to have a go at me rather than they are not ringing leisure, they are not kind of making that connection between… it's just all coming back to me

AW: 12:23 so they are not really sure that it is the leisure who are running the programmes.

CLW2: 12:24 yeah, I think so

AW: 12:26 and who's [HLO's name]?

CLW2: 12:28 [HLO's name]

AW: 12:28 [HLO's name]ok does he work

CLW2: 12:30 he is like acting lifestyles someone, I think, er let's see. yeah, but apart, it was that that made him, he was like right well, I am going to send you a copy of all of the forms so you have got them all on your laptops so it doesn't happen again so that hasn't happened since, but it still seems that everyone's asking all the time like when will they be in touch? What's going to happen? And that's not really, I don't, I don't know (laughs). Active healthy lifestyles and development officer.

AW: 13:02 ah right, ok so the referrals that you have processed for the East Riding are they quite similar to the other referrals that you do? Like are they as easy, are they more difficult to process?

CLW2: 13:12 erm, I think they are, they are quite easy actually. A lot of the other referrals like we said, do have the bit like any information, why is this referral being made. And I know we've got like tick boxes, but like I said, before just a bit more

AW: 13:25 just a bit more within that

CLW2: 13:25 yeah

AW: 13:27 and how do patients typically respond if you're, say if somebody comes in for weight management. The GPs has said, I think it's a good idea to lose some weight could you please speak with Eloise upstairs

CLW2: 13:38 yeah

AW: 13:38 and they a bit sort of taken back, or are they quite willing.

CLW2: 13:43 most of the ones I've had are quite willing. Erm, some of the ones didn't actually know that these existed erm so they didn't, they didn't kind of want to agree to it straight away. I gave them the information, told them all the different things and they were like right we will go away and kind of think about it. So, whether they will ever come back and agree to that I am not sure. Erm, but yeah, everyone has been quite willing and keen to do it, I haven't had much resistance.

AW: 14:06 that's good, but as you say the patients awareness perhaps isn't all there at times and that's probably why you're doing these sessions with the leisure centres just to try and get the name out there

CLW2: 14:18 yeah

AW: 14:19 ok anything else in terms of what has made it a bit difficult so you've said, the forms have made it a little difficult er, sometimes the patients don't know about the programmes so then that sort of, not makes it difficult, but

causes a delay in the process if you like because you've got to let them make their own informed decision

CLW2: 14:38 yeah

AW: 14:38 anything else in terms of the referral process or anything that you would like to see be run differently or improved? It could be hypothetical

CLW2: 14:42 yeah. Erm, I don't know if it happens at the moment because I've only just started referring, but maybe if they could let us know whether they were attending or if they've turned up. Just so I could update their medical records and say you know, this persons...cuz I know, I think leisure are on Pharmoutcomes aren't they, but we can't get onto that so it would just be nice to get a bit of feedback maybe about if we've sent the right people even for the right things Just to know for us that I am referring people right onto the right thing

AW: 15:15 yeah, yeah, absolutely. So, in terms of feedback that would be quite useful. Erm, so Pharmoutcomes, this surgery has no, sort of access to Pharmoutcomes whatsoever?

CLW2: 15:22 we do, but we have, well, I have my own, like the health trainers Pharmoutcomes. I can't get onto the practices Pharmoutcomes or leisure's Pharmoutcomes

AW: 15:31 ah right, ok so they're all got access to them, but

CLW2: 15:32 it is your own

AW: 15:34 ah, ok so there needs to be somewhere that the information can be somehow transmitted across

CLW2: 15:42 yeah, and the other thing is, for the LiveWell, ones, people are being kind of sent to me by the doctors to say they need to lose weight erm, and

the I, it’s kind of awkward because I don't have scales to work out peoples BMI, and obviously it’s a BMI limit isn't it for the LiveWell. So, it’s either a case of scrolling back through the medical records and trying to find the last time they were weighed, but sometimes that's like a year ago and you don't know whether its correct so then I have to say to people well, do you know how much you weigh and how tall you are? And I am BMI calculating it on the internet, but I don't know, they might not tell you the truth, you don't always know exactly how tall you are and exactly how much you weigh. Erm,

AW: 16:19 yeah, exactly because the BMI criteria is so strict, I think it’s 45 for the LiveWell, so if they are like 44. Something you're going to be like well, what if you've given me the wrong information

CLW2: 16:28 yeah, exactly

AW: 16:31 ok

CLW2: 16:32 so I've only actually done one LiveWell, but we worked out together that it was over 45, but still that's just from what she said, because the medical records weren't up to date with weight. I sent it, but I am not sure if the weight her when she gets there or... I don't know

AW: 16:47 ok so do the medical records tend to be up to date as a rule?

CLW2: 16:50 not really because you only really get weighed for certain, like if you're just going for a sore throat, the won’t weigh you will they? They will only weigh you if you have gone in for some, like a review for something or so it depends. It depends on what health conditions you have got and if you know, like diabetes, they will get weighed, but if not, then you kind of slip under the radar for being weighed so not everyone's is as up to date

AW: 17:11 yeah, so what would you like to see to overcome that issue? Would you like maybe your own scales in here?

CLW2: 17:17 yeah, maybe I don't know because I don't know whether that's really my place to weight people. I don't know it's just a bit complicated because I, you never know how accurate the online ones are, so I don't know. I don't really know what you could do to kind of, unless it's a case of just referring people and hoping for the best and if it is not then maybe leisure could have that conversation to see if something is suitable instead or...

AW: 17:41 yeah, so maybe if it is inappropriate, instead of sending them back here to do it again, maybe if they had that conversation with the patient and said, ok maybe you are not eligible to LiveWell, for instance, but there is exercise on referral.

CLW2: 17:52 yeah, rather than sending them back to me with someone who is unhappy because they thought they were doing something and it's not. Maybe it is about having that conversation, being like right what about that, or what about, you know something else.

AW: 18:03 yeah, so ideally would you like to see the GPs taking, so if they are going to do a referral so they know exactly what their role is, maybe like highlighting to them to say ok if you are going to process a referral if you could quickly take

CLW2: 18:19 the height and the weight yeah

AW: 18:19 the height and the weight which doesn't take too long

CLW2: 18:21 oh, no

AW: 18:21 I know it's about saving GP time, but again its delaying you if they are sending patients are you are not too sure, it's obviously taking your time to try and work out the BMI

CLW2: 18:33, I think for any referral that comes through from a GP for either, cuz I get some weight management for health trainers, but if someone is referred to me for the health trainers, I could have a conversation with them and they might also want to do this at the same time. So, for anything kind of weight or diet related, I think it would be nice from the GP, if it has come from the GP to have this is their height this is their weight, what can you do? Rather than...

AW: 18:53 you can fill out the rest of the things for the records

CLW2: 18:55 yeah, yeah

AW: 18:55 so you mentioned about the health trainers and weight management. How do you decide whether to refer a patient to leisure, or health trainers, or both?

CLW2: 19:04 I'll let them decide it's fully there, I'll explain both of them and then it's up to them what the wanna do. They might not wanna do any or they might want to do both or...

AW: 19:15 yeah, so it's just about giving the patient that choice to make their own decision

CLW2: 19:18 just so they know exactly what's out there and what will suit them best.

AW: 19:24 and what health conditions do they typically present with where you feel an East Riding leisure programme would be more suitable for them.

CLW2: 19:33 quite a lot of people who have got diabetes and they normally get referred by like the diabetes nurse or from diabetes clinic because maybe they are not managing it very well, and they need that kind of extra boast to kind of deal with it a little bit more. Erm, I do get quite a few for weight management as well., I think that's just because the doctors don't have the time to refer them to the health trainers themselves so they will go to me so I can....

AW: 19:59 so the diabetic nurses, if they have got a patient who is not managing their diabetes as well, as they should do, are they able to refer as well, or do all referrals get processed to you?

CLW2: 20:08 they can refer as well, yeah

AW: 20:11 OK. Do you know if they choose to do it themselves or do you think everyone just...?

CLW2: 20:14, I think before we came they probably did them all themselves and now, I think more get, I think some of them do it themselves and some will just kind of, it depends how busy they are I guess.

AW: 20:22 yeah. So, how do you think having a community link workers sort of benefits the surgery?

CLW2: 20.25, I think it just makes it more personal because, I think in a ten-minute appointment if someone starts breaking down about something they just haven't got the time. Cuz the way the system works, you can see who is waiting in the waiting room so they are just thinking right just need to get you out really quickly. So, rather than just saying, here's your tablets, see you in four weeks for a review, they can be like here's your tablets and I am going to book you in now with Eloise and you can go and see them and, I

think it just makes people not at such a loose end because otherwise you just get shipped out and yeah, I think it just helps it be more personal

AW: 21.06 yeah, absolutely as you say in ten minutes if someone has a sensitive problem, it's not

CLW2: 21:09 and, I think they worry that they don't want to talk too much about it in case they open can of worms that they can't shut within the ten minutes so if they try and address it without delving too deeply just because that's what they have got to do, not because they don't care, but yeah. And, I think for some people, they just need someone to talk to even if they don't need signposting or referring anywhere, they haven't got anyone else to talk to so it's nice of them to just come in and know that someone is there.

AW: 21:35 yeah, for loneliness. Do you have like a typical patient, if you like who comes to see you? Is it majority...?

CLW2: 21:46 majority of it is mental health.

AW: 21:47 is it mental health

CLW2: 21:48 yeah, and it's either depression or anxiety. And it's either people who are, you know when you ring the doctors, and you can't get an appointment they say oh, someone will give you a ring back. The majority are either from that and the people have said, right well, I don't think you need a doctor's appointment yet, try this first or from people who have already been given tablets, but need a bit more

AW: 22:09 yeah, there's something else that can be helpful

CLW2: 22:09 yeah,

AW: 22:12 and we spoke a little bit about feedback from the programmes- the East Riding leisure ones.

CLW2: 22:15 yeah

AW: 22:17 so what would you like to hear specifically regarding a patients progress?

CLW2: 22:23 just, I'd like to know if they are attending or not and if they're actually doing it. So, maybe they could do it because I mean if they didn't attend, but they had a conversation with me about how keen they were to do it, then maybe I could get in touch with them and say oh, how's it going and they would say oh, I'm not going, and you can have that conversation about why they are not going or maybe like half way through the programme if they are going that's great and I can update their records and just say this person is engaging really well, on this programme. They are getting this benefit, whatever. Cuz I'm meant to ring them four weeks in anyways erm, but it doesn't mean people will tell me the truth so it would be nice to be able to say oh, I can see that you've not been attending, but when you spoke to me you were really keen about it, what has kind of changed in that time? Cuz it might be something else happened, they need to come back in, and we need to

AW: 23:09 yeah, maybe something else has happened

CLW2: 23:10 yeah

AW: 23:10 as you say just to get that confirmation, not saying, they are lying, but you just have that confirmation

CLW2: 23:17 yeah, just make sure they are being supported by something

AW: 23:22 so at four weeks you've got to ring them to update, so do you have a gap within the medical record where you can free-type?

CLW2: 23:27 yeah,

AW: 23:27 yeah, ok so when would be the best time to send you feedback?

CLW2: 23:32 probably like half, maybe half way through. If they are doing it, maybe kind of like half way through the programme to say right they have made it this far because then it kind of looks like they are going to continue with it. But I guess for the 10-week one that would be fine, but I guess, is the LiveWell, a year?

AW: 23:47 it is I was just thinking if you update the records at 4 weeks, exercise referral is 10 weeks so 5 weeks would be the sort of half way point, but I didn't know it you had a really strict 4 week...

CLW2: 23:59 no, it doesn't have to be....

AW: 23:59 ah so it's quite flexible

CLW2: 24:01 yeah, it's just kind of 4 weeks or whenever it's just to kind of check in and say right are you being supported? Do you need anything else? Do you need to come back in or are you ok?

AW: 24:09 yeah, sorry the LiveWell, programme is 12 months so maybe every month?

CLW2: 24:16 yeah.

AW: 24:20 and what would be the best way to receive that feedback?

CLW2: 24:23 I don't know cuz, cuz we don't all use the same systems I guess the online way you could do it would be through email. Erm, and I don't mean send the life story you know like we do this every week, just like they are attending, they are doing well, whatever. Or they might say they are not attending, I can't get through to them, they have not rang us. Can you try to get through to them or something like that.

AW: 24:47 yeah

CLW2: 24:48 cuz I don't want it to make more of a workload for anyone else, but it would just be nice if they could, cuz then if the GP who referred them goes back onto the record, they can then see right well, you're attending this at the leisure centre and that's good as well.

AW: 24:59 yeah, cuz the good thing about you checking up on them and updating the records, because you're sort of transferring that feedback into the records, as you say the GP can look so if they are with the patient again they can say oh, well, I've seen that you attended this, and you've lost this much weight, lets weight you again. So, it sort of like bridges the gap

CLW2: 25:22 it does, yeah., I think it helps everyone communicate with each other better

AW: 25:25, but as you say it is important that the feedback is limited so you're not given pages of "on this day, we did this "... because that's just going to create more of a workload

CLW2: 25:32 for everyone! Yeah

AW: 25:35 it’s not something you need to know about. As you say more importantly, it’s whether they have attended ultimately and if there is anything else you can do

CLW2: 25:46 yeah

AW: 25:46 fab, I think that's all the sections I’d like to speak about today. Is there anything else that we have spoken about that you would like to elaborate on or anything you feel is important?

CLW2: 25:58 I don't think so, I think we've covered pretty much everything

AW: 26:00 yeah. Do you think there is anybody else in this surgery who wouldn't mind speaking to me to answer these questions.

CLW2: 26:08 to be honest I don't really know anybody. I have only been in this surgery for like four weeks and it's kind of..., but erm,

AW: 26:14 not a problem

CLW2: 26:15 there might be somebody, there might be people in Market Weighton though cuz I've been there since December, so I am more integrated into that practice. So, I, if you want me to I can send a few messages out and see if anyone would be...

AW: 26:25 yes, that would be really useful

CLW2: 26:26 yeah, cuz, I think the healthcare, the healthcare and the nurses do refer on to the LiveWell

AW: 26:33 that would be really good just to see if they have got any sort of different perspectives

CLW2: 26:37 yes, of course

AW: 26:37 of the referral process. So, is it quite similar at Market Weighton? Are you sort of in your own room and people get referred onto you?

CLW2: 26:44 yeah, same

AW: 26:46 similar set up

CLW2: 26:47 yeah, it just works a bit better at Market Weighton at the moment because I am on the GP system whereas here it has not been set up yet

AW: 26:53 so you're on the online system?

CLW2: 26:57 no, just like, even with the doctors I'm not on their system here. They are just emailing me referrals

AW: 27:01 oh, so you can even go into the patients records

CLW2: 27:03 not right at the moment

AW: 27:05 ok so how do you sort of fill in the reasons for referral?

CLW2: 27:08 I just ask them yeah, for here

AW: 27:11 wow ok

CLW2: 27:12 I know

AW: 27:13 is there a time scale when they are sorting that for you?

CLW2: 27:15 hopefully soon, but it not in my control so I just have to wait until they do it

AW: 27:21 exactly wow

CLW2: 27:24 I know it's crazy

AW: 27:24 well, thank you for letting me come in today

CLW2: 27:27 it's alright

AW: Interviewer **Interview date:** 27.03.2018

CLW3: Participant **Interview location:** Withernsea Leisure Centre, Withernsea

CLW3: 00:09 My manager is going instead so I've sort of had a free day

AW: 00:10 that's good. At least someone is sorting it out

CLW3: 00:11 yeah, exactly

AW: 00:13 right I'll just get my stuff together. Yep, so I have got your consent form, that is all sorted. Just to talk you through what we are doing again so you're absolutely right we're looking at different people who refer onto the East Riding of Yorkshire healthy lifestyle programmes and asking what the constraints are in that referral process or how we can sort of make that process a little bit more streamline and quicken that process up

CLW3: 00:41 yep. So, is it just like the leisure

AW: 00:43 it's all surgeries

CLW3: 00:44 all surgeries

AW: 00:47 all surgeries in the East Riding, yes. So, it could be GPs, Practice Nurses, there's Community Link Workers now, Care Navigators so it does work differently depending on where abouts I go, but just understanding how the different surgeries operate as in who is in charge of referrals, and any issues or constraints they face, and then we are trying to streamline this process as much as we can, erm just so it's as quick as possible for patients and practitioners. Does that all sort of make sense?

CLW3: 01:11 yes, absolutely

AW: 01:14 just as reminder about confidentiality so anything that you do say today will remain strictly confidential, and you are not going to be

identifiable in any way. It may be that I choose to repeat something that you've said, but it will not be identifiable to you. It will just be participant X mentioned this, sort of thing

CLW3: 01:31 that's fine

AW: 01:34 fab. So, in terms of your participant rights, er you're free to decline to comment at any time and your participation is completely voluntary.

CLW3: 01:42 yep

AW: 01:43 if you do find that a question is too uncomfortable, just say no, comment and we will move on, but I am sure there won't be anything (laughs)... I'm not going to ask you anything awkward so don't worry about that

CLW3: 01:51 that's fine (laughs)

AW: 01:53 and the interview is centred on, well, typically it's five key areas. So, it's the healthy lifestyle programmes that are available provided by the East Riding of Yorkshire Council, the information and referral resources that you are provided with, er any feedback that you receive from the programmes, and finally any support networks to ease your role. Now that's more appropriate for GPs because you might be that person, that support network

CLW3: 02:16 that support network yeah

AW: 02:16 yeah, so will probably avoid that section because I don't think it is directly relevant to yourself. So, there are the five key areas. Just before we begin can I take some really simple demographics from you

CLW3: 02:27 yep

AW: 02:28 so how old are you? If you don't mind me asking.

CLW3: 02:29 22

AW: 02:28 22, and what is your role

CLW3: 02:34 so I am a part-time health trainer, er and part-time community link worker so 18 and a half hours across here or in Hornsea, and 18 and a half hours at South Holderness Medical Practice

AW: 02:55 Ok. So, as you say both of them surgeries. You're employed as a part-time health trainer, part-time community link worker

CLW3: 02:59 yep

AW: 02:59 so how long have you worked as a health trainer

CLW3: 03:01 since August 2016 so what date are we on now? March. Just over a year, year, and a bit

AW: 03:09 about a year and a half? Yep, and community link worker?

CLW3: 03:11 since October 2016, so just a little bit less

AW: 03:19 so how many days approximately are you in general practice so within a surgery?

CLW3: 03:23 4 days a week

AW: 03:25 4 days a week

CLW3: 03:25 yep

AW: 03:27 and you've been doing both these roles for approximately a year and a half

CLW3: 03:30 yep

AW: 03:32 and that has always been within the East Riding of Yorkshire?

CLW3: 03:32 yeah

AW: 03:34 yep. So, can you tell me a little bit more about your role as a care navigator, so what that encompasses.

CLW3: 03:44 yes. So, I am in the waiting area of the surgery. The other community link workers actually have rooms, but the aim is that I am sort of there so patients can come by and see where I am. And the main aim is that I am signposting people onto different services. So, they will come in, we will do an initial assessment, we use a programme called Pharmoutcomes so on that we will ask them obviously their basic details which we have on system one anyways, and then it will be making sure we cover everything. So, they will come with their initial problem which could be anything relating to employment, housing, financial issues, mental health, er family, they want to get more active, they want to stop smoking, all the different things that you can think of and my job is to sort of, obviously talk to them, let them know the different services available, and then signpost them or make the referrals and encourage them to be independent as well. And, it's also working alongside the GPs. So, at the minute, when I first started off it was just the GPs and the Nurses that could refer to me, and then we brought in reception because we found it saved a lot of time. If someone rings up and wants an appointment to discuss their mental health, but they have already got the medication that they need, maybe they need a little bit longer than ten minutes and they can come and chat to me for up to 8 hours altogether. So, it's 8 sessions of up to a hour that they can see me for over a period of 12 weeks.

AW: 05:16 right, ok

CLW3: 05:16 and that basically, goes from the health trainer model, which is very similar. You see sometimes I refer to myself so I will be over there and I will refer to myself for weight management here

AW: 05:27 ah right, ok

CLW3: 05:27, but the main aim over there is initially finding where they need to go and hopefully saving the GPs time erm,

AW: 05:37 so yeah, as you say you get up to 8 hours and that GP only has 10 minutes so by having that outlet you are saving the GPs time

CLW3: 05:45 yeah, absolutely

AW: 05:44 so in terms of how patients are drawn into yourself. You say the GP or the Practice Nurse can refer. Recently, the receptionist can signpost to you as well,

CLW3: 05:56 yeah

AW: 05:56 and can patients approach you within the waiting room?

CLW3: 05:58 absolutely and social care as well, now

AW: 06:01 as right, ok so self-referral and social care

CLW3: 06:06 and we have got our own leaflets as well, so it is self-referral for people who aren't in the surgery as well, but that's sort of been rolling out and experimented at the minute. Er, we have a referral email address and it gets distributed, but it's a bit tricky. Obviously, the patients in the surgery are on system one, the patients that are not at the surgery, obviously I can't see their notes, but we can see on Pharmoutcomes.

AW: 06:29 ah right so you have access to sort of that through Pharmoutcomes.

CLW3: 06:32 basically, anyone can refer now so it's not just the surgery

AW: 06:38 so you mentioned about the health trainer referral pathway being slightly different, what is the referral pathway for the health trainers?

CLW3: 06:44 so the repair, referral pathway itself is very similar in that we can see them for up to 8 sessions over 12 weeks. Er, stop smoking is the same, but

it is 8 sessions over 8 weeks, but the difference is what we are actually discussing. So, across at the surgery, if someone comes for weight loss for example I would let them know about the different leisure services, let them know about the health trainers, er counselling if it was to do with their mental health, and then I would refer them on, set goals for them, but sort of short-term goals to access services whereas over here I would actually be discussing the nutrition, setting them goals to lose weight directly so it's more sort of focusing on directly losing weight whereas across there it's like where shall we go to get to lose weight

AW: 07:33 yeah. Why is it different over there?

CLW3: 07:39 because it's sort of two different jobs

AW: 07:38 ok

CLW3: 07:40 er so obviously this is my health trainer uniform so when I am here, I am seeing clients for stopping smoking, weight management, emotional wellbeing. Across there, I am signposting them to anywhere. It could be financial issues, it could be housing, but I am not trained in all them different areas so it's literally signposting

AW: 07:57 ah I understand. yeah, so, if you are there you can signpost them to yourself here, but obviously you need to have your uniform on for here and it's a completely different role. That makes sense. So, you mentioned about if someone comes for weight loss and you talk to them about the erm health trainers and the council services

CLW3: 08:16 yes

AW: 08:16 how then do you decided where to direct patients?

CLW3: 08:21 basically, off what they say. So, they might come in and say I really want to start the gym, er and then I will say ok have you been to the gym before? Sort of their level of confidence. A lot of people would rather start the gym on for example, exercise on prescription, if they are lacking confidence or they don't know what to do in the gym or they are lacking money as well, because it is actually free here erm, the exercise on prescription

AW: 08:48 right, ok

CLW3: 08:49 obviously, if they have got a BMI of over 45, if they join the gym it will be the LiveWell. Erm, if they are wanting an operation obviously it will be the HOP. So, obviously it goes on the criteria, but also what they want so if they say I want to start swimming, then it will be well, the options are swimming lessons, erm, starting swimming obviously on their own if they are confident enough, or through the exercise on prescription. It all goes on their levels of fitness, levels of confidence to start with.

AW: 09:16 yeah

CLW3: 09:17 and then if they are not interested in doing any exercise, I'd say right well, why don't we start off with the health trainers, having a discussion about what you can do at home or the other different ways of losing weight

AW: 09:29 OK. So, if they want to be in a gym environment, you would sort of advocate the council services. If they have not got the confidence you'll say ok so what can we do at home from the Health Trainers point of view

CLW3: 09:39 yeah, and they can see us at the same time as well

AW: 09:41 ok

CLW3: 09:44 so if they are wanting to talk to us about the nutrition side, but get support through exercise, through the gym, then they will need to be signposted to both of us at the same time.

AW: 09:51 that's brilliant, and health trainers is free?

CLW3: 09:52 yeah

AW: 09:58 yeah. So, how do you measure their confidence?

CLW3: 09:58 erm, sort of by obviously just speaking to them. We also ask them questions at the end of the assessment and it will be things like, one of the questions is, out of 5, how confident are you? So, that's one scale. Other scales are like just in mid conversation, we might say how confident are you on a scale of one to ten to attend the gym on your own? And if it's sort of a lower level I will say right well, what I suggest then is you go on the exercise on prescription and start that with a gym instructor.

AW: 10:28 yeah, depending on where abouts they are at

CLW3: 10:30 yeah, and little comments they will say like 'oh, I don't know if I would go to the gym on my own because people might judge me' and things like that so just start off with something else

AW: 10:43 so a lot of the time it is just about listening to what their preferences are, also obviously looking at the criteria, like you say if they need an operation, obviously it's the HOP programme

CLW3: 10:51 and if they are over a 45 BMI, er, they might as well, get a year free, rather than just 10 weeks

AW: 10:58 absolutely. So, do all patients get exercise on referral here?

CLW3: 11:02 well, yes. Every other leisure centre, I think it's £33, er, but for some reason here it is free. I don't know why

AW: 11:10 OK. It must be because of the demographics I am guessing

CLW3: 11:14 yeah, I think so, I think it was just a trial, but they just carried it on

AW: 11:18 ok so what healthy lifestyle programmes are you aware of that are run by the council. So, you have mentioned....

CLW3: 11:25 exercise on prescription

AW: 11:25 yep

CLW3: 11:25 erm, HOP, erm LiveWell, Young LiveWell

AW: 11:33 yep

CLW3: 11:35 and there's a heart one, but I am not really sure on that

AW: 11:37 yep, perfect so you know all of them. Erm, yeah, the HEART tends to be picked up at a hospital because it's after people have had a heart attack so you're not sort of expected to know. But the mains ones, absolutely exercise on prescription, health optimisation and LiveWell. Which one do you tend to signpost or refer patients to the most often?

CLW3: 11:55 probably exercise on prescription because most people are eligible for that one

AW: 12:01 right

CLW3: 12:03 erm so I can actually refer myself now. So, the meeting that you was in with me, that was when [HLO's name] showed us the system, and how to refer

AW: 12:13 the online system?

CLW3: 12:14 yeah, so that's basically, what I do across there. So, I refer a lot, like it's getting a lot. Like I had seen my manager yesterday to say erm, it's taken up a lot of my time because the word is getting about that I can refer

so people are just walking in to see me and say ‘oh, can I have free gym’, so I'm just keeping track of that at the minute

AW: 12:33 is that problematic for you because you're getting this additional workload burden?

CLW3: 12:37 it could be...potentially because the guys here can refer to me, erm, reception, GPs, Nurses, they all have, if they have anyone who wants exercise on prescription it comes to me now. And then anyone that passes by comes to me, so it probably could get problematic yeah, because it does take up a lot of my time. Especially if they aren't there because I've got to ring them and then if they don't answer I have got to task myself to ring them again and obviously the online system you choose an appointment whilst they are there don't you? So, you have to make sure they choose an appointment that they want

AW: 13:16 absolutely. So, we will go onto that if that's ok?

CLW3: 13:19 yeah

AW: 13:20 we can address this area. So, you're sort of telling me about the online system and that you've got to book patients in

CLW3: 13:28 yeah

AW: 13:28 did you ever use the paper referrals?

CLW3: 13:31 no

AW: 13:32 so you've always used the online. And is it problematic, because obviously with the patients not being there, you're having to chase that up as well

CLW3: 13:40 yeah, probably because obviously half of the patients that get referred to me I’ve not even met. I’ve just been told to make the referral for

them whereas I need to make sure that firstly they are eligible for it, which means ringing them up. I use to be, I use to book anyone in that I hadn't met in a half hour with me so that I could discuss that it is definitely what they want, see what other options they have got, see if there's anything else from my role that I can help them with

AW: 14:11 yeah, even if it's alongside

CLW3: 14:10 yeah, anything related to that, but then my referrals are getting that much anyways that it was starting to be like I couldn't get them in for three weeks and then it would mean that they are waiting three weeks before they even get an appointment for the gym. So, I have started just ringing them up and asking them on the phone is this definitely what you want? What medical conditions have you got? And then booking an appointment that they want.

AW: 14:31 yeah, so as you say before you was able to sort of allocate that half hour. You could get to know the patient, sort of address all their needs and see what you can do, but because you're getting flooded with different referrals, that's no, longer possible so you're having to just ring them up

CLW3: 14:48 I'm having to ring them up yeah

AW: 14:47 when you said, the guys here, do you mean the...

CLW3: 14:52 the other health trainers that I work with. There's three of us in Withernsea. Well, 4 of us, but three of us see clients. So, if for example they are in an appointment with someone taking about weight management and they [patient] mention that they want the gym then they will refer, they will send me a email saying, 'can you book this person in for exercise on prescription'

AW: 15:10 ok

CLW3: 15:12 across there so I've never met them which means I then have to ring them up, but, I think that the health trainers are going to get online soon so that would help me out.

AW: 15:20 ah right, ok

CLW3: 15:22, but that has not happened yet

AW: 15:23 so health trainers at the minute, is that paper referrals?

CLW3: 15:24 that's not, well, yeah, no. They can't refer at all they have to send them to the GP, but here they are sending them to be because I am across there anyways

AW: 15:35 yep, so you're the only community link worker, you're the only health trainer that has that additional role and the ability to refer people to different services?

CLW3: 15:43 yeah, yeah

AW: 15:43 right OK sorry I am trying to

CLW3: 15:47 no, it's cool

AW: 15:52 OK. What would be the alternative? What would make it easier for you because the whole point of this research is to sort of, well, we understand we have developed this new online system, but there are a lot of thing that we need to tighten up on, a lot of things we need to improve on which is why we are talking to you guys

CLW3: 16:05 erm, well, one of them is, like yesterday I was trying to book an appointment for someone erm and there was only one appointment left. So, I don't know how far in advance East Riding like put their appointments forward, but because I've referred so many people, I have just been

speaking with [Fitness Professional name] out there and she said, they are really busy, they've got, you know it's three weeks until an appointment, but I couldn't actually find any appointments past three weeks away. So, then I literally didn't know what to do because he couldn't make that appointment and I couldn't make an appointment past that if you get what I mean because the rota only went up to so long and there was only one appointment left. So, maybe having like a rota for like 6 weeks that I can book them in advance instead of just, I think it's just two or three weeks it goes up to

AW: 16:53 yeah, I am not sure about the rota actually, but yeah, if they are getting taken up quickly then there's need to be the option for you to book a little bit further in advance

CLW3: 17:02 yeah, yeah. Erm, another thing would probably be that I don't actually have to book the appointment with them. So, that I could literally just ping the referral across and say right I know what the medical conditions are cuz I can get on system one, er and I can just literally send it across and maybe leisure can contact them to book the actual appointment. Because then it saves me having to get in touch with the patient, and then having to ring them three times if they don't answer, and then booking the appointment that they want. Other than that, I would say it is quite a good system. It's not the system that's difficult, it's just the amount of referrals that I am getting

AW: 17:46 yeah, and also the time it is taking to, as you say if you have got that responsibility to book that appointment, and you're constantly ringing people, if that sort of responsibility was taken from you and removed from

the system then you can ping them across and that's it. Job done for you so there's no, sort of ringing the patients three or four times

CLW3: 18:05 exactly yeah

AW: 18:13 ok, fantastic. Anything else in terms of the online system? Are you happy with the format? What is it asking?

CLW3: 18:17 yeah, everything seems fine. Erm, the only thing I would say, well, it is difficult, but there's like three lines isn't there?

AW: 18:24 yeah, there's three different sections

CLW3: 18:27 yeah, so reason for referral, current health, and previous health. I feel like I duplicate it on each one. Obviously, you do need to know if they have had an additional previous health issue or whatever, erm, but I find that generally the reason for referral is because of the current health if you get what I mean

AW: 18:44 yep, which is probably something that they have had previously.

CLW3: 18:45 yeah, it’s all the same

AW: 18:50 I hear that quite a lot actually because the paper format, I will show what it used to be like. I have an example from exercise on referral. So, it use to look a little bit like this and we had obviously the reason for referral, the medical history. There was the requirement to take the patient signature, which is something we removed because it was a bit of a pain to get the patient to sign. Erm, this was an indication of their motivation, that was sort of the idea, but it wasn't something that any GP or anybody else did for any of the other referrals, so we took that out. So, they had this as a template and they sort of kept the reason for referral, but they have separated the medical history and the current health. In your opinion, is this something,

would you prefer to see something like this online as opposed to the three areas? Is it more user-friendly? Obviously, without the patient signature.

CLW3: 19:42 yeah, like tick boxes maybe. Yeah, I mean it's not bad. Either one is fine

AW: 19:56 yeah, if we could try and take out that duplication

CLW3: 20:00 yeah, and the appointment book ins. Obviously, it helps leisure, but it is not helping me because I am basically, doing their job

AW: 20:04 so have you found, do the GPs, Practice Nurses, the people in the surgery, are they still referring? Or because they have you have, they thought 'I'll use that outlet'

CLW3: 20:19 well, at the minute, at the minute not many of them know that I can do it, but we are sort of making people aware, but we are trying to be quiet with it as well, so that they don't send everyone across. But there is obviously [CLW's name] that can do it as well, so that's something that I might start using is, using her to help me if it gets too much. Just ping her some across and I can do some as well

AW: 20:39 is [CLW's name] a Practice Nurse?

CLW3: 20:43 Healthcare Assistant

AW: 20:43 Healthcare Assistant, of course she is!

CLW3: 20:46 yeah, so yeah, they all sort of keep referring, but we do a newsletter for community link and I put in the newsletter the other week, just to make people aware that I can do referrals and I got quite a few more after that. Erm, the receptionist tend to know that I can do it so the minute anyone comes to reception and asks for it, they are straight to me. So, if I am doing something at the time then that then means saying, to them right I'll give

you a ring in this slot, booking a slot that I am going to ring them or tasking myself if I can't see them straight away

AW: 21:21 and you said, you are half and half. So, half your job role is working as a community link worker, and half is the health trainer. Because of all the referrals, are you finding that you are able to maintain that balance, or is it taking over more of your workload? Does that make sense?

CLW3: 21:34 it's getting to the point where it could take over. Just for example, yesterday I was, I had like 20 minutes to read my email, sign in, do a little bit of thinking before my first client, but then someone walked around the corner wanting exercise on prescription. So, I had to cancel everything that I was doing and book him in because I thought I may as well, do it now rather than ringing him three times and he doesn't answer and having to take my time another time. So, yeah, I could say it taking up more of my time

AW: 22:10 OK. So, what information resources are you provided with regarding the different council services that are available?

CLW3: 22:17 erm well, I have been to a couple of training sessions, so a couple with [HLO's name] and [HLO's name]. And then our team meetings this month we had [HLO's name] came and did a PowerPoint to the other guys, but obviously it refreshed my memory. So, we got all the information about what everything is, and then how to use the online system and then he provided us with the leaflets and pathway. So, we had this A4 sheet of how many appointments HOP is and things like that, and the referral processes for everything really. All the information that I need to tell patients about really

AW: 23:00 I was aware of the leaflets, but I didn't actually know they had created some kind of pathway so if that is useful that is perhaps something we can, so did they do that for every single programme?

CLW3: 23:10 it was just HOP, I think, or was it? No, I think it was every programme. I have got it across at the leisure centre. But it was basically, like a A4 sheet and it had different colours on it and when the, when they have their health assessments in the weeks. Obviously, HOP they might not stay for the full 26 weeks, they might just go for 4. So, it basically, explained all that

AW: 23:34 Fantastic. Is there any information, so you've got the leaflets, is that something you give to the patients?

CLW3: 23:40 yeah, erm I could do with a few more and I have also got the appointment cards which I write their appointment on once I have booked it with them obviously so they know when it is.

AW: 23:54 I'll get on to getting you some more leaflets because quite a lot of people have said, that they need more leaflets. In terms of the content, do you find them patient friendly?

CLW3: 24:02 yeah

AW: 24:04 yeah

CLW3: 24:05 definitely yes. Really easy to read

AW: 24:06 brilliant. Anything else in terms of what makes it difficult to refer? So, it doesn't necessarily have to be about the referral process, it could be in terms of the patients, in terms of yourself, the system, anything that makes it challenging?

CLW3: 24:25 not really. Erm, is there an option, you know when you log on, to save your password and username so you don't have to keep typing it in every time?

AW: 24:33 to the online referral system? I am sure there is, but I honestly cannot remember how. I can get [HLO's name] to give you a call and instruct you how to do it. I know you can

CLW3: 24:43 it might just be a box that I haven't…

AW: 24:45 yeah, there is a way because I remember, particularly to the GPs they were saying, once you've logged on you can leave it up so you don't have to keep logging on each time

CLW3: 24:52 right because I have bookmarked it at the top, but obviously if someone walks around the corner really quick I want to get online as soon as possible and then I have been having to find my password from my emails or where I have wrote it on my computer to type it in again. Er, so that would be useful if I could literally save it, get straight on if I can

AW: 25:09 yeah, by the end of today I will let you know because I am not, I honestly can't remember, but I know that there definitely is a way that you can save that to prevent that

CLW3: 25:18 yeah

AW: 25:18 that's fine. So, in terms of the online system, if we could save your password so you don't have to keep doing it. Erm, we've spoken about the duplication with the current and previous health so if we could tighten that up so you didn't have to do that. And sort of the biggest thing that's taking up your time is that you've got to also book their first appointment. We've said, that because you can only see two or three weeks in the rota you are

not able to book further than that. And also ideally, if that was something the leisure centre was doing, it would stop that extra responsibility on yourself

CLW3: 25:52 yeah, yeah, yeah, yeah, yeah, yeah.

AW: 25:54 Fab. So, onto the next section is just a little bit about patient progress feedback. So, are you provided with any feedback regarding anybody you refer on to?

CLW3: 26:06 well, if we see the patient again, so generally exercise on prescription referrals or other leisure referrals will come in, I will see them once, ask them if there is anything they need, unless I ring them up now, and that will literally be it. So, we just sign them on and I wouldn't see them again so I wouldn't know erm feedback. But if I am seeing them in the health trainers as well, or if I am seeing them again at the surgery after I have referred them, then I do get feedback because they will come back, but it's not too often to be honest

AW: 26:38 OK. What involvement would you like in terms of feedback? Would it be useful?

CLW3: 26:44 erm, I do get a bit of feedback because obviously I go across there and then I come back here and I sometimes see them in the gym. But just to know like, maybe how they are getting on. If they actually did the full 10 week course. How quickly it was, well, no, I know how quickly it was generally because I book the appointment. But erm, yeah, just generally how they are getting on. Obviously, not bombarded with information because then I would know about every patient, but apart from that, that's it really

AW: 27:24 So, you've got this advantage as a health trainer as sometimes you might see them over here so you will get that feedback from them, but otherwise what you would like to hear is just how they are getting on in general, and in terms of completion, so did they actually complete the programme

CLW3: 27:38 yeah

AW: 27:40 what would be the best way to send you that information so you are not bombarded?

CLW3: 27:42 erm, I'd say the best thing is using system one, but obviously leisure are not on system one cuz then I could just check if I wanted to check. Cuz obviously, I wouldn't want to get, and it would be a pain for them as well, so send me information on how they have done, but just some system where I could check if I wanted to check rather than it being sent to me.

AW: 28:04 right, ok

CLW3: 28:05 I don't know how that would work though.

AW: 28:07 we, between me and you, what we are looking at it, obviously different practices are on different system. So, some are on system one, some are on EMIS, erm and I was told there is something called resource publisher so we can get a template and put it on system one or EMIS. So, we are actually looking at how we can integrate a form online. That's sort of, we can't promise anything, but that's the gold standard so what we would like to do, if it is on system one, it can pre-populate the form so that will save you filling everything out. But, I just wondered if we did have a template on system one, there might be some way we can feedback into it. Don't know how, it’s just an idea

CLW3: 28:50 yeah, something like that

AW: 28:52 if we could do that then obviously you could access that without being sent it directly, because the last thing you want is to receive loads of emails about patient progress

CLW3: 29:01 yeah, yeah, yeah, yeah, exactly

AW: 29:01 fab. Is there anything else we can do to improve the referral process or anything we can do to streamline the process?

CLW3: 29:10 er, no, not apart from what I have already said, I don't think. Everything else is quiet smooth. It's fairly easy

AW: 29:18 yep, no problem and I said, sort of the last section we will leave out because I don't think it's appropriate to your role. But is there anything we've spoke about that you feel we can expand upon or anything you feel is relevant to mention?

CLW3: 29:32 no, all good, all good

AW: 29:37 brilliant. Is there anybody else you feel might be interested in speak with me? Any GP links or...

CLW3: 29:41 let me just think. You've spoken to [CLW's name] haven't you?

AW: 29:44 I've spoken to [CLW's name] in Withernsea yes. She is my only contact, you and [CLW's name] within Withernsea.

CLW3: 29:53 and are you allowed to speak to leisure themselves?

AW: 29:53 erm, they have to be within a surgery or referrers

CLW3: 30:00 [Fitness Professional name], who works in leisure, she delivers exercise on prescription, but also goes and promotes in Hedon Surgeries to get clients to come to her. She doesn't actually work for the surgery though. Well, I suppose I don't work for the surgery, I am part of the Health trainers

and Humber, but I am placed in there. So, I guess she, she started going off to South Holderness and she was doing about 2 hours a week just trying to tell the patients about what's on offer. And now she is at Church View.

AW: 30:30 ok so it was more about sort of increasing that awareness with patients

CLW3: 30:38 yeah, so they can know about what is on offer really

AW: 30. 42 Do you find that patients are more educated in this area? Do you find when you mention to them

CLW3: 30.46 No. No-ones knows about it. As soon as I sort of mention 'oh, do you know what exercise on prescription is?' probably the only ones who know about is it the people who have done it. And then, I get quite a lot of people coming to me wanting it again. So, like, I had a man the other day who came to me and he had had it twice, and he wanted it again for a third time. So, he found me across there because obviously he knows I can do it and asked me, but then obviously I was put in a bit of a tricky position so I emailed [FC's name] to see if he could, to see if he could have another referral and he is emailing [HLO's name]

AW: 31:29 ah to see if they can push him through ok.

CLW3: 31:31 because obviously he knew about it, but generally no

AW: 31:34 how do they respond if they are not really aware and then you say oh, there's this thing called exercise on referral/ prescription

CLW3: 31:43 when I explain what it is they are all like oh, my god wow and then when I say like that is it free they are like oh. Because, I think it's sort of you can have this free course where you can go in the gym twice a week

with an instructor and then you get free access to the gym and swimming as well, they are sort of like amazed by it

AW: 32:03 so that's sort of a selling point that it is free for the patients

CLW3: 32:02 yeah, and that they can get obviously a reduction in the gym membership afterwards

AW: 32:11 aw perfect. yeah, everywhere else I go because it is not free you find people saying, well, patients are really enthusiastic about it, but as soon as you say the price, they are like I can't afford that. I am not going to go on that. But that's not a problem in this area. Fab, so that's everything that I wanted to speak about so thank you for your time today.

CLW3: 32:30 no problem

AW: 32:32 yeah, and I will see if I can get to speak to [Fitness Professional name] . So, can she actually refer then, can she send referrals through the system cuz that's the only issue I have, the sort of have to sort of engage with the referral process

CLW3: 32:44 I feel like she does

AW: 32:47 yeah, I can ask

CLW3: 32:49 she is literally out there as well, I don't know if she is still there, but as we walk out I will see if she is there and we can ask

AW: 32:55 not a problem, thank you

CLW3: 32:57 because I know when she goes there, I think she use to just to the paper referrals and then, I think she use to give that to [CLW's name] who would get that signed by the GP. So, she kind of is involved with it, but then she's obviously doing the exercise on prescription here herself.

AW: 33:12 ok so is she technically, she is a trainer?

CLW3: 33:16 she's a trainer

AW: 33:19 not a health trainer

CLW3: 33:21 she delivers the exercise on prescription, LiveWell, classes and then also goes and promotes in the surgeries

AW: 33:26 yeah, ok

CLW3: 33:28 and, I think refers people

AW: 33:32 yeah, makes sense, I will speak to her. So, do you know, I'm just curious, as a health trainer if they are not interested in going to the gym, do you just give them exercises they can do at home or do you run sessions for them?

CLW3: 33:41 yeah, we, I'll show you. We suggest obviously, we signpost them onto like walking group and things like that, but we give them something called the hundred calorie work out

AW: 33:58 ah right, ok

CLW3: 34:00 so that's sort of something they can start off doing at home or we signpost them to the chair-based exercise classes at leisure

AW: 34:09 ah right, ok. Am I ok to keep this?

CLW3: 34:09 yeah, of course you are

AW: 34:09 fab, yeah. It fascinates me because health trainers are so broad in terms of what you can do and I just thought god knows how you remember it all

CLW3: 34:17 I know! It's all just sort of helping people to, oh, yeah, the swim scheme as well, signpost you,

AW: 34:25 oh, I didn't know you had a swim scheme

CLW3: 34:28 yeah, do you want one?

AW: 34:27 yeah, sure so is this something, do the health trainers deliver this in the pool?

CLW3: 34:33 no, so we signpost to that. Basically, they get ten swims for ten pound or the swimming lessons are ten lessons for twenty pound. So, that's generally an alternative to, if they didn't want to go on the exercise on prescription, but they wanted to go in the pool, but they are not confident enough or it's just a cheap way to get them in the pool., I think it's between 11 and 3 they can go during the day, so it tries to get them in obviously during the required times

AW: 35:02 is this something just in this locality or across the whole East Riding?

CLW3: 35:07 no, East Riding yeah

AW: 35:06 ah fantastic

CLW3: 35:08 so a lot of our clients like that. Unless, if they are on the exercise on prescription already, there's no, point because obviously they can access the swimming pool whenever they want so we generally say we will give you that after

AW: 35:23 yeah, so you can use that discounted

CLW3: 35:22 yeah

AW: 35:24 yeah, I think it's really important, we have been really focused on our programmes and what we do and want with the referral process, but because you align so closely with what we do, I think it's really important that whatever we develop in terms of the referral process, we also need to be feeding into the health trainers as well. I know they sometimes already do, but so many people want smoking cessation, so we need to sort of think

about how we can align our referral process to include yourselves within that as well.

CLW3: 35:56 yeah

AW: 35:56 yeah, but we are working on that

CLW3: 35:58 do you know about the, you probably will be, where the smoking referral from leisure to us, it went wrong a bit.

AW: 36:05 no

CLW3: 36:06 so basically, when they do their health checks for people from exercise on prescription, I think they fill in Pharmoutcomes don't they? Erm, and that updates and if we on our health check system, when we do it, there's a signposting option or a referral option. So, when we press signpost , it just lets no-one know anything, we have just signposted them there. But if we press refer to, for example smoking cessation, it sends an email off and literally refers them in saying, 'please can you contact this patient, I have referred them for smoking'. Whereas leisure, there was something wrong with the system so every time they pressed signposted it sent a referral to us. So, then charlotte was then ringing, charlotte is our admin in Bridlington, ringing the patient and they actually didn't want to stop smoking, they had just got advice about stopping smoking.

AW: 37:02, but they didn't necessarily want that referral

CLW3: 37:04 want to stop yeah

AW: 37:05 that's really confusing. What system are the leisure using? Do you know?

CLW3: 37:08 I'm sure it was Pharmoutcomes

AW: 37:10 Pharmoutcomes yeah, so there was a problem within Pharmoutcomes?

CLW3: 37:12 yeah, and emotional wellbeing as well. I can't remember how that one happened, but, I think they may be discussed how their emotional wellbeing was, some people were actually fine, but leisure had documented in as saying, that they had discussed it and just put like signposted or whatever, but they were absolutely fine. We would get a referral saying, they want to see us for emotional wellbeing, and then we would ring them, and they would get quite offended cuz they think they're alright

AW: 37:37 I can imagine yeah, because they have not been told about that referral and then for you to, not your fault at all, but to ring and say we've had this referral, I bet they were like, 'what the hell?'

CLW3: 37:46 yeah, they was, but [HLO's name] knows about that

AW: 37:48 and that's all sorted now?

CLW3: 37:51, I think so at the last team meeting it was going to be sorted by the week after

AW: 37:56 yeah, I'll double check and I'll speak to [HLO's name], get you some more leaflets erm and I will let you know how to keep signed in online, so you don't have to keep doing that

CLW3: 38:02 yeah, on that thing, brilliant

AW: 38:06 right I'll just turn this off.

AW: Interviewer **Interview date:** 20.03.2018

CN1: Participant **Interview location:** Field House Surgery Bridlington

AW: 00:03 there we go. So, I have spoken about confidentiality, and I am going to allude to your rights as a participant really quickly. So, your participation in this study is completely voluntary. Anything that you do say will not be shared amongst anybody else except myself and you and if there is a question that you feel is too uncomfortable or you're not sure you can just say 'no, comment' and we will move on from there. So, the interview is going to be centred on five key areas. We can divert away from there if there's something you feel is relevant to talk about. The first area is about the healthy lifestyle programmes that are provided by the East Riding of Yorkshire Council such as the LiveWell, scheme, Young LiveWell, Exercise on referral. I would then like to talk about the information resources and referral resources that you are given, or you have access to and any issues or constraints you face when referring patients, or anything with this referral process that you feel could be better streamlined or improved. And then finally if you have any support networks in this surgery to help manage your patient load. So, that might not be necessarily relevant, it's more relevant to sort of GPs so we can avoid that area. OK, do you mind if we take some quick demographics? So, how old are you? If you don't mind me asking [CN's name].

CN1: 01:17 47

AW: 01:21 47

CN1: 01:23 I had to think about that one (laughs)

AW: 01:27 and what is your role within this surgery?

CN1: 01:26 I'm a head receptionist and care navigator.

AW: 01:33 and how long have you been, is it a recent thing, is it sort of a dual role?

CN1: 01:39 I've been head receptionist, I've been here for six years. Care navigation is just sort of started to come on board now so I've sort of take that as part of my role as well. Trying to build that up at the moment, still in the early stages really

AW: 01:51 and how long have you been doing that additional role?

CN1: 01:54 er probably about 6 months give or take something like that

AW: 02:03 and do you work full time or part time?

CN1: 02:04 full time

AW: 02:05 full time. How many sessions is that per week?

CN1: 02:06 er what do you mean?

AW: 02:12 or does it work differently with G, is it 5 days?

CN1: 02:13 I work four full days and one half a day

AW: 02:18 ok. And you say you've been working for 6 years as the head receptionist, has that always been within this surgery?

CN1: 02:28 yes

AW: 02:30 OK and can I ask your email so I can send your transcript to you?

CN1: 02:35 yeah, it's [CN's email]

AW: 02:38 i.e., dot is it

CN1: 02:40 [CN's email]

AW: 02:42 g yeah

CN1: 02:43 [CN's email], it's all in lower case

AW: 02:48 I'll write lower case because ill forget. Fantastic so onto the first section of the interview I'm going to talk about the healthy lifestyle programmes. So, what healthy lifestyle programmes are available in this locality for you to sort of direct patients towards?

CN1: 03:09 er it's the GP, GP referral, Exercise on referral, er then you've got your, is it HOP the hospital if they are due an operation, non-urgent operation and the one where the BMI is over 45, 12 month

AW: 03:27 is that the LiveWell?

CN1: 03:27 yes, sorry I couldn't remember the names off the top of my head

AW: 03:27 no, it's no problem

CN1: 03:32 there's the younger, the child one as well, but I've not really had to refer into that one as yet

AW: 03:39 yeah, so there's the adult LiveWell, and the young LiveWell

CN1: 03:41 yeah

AW: 03:42 fantastic so can you talk to me a little bit about what the process of referral is in this surgery?

CN1: 03:50 er it depends. It depends on which GP is referring and how they choose to do it. Some as still filling the old forms out which either come to myself or the secretary. Some are sending them to one of the nurses although the GPs should be directly referring themselves when they have the patient with them. It's not assuming to be happening. They have all been given log on details, but they are not, they are not actually doing it so... it could be tasked to myself or the nurse or the paperwork sent to the secretary. Any one of us really

AW: 04:27 ok so GPs tend not to refer directly, the delegate that work to someone else

CN1: 04:33 they pass it to us, yeah, to someone else

AW: 04:35 ok so when you complete the referrals, are you with the patient or without the patient

CN1: 04:40 without usually. normally, it would be sent, doctor would see the patient, they would decide that this is what is required, so they would either task us and then I would then contact the patient whilst I was on the system to arrange a suitable time for them to get an appointment

AW: 04:58 Ok and how do you contact the patient?

CN1: 04:59 I would usually ring them

AW: 05:01 via telephone yep. So, are you engaging with the online referral system where you can book a time

CN1: 05:07 yeah

AW: 05:08 and how do you find that process of being delegated?

CN1: 05:11 erm, it's fine with the GPs delegating it so long as they are specific about which actual, which programme they need to be on. Erm, they tend to think they can refer them onto anything, whether they are eligible or not so sometimes it would fall upon me to say to the patient well, actually no, that's not free and you don't fall within the remit of the free one or even though the doctors have told them that they probably could do. So, like for example booking people onto the one for the non-urgent operations and the doctor thought they could just say that they were due an operation when they weren't so it's made it a bit awkward with the patient

AW: 05:58 and how do patients respond when they are told they can have one thing and obviously when you see them you say well, actually you are not eligible for that one?

CN1: 06:05 they are not very happy that the GP has told them that they would be and they can get it for free, basically, a lot of patients just want something for free and if a GP says oh, yeah, you should be able to get that for free then they are not very happy when you then say that they have to pay or they have to fall within a certain criteria

AW: 06:24 and what do you think would sort of help that issue?

CN1: 06:26 probably the GPs having more information, but they have been given the information they just don't tend to absorb it, I think that's the right word! (laughs) I'm trying to be diplomatic (laughs)

AW: 06:43 why do you think that is? Do you think there's a perception that it's less important compared to... I'm trying to sort of say compared to medicine if that makes sense

CN1: 06:56 yeah, it all depends, because we've had a lot of locums as well, it, that doesn't help the situation. I mean hopefully we are going to have more regular, we have had more regular locum GPs and we are getting more permanent as well, so hopefully that information will get put to them and they will remember it because if they work in different locations as well, then it's maybe different in different locations which when could confuse the GPs sort of in some respects I suppose so erm

AW: 07:28 yeah, so as you say if they are locum GPs and they are working in different locations, obviously these programmes are only available to East Riding residents so that could pose some problems there

CN1: 07:39 yeah

AW: 07:40 and you said, that you have recently taken on the role as a care navigator. How are you made aware of what programmes are available?

CN1: 07:48 we actually erm, this East Riding leisure one, she actually came in to talk to us and then I went down to the leisure centres and she showed me around and we had a chat about everything and showed me the facilities so I could sort of pass that back on to patients

AW: 08:07 was that [HLO's name]? Blonde hair?

CN1: 08:11 it was [HLO's name] yeah

AW: 08:15 Fantastic so do you feel you've been provided with enough information?

CN1: 08:20 yeah, but I am still waiting for more leaflets to come through she was going to drop some off for me, but I don't know. I know she was waiting for a delivery herself at the time so I don't know if that's just fallen through the net or anything, but I could do with a bit more documentation you know some more information, leaflets

AW: 08:37 what leaflets do you have at the moment? There's these ones, I don't know if these are old versions now. Are you provided with any of these? The healthy lifestyle programmes

CN1: 08:49 that one

AW: 08:50 these are the referral forms actually

CN1: 08:52 yeah, we've got that one, I think it's just the one that sort of splits up exactly what, yeah, that's the only one I have got and I have only got one of them so

AW: 09:02 ok

CN1: 09:03 and I'm going to keep hold of it because I don't know if there's any more. I have been meaning to get in touch with her to be honest and I just haven't had chance to, but yeah, that's the only one I have got at the moment

AW: 09:12 okay dokey and how useful do you think these leaflets are

CN1: 09:16, I think yeah, they are very useful because they are defined and it, it's specific so you can specify each different programme

AW: 09:26 yep. Are they patient friendly do you think? Is this something you would give to your patients?

CN1: 09:27 yeah

AW: 09:30 ok just because we are looking at the whole process so if there's anything that can be improved on these forms for instance, anything we are keen to hear about it

CN1: 09:39 I find them quite useful to explain the different programme and what they involve

AW: 09:48 so you've said, earlier that occasionally the patients are with you when you are completing the referral. How does that happen?

CN1: 09:57 it, if the doctors erm decide to refer on to me for more of your social prescribing so you know loneliness or, any sort of activities or anything that they feel that the patient, it's not actually medical, but it's more of a personal thing ,that maybe included within that so that might be mentioned when the doctor refers onto me so it's something that I discuss with the patient and if they fell within that remit then I could refer on

AW: 10:33 How do you decided whether to refer them onto an East Riding Council scheme or some of the social prescribing schemes?, I think the health trainers, correct me if I am wrong, do they do some physical activity things as well

CN1: 10:46 erm I've not referred to the health trainers for physical activities so to me that would be the initial one

AW: 10:55 I just wondered how you sort of decided which

CN1: 10:57 no, the health trainers, I mean they do, do sort of healthy living and things like that, but this is more of your exercise type thing so patients are more specific about if they are wanting to go to the leisure centres basically, or... and that sort of support that's available there with the gym and everything

AW: 11:17 brilliant so that's all sort of about the healthy lifestyle programmes. So, next about the constraints of referral or anything that you feel could be improved on. So, is there anything that you feel, do you experience any challenges or is there anything you feel could be streamlined better in terms of the whole referral process?

CN1: 11:38 erm the electronic referral is a bit confusing sometimes., I think when we went through it originally, it was like you don't have to tick on every section because if they wanted, certain programmes if they could be referred back again, you could use a different option next time. And then sometimes you don't get any dates or times come up, but there's nothing saying, there is nothing available on that date it just doesn't bring anything up so you're like have I pressed the right, button or you know and sometimes sort of question myself thinking. Because I don't use it that regularly I sort of think 'am I doing this right?', because there's nothing actually popping up on the screen. So, for it to maybe say sorry there's no, times or dates available on that you know what you've chosen or whatever might be helpful

AW: 12:24 that's a really good point so maybe if there's some sort of prompt that comes up and say I don't know please select thing, or there's no, dates just so you have that confirmation

CN1: 12:33 yeah, yeah, yeah, and sometimes I've been pressing on it and I have pressed another day and just nothing comes up at all so you question yourself and whether you're actually doing it correctly and obviously if you have the patient on the other end of the phone you sort of like jumping about from one screen to another.

AW: 12:52 yeah, because the online referral system, well, the electronic one should I say is really new, but we recognise there is still a lot left to do on that so yeah, you say it would help if there was some sort of prompt just to help you navigate through it

CN1: 13:07 yeah

AW: 13:07 anything else? You said, about the three sections, can you remember the three sections

CN1: 13:11 it depends on which programme you are going on

AW: 13:13 ok do you select the programme first?

CN1: 13:16 you select the programme first if I remember correctly. you select the programme, select the area, and then it will go into the reason for it so you've got your BMI or heart disease or diabetes or whatever, but then you seem to have the same things in another section and then the same in another section and it's like do I fill all three in or do I just fill one in or.... that's a bit questionable sometimes

AW: 13:47 so did you ever use the paper referral before the online or have you always...

CN1: 13:48 I didn't they always use to go through a nurse and now we've moved it away from the nurses because it use to go to her and then she would send them off in the post and what have you, but now, so some doctors are still, keep finding the paper referrals I don't know where they get them from, but they keep finding them, filling them in and then we just transfer it then directly to the

AW: 14:08 right, ok so you have seen the paper forms?

CN1: 14:09 I have,

AW: 14:13 the exercise on referral one

CN1: 14:14 it's a duplicate form

AW: 14:17 oh, right, ok

CN1: 14:17 it's in a booklet you know that you tear off

AW: 14:20, I think it's a smaller version of this because this is blown up

CN1: 14:24 probably

AW: 14:26 so how does that form compare to the online, is there something on this that you would like to see online because obviously there's the three sections online and I am just wondering what we can do to sort of make that more condensed so there's not three sections.

CN1: 14:46 I'm not sure because at the top of my head I can't remember exactly why there's three different sections, but they do have the same, pretty much the same information in them

AW: 14:54, I think it's reason for referral, previous medical history, but I don't know what the last one is I will have to look into that.

CN1: 15:04 current

AW: 15:05 is it previous and current because that does make sense. Well, I guess... what would be the alternate if we are just brainstorming. Rather than having three sections so rather than having reason, previous and current

CN1: 15:22 well, if you don't need to fill out all three then there's point of all three being there and that's sort of what we were told when we were first given the information it's like just fill the first one in because you can always come back and re-refer again so you know it could just be you know the reason for, the criteria they fit within erm for the referral, which also includes the current medical history because again we was told we don't have to put everything down so if they have got diabetes and heart disease then we only have to put one down or if there's got a high BMI we just need to put that down and not everything else

AW: 16:02 so there definitely needs to be some sort of clarity surrounding what you need to fill in

CN1: 16:08 yeah

AW: 16:08 have you got any other online referral systems for any other places you refer on to I'm just wondering if we could take anything from them and your experiences

CN1: 16:17 I haven't currently I'm not sure if anyone else does, but I don't because I tend to

AW: 16:24 I just wondered how it compares that's all if there's an easier one

CN1: 16:26 I tend to see the patients and again I've not had a lot of people in and a lot of it has been more to do with depression and referring them onto emotional wellbeing services and things like that that's the only other online

thing I've tried to use with a patient which is horrendous so! the emotional wellbeing service

AW: 16:47 and the measures that are required, I think, does it still require you to take the blood pressure

CN1: 16:54 well, the GPs should have done all this so that he has done the blood pressure which obviously and the height and the weight so got the BMI for that information to be passed on to the person who is referring that for them

AW: 17:05 ok so that information is all up to date for you to pop in

CN1: 17:08 that should be yeah, if it's not then obviously I have to refer back to the GP if he has not done it because it's not something that I would be able to do because I am not clinical so it would have to be a clinical staff member that does it

AW: 17:19 has there ever been an instance when you've had to send them back?

CN1: 17:22 I'm not sure because as I say sometimes they refer them to the nurses so they might make an appointment with the nurse who will then, if the doctor hasn't done it she would then do the weight and the height

AW: 17:35 so potentially it could go from the GP, he thinks, well, he hasn't got time to take the blood pressure for instance, he would pass that onto the practice nurse who will then take the blood pressure, will she then complete the form?

CN1: 17:43 she can do the, she can do the referral form

AW: 17:46 so she won't then delegate that to you?

CN1: 17:47 no, she won't then pass it on to me, but really we could do with one totally central point. Either myself or well, probably myself which then takes it away from any of the clinical staff so long as they have filled in that

information correctly because then that saves then the nurses time and the GPs time, they just refer onto me, but they just need to ensure that they have got that up to date information

AW: 18:11 so in an ideal situation as you say you would act as that central sort of point, everyone would refer to you once they have given the relevant measures that are requires and that would save some of the delegation

CN1: 18:23 yep, it come straight to me and I can the contact the patient and arrange the appointment and do it from there

AW: 18:30 brilliant, so next onto , I'm not sure how much you will be aware of this, do you receive any feedback, or is there any feedback transmitted from the schemes back to the surgery

CN1: 18:41 I haven't had any now I do know when [HLO's name] first came to talk to us , she said, there would be some sort of feedback coming back in and letting us know how patients are getting on, but I personally have not seen or made aware of any. But whether that goes somewhere else, or not I'm not sure, but I haven't

AW: 19:04 that's fine. Is it something you would like to be involved with, the feedback loop? Would it be useful for you?

CN1: 19:09 if I am moving forward with the care navigation role then it would if I am going to be that central point, I would like to know what it happening with the patient and then I can feedback to GPs or and it just shows a trail of what is happening and where abouts we are with them

AW: 19:26 OK. So, as you say it's not just feedback, it's an audit for you so you know where about the patient is. So, in an ideal situation is there anything

specifically, you would like to hear regarding the feedback or patients progress?

CN1: 19:40 erm, just generally as to how they are getting on. If they are still continuing with it, if they have dropped out of the programme, erm if they are actually losing weight or... just general really based around what they are doing

AW: 20:01 so if they are sustaining that lifestyle, have they adhered to the programme fully and then some measures of how much weight they have lost. Brilliant. I am not sure this last section on support networks is directly relevant to yourself because we have spoken about how GPs refer to you so I guess in terms of this surgery, you are the support network because you support the GPs and protect that time for them. Likewise with the practice nurses so I don't feel that's an area we can explore. That's sort of all the areas I wanted to talk about. Is there anything you feel you can draw upon that you feel is relevant or interesting about anything? So, the referral resources, actual referral, the feedback loop

CN1: 20:44 no, I just think if there was more feedback in place it would help because you tend to pick up on these programmes and I went, like I say I went and had a good look around and we had a good chat about everything, but then I have not heard from anybody since apart from the odd phone call if I have referred someone through and it's like can you just clarify that this person is... because.... and then it turns out that they don't fit the criteria that the GPs have put them forward to

AW: 21:13 ok

CN1: 21:14, but I suppose from that's something we need to work on in practice is to educate the GPs to ensure that they are fully aware that it is a strict criterion and they need to follow that and they can't just pretend to people

AW: 21:36 and how do you think we could do that? educate GPs

CN1: 21:39, I think we need more, we need more documentation, more leaflets

AW: 21:44 more resources

CN1: 21:48 and then us as staff members need to keep reiterating it sometimes you just feel there's only so many times you can tell them.

AW: 21:58 yeah, like you said, as well, you've had a really good experience at the leisure centres, looking around, but then there's not been that communication. As you say, the only sort of contact you when they want you to clarify something. Perhaps would you like more ongoing communication?

CN1: 22:17 yeah, possibly

AW: 22:20 particularly for resources when you're running low. That's sort of the final area. You mentioned about your practice nurse, do you think the practice nurse might be happy speaking with me at some point?

CN1: 22:31 yeah, she's only in Tuesday and Thursdays this particular nurse and she is on leave this week and next

AW: 22:38 ok

CN1: 22:39 it's Claire so we've been trying to work between ourselves because obviously she is like oh, I've been trying to do this, but I can't do it and so we try and sort of work between us to do it the actual referral. Again it just needs streamlining from our point of view as in who is doing it or when. Are they referring to the nurses because they haven't had time to do the weight and

blood pressure etc. or you know, so, I think again it's a practice point of view that we need to maybe tighten up on

AW: 23:15 I guess ideally it would be really good if you could take those measurement, but as you say because you're not clinical it's tricky

CN1: 23:22 we can't do that

AW: 23:25 and what is Claire's last name? Do you have an email you could pass on by any chance?

CN1: 23:30 Claire Jones and I don't know what her email is. It's a NHS.net one, but I don't actually know it

AW: 23:37 no problem fantastic. So, that wraps up the interview if you're happy and there's nothing else, we can stop the recording

CN1: 23:45 yep

AW: Interviewer **Interview date:** 04.04.2018

CP1: Participant **Interview location**: Bridlington Practice 2

AW: 00:02 and they are actually the highest referrers for all the schemes so it's really interesting to come to all the different places within the East Riding. For instance, if you go to the more affluent areas such as Beverley, erm a lot of them don't even refer at all They are not interested. So, it's very different, very interesting.

CP1: 00:21, I think we've got lots of needs in Bridlington, I mean just walk through the town and you will know

AW: 00:24 absolutely completely different patient demographics. Brilliant so I will just take some quick demographics from yourself if you don't mind before we begin. So, how old are you if you don't mind me asking?

CP1: 00:35 45

AW: 00:36 45 and what is your role within this surgery?

CP1: 00:39 I'm the clinical pharmacist

AW: 00:40 yep. Do you have any other roles?

CP1: 00:44 er no, that's plenty (laughs)

AW: 00:46 ok yep, I can imagine (laughs), and do you work full time or part time?

CP1: 00:51 part time

AW: 00:53 part time. How many sessions is that per week?

CP1: 00:55 it's very difficult to say so theoretically I work 26 hours a week, but I do about 34 most weeks so

AW: 01:03 is that because of workload?

CP1: 01:05 yeah, yeah. So, I really, kind of work nearly full time so

AW: 01:12 yeah, pretty much full time and how long have you been working as a clinical pharmacist?

CP1: 01:17 well, as a clinical pharmacist about 20 years, but in this practice, 2 and a half years

AW: 01:22 two and a half in this practice

CP1: 01:24 yes, because it was hospital before

AW: 01:29 so is it 2 and a half years within the East Riding of Yorkshire specifically?

CP1: 01:32 well, I, I, I, I use to work at Hull and East Riding, er Hull and East Yorkshire Hospitals for, so I worked there for 10 years and before that I was in London so...

AW: 01:44 [belly makes loud noise] sorry my belly is rumbling I am really hungry today I don't know why!

CP1: 01:48 do you want a, I'll see what I've got

AW: 01:50 oh, no. It's fine honestly. It's fine honestly. No, honestly.

CP1: 01:57 if you change your mind...

AW: 01:57 thank you. I don't know why because I had dinner before I came out (laughs). Brilliant so the first section as I say we'll focus on the healthy lifestyle programmes. So, what programmes are available for you to refer patients on to?

CP1: 02:11 er there's the exercise on prescription, and there's the LiveWell, one, but I've never referred anybody on LiveWell, so really only done exercise on prescription. What's HOP?

AW: 02:22 er, the health optimisation scheme so it's a new sort of scheme, you've probably, it's all very up in the air at the moment, but it's for patient that

require non-urgent surgery, so usually it's the GPs who sort of refer them onto that scheme and before they are allowed the surgery they have to...

CP1: 02:37 oh, is it the BMI?

AW: 02:36 Yep, so they have got to prove that they have showed some motivation to change. Yep, absolutely so the exercise on prescription and the LiveWell, scheme, but you've not actually had to refer patients onto that.

CP1: 02:52 erm a lot of times it's the nurses who refer onto the LiveWell, because they see all of the diabetic patients so because a lot of the times when they want to initiate medication they will ask me, but they will do all the rest of the assessment kind of with the patient, so I usually only come in when they suggest a new medication to prescribe or...

AW: 03:11 absolutely, so as you say that would probably be the nurse who picks that up and does the assessment and referral

CP1: 03:17 yes, yes

AW: 03:19 so what's the process of referral in this surgery? Is it typically the practice nurses that refer on or do the GPs refer? Does everybody...

CP1: 03:26, I think anybody can refer so it can either be the nurses, the GPs or myself er yeah

AW: 03:34 and do you think there is anybody who is particularly best placed to refer? Or do you think it should be shared?

CP1: 03:36 erm, to be honest, I mean obviously if I see a patient I you know, and if, I think they could do with some exercise on prescription etc. then, I think I am a good person to be placed to do that, but then sometimes I also think why couldn't receptionist refer people because you know some people come to the desk and you know have got obvious problems, you know? Also in this

surgery we've got one of the receptionists of the seniors who has got a navigator role and is basically, it kind of derived from, we had this over 75's MDT and because a lot of people who are older, they have got lots of problems, but they are not necessarily medically related as such. So, you know, they just come to the GP or the nurse for maybe a chat, or loneliness or etc. So, there is obviously a huge voluntary sector out there as well, so we've got [CN's name] who's the navigate and kind of accesses all the voluntary sectors at the same time she might be, probably would be able to refer to something like this as well.

AW: 04:43 is she able to refer at the moment? Do you know?

CP1: 04:49 I don't really know. I don't think she would because she is very much in the voluntary sector involved in that so I don't think she probably has referred to this, but I would have to double check that

AW: 05:01 yeah, no problem., but as you say it would be really good if actually the receptionist could direct patients

CP1: 05:05, I think it would be good because some people might just come in and you know might just ask for exercise on prescription because they might have heard about it and the question is why would they need either a nurse appointment, a GP appointment or an appointment with myself just kind of like to discuss that unnecessarily so..

AW: 05:23 absolutely

CP1: 05:23 or even the HCA's [healthcare assistants] you know, if they are taking bloods and someone mentioned that, but that's just a thought obviously

AW: 05:30 yeah, so it's important that we are all doing it because as you say what's the point in taking up a GP appointment, a nurses appointment

CP1: 05:36 exactly, exactly

AW: 05:37 cool and how are you made aware of the programmes available?

CP1: 05:42 I basically, just ask and you know, the nurses obviously know the programmes so, so it's just like, I think I ask when people are working with people you know so

AW: 05:54 yeah, so just speaking with your colleagues and finding out what's available

CP1: 05:57 yeah, exactly, exactly

AW: 05:57 is there anything that you would like more information on or do you feel that you have been provided with enough?

CP1: 06:03, I think it would actually sometimes quite nice just to have like a register with all the referral criteria etc. So, for instance, if you go on exercise on prescription so we've got those all in line, referral form so you kind of have to double check every time and if you haven't done it in a while whether you've actually fulfilled the criteria. So, it would be good just to have like I don't know a crib sheet or something just you know, just basically, giving you all the different options which are available so that you know very quickly and you can kind of like see if the criteria are met or not.

AW: 06:38 yeah, because if you have not done that in a long time it can be quite difficult to remember...

CP1: 06:42 exactly and then you have to go into the online thing and then the problem is because when you go into the online referral at the beginning it makes you fill out in all the demographics and then after why it comes to page where you can actually see if they meet the criteria or not so it's not

AW: 06:58 ah, ok so it's demographics first

CP1: 07:01 so it’s not that fantastic basically

AW: 07:02 well, we can talk about the online referral if you like and go into that.

CP1: 07:08 sure

AW: 07:09 so you said, it starts with the patient demographics...

CP1: 07:11 I'm sure it starts with the patient demographics, let's see... [logs on to e-referral]

AW: 07:26 yes, the online system is pretty new, but , it was created originally, by the leisure centres which is why they have asked the university to help because it has been developed by the ER leisure for them, not necessarily for the surgeries so we are trying to make it more user friendly for yourselves.

CP1: 07:42 I mean, it’s all up there and you have to put the patient demographics, OK, it is actually on the first page (scoffs) sorry

AW: 07:48 no, no, it’s fine

CP1: 07:50 so, so yeah, and then you basically, just go through the full thing so

AW: 07:58 ok any sort of comments of the online referral form in terms of how it looks, how it is used. Is it user friendly?

CP1: 08:03 er, I think, I don't find it very user friendly. For instance, the other day I tried to refer somebody and then you kind of like come to the page where you pick the appointment so if gives you a whole load of appointments and every time I tried to pick it, it just wouldn't move on to the next page. So, you kind of like lose the will to live. So, I went to one of my colleagues and she tried it an she couldn't do it and then she said, oh, maybe there are no, appointments available on that day an I'm like yeah, but it just gives me the option. So, then, we went like a few days further down the line and you could pick that one, but it wouldn’t tell you. So, it gives you all these appointment, but it doesn't tell

you actually next week on that day there actually no, appointments available so you have to click through the days

AW: 08:46 to see what's available?

CP1: 08:47 yeah, so it would be easier if only the days come up when you can actually pick the appointment kind of thing. It's just saving a bit of time...

AW: 08:57 absolutely. Do you typically have the patient with you when you are trying to book?

CP1: 08:59 yes, because that's the other thing. The first time when I did it erm, I said, "I'll give you a ring later on", but then you have to ask the question, "when do you want it"? So, it's much easier if the patient is there and also you have to print it out and give them a copy which they take to the leisure centres. So, although it's an online referral, you still print out the copy and then obviously I would ring the patient again, ask them all the questions, and they had to come back to get the form as well, so yeah.

AW: 09:28 what would be a better alternative because obviously that's taking up your time, you are having to ring them, they are having to come back...

CP1: 09:33 I mean the thing is obviously after the first time I knew., I think the only other problem is, if for some reason the referral system is down, the online system, then obviously you do have to ring again etc. etc., but it actually is a big issue, but as I say so now I know to save me the hassle

AW: 09:57 and in terms of the measures that it is asking for on the form, is it all appropriate? Do you find...

CP1: 10:04 I mean this is one quite good because it's got lots of referral criteria for instance, if you do the LiveWell, programme, you've got to have a BMI greater than 35 so if somebody has got 34.5 or something than you can't refer

them, and then sometimes the nurses say oh, just measure their height again, maybe they have shrunk a little bit and the BMI goes a bit bigger

AW: 10:26 it is very strict, isn't it?

CP1: 10:28 yeah, which is not really great and I am just thinking if I've got someone with a BMI of 34, surely

AW: 10:35 so if there was a little bit of flexibility around that

CP1: 10:41 yeah, or maybe they should just lower it to 30 or whatever, I think that would be quite good

AW: 10:48 hm, as you say so more people would be eligible for it so you don't have to mess about thinking your 1% or whatever lower than you should be.

CP1: 10:56 I , I mean I can obviously see the problem because there's more and more problems of obesity so the service might think that they cannot cope if they lower the threshold so I don't know [phone rings]

AW: 11:10 you can get that if you like. It's fine. So, when are you prompted to refer patients onto these programmes? Do the patients come in asking for it or do you sort of assess their physical activity levels?

CP1: 11:21 erm, it can be two ways really. Erm, I mean obviously kind of like weight and not exercising is a big thing so for a lot of our health promotion it includes kind of like addressing people's weight and addressing people's lack of exercise so I do suggest it sometimes. Some people do ask for it and then maybe sometimes they will be disappointed that they still have to pay something for the prescription of exercise although it is a really minimal amount for what people get. Or sometimes for instance, I've had somebody coming in who had a stroke and felt very immobile, very isolated etc. so I suggested that for them and they were very, very happy to kind of like take

that up. So, it's really both ways. Some people ask, but lots of times people just want everything for free really so

AW: 12:18 so is the cost a big issue?

CP1: 12:20 for some people it is yes, for some people it is

AW: 12:24 are you, because you are in Bridlington, are there any sort of free places for patients? I know sometimes the leisure centres offer so many free places

CP1: 12:34 I mean I know the exercise on prescription you say £33 for 10 weeks so, but I am not aware that there are free places, I don't know

AW: 12:40 right, ok

CP1: 12:43 I am not aware that there are

AW: 12:42 I'll double check with [HLO's name], the leisure centre co-ordinator. I know for sure Withernsea get so many free places so it might be the same for Bridlington

CP1: 12:53 ah right, ok, probably would be then.

AW: 12:55 yeah, I imagine so and if it is the it would be really good to utilise those places

CP1: 12:58 and then to also know what the criteria are for free places. Ok

AW: 13:03, I think, I think you have got to ring up and discuss the patients and they decide whether..., but I am not sure. I will double check and find out for you

CP1: 13:12 that would be good thank you

AW: 13:14 no problem. So, are you provided with any information resources for patients to give out...Any leaflets anything like that?

CP1: 13:24 nope

AW: 13:25 ok the exercise on referral, they have developed these healthy lifestyle programme booklets

CP1: 13:36 oh, good

AW: 13:38 so these booklets show every single programme that is available so the LiveWell, scheme, the Young LiveWell, scheme, the Exercise on referral. Do you have these within this surgery? These little booklets?

CP1: 13:49 erm I do not know I mean I haven't seen them, but that doesn't mean that we do not have them

AW: 13:51 that they are not there, yep, absolutely. Would it be something you would like to hand out?

CP1: 13:55 yeah, it would be brilliant yeah, it would be fantastic

AW: 14:01 you can take that one if you like

CP1: 14:01, but that is your last copy, isn't it?

AW: 14:03 it's fine I will get some more

CP1: 14:05 you sure?

AW: 14:06 yeah, honestly it's fine

CP1: 14:07 thank you

AW: 14:07 I will speak to [HLO's name] as well, and get her to deliver some more to this surgery as well. It might just be…I'm not sure if you would like to hand them out. I am not sure if it has the referral criteria on there

CP1: 14:19 well, it's kind of... [Reads leaflet]. Ah LiveWell, I thought it was BMI over 35 it's actually 45

AW: 14:29 45 yes

CP1: 14:31 ah I see, I've got it wrong already., I think it would be quite good to hand it out actually. yeah, I think it would be great.

AW: 14:40 do you find, I know you've only had a quick look, but do you think they are patient friendly in terms of the language? Is there anything we can improve on the forms?

CP1: 14:56, I think it's quite good actually

AW: 15:08 yeah, fab I will get some of those delivered as well. As I say if you do like to give them out it's handy to have them and you can send patients away with something.

CP1: 15:13 yeah, I think it is good, no, it's great! I would love some of those

AW: 15:18 brilliant yeah, you can keep that one and I will get some more ordered for you

CP1: 15:22 excellent

AW: 15:25 ok are there any other challenges you have experienced or anything that has made it difficult to refer or is it relatively straightforward?

CP1: 15:35 er as I say I have only done exercise on referral and obviously for the LiveWell, not everybody fits it so that's really the only restraint

AW: 15:46 yeah, in terms of the criteria

CP1: 15:48 yeah, and obviously some of them, obviously I don't know the HOP one

AW: 15:54 and you said, that sometimes, what could be improved is the appointment slots so if it was able to show exactly what you had available.

CP1: 16:01 yeah, exactly, exactly

AW: 16:01 fab, ok and have you always used the online system or did you ever use the paper referrals?

CP1: 16:09 no, because they had just changed to online when I started

AW: 16:12 ah, ok so you've always used the online. No problem at all. And are you provided with any feedback about your patient's progress?

CP1: 16:19 I actually haven't been from one single one of them, but then that might also be because I usually do medication reviews or any er, I don't know if someone was started by a specialist or something then I would try and check them up so it's not necessarily..., I think for the nurses it is different for instance, if they see a diabetic person, so they will see them at least twice a year so they might be more able to get feedback

AW: 16:45 yes, if that patient is coming back they can have that catch up

CP1: 16:47 yeah, exactly, exactly

AW: 16:51 how do you feel about receiving feedback? Is it something you would like to receive?

CP1: 16:55 that would be great. Obviously, it would be great

AW: 16:56 anything in particular that you would like to hear about?

CP1: 16:58 just really erm you know how people are doing and if they keep it up after the 10 sessions are finished because, I think that sometimes can be a problem if people get it discounted or for free then they might do the 10 weeks and then, I think the idea should be to change habit, isn't it? You know, to form a new habit rather than "ok I've had this for free, now I will go back to my old ways" which would defeat the goal really. So, that would be really great if people say you know I've done this, or if the leisure centre could feedback, they have done this, they have lost weight, they are fitter, they can do more exercise, and also they have signed up to continue on with it. So, that would be fantastic

AW: 17:45 absolutely because it is about sustaining that change, so not just going on a programme and reverting back

CP1: 17:48 exactly

AW: 17:50 ok so you would like to hear generically about how they are doing, but as you say more importantly are they maintaining that change. Are they keeping it up? Have they joined the gym? Doing their own thing?

CP1: 17:59 yeah, yeah

AW: 17:59 ok

CP1: 18:04 because otherwise the health promotion thing just becomes an extra cost in a way doesn't it? Because 10 weeks will probably not make a long term difference to people's lives

AW: 18:15 absolutely., I think when they do complete the ten week period they do get the membership discounted if they have been through the scheme

CP1: 18:20 ah, ok

AW: 18:21, but I am not sure the exact discount, but I know they get a little bit off.

CP1: 18:26 good

AW: 18:26 so you said, you do quite a lot of health promotion in this surgery. What does that sort of encompass? So, you obviously refer onto these programmes...

CP1: 18:35, I think, I think maybe the three, or the three to four big areas are the smoking cessation, weight loss, and then obviously weight loss kind of includes teaching people about a healthy diet, what they should be eating and exercise. So, so they really kind of like the big ones if you could sort that one out in Bridlington, that would be marvellous

AW: 19:04 yeah, they are the three key areas

CP1: 19:05 absolutely, marvellous. I am sure there would be many, many more, but you could go on forever. They are the basics really.

AW: 19:11 absolutely is one more of a problem than the other do you find?

CP1: 19:14 I find that most people you might find all the problems come back together so they are not necessarily isolated so

AW: 19:27 so it's a little bit of everything?

CP1: 19:27 yeah, exactly

AW: 19:27 and what sort of issues do patients present with that makes you think it may be useful to go on an East Riding leisure scheme? Is there anything that they present with? Or is it how they look?

CP1: 19:42 I mean one of the things is a lot of people have long-term conditions and especially if you look at diabetes and patients who present with type 2 diabetes are getting younger and younger and younger. So, it's not any more like somebody is in their 70's, you know, has not worried about their diet, has not worried about their weight, exercise etc. and suddenly they have got type 2 diabetes. But now you get people in their 30's and their 40's, which is obviously extremely concerning basically. So, that's a big one and you know diabetes on the whole is obviously increasing in the nation so that's on the whole and obviously if someone comes in, how they look. And there's also other things, muscular-skeletal problems, you know? A lot of people come in presenting with pain er requesting lots of analgesia (pain killer), but, I think a vast amount of the pain could be helped with just by losing weight.

AW: 20:36 yeah, there's that link

CP1: 20:41 for their joints, yeah. So, they are just too big ones and then obviously cardiovascular disease. So, you know it is really endless

AW: 20:48 yeah, there's a lot of different conditions

CP1: 20:50 yeah, I mean even a lot of people with respiratory problems, that's another thing. Some people you do all the tests, they haven't got COPD, they haven't got asthma, but they are just very large and can't breathe so

AW: 21:01 and how do they respond if they come in with a problem, and they really want medication, and you say look we've sort of explored all these options it's not COPD for instance, it's something else. I suggest you go this way. Are they sort of taken back by that?

CP1: 21:17 erm, I think a lot of people would like a free pill for everything, really., I think, not many people are necessarily very motivated to change their lifestyle because, it sounds a bit boring now, but coming back to obesity, because, I think a lot of people maybe don't recognise any more that they are obese because if they look around them, they might find that they are quite slim compared to some other people. Because, I think that the picture has gotton a bit distorted. Kind of, like, what is obese, what is not obese? It's just like you know one example, and I had a lady the other day, she had a BMI of 39 or 40 and I said, it would be really good to lose some weight and she said, oh, when I look in the mirror I look really slim. And erm, it's kind of you're then trying to explain to people that that is maybe not the case. So, erm, but then some people are really responsive to it, but I would say still the majority it's more like that you have to constantly try to motivate them. But then they're are people who are responsive to it and do actually do go, do, do the exercise, do change their diet, come back, feel much better, and you know you can take them off some medication so...

AW: 22:35 brilliant

CP1: 22:37 it's not all doom and gloom

AW: 22:39 yeah, there are some people who are, as you say motivated to change. It's interesting what you said, about the imagine becoming distorted

CP1: 22:46, I think it has

AW: 22:49 and they don't actually see themselves as being obese. That's really interesting! When they compare to other people. Yeah, really interesting stuff! That's sort of all the areas I wanted to discuss today. Is there anything that you feel is relevant to add or anything you want to expand on further?

CP1: 23:07 er no, it's actually… no

AW: 23:09 ok, not a problem at all. Thank you for allowing me to come today to speak with you

CP1: 23:12 that's great thank you for coming and taking the trip

AW: 23:17 that's fine, and I'll just turn this recorder off....

AW: Interviewer **Interview date**: 14.07.2017

HCA1: Participant **Interview location**: Withernsea St Nicholas Surgery

AW: 00:04 how old are you if you don't mind me asking.

HCA1: 00:06 23

AW: 00:08 23

HCA1: 00:08 yep

AW: 00:08 and what's your role within this surgery?

HCA1: 00:09 healthcare assistant

AW: 00:11 Healthcare assistant. Do you have any other roles or is that your only role within this surgery?

HCA1: 00:16 jack of all trades (laughs). Just healthcare assistant, but I do help out in the reception er, you know. We work closely with the GPs and I train the healthcare assistant apprentices as well

AW: 00:31 ah right, ok and are you full time or part time?

HCA1: 00:34 full time

AW: 00:36 full time. So, do you deliver 5 sessions a week in general practice?

HCA1: 00:41 yeah, I work 5 sessions

AW: 00:43 and how long have you worked as a healthcare assistant?

HCA1: 00:45 er... 3 years here and then I was just a care assistant for 5 years...well, since I was 15, before that

AW: 00:53 ok so have you worked for three years within the East Riding of Yorkshire.

HCA1: 00:59 yeah

AW: 00:59 fantastic. Ok, so as I say the first section of the interview will be focused on the healthy lifestyle programmes available in this locality. So, what's available for patients here in Withernsea?

HCA1: 01:11 er, the Livewell, programme. The Livewell, for young chil, er people. Exercise on prescription and that's it because the health trainers aren't part of the East Riding are they?

AW: 01:26 that's right they are NHS run ones yes. And how are you made aware of what programmes are available in the area?

HCA1: 01:32 we work really closely with the leisure centre with it only been around the corner. We have er, [FC's name] and the team from the leisure centre come and they stand in the waiting room and promote what they have.

AW: 01:47 ah with the patients?

HCA1: 01:48 yeah. We have meetings and each week we have like, we promote different things so it might be the health trainers. It might be the live, leisure centre, erm, loads of different ways.

AW: 02:00 and that's meetings within the surgery?

HCA1: 02:01 yeah, within the practice yeah

AW: 02:07 and which ones do you find that you refer patients to most often out of the available programmes?

HCA1: 02:11 er, exercise on prescription

AW: 02:14 exercise on prescription. Why is that?

HCA1: 02:15 er, just because it's not as tight remit, is it? They don't need a BMI over a certain amount, and anybody can be referred as such. Now, it's the,

they don't have to be inactive now it's the online referral. I know that is it ideal that they should be. Erm, but yeah.

AW: 02:34 OK so the referral criteria is maybe not as strict with exercise on referral?

HCA1: 02:38 yeah

AW: 02:38 do you find, is it quite difficult to refer onto LiveWell? Do you find that many patients meet that criteria?

HCA1: 02:43 yeah, but the ones that want to do something, very few

AW: 02:47 ah right OK

HCA1: 02:50 we do refer you know a couple a week, but not as many

AW: 02:53 yeah. So, who else can refer in this practice? Is it just you?

HCA1: 02:58 anybody really. I'm the only one who is trained to use the new online portal, but anybody can refer

AW: 03:07 and how long has the online portal been running for?

HCA1: 03:10 maybe 2 months

AW: 03:13 ah so very, very new at the minute...

HCA1: 03:16 it might be longer, but I've been on and off at work recently

AW: 03:18 right OK. Erm, so LiveWell, and Exercise on referral have information booklets and referral forms such as these ones. Is there any other information that you can give patients regarding the programmes? So, there is these information sheets, is there anything else?

HCA1: 03:36 no, we have all of these and that's all we give them, and I explain the exercise on prescription verbally because of what I've been told by the leisure centres by [FC's name]

AW: 03:48 OK so you find it, because you've had that information from the leisure centres, is it a lot easily to communicate?

HCA1: 03:53 promote it yeah

AW: 03:53 and promote it

HCA1: 03:54 absolutely yeah. Absolutely. Erm, we don't use these leaflets any more really because they don't provide them with it all been online, erm, but we just verbally communicate what they are. Erm, we have got, somewhere, a big booklet with the LiveWell, criteria, it's somewhere in here...somewhere

AW: 04:15 the big A4 one?

HCA1: 04:17 yeah, and it has all the criteria and then just those little healthy lifestyle booklets

AW: 04:23 ah yeah, those as well. So, do you prefer verbally communicating or would you like more booklets to hand out, is that easier?

HCA1: 04:30 er, are they the only booklets available?

AW: 04:34 they are yeah

HCA1: 04:35 we keep on top of those anyways so yeah

AW: 04:35 That's fine yeah. So, er, as you say the exercise on referral you verbally communicate, with the LiveWell, do you tend to give them the leaflet?

HCA1: 04:49 give them the leaflet and verbally communicate yeah, because we have to refer them anyways, so we just like to tell them what is likely to be entailed and that if they don't fully partake then they won't continue with the course basically. Er, because it's quite, it's quite a good course. The fact that a friend can go with them and things you know. It's not to be wasted

AW: 05:10 and it's good that you've got that information because, in some areas where they are not closely aligned with the leisure centres, the GPs do not know about that feature so they cannot communicate that with their patients. Er, and sometimes it's put across as boot camp so obviously that puts people off

HCA1: 05:26 yeah, well, I actually, I did a lot of work cuz I was doing a lot of promoting for pre-diabetes, I worked really closely with them and I actually sat in a few of their sessions, the LiveWell, sessions, the exercise on prescription and the health trainers. Er, so they let me, you know, do a bit of learning from what they do, and er some of their counselling kind of tips and then obviously they explained exactly what they do on the, on the courses so I can tell patients that I have had my own experience there

AW: 05:56 that's really interesting so do you think that maybe could be something that other...

HCA1: 06:01 at practices., I think it would be beneficial er obviously not everybody, but if somebody from the practice or wherever they are referring from could have a bit more insight then, I think they would use it more. They've got a new machine that checks all your body fat that you stand on and hold onto as well, and it's part of the scheme

AW: 06:19 the Boditrax?

HCA1: 06:20 yeah, the trax and they took us in and we did our own, they did a session with us and it was brilliant!

AW: 06:25 it's weird, isn't it?

HCA1: 06:26 it is really cool, but it's a bit depressing!

AW: 06:28 is that, can you remember which one that was used in? Was it exercise on referral or LiveWell?

HCA1: 06:34 that was, they just took us, that wasn't in, that was just us as professionals, there was a team of us, and they was training us with it, so they just did the session on us.

AW: 06:43 ah because, I think, I think eventually they are going to try and implement that within exercise on referral, but obviously we can't tell patients yet because it's something they are thinking about

HCA1: 06:50 yeah, yeah

AW: 06:52 that's fine. We've kind of already spoke about this, but I was going to ask if you feel like you've been provided with enough information about each of the programmes to promote that with your patients effectively?

HCA1: 07:00 yeah

AW: 07:03 yes, and do you think that some programmes are better publicised or is it quite equal?

HCA1: 07:08 it's quite equal, I think yes

AW: 07:12 and do you receive any incentive for referring patients onto these programmes?

HCA1: 07:17 what do you mean?

AW: 07:19 is there any kind of incentive on your behalf? Do you have perhaps a target or any financial incentive?

HCA1: 07:24 er, no, not really. Er I have, we did , I won an award because I did so many referrals back when it was promoting pre-diabetes yeah, but no, not as a rule

AW: 07:37 And what are your sort of ex, expectations from referring patients onto these programmes?

HCA1: 07:42 er, well, really to me I am referring and then it is out of my hands. However, I have found since the new referring system, I am getting a lot sent back to me and I feel like a lot of it is their admin role not something that should be coming back to us. Er, I like to, because we are close with one another, you know, professionally, we can discuss the patients, they tell us so and so has done really well. Or sometimes if we are putting, like I have done some, oh, what's the word? Minds gone blank. I've been gathering examples of people…

AW: 08:26 case studies?

HCA1: 08:27 case studies! That's the word I was looking for! Er, when I do case studies, I erm, we work together to get the information to see where they started with me and how they ended up after they had seen them, and now where they are so many months done the line after they've seen them. So, we've had a few case studies like that, but other than that that's just it

AW: 08:46 and what, er, so when are you prompted to make a referral onto the programmes? What kind of symptoms do patients come in with you might initiate a referral?

HCA1: 08:52 er patients might just ask, you know they might just say I need some help dietary, or even if its anxiety, depression and they need some sort of incentive to get out and do something. They are really good for that. Erm, but generally it's when people come in with diabetes, pre-diabetes, high cholesterol, come in for their heart checks, things like that. Er...

AW: 09:21 so all lifestyle related issues?

HCA1: 09:21 yeah, exactly, all chronic conditions that can be changed through diet and lifestyle. Er, but we do get quite a lot of patients that see it promoted because we always have big banners up. Er, we've got those in the waiting room in both waiting rooms. They just come in and ask and we will do the referral, you know, as long as they fit the criteria. To us the more the better because in our area we've got a really high number of diabetics and pre-diabetics for the size of the area, so

AW: 09:52 so that's something quite prominent in your area that you need to tackle

HCA1: 09:54 yeah

AW: 09:55 er, to be honest your surgery is the only surgery where you have the big banners

HCA1: 09:59 oh, really

AW: 09:59 yeah, I was going to ask, do you think that helps, obviously to increase patient awareness?

HCA1: 10:03 it [name] absolutely does! I mean is a bit better to speak with on that behalf because [name] has been working so closely. It's like, we've got like a campaign in this area to prevent diabetes and to make, even people without diabetes, healthier. They did a mile walk as a surgery last Sunday, 150 people from the area turned up to do a mile walk with the surgery

AW: 10:27 oh, wow

HCA1: 10:28 and, I think the, the stand came from the leisure centre or the health trainers or something to promote and do it with us. Er, so we do have a lot of promoting

AW: 10:39 so that kind of advertisement really does help patients awareness of what's out there

HCA1: 10:41 yeah, it did get to a point where [Fitness Professional name] did say to us, you're going to have to slow down because we don't have any appointments left!(laughs)

AW: 10:50 there's no, more capacity!

HCA1: 10:50 yeah

AW: 10:50 that's brilliant. As I say it's the only one I've been to so far where there is that so it was really good to sit in the waiting room and see all the different programmes, and patients can see that as clear as I can. Ok, so that's kind of the first section about the programmes that are available.

HCA1: 11:06 yeah

AW: 11:06 next we will talk about the constraints of patient referral. So, it will be a little bit different with this one because you've got experience of both the, er,

HCA1: 11:14 paper and the electronic

AW: 11:15 the online one yes. Er so how easy or difficult is it to refer patients onto these programmes?

HCA1: 11:21 er electronically, well, both ways, easy. Er, the only quime I've got is with the new electronic, er, the GPs don't have physical time to do that whilst they're in practice. So, it all gets sent back to us and it takes a lot of our clinical time up to do that. You know if we're getting so many referrals in. Whereas before they would just fill in a piece of paper and it would be sent whereas now it takes a bit more of the nursing time or the admin time having to do those online referrals. Er, and it's a very bland referral form.

There isn't many conditions on there, that you can tick. Er, not even as many as, it's not the same as it is on the paper

AW: 12:06 is this in terms of exercise on referral, LiveWell, or all of them?

HCA1: 12:08 all of them

AW: 12:10 all of them OK

HCA1: 12:11 there isn't, there isn't the same amount of conditions or options on there as there was on the paper. Erm, so I don't think it's, you know, it doesn't have the BMI section, it doesn't have blood pressure, so I feel like I am referring to them and they are a bit blind. That they are not receiving any information from us

AW: 12:30 ok, er, does that, does that have implications in terms of who you refer if you forget what the criteria was before?

HCA1: 12:37 no, no, but then, like there isn't an opt, like if we tick something and it's not on there then it looks like they're not eligible. We know they are, but I cannot refer them because it is not on there and there isn't even a box that you can freehand

AW: 12:51 for anything extra?

HCA1: 12:50 yeah

AW: 12:52 ok so it would be useful to have perhaps more conditions and a section so if there's anything else you want to add in.

HCA1: 12:58Don't get me wrong, I think it's good I just think it needs tweaking

AW: 13:01 just improving yeah

HCA1: 13:02 and its new so it's bound to have some room for improvement, isn't it?

AW: 13:05 yeah. So, in terms, of the, you say there no, BMI, no, BP, er how does that influence your referrals? So, you say you're, it kind of gives a blank picture

HCA1: 13:16 it doesn't, but when you're referring to LiveWell, that's the main point of LiveWell, is it's people with a high BMI so the form is exactly the same for both

AW: 13:28 ah, ok

HCA1: 13:30 so it's hard to, when they receive it will they receive it as the right referral? Because there has been times, where I have done a referral and I've wanted it to go to LiveWell. I've sent the referral off and, but I've printed the letter and it says you've been, you've been booked onto an appointment for exercise on prescription and it's like argh!

AW: 13:48 ah, ok. So, it automatically, with that information, even though you know they are eligible for LiveWell, it is referring them on to exercise on prescription.

HCA1: 13:55 yeah

AW: 13:58 ok so do you think there definitely needs to be some distinguishment between the forms?

HCA1: 14:02 what they are yeah! And mainly because if people are a little less computer literate, it's clear which is which. It's a really easy site to use like they have made it so simple, but it's that simple that's there's no, distinguish

AW: 14:22 a bit too simple (laughs). And when you say it takes a little bit longer than the paper referrals, in terms of time, how long?

HCA1: 14:29 only the fact that the GP would have to log on and, and do it. The actual referral doesn't take that much longer it's the fact that you're having to click back onto system one get the patients name, click back onto the other one type it all in, then back and forth. Whereas before you would just write it down

AW: 14:42 yeah, yeah

HCA1: 14:42 er, they both take the same amount of time really it's just that getting other people from paper to computer is, not just in this area, in all areas, it's difficult

AW: 14:53 yeah, what do you think might be a better alternative? Rather than the separate. I know it's a big question, have you got any ideas?

HCA1: 15:00 I don't think there is a better alternative, I like both options. I just wish that you could use both options. So, for example, I think the online is good like for us as a nursing team er, because you're sat with the patient when you do the referral. So, cuz you've got to make the appointment, you've got no, choice you have to make the appointment on there. So, I think for us it's good, but, I think you should still be able to use the paper referrals for likes of GP so that the appointment can be made by the East Riding. Because the GP only has a set allocated time they do the referrals after, so they can't book the appointment because the patient is not there. And the same if they send it to the secretary, the secretary is then having to call the patient and its taking a lot more time to book the appointment and, I think it's just time that's kind of been pushed off the East Riding and brought to us if that makes sense?

AW: 15:57 yeah, absolutely

HCA1: 15:57 I feel like they are gaining time by making us do more of their admin if that makes sense. But I prefer the online, doing it I just quickly log on and I do all my referrals once a week on a Tuesday and its bish bash job done, but I don't like that you can't use both options

AW: 16:14 yeah, so ideally there would be the choice to use either the paper or the electronic?

HCA1: 16:18 yeah, because the GPs have been, they still do now, send paper, but then I get an envelope through with all these referrals and I do them after

AW: 16:26 ah so it's double the workload?

HCA1: 16:25 yeah, yeah

AW: 16:27 right, ok, so, is it, do GP's typically do the referrals or would they kind of say to the patient, I think it would be best if you speak to...

HCA1: 16:38 no, no, they will do the referral, or they will send a task to the reception. can you do a referral for such and such. Er, but yeah, they do refer

AW: 16:49 and do you think, when it does become online, where they are not allowed to use paper do you think they will have...

HCA1: 16:54 it will slow down

AW: 16:57 because of that. Ok.

HCA1: 17:03 we've also got a community navigator [CN's name] who works within the practice. She's, erm she's there predominantly to help people. She's a health trainer as well, but she has a second role with us and she refers people also, but I am not sure if she is trained on the online system yet either

AW: 17:24 ah right so, is she involved with patient referral as well?

HCA1: 17:30 yeah, so basically, er, so a GP might refer a patient to [CN's name], or a patient might walk in and see [CN's name] and say I've got problems with anxiety or depression, but I don't think I need to see a GP, or er, I'm really, I'm really big I want to lose some weight, and [CN's name] will , she's like a sign poster, so she will triage and signpost people to the right places so she does do a lot of referrals.

AW: 17:53 ok so as well, as you having your GPs, Healthcare assistants, you've also got a separate care navigator who is also there to signpost and refer patients?

HCA1: 17:59 yeah, yeah. So, she's like that middleman. So, sometimes appointments can be, not wasted with a GP er, but may not quite, may not be enough to see a GP, but not to be ignored, so [CN's name] is there to do that. She helps people with finances, helps people with everything

AW: 18:18 a little bit of everything

HCA1: 18:20 yeah, yeah. She's literally just the go to kind of guy. So, she's, she's a referrer

AW: 18:27 ah brilliant. Is it quite common for surgeries to have a care navigator?

HCA1: 18:30, I think we're the first one it's a brand new role so er, I think it's something that is getting promoted, but it's all brand new

AW: 18:40 yeah, your surgery seems to be completely ahead of every other surgery

HCA1: 18:45 [name] will be glad to hear that! (Laughs). We do work hard to do it

AW: 18:49 I can imagine. In terms of the measurements that are required, what, what do you think would be the most appropriate patient measures for the

online one? So, you've said, at the minute there's not the BMI or blood pressure...

HCA1: 19:02 yeah, do I have...

AW: 19:05 in your opinion what...

HCA1: 19:07 do you have your sheet, exercise on prescription?

AW: 19:09 yeah, sure

HCA1: 19:09 the, it doesn't have er, all of these options, so like if I show you, if I log on will it be easier and show you?

AW: 19:17 yeah, yeah, I was just wondering if you think these are all relevant

HCA1: 19:22 these are all relevant, this [holding paper referral form] online would be perfect

AW: 19:26 so this would be perfect ok

HCA1: 19:25 yeah, that's it that's all I needed to say, to show you. That online would be perfect because it's got everything that you need to tick. The online one has got three boxes and it says current, previous, and historical medical conditions. So, not even, you're just clicking the same thing over and over again, but they're not even the same on each one. So, one might say diabetes and then the historical won't have diabetes on there and it's like well....

AW: 19:52 I've just marked that it's on there yeah, that makes sense

HCA1: 19:54 you know it, yeah, it's, there's not a lot of option on there

AW: 19:57, but in terms of everything on these forms you're happy?

HCA1: 20:00 spot on yeah

AW: 20:01 you're happy with the forms just make them electronic and they will be perfect?

HCA1: 20:02 easy peasy yes!

AW: 20:04 fab, nice and easy. Are there any other constraints in terms of patient referral, it could be perhaps on the patient behalf if they're not interested or? Is there anything else that you find difficult?

HCA1: 20:15 this area is very limited so patients can be stuck in their ways. So, patients, you know, sometimes patients do, they might get embarrassed or whatever and don't want referring, but no, not really., I think er, with the exercise on prescription, because it's quite a deprived area, some of them don't want to pay the £30 charge, or can't afford the £30 charge and I am aware that there are limited spaces that are free, but it's not for me to say that so, I think sometimes that can be a barrier. Erm, so for us to have maybe a larger remit of free spaces would help, erm, but other than that not really.

AW: 20:52 and do you tend to find that there's enough capacity for all your referrals at the leisure centres?

HCA1: 21:00 yeah, yeah, yeah

AW: 21:00 ok

HCA1: 21:03 the only thing that we have had is erm... what is this? [Looks at notes from business manager] what's it mean? Exercise on referral booking has been made for the following customer: the booking was done by [name]. Erm, further details, I don't know why that's come to me to discuss in the meeting. But erm, basically, like this one here, the LiveWell, I got a letter through, erm I did not realise they could only do it once

AW: 21:43 the LiveWell, programme?

HCA1: 21:43 yeah, which isn't a problem, but because we've got no, way of seeing, if they have done it or not as such, I've referred this person booked the appointment, they've turned up and now they have sent it back to me and it's like what do you want me to do with it? This is what they should deal with, like they should then say OK you've already done the LiveWell, but there is this option

AW: 22:09 yeah

HCA1: 22:10 you know, I think to then send it back to us to do more referrals is a bit of a, messing about really you know we don't physically have the time to do it

AW: 22:21 so in that case scenario it should be their responsibility to say ok well, you've done this, perhaps if they had more signposting skills and was more aware

HCA1: 22:32 yeah, absolutely

AW: 22:35 we could maybe er, incorporate that online so it says when you're doing referral...

HCA1: 22:41 if this person has already

AW: 22:40 yeah

HCA1: 22:40 yeah, I was thinking that yeah, it would recognise the name and say this person has already been booked are you sure you want to book it

AW: 22:48 yeah, or these are the available options for this patient, if that would help

HCA1: 22:51 yeah, yeah, absolutely

AW: 22:55 ok so we've spoke about what's makes it hard, and because you do so much referral in this surgery, I wanted to know what sort of facilitates

referral. So, what makes the referral process so easy to use in this surgery? Do you think it's because you've got many referrals in different roles?

HCA1: 23:11 just because everybody knows about it

AW: 23:14 ok so it's awareness?

HCA1: 23:14 yeah, so everybody is aware of it er and because it's a really valuable resource to us, I think. We don't have anything else like that around here. We don't have many options round here because is it, we're so far away from anything else er so it's something that gets used by everybody. All the GPs know about it, and if they don't refer themselves, they will send it to a secretary, or they will tell the patients to refer themselves on it you know. Erm, I don't know, I think it's just awareness to be honest.

AW: 23:46 yeah, so all the people who work here really valuable the programmes and appreciate that it's something that is unique to the East Riding of Yorkshire. So, in terms of patient progress, what information is comes back to you regarding....

HCA1: 24:01 nothing

AW: 24:01 nothing at all?

HCA1: 24:01 not unless we ask, but even then, nothing comes through officially, but because we know the people that they work with we can sometimes say, or they might ask us for me help, they might say what the most recent bloods were or whatever

AW: 24:16 ok and is feedback something that you would like? Is it something you've considered?

HCA1: 24:20, I think it would be beneficial however, with it being a adminny thing I don't know if that's for me to say., I think that's something would have to

decide on, but yeah, it would be nice to hear some feedback to see like, maybe not regular, but at the end what's happened. We can sometimes follows, we can follow the health trainers because they're in system one so we can see what they do every week and the progress erm obviously with East Riding you can't do that. But some sort of progress, "this patient has completed the course", might be good

AW: 24:54 so at the end, at the end of the programme...

HCA1: 24:59 with patient consent obviously!

AW: 24:59 yeah, so you'd like to know if they have completed. Is there any of patient indicator that you would like to...?

HCA1: 25:05 yeah, or er, if they would like to carry on doing something else

AW: 25:09 OK because I guess that would help you decided what other programmes might be available....

HCA1: 25:12 yeah, because that is something that I have found. I will refer patients who will do the course, but then that's it and they can't afford to, to buy a gym membership, but then that's it they just stop. Erm, so it's, where do you go from there?

AW: 25:30 so it's kind of knowing what stage they're at and if they want any ongoing help to help them carry on and maintain what they are achieved

HCA1: 25:36 yeah

AW: 25:41 er so that's kind of what makes it easier, or kind of a little bit about feedback. The next section we've kind of spoke about loosely all the way through so it's just about the support networks that you have in this surgery to help triage patients and signpost, but as you say you've got a dedicated

care navigator, er GP can refer, you've got healthcare assistants, practice nurses

HCA1: 26:02 yeah, we get messages through so we've got a group tasks where people will just refer through, this patient wants exercise on prescription, and we will just pick them up and do them between us all and just send the referrals off

AW: 26:15 yeah, so that can be done by anybody. How do you get patient consent? Do you get that first?

HCA1: 26:18 so yeah, if somebody had a consultation, one of the GPs for example, and they say I'd like to do one of the exercise options er, a GP will just write it in the notes that the patients given consent and send a task to us, and we will just do it. Er, what I have started doing now is because I find getting in touch with the patient is difficult. I book further appointments into the future, so I book their appointment for them send them a letter to inform them of their date and if they are not happy with their date they will have to ring and change it themselves because we, it's too difficult to be constantly ringing.

AW: 26:58 and I guess you haven't got the time

HCA1: 26:59 no

AW: 27:03 to wait for their consent, but if they've already provided their consent like you say it's just a case of it, they can make the appointment

HCA1: 27:07 exactly

AW: 27:12 and does this practice engage with the new online system Web GP?

HCA1: 27:17 Web GP

AW: 27:21 it's an online query tool

HCA1: 27:23 oh, no, I don't think so I've not heard of it

AW: 27:25 that's kind of everything that I wanted to talk about today, is there anything that you think is relevant in terms of anything we've spoken about?

HCA1: 27:31 no, not really, it's purely just those little bits with the website that er were a concern and, I think time is a big concern to maybe, to maybe [name] has just messaged me, bear with me.

AW: 28:01 we're just finishing up, but tell her I can hang on if she wants to talk to me

HCA1: 28:01 er [types] right so yeah, I will see what she says. But yeah, I think time was, one of [name] concerns is our time is really quite precious to obviously the practice and with the new referral it feels like a lot of time has been taken away from them and put onto us. Erm, but like I say I don't know that's something [name] would discuss with you, but other than that no, I am quite happy with it all I just do wish that you could just use both

AW: 28:49 yeah, yeah. So, for you it's having the option to use both and all these patients measures could be electronic on the online system then perfect

HCA1: 28:57 yeah, absolutely I would always use the electronic now because to me it's easier and I can just quickly do it, but not everybody is that into computers you know and it is, it is time and GPs are so busy they've got so much to talk about. The secretary's do the referring everywhere else so it's not as easy for this referral as it is the others

AW: 29:17 yeah, that all makes sense cuz as you say it's not integrated into system one,

HCA1: 29:22 so [name] said, that she is struggling with time er, but if you've got a number, she can call you and she will catch up with you and catch up with me as well

AW: 29:33 yeah, do you want me to...

HCA1: 29:35 leave a number?

AW: 29:35 yeah, I can leave a number that's fine

HCA1: 29:27 I'll write it and I'll give it to her

AW: 29:38 I've got some paper if you'd like to jot it down

HCA1: 29:42 yeah, please

AW: 29:42 no, worries and do you think there's anybody else in this surgery who wouldn't mind me talking to them to ask these exact same questions?

HCA1: 29:50 erm I don't think there's anybody else, [HCA's name] might, the other health are assistant who's popped in, erm she might er, but again it's difficult for timing so what I will do is I will ask [name] to ring you because she's in charge with our time keeping.

AW: 30:08 yeah, no, worries

HCA1: 30:09 so she will decide if we can take some more time out for your interviews. Is that all right?

AW: 30:15 yeah, absolutely thank you very much

HCA1: 30:16 But [HCA's name] will definitely be happy to do it I'm sure she would

AW: 30:19 yeah, as long as, I'd really like to get into obviously every surgery. Even just one person from each surgery

HCA1: 30:25 yeah

AW: 30:25 I'll just stop this, just so I can see how [turns off recording device]

AW: Interviewer **Interview date:** 20.03.2018

MS1: Participant **Interview location**: Field House Surgery Bridlington

AW: 00:00 I'm just going to do a backup on my mobile, as it has not been brilliant. There we go so we've already spoken about confidentiality and your participants rights. Are you happy that we've gone over that, and you are happy to continue?

MS1: 00:15 yeah, that's fine (laughs)

AW: 00:19 I've got to ask and can I take some simple demographics from you [MS's name].

MS1: 00:23 you can

AW: 00:23 so how are old are you?

MS1: 00:25 43

AW: 00:25 43 and what is your role within this surgery?

MS1: 00:28 medical secretary

AW: 00:30 medical secretary. Are you considered full time or part time?

MS1: 00:34 full time er 4 full days and 1 half day

AW: 00:40 and how long have you worked as a medical secretary?

MS1: 00:40 since 21st April 2017 almost a year (laughs)

AW: 00:47 very, very specific (laughs) 21st April I'm going to write that down because you was so specific (laughs) and has that always been within this surgery?

MS1: 00:55 yes

AW: 00:56 the East Riding of Yorkshire

MS1: 00:56 yes

AW: 00:56 fantastic and I have your email already wrote down actually. Is it [MS's email]?

MS1: 01:06 yes

AW: 01:06 nhs.net brilliant and could you just tell me a little bit about what a medical secretary is?

MS1: 01:13 er my basic role is any form of referral for the patient comes through to me. Er, the doctors will generally task me and indicate that they want a referral to a specific speciality. I would then go into the patients notes. If they haven't indicated in the task, I would go into the patients notes, draw the information from that and transfer it to an e-referral, which is your online booking system. Probably about 90%....

AW: 01:37 is that the choose and book system?

MS1: 01:40 choose and book yep.

AW: 01:43 as you say 90% of them are completed on the choose and book system

MS1: 01:45 that's it yeah, choose and book. Some are still manual, but it's not a lot of them any more

AW: 01:52 manual as in paper referrals?

MS1: 01:52 paper referrals yes, or a referral form. There's quite a few that are emailed as well, now

AW: 02:03 ok so there's lots of different ways that the information can be transmitted

MS1: 02:07 very much so yeah, (laughs)

AW: 02:06 what's the ideal?

MS1: 02:09 ideal is the choose and book online the e-referral system so online is always better

AW: 02:20 and why the choose and book system as opposed to sort of the separate electronic systems

MS1: 02:23 choose and book you've got a work list. Once you've processed the referral you can go in and follow up. There's every single process of that referral registered in it either on a daily or weekly basis so you can check up to see whether it has been accepted, rejected. If it's been rejected the reasons so you can go back to the GP, indicate to them and you can go forward from that.

AW: 02:48 perfect so all the sort of issues that we've mentioned prior to this could be solved with the choose…

MS1: 02:56 definitely that's it a lot of things need individual funding. Some things aren't covered so we would then have to do an individual funding request which now from last week, I went on a training course last, and I do that online, or the GPs fill it out online. That's a really good referral system

AW: 03:15 which one is that sorry?

MS1: 03:16 individual funding. I can actually show you it on the system after this yeah, then you can have a look

AW: 03:22 yeah, that would be great. I am not really sure what you mean by independent funding request

MS1: 03:24 say for instance, a patient has got a ganglion or a lesion or something, we would refer them to general surgery, it wouldn't be covered by there, by the system. We would have to get funding individually for that patient, for the CCG to pay for that patient to go down and have it done. They could either go private if they wanted to, but a lot of folk go forward with the individual

fundings, but there has got to be an exceptional reason why they need that funding

AW: 03:53 and is this ever relevant to the East Riding of Yorkshire healthy lifestyle programmes? Have you had to get an individual funding request for...?

MS1: 03:59 no, we never have that I am aware of, not since I have been here no. There hasn't been any individual funding for that so...

AW: 04:06, but is it an option? Say if someone has been on the LiveWell, programme and then want to go back on it. Is there an option to go down that route?

MS1: 04:13 no, not really, I don't think it ever really ties in no

AW: 04:19 no problem I was just interested because I didn't know what that sort of area was

MS1: 04:22 it would be good for you to have a look at it

AW: 04:24 yes, definitely just to see if that, as you say if it is one of the easier e-referral systems,

MS1: 04:30 it's very simple. How I feel is it's got to be very simple for a GP. A GP might have 5 minutes to sit and do a referral. It needs to be very, very user friendly and simple

AW: 04:43 as you say it's got to ultimately appeal to GPs

MS1: 04:45 that's it it's got to be quick. If they are faced with too much information, or they request too much they just don't have time. That's when they sort of push it over to us, not push it, but please can you fill out all of this please

AW: 04:49 delegate them tasks to you

MS1: 05:00 and a lot of the clinical stuff it's not for us to put in. It's not our call. You know we are administration staff at the end of the day

AW: 05:12 so yeah, the simpler we can get that, it's going to encourage more GPs to engage and again stop that delegation to yourselves.

MS1: 05:18 yeah, the facility to attach documents would be useful so instead of the GP having to fill out the BMI or the, the, the BPs, it's in a summary print out attached to that submission.

AW: 05:33 perfect so am I right in thinking that on your systems you can do a summary print out that has all that information ready

MS1: 05:41 yep, it's all there from the patients records

AW: 05:42 so it's not a case, you don't have to select it all, it's all there?

MS1: 05:46 nope. We've got them all set up, so we just attach the document

AW: 05:52 that's really interesting. So, on our new online referral system, as you say it will be really easy just to say ' please attach summary submission sheet and all that information is there and it's going to stop you filling all that out manually

MS1: 06:06 it's like the online referral, with it at the moment, if that was just what you had online to fill in [referring to the paper exercise on referral form] one screen then we could, the thing is as well, you can't save it and go back into it like we could populate the form for the GP, the GP could then log in to it, put the relevant details if it wasn't us, er and then send the referral

AW: 06:33 ok is that something you can do in the choose and book system?

MS1: 06:36 er yeah, we can save it for future editing. It's like with the two-week waits there's a separate form. The GPs have to fill that out o if they say two week wait, I would populate the form for them, please tick the relevant boxes

and add the clinical information you require, and then I go back into the referral, attach and send it

AW: 07:00 what we have found is something the other people [referring to previous conversation with MS1 and head receptionist prior to the interview] are missing information [which programme patient needs to be referred to] so they have to send that back to the GP. So, if there was that option, as you say, fill out part of the form and send it on to the GP electronically. That's going to save that delegation again back to the GP, back to the are navigator.

MS1: 07:23 definitely yeah!

AW: 07:25 fantastic. So, the first area is centred on the healthy lifestyle programmes, but we can focus more towards the referral side of things because I know you fill out quite a lot of the electronic referrals. So, what healthy lifestyle programmes are available for patients in this locality?

MS1: 07:42 as I am aware it's the exercise on referral, LiveWell, the HOP one, er there's the health trainers down the road. I know we can refer to them and I know that they do the smoking cessation don't they? There as well.

AW: 07:54 yep

MS1: 07:56 I've only been made aware of the younger LiveWell, one. I don't have a copy of this form, but [CN's name] dealt with more of that. Because I am the med sec, generally if it's a referral I would send it to [MS's name]., but it would be a lot better if [CN's name] was the main contact with regards to it and looking after it basically.

AW: 08:20 so what's [CN's name] role within the surgery?

MS1: 08:20 she's the head receptionist and the care navigator so if either of us have got queries with regards to er the referral we kind of

AW: 08:32 so as you say it would be really nice if [CN's name] is that central point for everything to do with

MS1: 08:38 with this, I think, because it's more of a, not specialist, but it's more of a, because she contacts the patients more with regards to things like that, you know, it's more her role to ring and, er, the online referral system is, erm, I was talking to one of the patients the other day to try to book her in and it kept crashing. It wouldn't go on and it was a, I tried two times to ring her in a succession of days and I was having to apologise, she was like oh, don't worry. I got in touch with [HLO's name]at the sports centre and I said, it's a nightmare it's just crashing all the time so she booked something in for her and I contacted the patient, told her what her appointment was and that the sports centre would get in touch, so they are always brilliant there, they are really, really good if you have got any problems, but it is just the erm, website is a bit slow

AW: 09:39 slow so as you say they are really helpful, but that is something that you could have done without doing

MS1: 09:44 it's just a bit embarrassing when you are talking to a patient on the phone, and you are trying to look professional and it's like ' sorry the website is not working'

AW: 09:50 it's crashing (laughs)

MS1: 09:54 yeah, (laughs)

AW: 09:54 it's definitely something that needs sorting out, you can be ringing patients and be constantly ringing the leisure centres and then be ringing the patient back to see if that's date is ok. That's one of the glitches.

MS1: 10:06 and then the actual layout on the screen, it's quite a big layout so you're having to scroll from one side of the screen to the other. If it was basically, like that just on one page where you scrolled up and down, that would be better

AW: 10:19 do you have to scroll from left to right

MS1: 10:20 yeah, I can go on to it and show, have you seen it?

AW: 10:23 I've seen, only sort of screenshots, but I have not actually seen it in a practice

MS1: 10:28 oh, well, we will have a look at that as well, then because it's , yeah, its

AW: 10:31 so ideally if it was all on one page

MS1: 10:34 it's a very old fashioned layout I would say

AW: 10:41 ok. How could we improve the layout?

MS1: 10:40 again just more user friendly, clean cut, scrolling up and down rather than side to side and up and down, its, you just want to sit and roll your mouse up and down rather than yeah. Anything easier. Again if the GPs are going on to it, it's got to be, it's got to be

AW: 11:00 so a lot, about how it looks visually in the first instance, Not just necessarily the information, but as you say it cannot be on separate areas. It needs to be all on one page, very sort of user friendly

MS1: 11:11 yeah

AW: 11:12 and in terms of the content, if you can cast your mind back to the referrals, is there anything that you feel is perhaps not relevant or anything we can...

MS1: 11:21 asking too many questions. There are three rows isn't there? Is it why you're referring, current health, and past history? It's kind of, that's not all of this on here, is it? [referring to the exercise on referral form] well, reasons for referral, medical history, but again we would tick these boxes because the GPs can indicate, but a lot of it, your summary print out, if we can attach that you've got that information there. You've got a bit more background on the patient as well, if they have recently been in to see a GP, that's all there for you to view. You kind of get a better idea of the patient.

AW: 11:54 as you say if you was able to attach that they would probably get more information then what they need which is going to benefit them because they are going to know who's coming through the door and you don't have to mess about filling all this in

MS1: 12:03 that's it. It's like the patient I referred the other, last week it was and I advised her that it was going to be £33 and she said, I was told it was free and I said, well, it's not actually free it's you know, its 10 weeks. And she said, but I'm already a member of the gym, so I was like OK and she said, but I want to come for the advice more than anything. so when I spoke to [HLO's name] she said, well, we will just sort of freeze her gym membership and then she wouldn't have to pay for that and pay for the... so she was quite happy with that, but she sort of was like well, I am already a member of the gym and I thought to myself well, why, this is what this is its gym membership, but I suppose it's more 1 on 1, isn't it? It's more, they need to feel supported when they are in the gym.

AW: 12:46 yeah, I guess the extra is they have that 1:1 guidance and support around their lifestyle, but yeah, it was really good that they were able to

freeze that. But you're absolutely right one of the main aims at the end of it is for them to sustain that lifestyle independent of them, so they do try and get them onto a gym membership to keep that connection

MS1: 13:05 yeah, yeah

AW: 13:08 so you've said, that the patient was told it was free. Who gave the patient that information?

MS1: 13:11 I believe it's the GP because they think that it's, they are getting on to a, because it's the LiveWell, isn't it where you get the 12 months and that the free one? So, one of GPs had even filled out the LiveWell, form, but you check the BMI and she's not, she can't go onto this, and then it's like OK well, if you could let the patient know that it's not going to be free. Even on the form it says BMI 45 and above and it had just been disregarded, but they don't read it because they, they don't have time to. It's got to be simple, it's got to be big over BMI at the top you know it's got to be...

AW: 13:52 again back to the visual sort of thing it's really got to stand out what is essential because if they are giving patients the wrong sort of indication that it is free, then once they find out that they are not eligible they're got to go down the exercise on referral route which is £33

MS1: 14:04 and it's like sometimes, the patients, literally their BMI is just below, but you've got to be over 45 before you can get this and so they go 'what so I've got to put more weight on before I am'... you know and you don't want to say 'well, yes', but it's kind of, that's what they feel they are been forced into and it's you know, they want to lose weight, but you're telling me that I have to put more weight on so I can get a free years

AW: 14:33 yeah, that is a difficult one because obviously there's no, exceptions with that. It is clear-cut. It’s 45

MS1: 14:38 very much so yes

AW: 14:39 so if they are 44. Whatever

MS1: 14:42 it’s a no, go yeah

AW: 14:45 that's a bit of a tricky situation

MS1: 14:46 and it just upsets them as I say you know they are wanting to lose weight and

AW: 14:52 so is, is the cost a problem to patients?

MS1: 14:56 I believe in this area. I believe Bridlington, yes

AW: 15:03 what do you think might help with that? Do them for any sort of free waivered...

MS1: 15:16 I don't believe they do. I have not had any indication that they do. I don't even know how the patient is expected to pay for it. I don't know if it is like a weekly thing, or they've got to pay up front er.

AW: 15:27 yeah, I am not too sure either

MS1: 15:29 I mean anything like that would make it easier for people. You know if they think that they have got to provide £33 out there, you would have a lot of people saying, where am I going to find that. So,

AW: 15:41 so you would like more information on the costs so you can communicate that to your patients?

MS1: 15:48 yeah, yeah, yeah, definitely.

AW: 15:51 that's something I will bring up with [HLO’s name]. I've got scribbles everywhere where I am trying to highlight so I don't forgot it! Brilliant, so I'm just trying to find out where we are. So, we've spoken about the, the

information resources, do you have anything in this surgery to give out to patients or do you verbally communicate about the programmes

MS1: 16:07 generally verbally, but I don't have a lot to do with the patients to be fair it's more the GPs might ask me the question, where can I refer. So, I've still got the paper referral forms upstairs because sometimes I will just say [to GP] 'fill out the form, hand it back to me' and I will do it online. It's just quicker that way.

AW: 16:26 so how are you made aware of the programmes and what's available?

MS1: 16:29 erm again I was, I met with [HLO's name] that was the first time I got to know a lot more about it. Just because I've only been here a year, I've kind of picked up the role. I have worked in a GP surgery before, administration and then I went on to be the admin supervisor so that was, I got a lot of knowledge there. But I haven't been in a GP practice since maybe 2013 and a lot of things have changed. Because we are part of a trust, it is very different. We were like, the doctors, they all owned the doctors surgery basically, so it was very different there. You were guided a lot more whereas here you've got to, if you want the information you've got to go out and find it, but it's, I mean if I do need anything about this I just go downstairs and see [CN's name] so...

AW: 17:23 that's interesting. Was the GP surgery you use to work in, was that in the East Riding of Yorkshire?

MS1: 17:27 it was in Driffield yes

AW: 17:27 it was

MS1: 17:29 Cranswell, in Driffield

AW: 17:33 because I didn't realise that some of the practices were owned by GPs, and some weren't and it's interesting that you said, you was more sort of guided with that information

MS1: 17:43 it was like you will do this and you will do that, and you won't spend our money that way

AW: 17:44 yeah

MS1: 17:46 you know because it was, you know

AW: 17:48 because it is their surgery yeah. So, is it very different here?

MS1: 17:56 because services are always changing and getting taken over so, so many times you know you're referring somebody somewhere and it's like oh, they don't own it now you will have to email City Healthcare Partnership, they deal with that and it's all so fragmented. But as soon as you learn anything you write it down in your little black book.

AW: 18:18 is that an issue, all these services being fragmented? I imagine from your point of view you've always got to be on the ball and remember who runs what

MS1: 18:27 yeah, and this is why the choose and book system is so brilliant because you can even go into it first and see whether that service is available otherwise it's a phone call, do I post it to you? We've only just got the neuros on choose and book other than that it use to be a manual referral fax to the reception or the secretary there so that's only just come on new now. So, every week I kind of have a look and see what else has been added. Or we do get advised what has been added. The CCG let us know

AW: 19:01 and when you was working at Driffield did you ever refer onto the programmes or where you just aware of them. Obviously, it was a different role.

MS1: 19:05 I don't think there was a lot of that really back then er referrals were all, they were paper referrals, and the GPs were signing them. There wasn't a lot of choose and book use then. This is the first time I have used choose and book. I know it has been going a quite a long time, but they wasn't actually using it properly here either until I started and then Alison [Practice Manager] had said, we need to be on with the e-referrals because they are going to stop the paper ones. It's a lot easier as well, it, it's brilliant actually

AW: 19:38 it would be absolutely fantastic if we could get into the choose and book system and that would solve all of our problems

MS1: 19:43 yeah!

AW: 9:43 I'm just not sure, in terms of the scope of this research, I am not sure if that, if we have to bid for that... I'm not really sure what the process is

MS1: 19:50 no, I'm not sure

AW: 19:52, but that's the gold standard that we are aiming for to get this into the choose and book. Everything is going to be pre-populated, as you say there's all these different fragmented services and it's really going to help unite them all into one place so that's sort of the gold standard which is why we are also looking at different options just in case so if they say look, we are really sorry it is only East Riding of Yorkshire Programmes so it is not feasible, because obviously the choose an book if I am correct is national

MS1: 20:19 that's it, if a patient wants to its their choice and they can go wherever they want so

AW: 20:24 is there anything in the choose and book system that is run by the council. Like can you, I'm just thinking, can you restrict certain users to choose and book to services that are only relevant in their area? because obviously people in different areas are not going to want to know about the healthy lifestyle programmes

MS1: 20:42 no

AW: 20:43 so I just wondered

MS1: 20:46 well, again we can have a look, can't we? I don't think there is no, it, you're restricted by speciality as to where you can send the patients. It's like neurology and your neurosurgery, they are only York or Hull. You don't do it Scarborough, Bridlington so if any patient says I want to be seen in Bridlington I'm sorry you can't you know.

AW: 21:07 because it's not in that locality yeah. It's really interesting I'm just wondering sort of, if we could wangle it into the choose and book and say well, we can restrict it to this locality, but as I say that's sort of the gold standard. Anything else that sort of makes it challenging in terms of referral that we have not discussed?

MS1: 21:23 erm for me the online referral, I just find it, because it has crashed so many times on me recently as I say when you are on the phone with a patient, you don't ring the patient any more you would just book them an appointment because you know it's easier to just get an appointment and then ring them and say you're booked in.

AW: 21:40 ok

MS1: 21:41 one thing I found, a GP had referred a patient and not indicated to me so I rang up to say can you let me know, this is the patients name, I am sorry

if you don't have the date of the appointment and the time, we can't help you so there is no, proper search. I couldn't go back into that and look up that patient and see you know if they had attended maybe or just to double-check that patient's appointment. There's no, way of checking that out. That would be useful

AW: 22:14 so as you say there is no, audit from that so unless you have the precise date

MS1: 22:19 no, because we print out a copy. I print out a copy to send to the patient and I print one out for the patients notes which is scanned in

AW: 22:24 oh, right, ok so in this surgery so in this surgery you make your own audit trail because you scan that back on, but otherwise because of the way it is set up it is not automatically...

MS1: 22:39 no, I think it was [HLO's name] that I spoke, or maybe Nicola, but she said, unless you've got the appointment date and time then I can't tell you if the appointment has been booked and it was like aw

AW: 22:50 so again that would be really useful in terms of feedback

MS1: 22:51 yep, definitely. Feedback, we do need feedback because we fill out a questionnaire on the patients records that indicated the stages of where they are from the initial referral to you guys. If we refer to you, we would fill out a questionnaire then after the 10 weeks I would then look at the feedback we have received because I would need to then go into this questionnaire to see if the patients, how they have got on with the referral. If it was the HOP, have they, you know are they now eligible to be put forward for that operation?

AW: 23:24 so this questionnaire, is this something you have developed in this surgery?

MS1: 23:28 I believe so yes. It's just something that we follow up, but we need it for our records that....

AW: 23:38 which is really good because some of the problems from other places is that their records are not up to date, but if you are making that conscious effort to do these questionnaires and

MS1: 23:45 I've got a spreadsheet of everybody that we refer in everything

AW: 23:49 wow so you are really on board with tracking progress. on the other hand, it would really help if it was another job you didn't have to do, so if this was done automatically

MS1: 24:00 yeah

AW: 24:02 yeah, there need to be that feedback loop. So, you have said, that you have this questionnaire. What is on the questionnaire? What can we provide back to you that would help you fill in this questionnaire?

MS1: 24:13 de, de, de I suppose I can show you the questionnaire after

AW: 24:15 no, worries

MS1: 24:15 I'll show you that as well

AW: 24:15 that's fine. So, we've spoke about progress, sorry feedback in terms of patient progress, constraint particularly with the online referral and we have referred to the choose and book system being the ideal or if that's not possible some sort of summary sheet that you can attach from the patients notes

MS1: 24:40 I know there's a little box on your referral, that sort of says please indicate this, but it's, you'd be then having to go onto the summary, copying and pasting, putting it into there and it's just easy to just click attach and put it on

AW: 24:56 ok I'm just trying to remember which section that is. So, you would have to go back to the patient's notes, copy and paste put it in there, which again is not compatible with your clinical systems. Brilliant, and the other area so spoke about is making it as user friendly particularly for GPs, as you say having it all on one page and having a lot of visuals, so as you say the BMI section, making sure they are absolutely crystal clear that it needs to be that and that's going to prevent patients getting the wrong information, and you picking up the pieces on the other end of the scale

MS1: 25:32 yeah, and possibly that please indicate which operation or which speciality you're going to, so then they can't say they are going for an operation without saying, what because that was a bit embarrassing for [CN's name] the other week [referring to an instance when a GP signed a patient up for HOP when patient didn't need surgery]

AW: 25:49 I'm just thinking, say, you are putting the patient's details and you click on the appropriate programme, maybe if then there was a prompt...

MS1: 25:57 a prompt yep, definitely and said, this field must be filled out kind of thing as well, so it's got to be indicated

AW: 26:05 yes, or perhaps this patient is not eligible for this programme.

MS1: 26:12 yes, yes, yes

AW: 26:15 anything else in terms of anything we've spoken about or anything else you feel is important to discuss

MS1: 26:18 no, I don't think so, I think that's all

AW: 26:20 Fantastic. Well, thank you very much for speaking to me. I have learnt loads today

MS1: 26:22 you're welcome

AW: Interviewer **Interview date:** 21.06.2018

MS2: Participant **Interview location:** Manor House Surgery, Beverley

AW: 00:00 I charged it earlier on. It has just been a miss hit and miss today. I'll pop it on there. Can I take some simple demographics [MS's name] before we begin?

MS2: 00:07 yep

AW: 00:09 how old are you if you don't mind me asking.

MS2: 00:10 42

AW: 00:11 42 and what is your role within this surgery?

MS2: 00:15 er secretary, medical secretary

AW: 00:15 medical secretary. Are you full time or part time?

MS2: 00:18 I'm classed as part time, I work four days a week

AW: 00:21 yep

MS2: 00:23 30 hours I do

AW: 00:25 and how long have you worked as a medical secretary?

MS2: 00:28 erm... 12 years

AW: 00:34 12 years. Has that always been within the East Riding of Yorkshire?

MS2: 00:36 it has yes

AW: 00:38 fantastic and have you got an email I can have so I can send your transcript back to you.

MS2: 00:42 yeah, it's [MS's email]

AW: 00:57 brilliant thank you. So, in terms of the healthy lifestyle programmes that are provided by the East riding of Yorkshire council. What can you complete referrals for?

MS2: 01:08 for the exercise on referral, the HOP, and the LiveWell

AW: 01:14 ok and of them three programmes, which do you find you refer patients onto the most often?

MS2: 01:16 the exercise referral

AW: 01:20 why is that?

MS2: 01:22 er either they don't fit the criteria for the other two or it's just generally the reasons that the patients are coming to the GP for so it, it's usually either weight loss or oesteo pains, things like that so it just tends to be the, the, they are the most referrals that we get

AW: 01:44 yes, so it goes on their conditions and as you say the criteria is more broader for the exercise referral

MS2: 01:48 yes, yes, yes

AW: 01:48 so what's the process of referral in this surgery?

MS2: 01:52 the patient would see the GP, and then the GP would send the secretarial team which is myself and two others a task through the patients records just saying, please refer to the exercise referral scheme and it just gives a reason so that would be either, i.e., weight loss, but then we basically, once we get that task, we the would go on the online system and just fill in the patient details, the reason for referral, and confirm the booking

AW: 02:24 yep. So, the patients are not with you

MS2: 02:26 they are not with us no

AW: 02:29 ok so we will talk about the online referral system. What is your overall, opinion of the, the online referral system?

MS2: 02:34 much easier actually then the paper appointment because it means you're actually booking the actual appointment slots so it's guaranteeing that you know, you can offer the patient something instead of saying, yes, we have sent he referrals off, they will contact you so. So, yeah, we, we don't have a problem with it doing it online

AW: 02:54 so you are quite supportive of booking that first appointment?

MS2: 02:57 yeah, yeah

AW: 02:59 and how do you, because obviously on the online system you've got to pick a time for the patient.

MS2: 03:03 yeah

AW: 03:03 do you tend to pick that and then ring the patient or...?

MS2: 03:05 we, we, we don't contact the patient. What we do is we pick it and choose it and we do tend to look at the patient's age and fit one accordingly. So, if they are of retirement age, we would tend to pick morning or afternoon. If they are of working age, we would try and pick a, an evening appointment

AW: 03:22 oh, right, ok

MS2: 03:23 and then what happens is, we've created our own letter. We, we print off the letter that is on the system which obviously we would normally be giving to the patient, but we've also sent a, created a letter that we send to our

patient saying, please find attached the letter, an appointment has been booked for you, the details are on the letter

AW: 03:44 ah right, ok

MS2: 03:46 and you will need to take this along to your first appointment and give to the instructor

AW: 03:52 yeah, so as you say you sort of look at the patient, and how old they are

MS2: 03:56 yeah, we kind of decide...

AW: 04:00 on their behalf?

MS2: 03:59 well, decide, we sort of you know look through to see if they are retirement age

AW: 04:06 and what time would be suitable for them yes.

MS2: 04:09 and we always try and book their appointment quite in advance simply because obviously we are not contacting the patient via phone, we are just sending them a letter and you know that the leisure centre would ring the patient, so we tend to do it from a week plus just to give the patient more time

AW: 04:26 just in case yeah

MS2: 04:26 yeah, yeah, and if they change their mind for any reason as well

AW: 04:29 absolutely. Are the East Riding happy for you to book that appointment or have they asked you to book it with the patient?

MS2: 04:35 they, they did come and do the training, so they know that haven't the patient with us and erm we've never had any feedback from them to say otherwise

AW: 04:42 brilliant yeah, and as you say, you give the patient enough time so if it's not suitable, they can, they can change that. So, you say it's easier than the paper referral format, what was the difficulty with the paper referrals?

MS2: 04:53 just that you're having to send it to, the GP would send you a message saying, can we refer to exercise on prescription or exercise on referral sorry and then we would have to send them the form, they would send it back to us not completely filled in and then you would have to get the patient in to sign the form before we could then post it, so it is actually easier. It's quicker for us to do it online

AW: 05:17 absolutely so it had to go from the GP to yourself, and then back to the patients

MS2: 05:20 then we had to get the patient to come back in which they wasn't always happy about

AW: 05:26 and how long have you been using the online system?

MS2: 05:29 well, over a year, quite a long time

AW: 05:32 ah right, ok and there's three of you using the online system?

MS2: 05:35 yeah,

AW: 05:38 and in terms of what it is asking on the online system, so, I think there's three sections, the previous medical history, the current and the reason for referral. Are you happy in terms of the measures it is asking for?

MS2: 05:49 yeah, er yeah, to be honest when it is asking for the history, the third box, I can't remember what it is. It asks for the reason, doesn't it?

AW: 05:59 yeah, then the current and the history

MS2: 06:01 the history we don't always complete because we don't always have that information to hand so, and it's never, they have never rejected any of the referrals because that's has been left blank

AW: 06:10 ah right so it does let you complete the referral.

MS2: 06:12 yeah, it does let you go ahead without it yeah

AW: 06:16 so do you have access to the patients notes to

MS2: 06:18 yes, but obviously with us not being clinicians then we don't want you, you know, tick something that is incorrect

AW: 06:28 absolutely and transfer that information

MS2: 06:29 yeah

AW: 06:29, but it's useful that it does let you progress

MS2: 06:32 it does. Yes, yes, yes

AW: 06:36 so overall, it sounds like you're quite happy with the online referral system, is there any improvement you would like to see to it?

MS2: 06:42 the letter that it prints automatically, we didn't, yeah, we didn't have any input in that so that maybe could be set out differently because the address is very high up and it doesn't, it doesn't make it, it's not very user friendly and I'm just trying to think... It does mention on there about the payment, there is a charge, but it could maybe be bolded or highlights because quite often even though we have asked the GP to mention to the patient when they have got them in front of them. If we are referring you for this scheme there is a charge. The patients always are not aware of that, so

they think it is a free scheme erm, so to make it more obvious on the letter really that they, there is a charge for it

AW: 07:36 yeah, just making it crystal clear that if they are on that scheme there is, exercise on referral, the associated cost with that

MS2: 07:42 absolutely

AW: 07:42 ok. You said, that you've created your own letter instead of the one that's produced...

MS2: 07:50 it's, it's to go in addition to it

AW: 07:52 ah

MS2: 07:54 yeah, it's basically, I think it says something like please see the attached letter. An appointment has been booked for you to attend at the leisure centre. The details are on the attached letter. You will need to take this along to your first appointment and we also include like the patients repeat medication as well, print that off. So, it's just basically, a covering letter for the patient to go with the actual appointment letter as such

AW: 08:24 and as you say the medication is also given so the leisure centre can see exactly...

MS2: 08:28 so they have got a copy of

AW: 08:29 so you've said, it's not user-friendly and said, about the address being quite high up. Are there any other examples you ca provide where it's not particularly user-friendly? Sorry I know it's asking you to...

MS2: 08:41 without looking at it I can't think what else is on there. We did, we did actually, when we had the training, a lady did come down form the leisure

centre and we did ask, we did kind of go through with her with regards to what we would like... erm [HLO's name]

AW: 08:53 ah [HLO's name]yes

MS2: 08:55 erm so she did, and she did take that on board and listen to what we said. It's just not quite set out how we, when you put it in a window envelope it's sort of, if you was just to send that, it's not pushed down far enough, it, it's just...

AW: 09:13 it's about the position and structure and things

MS2: 09:18 yeah, I can't think what it says on the letter

AW: 09:20 it's fine. It was a difficult question. So, do you find the training sessions useful? Has it helped?

MS2: 09:28 we've only had the one. She came down and spent quite a lot of time with us and we can contact her if we have any queries so yeah, the training was absolutely fine

AW: 09:36 was that recent?

MS2: 09:36 it was about, well, it was the beginning of last year, whenever we went live on the system

AW: 09:42 ah right, ok

MS2: 09:42 and we haven't really needed any since because erm,

AW: 09:46 you're all quite confident

MS2: 09:47 yes, we are confident using the system and we know if there's a problem for any reason, we can just ring and ask what we should do so we are happy with that

AW: 09:58 you're happy with that communication as well

MS2: 09:59 yeah

AW: 09:59 brilliant. Anything else in terms of the online referral or the paper referral. Any comments?

MS2: 10:05 no, not that I can think of

AW: 10:06 no, brilliant well, thank you very much for that. As I say, we will miss the feedback section because you don't necessarily get the feedback directly

MS2: 10:14 yeah, we don't get the feedback

AW: 10:15, but yeah, I have not spoken to many users of the online referral, so it is really reassuring to know that it is actually helping

MS2: 10:21 are the minority then doing the online referrals?

AW: 10:22 absolutely yeah

MS2: 10:23 oh, really

AW: 10:25 we've transferred a lot of people over, but a lot are still using the paper referrals erm and obviously I they are in GP draws they will just grab them and fill out an old form, but I guess the benefit with the online one is if anything does get updated it's on the system as well

MS2: 10:40 does the patient, the patients signature then obviously if they do take that along with them, they can sign it there at the leisure centre? That's not a problem, is it?

AW: 10:47 we've tried to remove that

MS2: 10:49 it was a problem with the paper ones yeah

AW: 10:52 and a lot of people who are still using the form are saying, well, it's really annoying that I have to take the patients signature. GPs especially are not always consulting on a face-to-face basis, it might be a telephone consultation, so it doesn't always quite fit, so we have took that on board with the online referral, but obviously not everybody is on the online one yet

MS2: 11:10 using it yet

AW: 11:10 so erm yeah, it's difficult every single surgery I have visited operates differently so

MS2: 11:16 we do a lot of our things online, so we are quite happy doing it

AW: 11:19 quite savvy online

MS2: 11:20 it's easier because it's more accurate. The GPs when they fill in paper referrals, they never fill on half the details and if you don't check everything and it gets sent with information missing it comes back to you so it's just delaying it for the patients from our point of view it works quite well.

AW: 11:37 has it been a lot easier... How long does it take roughly from start to finish?

MS2: 11:42 not even minutes really because, because we, we get the task sent electronically through our own copy of the system linked via the patient records, so it's literally you know, obviously we work prioritise and we would maybe do them you know at the end of the day or something. And per referral, it takes minutes, not even that really. It's really, really quick. There's only about the two pages erm, the first page which is asking you for the reason for referral and thee the current health and then the second page is just

booking the appointment and the third page is just printing the letter and confirming so it's easy

AW: 12:20 could you ever see clinician staff doing that in the future?

MS2: 12:22 no, no, because they like us to do it. The GPs just, they are happy to fill forms in online, but they would rather us deal with all the admin side of everything

AW: 12:36 you take away their admin burden

MS2: 12:37 basically, they say they wouldn't have time to do it so it would be something that we would do, and we are not bothered about that anyways

AW: 12:44 and if it's easier for you then that's all we are after. We just want to make it as streamline as possible, but considering everyone. Not just focused on clinical staff, my argument is there are community link workers now, care navigators, medical secretaries, and because it's so different we can't exclude people from the process if you're involve ion referral, we need to make it easier for everybody so we are looking how we can pull all these pieces together

MS2: 13:13 I'm sure other surgeries, their GPs would be happy to do it

AW: 13:13 some, yeah, same very little, but if they have got medical secretaries in place then you are there to help the GPs

MS2: 13:21 absolutely that's our job role anyway

AW: 13:22 what's the point in not using that outlet. Absolutely, yeah. Whereas some surgeries are forced to because they might not have that outlet. It's really reassuring as I say that it has made it easy for you

MS2: 13:33 yes, it's easy yeah

AW: 13:37 brilliant. Well, thank you very much for that and I'll just stop the recording

Appendix 7: Ethics Documents for Research Phase II

7.1. Form A

RESEARCH ETHICS COMMITTEE

FORM A – New Application

(Involving human participants, subjects or material)

It is essential that you are familiar with the University Code of Good Research Practice, Research Ethics Policy and the Procedures for Granting Ethical Approval before you complete this form that can be found here. Please confirm that you have read and understood these documents:

☑ Yes ☐ No

Please read each question carefully, taking note of instructions and completing all parts. If a question is not applicable please indicate so. Where a question asks for information which you have previously provided in answer to another question, please refer to your earlier answer rather than repeating information.

Ethics reference number (for office use):	
WorkTribe project URL	

PART A: SUMMARY

A.1 Title of the research Leisure customers and leisure employee's perspectives of the referral process onto East Riding of Yorkshire council healthy lifestyle (ERoYc) programmes.	
A.2 Principal investigator's contact details	
Name *(Title, first name, surname)*	Miss Amy Wilkinson
Position	PhD researcher in Sport, Health and Exercise Psychology
Faculty/School	FHS/SHES
Telephone number	07845756130
University of Hull email address	a.m.wilkinson@2016.hull.ac.uk
A.3 To be completed by students only	
Qualification working towards (e.g. Masters, PhD, ClinPsyD)	PhD
Student number	201202743
Supervisor's name (Title, first name, surname)	Dr Caroline Douglas
Faculty/ School	FHS/SHES
Supervisor's telephone number	01482 463345
Supervisor's email address	c.douglas@hull.ac.uk
A.4 Other relevant members of the research team (e.g. co-investigators, co-supervisors)	
Name *(Title, first name, surname)*	Dr Samantha Nabb
Position	Head of Student Engagement and Transition
Faculty/ School	n/a
Telephone number	01482 463277
Institution	University of Hull
Email address	s.nabb@hull.ac.uk

Name (Title, first name, surname)	
Position	
Faculty/ School	
Telephone number	
Email address	

A.5 Select from the list below to describe your research: (Select all that apply)

- ☑ Research on or with human participants
- ☑ Research working with data of human participants
- ☑ New data collected by qualitative methods
- ☑ New data collected by quantitative methods
  - ☐ New data collected from observing individuals or populations
  - ☐ Routinely collected data or secondary data
  - ☐ Research working with aggregated or population data
  - ☐ Research using already published data or data in the public domain
  - ☐ Research taking direct measurements from individuals e.g. physiology
- ☐ Research working with human tissue samples
- ☐ Research involving any invasive techniques including administering substances, food (other than refreshments), vitamins or supplements.
- ☑ Research involving discussion of sensitive topics or topics that could be considered sensitive
- ☐ Research involving discussion of culturally sensitive issues
- ☐ Prolonged or frequent participant involvement
- ☐ Research involving members of the public in a research capacity (participant research)
- ☐ Research conducted outside the UK
- ☐ Research involving accessing social media sites
- ☐ Research involving accessing or encountering security sensitive material
- ☐ Research involving accessing websites or material associated with extreme or terrorist communities
- ☐ Research involving storing or transmitting any material that could be interpreted as sympathetic, endorsing or promoting terrorist acts

- ☐ Research involving financial inducements for participants (other than reasonable expenses and compensation for time)

PART B: THE RESEARCH

B.1 Give a short summary of the research (max 300 words)

In plain English provide a brief summary of the aims and objectives of the research.

- The summary should briefly describe the background to the research and why it is important,
- the questions it will answer and potential benefits,
- the study design and what is involved for participants.

Latest Public Health England health profiles for the East Riding of Yorkshire indicate that a large proportion of adults exhibit unhealthy lifestyle behaviours, with almost 32% considered physically inactive, and 67.4% classified as overweight or obese. The East Riding of Yorkshire council (ERoYc) offer a novel suite of healthy lifestyle programmes to help guide individuals towards adopting healthier lifestyle behaviours. The University of Hull have previously undertaken qualitative interviews with primary care personnel (e.g. General Practitioners) to explore their experiences of referring individuals to the ERoYc healthy lifestyle programmes. However, little is known about an individual patient's journey onto these programmes, or how East Riding leisure (ERL) employees view and experience the referral process.

The purpose of this study is to triangulate the previous research by gaining a rich insight into the retrospective perceptions and experiences of individuals who have been referred onto the ERoYc healthy lifestyle programmes (ERL customers), and East Riding leisure (ERL) employees who are at the receiving end of the referral process. This insight will offer a holistic and complete picture of the referral process from the perspectives of all stakeholders involved, which will inform changes to streamline the existing referral pathway.

The study will adopt a mixed-methods design utilising online surveys and interviews with three separate cohorts: 1) ERL customers who have completed a healthy lifestyle programme, 2) ERL administrative employees who process referrals from primary care (e.g. business technicians), and 3) ERL fitness professionals who deliver the ERoYc healthy lifestyle programmes. A separate online survey has been developed for each cohort to retrospectively explore their perspectives and experiences of the referral process. Completion of each survey is anticipated to take around 15 minutes. At the end of each survey, respondents will be asked if they would like to elaborate on their experiences and perspectives through follow up interviews. If so, they will be asked to provide their contact details in order to arrange a suitable time and date for an interview. Interviews will be semi-structured and will be conducted either face-to-face or via telephone for participant convenience. Interviews are anticipated to last no longer than one hour.

B.2 Proposed study dates and duration

Research start date: 01/12/18 Research end date: 01/08/19

Fieldwork start date: 01/12/18 Fieldwork end date: 01/04/19

B.3 Where will the research be undertaken? (i.e. in the street, on University of Hull premises, in schools, on-line etc.)

Surveys will be undertaken online via Online Surveys (formerly known as Bristol Online Surveys) on multiple electronic devices (e.g. mobile phones, tablets, or laptops).

Follow-up interviews, with interested participants, will be arranged and undertaken at East Riding leisure sites (e.g. East Riding Leisure Beverley) in an appropriate quiet and/or private space within the centre that is agreeable to the interviewee (e.g. the leisure centre café).

Do you have permission to conduct the research on the premises?

Permission for on-site testing has been granted by Peter Haley, Senior Business Commissioner (see letter of permission alongside this application).

B.4 Does the research involve any risks to the researchers themselves, or people not directly involved in the research? *E.g. lone working*

(•) Yes ( ) No

If yes, please describe and say how these will be addressed (include reference to relevant lone working policies)

Risks to researcher

Researcher will conduct research within East Riding leisure centre sites.

Control measure
The student investigator will liaise with East Riding employees to gain full knowledge of what action to take in an emergency, and will familiarise themselves with the nearest fire exits to the interview location.

If yes, please include a copy of your complete risk assessment form with your application.
Risk assessment form is attached.

NB: If you are unsure whether a risk assessment is required visit the Health and Safety SharePoint site. Risk assessments are required for all fieldwork taking place off campus.

B.5 What are the main ethical issues with the research and how will these be addressed?
Indicate any issues on which you would welcome advice from the ethics committee

The principle ethical considerations are primarily focused on data collection, data storage, and informed consent. These issues and the control measures put in place to minimise these issues are detailed below.

Ethical issue 1
Anonymity

Control measure 1
Surveys will be developed and distributed through Online Surveys (formerly known as Bristol Online Surveys) whom are the licensed University of Hull provider for online data capture. Online Surveys are fully compliant with all UK Data Protection Laws. The survey will be designed to protect respondent anonymity. The researcher will ensure that survey questions will NOT ask the respondent to provide directly identifying information such as their name or contact number UNLESS they are happy to participate in follow-up interviews. In this case, respondents will be asked to leave their name and contact number to arrange an interview. This study aims to recruit at least ten completers of each healthy lifestyle programme, and at least 20 East Riding Leisure employees, which will help ensure the survey population is diverse enough to maintain the anonymity of individual respondents.

All collected data will be treat in accordance with legislation relating to the General Data Protection Regulations, and will be destroyed five years following the conclusion of the study. During this time, this data will only be accessible by the University of Hull research team and information regarding who has participated will not be available to East Riding of Yorkshire council or Primary Care providers.

Each participant will be allocated a unique identifier (pseudonym) that will not reveal their identity. This will ensure that the people whom the data describe remain anonymous. Participant consent forms and any other personal forms will be secured separately from the results data to avoid any unearthing of identities.

Ethical issue 2
Confidentiality

Control measure 2
All paper data will be filed in a lockable filing cabinet in a lockable room on University property. All electronic forms of data will be stored on a secure electronic device that will require a specific access code, which only the postgraduate researcher will know. Only the research team (i.e. the postgraduate researcher and research supervisors) will have access to collected data. All data that will be gathered and shared will follow in accordance to the General Data Protection Regulations, and will be destroyed five years following the conclusion of the study. During that time, no other party or resource will have access to this data, which could reveal any identities.

Ethical issue 3
Informed consent

Control measure 3
Survey: Prior to completing the survey, respondents will be directed to a consenting statement which will clearly outline the study aims, procedure to undertaken, the potential risk of participation, how their results will be used (in terms of dissemination), how their data use will comply with General Data Protection Regulations, and their rights as a participant. Participants will only be allowed to progress to the survey questions once they have electronically provided informed consent. The electronic informed consent form is included with this application

Interviews: All prospective participants filtered through the online survey will be provided with a 'Participant Information Sheet' and an 'Informed Consent Declaration Form' to help them decide whether they would or would not like to take part in the research study. This documentation will clearly outline the study aims, procedure to undertaken, the potential risk of participation, the potential benefits of participation, the study duration, how their results will be used (in terms of dissemination), how their data use will comply with General Data Protection Regulations, and their rights as a participant. There will be an opportunity to raise any issues or concerns to ensure full understanding of what is required before consent is taken. Participants will be given as long as they need to make an informed decision, and will not be pressured into participation. No arrangements will be made with participants until the researchers are provided with a completed informed consent declaration form. The informed consent form is included with this application.

Ethical issue 4
Coercion

Control measure 4
It is the participant's choice whether to participate in the research project or not. Participants will be invited to participate in research. During the consent process, participants will be advised that they can withdraw from the study at any point without providing any reason for doing so or any adverse implications. There is no financial incentive to partake in this research project. Information regarding who has participated will not be available to East Riding of Yorkshire council or Primary Care providers.

B.6 Does the research involve an international collaborator or research conducted overseas:
No

If yes, describe any ethical review procedures that you will need to comply with in that country:
N/A

Describe the measures you have taken to comply with these:
N/A

Include copies of any ethical approval letters/ certificates with your application.

PART C: HUMAN PARTCIPANTS AND SUBJECTS

C.1 Are the participants expected to be from any of the following groups? (Tick as appropriate)

- ☐ Children under 16 years old. ***Specify age group:*** _____
- ☐ Adults with learning disabilities
- ☐ Adults with other forms of mental incapacity or mental illness
- ☐ Adults in emergency situations
- ☐ Prisoners or young offenders
- ☐ Those who could be considered to have a particularly dependent relationship with the investigator, e.g. members of staff, students
- ☐ Other vulnerable groups
- ☑ No participants from any of the above groups

Include in Section D5 details of extra steps taken to assure their protection.

Does your research require you to have a DBS check ○ Yes ◉ No

It is the researcher's responsibility to check whether a DBS check (or equivalent) is required and to obtain one if it is needed. See also http://www.homeoffice.gov.uk/agencies-public-bodies/dbs

C.2 What are the potential benefits and/ or risks for research participants in both the short and medium-term? *Risks may include health and safety, physical harm and emotional well-being*

There are a number of risks to the participants involved with this study. These risks are detailed below followed by a thorough explanation of how these risks will be mitigated.

Potential risks

1) The participant may become frustrated at the length of the survey/interview (short-term risk).
2) The participants may take offence to some of the survey/interview questions, possibly resulting in them becoming rude/aggressive/abusive (short-term risk).
3) A survey/interview question may uncover experiences that may cause minor embarrassment to the participant (short-term risk).
4) The participant may be offended by the lack of immediate results of data (medium-term risk).

What will be done to avoid or minimise these risks?

Potential risk 1 control measure

A consenting statement will appear before the respondent can fill out the survey. This statement will give an indication of how long the survey will take to complete. Survey questions will be piloted to ensure the survey is of an appropriate length. There will be no more than 20 questions for each cohort survey, answered predominantly by short written answers and Likert scales for swift completion. This will prevent the respondent becoming uninterested and frustrated. Those opting to share their experiences further via interviews, a participant information sheet will be provided which will give an approximation of the interview length. Furthermore, interviews will be piloted to help ensure that the interview is of an appropriate length as indicated on the participant information sheet. Prior to the interview, the researcher will remind the participant of the anticipated interview length, and participants will be provided with the option for a break during the interview if they feel necessary.

Potential risk 2 control measure

To minimise the chances of the participant taking offence to the questions, all survey and interview schedule will be piloted, critiqued and refined accordingly. This will ensure that the questions are carefully formatted to reduce the risk of upsetting participants. Moreover, participants will be reminded prior to the interview that they can refuse to answer any questions if they so wish by saying "no comment", in which case the researchers will move on to the next questions without delay. Likewise, if the researcher feels that the participant is becoming offended following an interview question, the researcher will move onto the next question without using prompts or follow-up questions. Interviews will be terminated immediately if this proves unsuccessful.

Potential risk 3 control measure
By piloting all three surveys, this is going to minimise the risk of having poorly formulated questions that may cause embarrassment to participants. Furthermore, during interviews the investigator will handle any sensitive situations with caution and care, and will try to refrain from embarrassing the participant at all costs. The investigator will remain sensitive through-out the whole data collection process.

Potential risk 4 control measure
The participant information sheet provided to those opting to participate in an interview will clearly outline when participants can expect to receive a copy of their transcriptions. The investigator will strictly abide to the time-frame to ensure that participants are emailed a typed copy of their transcripts within 4-6 weeks of their interview (which is also for member checking purposes). Participants will also have the option to receive a copy of the doctoral thesis, or any other publications if they so wish.

C.3 Is there a potential for criminal or other disclosures to the researcher requiring action to take place during the research? (e.g. during interviews/group discussions, or use of screen tests for drugs?)

If yes, please describe and say how these will be addressed:

C.4 What will participants be asked to do in the study? *(e.g. number of visits, time involved, travel required, interviews)*

Participants will be asked to complete on online survey that can be accessed by either scanned a QR code or following a link. Each individual cohort will be provided with a separate QR code and link to ensure they are directed to the correct survey. It is anticipated that irrespective of the cohort, survey completion will take around 15 minutes. There will be no more than 20 survey questions which will be predominantly short answer questions and Likert scale answer for swift completion.

Surveys can be completed wherever the participant chooses and will be compatible with a range of electronic devices (e.g. mobile phones, tablets, computers).

At the end of the survey, each participant will be asked if they would like to elaborate on their experiences and perspectives through a follow-up interview. Only one cohort (ERL employee's receiving and processing healthy lifestyle referrals) will be given the option to share their experiences through focus group interviews (if this is more expedient and appropriate to cohort size as many of cohort share offices). The other cohorts (i.e. ERL customers or ERL fitness professionals) will be asked if they would like to participate in individual interviews. These interviews are anticipated to last no more than one hour and will be conducted on East Riding leisure sites. These leisure sites were selected as it is anticipated that the majority of respondents will be recruited at this location.

PART D: RECRUITMENT & CONSENT PROCESSES

How participants are recruited is important to ensure that they are not induced or coerced into participation. The way participants are identified may have a bearing on whether the results can be generalised. Explain each point and give details for subgroups separately if appropriate. Also say who will identify, approach and recruit participants. Remember to include all advertising material (posters, emails etc) as part of your application.

D.1 Describe how potential participants in the study be identified, approached and recruited and who will do this:

(i) identified:
Purposeful sampling will be utilised to access each of the 3 cohorts (ERL customers who have undergone referral, ERL employees processing referrals, and ERL employees delivering healthy lifestyle programmes). The East Riding Leisure Healthy Lifestyle Officer will aid recruitment of East Riding Leisure employees by identifying individuals who may be interested in participation, and facilitating contact.

For the recruitment of ERL customers only, advertisement posters will be displayed in each of the 10 East Riding leisure sites in January 2019 (see recruitment posters attached) inviting interested individuals to get involved. Posters will have a QR code that ERL customers will be able to scan with a smart phone to access the online survey.

After survey completion, all respondents will be asked to indicate if they would like to take part in a follow-up interviews to further explore their perspectives and experiences of the referral process. This will filter interested respondents who will be presented with a formal EC2 letter of invitation and a project information sheet.

(ii) approached:
The posters displayed in East Riding leisure premises will be used to encourage customer participation. The East Riding Leisure Healthy Lifestyle Officer will facilitate contact between the primary investigator and East Riding leisure employees. This contact will occur either face-to-face or via email. A draft email template that may be used to approach ERL employees is attached alongside this application. No incentives will be provided and there will be no pre-existing relationships between the investigators and participants.

(iii) recruited:
Interested participants who meet eligibility criteria will be provided with a QR code to access the relevant online survey. Before they are able to complete the survey, participants will be directed to a consent paragraph which will explain the reasons for the study, all risks and benefits, what participation entails, and participant rights to withdraw. Furthermore, after completion of survey questions, a debriefing statement will be provided which will provide the investigator's contact information, and restate that participants have the right to withdraw, but that by submitting they are agreeing to participate. Whilst respondents will not sign a separate consent form, consent will be obtained by virtue of survey completion. Those interested in participating in a follow up interview will not be recruited until they have received a participant information sheet, and have signed the informed consent form.

D.2 Will you be excluding any groups of people, and if so what is the rationale for that?
Excluding certain groups of people, intentionally or unintentionally may be unethical in some circumstances. It may be wholly appropriate to exclude groups of people in other cases

East Riding leisure customers who are currently on a healthy lifestyle programme will be excluded from participation to ensure that only participants are able to reflect wholly on their whole programme experience are included.

East Riding leisure customers under the age of 18 years will be excluded from participation. The rationale for this is the referral process onto the adolescent healthy lifestyle programme (i.e. Young Live Well), has a significantly different referral process in comparison to the referral pathway for the adult healthy lifestyle programmes (e.g. Live Well, Exercise on Referral). To elaborate, primary schools can refer adolescents onto Young Live Well, whereas the other healthy lifestyle programmes for adults can only be accessed through a referral from a primary care site (e.g. General Practice). Thus, the focus of the study is on different stakeholder's experiences and perspectives of the referral process onto adult healthy lifestyle programmes.

D.3 How many participants will be recruited and how was the number decided upon?
It is important to ensure that enough participants are recruited to be able to answer the aims of the research. The number of participants should be sufficient to achieve worthwhile results but should not be so high as to involve unnecessary recruitment and burdens for participants. This is especially pertinent in research which involves an element of risk. Describe here how many participants will be recruited, and whether this will be enough to answer the research question.

For the online survey, this study aims to recruit at least ten East Riding leisure customers who have completed each of the healthy lifestyle programmes (i.e. Live Well, Exercise Referral Scheme, Health Optimisation Scheme, Cardiac Rehabilitation), and at least 20 East Riding Leisure employees. This will help ensure the survey population is diverse enough to achieve a comprehensive understanding of the referral process, whilst also maintaining the anonymity of individual respondents.

For the follow up interviews, this study aims to recruit at least 5 participants from each of the three cohorts. However, the final sample size will ultimately depend on when data saturation is reached.

If you have a formal power calculation, please replicate it here.
N/A

D.4 Will the research involve any element of deception?

No

D.5 Will informed consent be obtained from the research participants?

Yes

If yes, give details of how it will be done. Give details of any particular steps to provide information (in addition to a written information sheet) e.g. videos, interactive material. If you are not going to be obtaining informed consent you will need to justify this.

Before accessing the survey (via Online surveys), all participants will be directed to an online information sheet and a consenting paragraph. This will highlight the reasons for the study, all risks and benefits, what participation entails, participant rights to withdraw, investigator contact details. Participants will not be able to proceed to the online survey until they have clicked a button to certify that they fully understand the information sheet, and agree to participate. Moreover, a debrief statement will be incorporated immediately after the final survey question which will reiterate the participants right to withdraw and investigator's contact details whilst stating that by submitting their survey, respondents are consenting to participate. Thus, although participants will not provide a physical signature, consent will be obtained by virtue of survey completion.

Those indicating that they would like to participate in a follow-up interview, will be provided with a participant information sheet and informed consent form. These documents highlight the reasons for the study, all risks and benefits, what participation entails, participant rights to withdraw, and provides investigator contact details and the possible effects on the participant. For follow up interviews, consent will be obtained through the signing and dating of the informed declaration consent form prior to interview commencement.

The paper-based and electronic versions of the participant information sheets, and informed consent forms are supplied alongside this application.

If participants are to be recruited from any of potentially vulnerable groups, give details of extra steps taken to assure their protection. Describe any arrangements to be made for obtaining consent from a legal representative.

N/A

Copies of any written consent form, written information and all other explanatory material should accompany this application*. The information sheet should make explicit that participants can withdraw from the*

research at any time, if the research design permits. Remember to use meaningful file names and version control to make it easier to keep track of your documents.

D.6 Describe whether participants will be able to withdraw from the study, and up to what point (e.g. if data is to be anonymised). If withdrawal is <u>not</u> possible, explain why not.
Any limits to withdrawal, e.g. once the results have been written up or published, should be made clear to participants in advance, preferably by specifying a date after which withdrawal would not be possible. Make sure that the information provided to participants (e.g. information sheets, consent forms) is consistent with the answer to D6.

Participants will be directed towards the section of the informed consent form that outlines their right to refuse consent, and discontinue participation at any time.

D.7 How long will the participant have to decide whether to take part in the research?
It may be appropriate to recruit participants on the spot for low risk research; however, consideration is usually necessary for riskier projects.

This research is based on a low risk activity so participants will be able to decide on the spot if they would like to participate and provided with the necessary materials to make an informed decision. They may however choose to withdraw consent at any time without needing to give a reason.

D.8 What arrangements have been made for participants who might have difficulties understanding verbal explanations or written information, or who have particular communication needs that should be taken into account to facilitate their involvement in the research? *Different populations will have different information needs, different communication abilities and different levels of understanding of the research topic. Reasonable efforts should be made to include potential participants who could otherwise be prevented from participating due to disabilities or language barriers.*

The investigator will make every effort to ensure that those who may have difficulty understanding are given equal opportunity to participate. Anyone requiring additional explanation can contact the postgraduate investigator to ask any further questions they may have. These questions will explained in their preferred format (e.g. auditory, visual). The postgraduate investigator will make every effort to ensure that potential participants do not face any barriers to participation.

D.9 Will individual or group interviews/ questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could take place during the study (e.g. during interviews or group discussions)? *The information sheet should explain under what circumstances action may be taken.*

Yes- An interview question may uncover experiences that may cause minor embarrassment to the participant

If yes, give details of procedures in place to deal with these issues.

The investigator will handle any sensitive situations with caution and care, and will try to refrain from embarrassing the participant at all costs. Furthermore, piloting all three surveys will minimise the risk of having poorly formulated questions that may cause embarrassment to participants. The investigator will remain sensitive through-out the whole data collection process.

D.10 Will individual research participants receive any payments, fees, reimbursement of expenses or any other incentives or benefits for taking part in this research?

○ Yes ◉ No

If Yes, please describe the amount, number and size of incentives and on what basis this was decided.

PART E: RESEARCH INVOLVING HUMAN TISSUES OR MATERIAL

E.1 Will the research involve the use of any of the following? (Select as appropriate)

- ☐ Foetal material
- ☐ The recently deceased
- ☐ Cadavers
- ☐ Human bodily fluid
- ☐ Human tissue
- ☐ Human organs
- ☐ Human gametes

Go to Section F if the research does not involve any of the above material.

E.2 Will the material to be accessed be collected as part of this study or 3rd party accessed (E.g. material collected as part of another study or purchased)?
If yes to 3rd party access, please provide details on appropriate consent for this use.

E.3 What type of tissue or material will be collected?

E.4 How will the tissue or material be collected and who will do this?

E.5 How many samples will be collected?

E.6 How long will samples be stored?

E.7 Do you require a regulatory licence to use or store this material?
○ Yes ◉ No

All material is expected to be stored in line with the Human Tissue Authority storage expectations.

E.8 Do you have the appropriate Health and Safety procedures in place for the researchers to handle the samples?
○ Yes ◉ No

PART F: RESEARCH DATA

F.1 Explain what measures will be put in place to protect personal data. E.g. anonymisation procedures and coding of data. Any potential for re-identification should be made clear to participants in advance.

All paper data will be filed in a lockable filing cabinet in a lockable room on University property. All electronic forms of data will be stored on BOX. All information gathered irrespective of the means of collection, will be stored confidentially. Participant data will be allocated pseudonyms and will be presented in an anonymous coding system that will not divulge any names or identities that are involved in the study

Only the research team (i.e. the postgraduate researcher and research supervisors) will have access to collected data. All data that will be gathered and shared will follow in accordance with General Data Protection Regulations, and will be destroyed five years following the conclusion of the study. During that time, no other party or resource will have access to this data, which could reveal any identities.

F2. What security measures are place to ensure secure storage of data at any stage of the research?

Provide details on where personal data will be stored, any of the following: (Select all that apply)

- ☑ University approved cloud computing services
- ☐ Other cloud computing services
- ☐ Manual files
- ☐ Private company computers
- ☐ Portable devices
- ☐ Home or other personal computers (not recommended; data should be stored on a University of Hull server such as your G,T, X or Z: drive where it is secure and backed up regularly)

Please attach the data management plan in the appendices; for further information visit http://libguides.hull.ac.uk/researchdata

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F.3 Who will have access to participant's personal data during the study?

Only the research team (i.e. the postgraduate researcher and research supervisors) will have access to collected data. No other party or resource will have access to this data.

F.4 Where will the data generated by the research be analysed and by whom?

The data generated will be analysed on campus at the University of Hull by Amy Wilkinson, Dr Caroline Douglas, and Dr Samantha Nabb.

F.5 Who will have access and act as long term custodian for the research data generated by the study?

Amy Wilkinson

F.6 Have all researchers that have access to the personal data that will be collected as part of the research study, completed the University (or equivalent) data protection training?

◉ Yes ○ No

It is mandatory that all researchers accessing personal data have completed data protection training prior to commencing the research.

F.7 Will the research involve any of the following activities at any stage (including identification of potential research participants)? (Select all that apply)

- ☐ Examination of personal records by those who would not normally have access
- ☐ Access to research data on individuals by people from outside the research team
- ☑ Electronic surveys, please specify survey tool: Online Surveys (formerly known as Bristol Online Surveys)
- ☐ Other electronic transfer of data
- ☑ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers
- ☐ Use of audio/ visual recording devices (NB this should usually be mentioned in the information for participants)

F.8 Are there any reasons to prevent or delay the publication of this research? E.g. Commercial embargoes, sensitive material.

○ Yes ◉ No

If yes, provide details:

F.9 Where will the results of this study be disseminated ? (Select all that apply)

- ☑ Conference presentation
- ☑ Peer reviewed journals
- ☑ Publication as an eThesis in the Institutional repository HYDRA
- ☐ Publication on website
- ☐ Other publication or report, please state: _____
- ☐ Submission to regulatory authorities
- ☐ Other, please state: _____.
- ☐ No plans to report or disseminate the results

F.10 How long will research data from the study be stored?

5 years

F.11 When will the personal data collected during the study be destroyed and how?

All data that will be gathered and shared will be followed in accordance to the General Data Protection Regulations, and will be destroyed five years after the data has been collected with an electronic shredding device.

Researchers must comply with the General Data Protection Regulations that are live from May 2018.

PART G: CONFLICTS OF INTEREST

G.1 Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above normal salary or the costs of undertaking the research?

○ Yes ◉ No

If yes, indicate how much and on what basis this has been decided

G.2 Is there scope for any other conflict of interest? *For example, could the research findings affect any ongoing relationship between any of the individuals or organisations involved and the researcher(s)? Will the research funder have control of publication of research findings?*

○ Yes ◉ No

If so, please describe this potential conflict of interest, and outline what measures will be taken to address any ethical issues that might arise from the research.

G.3 Does the research involve external funding? (Tick as appropriate)

Yes

If yes, what is the source of this funding? Yes. The project is funded by the ERoYc. There are no actual or potential conflicts of interest.

PART H: TRAINING

Please provide details of any training required to conduct this research by any member of the research team.

No training is required for the principle researcher to conduct interviews, as this individual is an experienced interviewer at postgraduate level.

PART I: DECLARATIONS

Declaration by Principal Investigator

1 The information in this form is accurate to the best of my knowledge and belief.

2. I take full responsibility for the information I have supplied in this document.

3. I undertake to abide by the University's ethical and health and safety guidelines, and the ethical principles underlying good practice guidelines appropriate to my discipline.

4. I will seek the relevant School Risk assessment/COSHH approval if required.

5. If the research is approved, I undertake to adhere to the project protocol, the terms of this application and any conditions set out by the Faculty Research Ethics Committee.

6. Before implementing substantial amendments to the protocol, I will submit an amendment request to the Faculty Research Ethics Committee seeking approval.

7. If requested, I will submit progress reports.

8. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of participants or other personal data, including the need to register when necessary with the appropriate Data Protection Officer.

9. I understand that research records/data may be subject to inspection for audit purposes if required in future.

10. I take full responsibility for the actions of the research team and individuals supporting this study, thus all those involved will be given training relevant to their role in the study.

11. By signing the validation I agree that the Faculty Research Ethics Committee, on behalf of the University of Hull, will hold personal data in this application and this will be managed according to the principles established in the Data protection Act (1998).

Sharing information for training purposes: Optional – please tick as appropriate:

☑ I would be content for members of other Research Ethics Committees to have access to the information in the application in confidence for training purposes. All personal identifiers and references to researchers, funders and research units would be removed.

Principal Investigator

Signature of Principal Investigator:

A.Wilkinson

Print name: Amy Wilkinson Date: 23/11/18

Supervisor of student research: I have read, edited and agree with the form above.

Supervisor's signature:

(This needs to be an actual signature rather than just typed. Electronic signatures are acceptable)

Print name: Dr Caroline Douglas. Date: 04/12/2018

Remember to include any supporting material such as your participant information sheet, consent form, interview questions and recruitment material with your application. Version control should be adopted to include the version number and date on relevant documents in the appendices.

7.2. Risk assessment

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FHS RESEARCH ETHICS COMMITTEE

RISK ASSESSMENT

Title of the research	Leisure customers and leisure employee's perspectives of the referral process onto East Riding of Yorkshire council healthy lifestyle (ERoYc) programmes.
Name of Principal Investigator	Miss Amy Wilkinson
Location of research	Surveys will be undertaken online via Online Surveys (formerly known as Bristol Online Surveys) on multiple electronic devices (e.g. mobile phones, tablets, or laptops). Follow-up interviews, with interested participants, will be arranged and undertaken at East Riding leisure sites (e.g. East Riding Leisure Beverley) in an appropriate quiet and/or private space within the centre that is agreeable to the interviewee (e.g. the leisure centre café).

Brief description of research activity

This is a mixed methods study design utilising online surveys and interviews with three separate cohorts: 1) ERL customers who have completed a healthy lifestyle programme, 2) ERL administrative employees who process referrals from primary care (e.g. business technicians), and 3) ERL fitness professionals who deliver the ERoYc healthy lifestyle programmes, in order to explore their perspectives and experiences of the referral process. A separate survey has been developed for each cohort. At the end of each survey, respondents will be asked if they would like to elaborate on their experiences and perspectives through follow up interviews. If so, they will be asked to provide their contact details in order to arrange a suitable time and date for an interview. Interviews will be semi-structured and will be conducted either face-to-face or via telephone for participant convenience.

RISK IDENTIFICATION

Please identify all risks related to this research and indicate WHO is at risk and the measures that are in place or are required to mitigate these.

RISK(S)	MEASURES IN PLACE / REQUIRED *(e.g. alternative work methods, training, supervision, protective equipment)*
Training / supervision: *(e.g. information or training required, level of experience, supervisor's input and oversight)*	No further training is required for the postgraduate researcher to conduct interviews. The researcher is an experienced interviewer and has undertaken previous qualitative studies at postgraduate level.
Location: *(e.g. remote area, laboratory, confined space, entry or exit, level of illumination, heating etc.)*	Interviews will be carried out in one of the ten East Riding leisure centre sites in an appropriate quiet and/or private space that is agreeable to the interviewee. However, this could lead to the postgraduate researcher and participants being vulnerable in terms of health and safety (e.g. fire procedures, first aid response). To mitigate this risk, the postgraduate researcher will liaise with coordinators at the East Riding leisure centres to discuss fire procedures and first aid response.

Faculty of Health Sciences Research Ethics Committee: Risk assessment (v1.0 / 27.10.2017)

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Research processes: *(e.g. use of electrical systems, gas, liquids, tissue, potential for contamination, flammability etc.)*	In order to capture participant data in its natural form, a recording device (Trustin professional digital audio voice recorder) will be used. This recording device has undergone safety testing, and is battery powered, so there is no risk of mains electrocution.
Equipment use: *(e.g. manual handling, operation of emergency controls etc.)*	The recording device is compact and will be placed in plain view of the participant. The interview will commence whilst the participant is seated to minimise the risk of slips, trips, or fall during the interviews.
Violence / upset / harm: *(e.g. potential for violence, sensitivity of topic, previous incidents etc.)*	Participants may become frustrated at the length of the survey/interview, or may take offence to questions. Moreover, questions may uncover experiences that may cause minor embarrassment. Several control measures will be put in place to minimize these risks. Firstly, a consenting statement will appear before the respondent can fill out the survey. This statement will give an indication of how long the survey will take to complete. Survey questions will be piloted to ensure the survey is of an appropriate length. There will be no more than 20 questions for each cohort survey, answered predominantly by short written answers and Likert scales for swift completion. Furthermore, for those opting to share their experiences further via interviews, a participant information sheet will be provided which will give an approximation of the interview length. Likewise, interview questions will be piloted to help ensure that the interview is of an appropriate length. Participants will be provided with the option for a break during the interview if they feel necessary. By piloting all three surveys, this is going to minimise the risk of having poorly formulated questions that may cause embarrassment to participants. Furthermore, during interviews the investigator will handle any sensitive situations with caution and care, and will try to refrain from embarrassing the participant at all costs. The investigator will remain sensitive throughout the whole data collection process. Participants will be reminded prior to the interview that they can refuse to answer any questions if they so wish by saying "no comment", in which case the researchers will move on to the next questions without delay. Likewise, if the researcher feels that the participant is becoming embarrassed when answering a particular question in interviews, the researcher will move onto the next question without using prompts or follow-up questions.

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CONTINUED…..

Individuals: *(e.g. medical condition, young, inexperienced, disability etc.)*	In the highly unlikely event of an incident during participant interview, the East Riding leisure first aider on-site will be contacted immediately.
Work patterns: *(e.g. lone working, working out of hours, working off site, isolated or remote location etc.)*	The postgraduate researcher will conduct all interviews, however all interviews will be conducted on external premises (i.e. East Riding leisure centre sites) during normal operational times and in an open, public area. This location was selected for participant convenience as the majority of the sample population can be found on these premises.
Other:	

Name of Principal Investigator:	Amy Wilkinson
Signature:	A.Wilkinson
Date:	23/11/18
Name of Supervisor (if relevant):	Dr Caroline Douglas
Signature:	
Date:	04/12/2018

7.3. Data Management Plan

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University of Hull

Faculty of Health Sciences

Data Management Plan

(NB: This form should be completed at the start of all projects where data are not being stored in alternative sources, eg Clinical Trial Data held in the NHS). Shaded areas are considered essential.

Date	23/11/18
Researcher(s)	Miss Amy Wilkinson Dr Caroline Douglas Dr Samantha Nabb
Project title	Leisure customers and leisure employee's perspectives of the referral process onto East Riding of Yorkshire council healthy lifestyle (ERoYc) programmes.
Brief description	In order to gain a comprehensive understanding of the referral process onto the ERoYc healthy lifestyle programmes, it is imperative that all stakeholders involved have the opportunity to share their experiences and perspectives. This mixed methods study design utilises online surveys and interviews with three separate cohorts: 1) ERL customers who have completed a healthy lifestyle programme, 2) ERL administrative employees who process referrals from primary care (e.g. business technicians), and 3) ERL fitness professionals who deliver the ERoYc healthy lifestyle programmes.

For detailed, updated explanations of the various parts of the document that require completion, please refer to the accompanying Appendices.

Contents

Section 1: Project Information

Project title: Leisure customers and leisure employee's perspectives of the referral process onto East Riding of Yorkshire council healthy lifestyle (ERoYc) programmes.
1.1 Project duration 01.12. 2018 to 01.06. 2019
1.2 Partners (if applicable) N/A
1.3 Brief description This is a mixed methods study design utilising online surveys and interviews with three separate cohorts: 1) ERL customers who have completed a healthy lifestyle programme, 2) ERL administrative employees who process referrals from primary care (e.g. business technicians), and 3) ERL fitness professionals who deliver the ERoYc healthy lifestyle programmes, in order to explore their perspectives and experiences of the referral process.
1.4 Faculty or University requirements for data management Completion of data management plan prior to commencement of the research.
1.5 Funding body(ies) The project is funded by the ERoYc. There are no actual or potential conflicts of interest.
1.7 Budget (estimate if necessary) N/A
1.8 Funding body requirements for data management N/A

Section 2: Data, Materials, Resource Collection Information

2.1 Brief description of data sources

Personal data

- Names and email addresses for those opting to participate in follow up interviews
- Consent forms (paper and electronic)

Research data

- On-line survey data
- Audio files for those who participate in follow up interviews
- Interview transcriptions in Microsoft Word format

2.2 Data collection process

Online survey data will be collected via Online Surveys (formerly known as Bristol Online Surveys) on multiple electronic devices (e.g. mobile phones, tablets, or laptops).

At the end of each survey, respondents will be asked if they would like to elaborate on their experiences and perspectives through follow up interviews. If so, they will be asked to provide their contact details in order to arrange a suitable time and date for an interview. Interviews will be semi-structured and will be conducted either face-to-face or via telephone for participant convenience.

Interviews will be recorded on a recording device (Trustin professional digital audio voice recorder). After each interview, recordings will be immediately transferred onto BOX, before being permanently deleted off the recording device.

2.3 Will data be available in electronic format (if so then state format(s))?

Personal participant data such as names and email addresses will be stored in a password protected Microsoft word document saved on BOX. These will only be accessed by the principal investigator in the event of sending a participant their transcript, or withdrawing participant data.

Interviews will be recorded using a recording device before being transferred onto BOX. Immediately after transferring this audio file, it will be permanently deleted from the recording device. Interviews will then be transcribed within a password-protected Microsoft Word document and saved on BOX to be analysed. Transcriptions will be stored on BOX. Once the data has been analysed, the findings in the form of emerged themes will be transferred to a password-protected Microsoft Word document, saved on BOX.

On-line survey data will be held for the duration of the study on Online Surveys (formerly known as Bristol Online Survey). The data will then be transferred in Microsoft excel format to BOX before being inputted into a statistical software for analysis (SPSS).

2.4 Will the data be available in hard copy (if so then state format(s))?

The paper consent forms that contain an allocated identity code that link identities to the transcript and the data will be held in a locked cabinet in a lockable office on University of Hull premises. All other data will be held electronically on BOX.

2.5 Will the data stand alone and be comprehensible to a third party or be accompanied by explanatory documentation?

Interview recordings, transcriptions and analysis will be stored on BOX. Electronic files of data containing pseudonyms or codes will be stored in separate files on BOX. All interview transcriptions will be held on BOX in a format that will clearly denote the nature of the interviews and the project to which they relate.

2.6 Describe quality assurance process for data management

The progress of the project will be monitored during monthly supervisory meetings with Dr Caroline Douglas and Dr Samantha Nabb.

Section 3: Ethics, Intellectual Property

3.1 How have the ethical aspects of data storage and subsequent access been addressed?

- The information collected during the study will be strictly confidential and securely stored. It is anticipated that some direct quotes from the participants' interviews will be used for data analysis and the identification and explanation of themes that will emerge from the analysis. The participants will be made aware that anonymised direct quotations may be used in the write-up of the study and possible subsequent publication. However, participants can be assured that any direct quotations used will not divulge their identity and will not be linked to any personal identifiable information
- To protect participant confidentiality, participant data will be allocated pseudonyms and will be presented in an anonymous coding system that will not divulge any names or identities of those involved in the study.
- All the interviews will be digitally recorded on a recording device before being transferred to BOX. These recordings will then be transcribed by the Principle Investigator using Microsoft Word document using pseudonyms for any names disclosed during the interview. Participants will be allocated an identity code on the consent sheet. The paper informed consent sheets that contain information that link identities to the transcript and the data will be held separately to the digital transcripts in a locked cabinet in the supervisor's office at the University of Hull. Following transcription all recordings will be erased. No data held electronically will contain any personally identifiable data.
- The on-line survey data will only contain identifiable information should a respondent wish to participate in a follow up interview. This information will only be used to arrange this interview.

3.2 Will the data comply with relevant legislation such as Data Protection Act, Copyright and Intellectual Property?

Yes.

- Only data relevant for the project will be collected and stored appropriately.
- Data will be kept confidentially through the use of pseudonyms and codes.
- Data will be collected direct from participants and where possible, data will be captured in its naturalist form (recording interviews).
- All the data will be kept securely and appropriately for 5 years after completion of the project.
- Electronic data will be stored on BOX. Following completion of the study research data will be held for a total of 5 years on BOX under the custody of the research supervisor. After 5 years, all study data will be permanently destroyed.

Data will not be transferred to countries outside of the EEA.

3.3 If several partners are involved how will compliance with 3.2 be assured?

Section 4: Access and Use of Information

4.1 Are you required, and with whom, to share the data subsequent to completion of the project? Data gathered will form part of a Doctoral Thesis. Data may be submitted for publication in a scientific journal, or may be presented at a conference.
4.2 If 'yes' to 4.1, in what format will data be shared? Research findings will form a Doctoral Thesis. If this data is submitted for publication, it is not intended that raw data sets (e.g. interview transcriptions) will be shared.
4.3 Will the data have to be stored for a specific period (if so, how long)? 5 years
4.4 Who may need to have access to the data? The principal investigator and the supervisory team (i.e. Dr Caroline Douglas, and Dr Samantha Nabb) will have access to the dataset for the analysis and write up of this project.
4.5 How do you anticipate the data being used subsequent to the project? There is no anticipated use of the raw data once it had been analysed.

Section 5: Storage and Backup of Data

5.1 Where and how will the data be stored **during the lifespan of the project?** Hardcopy Hardcopy of data (consent forms with identity code) will be stored in a locked cabinet within a lockable room on the University of Hull's premises. Electronic Electronic files (auditory interview file, transcriptions of interviews, analysis of interviews, raw survey data, analysis of survey data, results of the surveys) will be password-protected and saved on BOX.
5.2 Where and how will the data be stored **on completion of the project?** Hardcopy Hardcopy of data (consent form with identity code) will be stored in the room of principal investigator's supervisor at the University of Hull in a locked cabinet. Electronic Electronic files (auditory interview file, transcriptions of interviews, analysis of interviews, raw survey data, analysis of survey data, results of the surveys) will be password-protected and saved on BOX.
5.3 What provision is being made for backup of the data? Transcripts will be uploaded straight onto BOX (an online back-up cloud server) for the duration of the project.
5.4 Will different version of the data be stored? Different versions of the data will be saved under appropriate file names that will explicitly state the version number in chronological order.

Section 6: Archiving and Future Proofing of Information

6.1 What is the long-term strategy for storage and availability of the data? Long term storage will be on secure BOX under the custody of the research supervisor. Should the research be published within a journal, then it may be available in electronic copy.
6.2 Will the information be kept after the life of the project, for how long and in what format? Data will be kept for 5 years after the completion of the project in the following format: <u>Hardcopy</u> Hardcopy of data (consent forms with identity code) will be stored in a locked cabinet within a lockable room on the University of Hull's premises. <u>Electronic</u> Electronic files (auditory interview file, transcriptions of interviews, analysis of interviews, raw survey data, analysis of survey data, results of the surveys) will be stored on BOX under the control of the research supervisor.
6.3 If the data include confidential or sensitive information, how will these data be managed? All data collected will be confidential and pseudonyms or codes will be allocated to each participant which will be used consistently on all data collected. Electronic data will be password protected and stored on BOX for the duration of the project. For supervision purposes, there may be a possibility that anonymised transcripts are shared amongst the research team via the University secure email system, or via BOX.
6.4 If meta data or explanatory information is to be stored, how will this be linked to the data? Each data set will have attached an explanatory note in the headings to advise the content of the data and details of the study that it relates to.
6.5 How will the data be cited? n/a

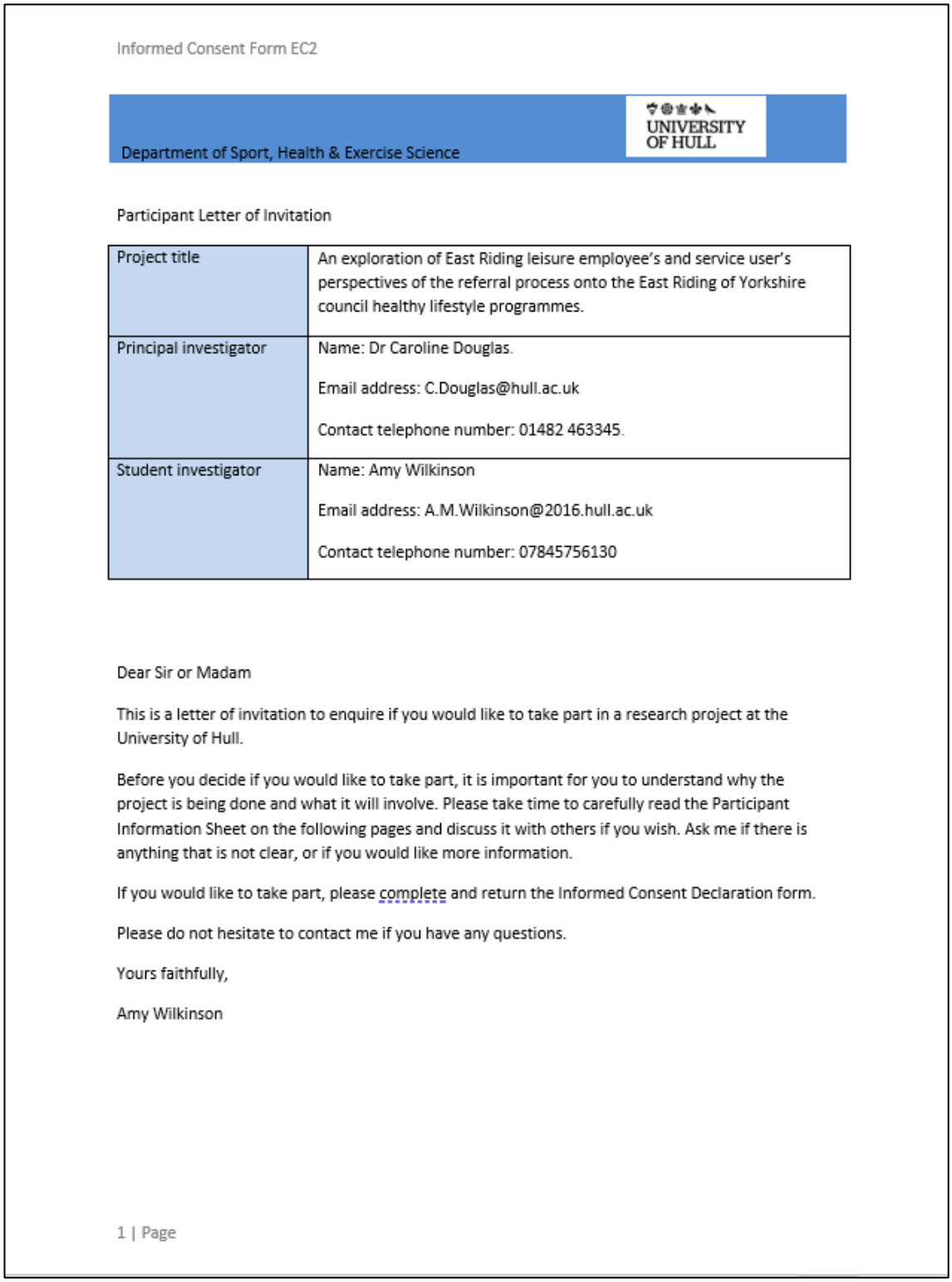
Section 7: Resourcing of Data Management

7.1 List the specific staff who will have access to the data and denote who will have the responsibility for data management. The principal investigator will have full responsibility for data management under the scrutiny of the supervisory team (Dr Caroline Douglas and Dr Samantha Nabb). All hard copies of data will be stored in a locked filing cabinet in a lockable room on University premises.
7.2 How will data management be funded? By the University of Hull
7.3 How will data storage be funded? No additional costs of storage are anticipated and data will be held on BOX for the prescribed storage period of five years.

Section 8: Review of Data Management process

8.1 How will the data management plan be adhered to? The Principle Investigator has outlined this data management plan prior to the commencement of this research, and will ensure that this plan is implemented throughout the duration of this project and beyond. This plan will be reviewed during monthly supervisory meetings with Dr Caroline Douglas and Dr Samantha Nabb to ensure adherence and to resolve any unexpected issues.
8.2 Who will review the data management plan? The supervisory team consisting of Dr Caroline Douglas and Dr Samantha Nabb.

7.4. Participant Letter of Invitation, Information Sheet, and Informed Consent Form



Informed Consent Form EC2

Department of Sport, Health & Exercise Science

UNIVERSITY OF HULL

Participant Letter of Invitation

Project title	An exploration of East Riding leisure employee's and service user's perspectives of the referral process onto the East Riding of Yorkshire council healthy lifestyle programmes.
Principal investigator	Name: Dr Caroline Douglas. Email address: C.Douglas@hull.ac.uk Contact telephone number: 01482 463345.
Student investigator	Name: Amy Wilkinson Email address: A.M.Wilkinson@2016.hull.ac.uk Contact telephone number: 07845756130

Dear Sir or Madam

This is a letter of invitation to enquire if you would like to take part in a research project at the University of Hull.

Before you decide if you would like to take part, it is important for you to understand why the project is being done and what it will involve. Please take time to carefully read the Participant Information Sheet on the following pages and discuss it with others if you wish. Ask me if there is anything that is not clear, or if you would like more information.

If you would like to take part, please complete and return the Informed Consent Declaration form.

Please do not hesitate to contact me if you have any questions.

Yours faithfully,

Amy Wilkinson

1 | Page

Department of Sport, Health & Exercise Science

UNIVERSITY OF HULL

Project title	An exploration of East Riding leisure customer's and employee's perspectives of the referral process onto the East Riding of Yorkshire council healthy lifestyle programmes.
Principal investigator	Name: Dr Caroline Douglas. Email address: C.Douglas@hull.ac.uk Contact telephone number: 01482 463345.
Student investigator	Name: Amy Wilkinson Email address: A.M.Wilkinson@2016.hull.ac.uk Contact telephone number: 07845756130

What is the purpose of this project?

The purpose of this study is to gain a rich insight into the perspectives of customers who have previously undergone referral to an East Riding of Yorkshire council healthy lifestyle programme (e.g., Live Well or Exercise Referral Scheme), and East Riding Leisure employees who are involved in the processing and operation of healthy lifestyle programmes. This study will gather data through surveys and optional follow-up interviews.

Why have I been chosen?

You have been invited to participate in a follow up interview following survey completion as you are either a customer who has completed a healthy lifestyle programme (e.g., Live Well or Exercise Referral Scheme), or you are an East Riding Leisure employee who is heavily involved in the operation of healthy lifestyle programmes. Your experiences and opinions of the referral process will be invaluable in highlighting the strengths and weaknesses of current referral processes and will help inform the design and development of a more streamline referral pathway.

What happens if I volunteer to take part in this project?

First, it is up to you to decide whether to take part in a follow up interviews. If you decide to take part, you will be given this Participant Information Sheet to keep and asked to complete the Informed Consent Declaration at the back. You should give the Informed Consent Declaration to the investigator at the earliest opportunity. You will also have the opportunity to ask any questions

you may have about the project. If you decide to take part, you are still free to withdraw at any time and without needing to give a reason. If you decide to do so, all data collected will be destroyed promptly.

What will I have to do?
You will be contacted to arrange a convenient location and time for you to meet with the postgraduate investigator. On arrival, the postgraduate investigator will brief you on the procedure and will give you the opportunity to ask any questions or express any concerns that you might have. You will then be asked to read and sign a consent form. Following this, you will be interviewed, which will be recorded electronically on a digital voice recording device. Once the interview is over, you will have the opportunity to express any views or raise any relevant points that you may feel you were either not able to do so during the interview, or were not covered within the scope of the interview questions. The interview process should last no longer than 60 minutes.

Will I receive any financial reward or travel expenses for taking part?
No

Are there any other benefits of taking part?
You will be contributing to a better of understanding of the referral process from the perspective of either a customer or East Riding employee, and this is going to inform the development of a streamline referral pathway to benefit all users involved.

Will participation involve any physical discomfort or harm?
No

Will I have to provide any bodily samples (e.g., blood or saliva)?
No

Will participation involve any embarrassment or other psychological stress?

With the interview focusing on your feelings and opinions of referral to the healthy lifestyle programmes, this could provoke an emotional response during the interview. Although this cannot always be prevented, you can be assured that the interview will be confidential and anonymous at all times. Moreover, you are free to withdraw from study at any time without having to give a reason for doing so, if the interview becomes too demanding.

What will happen once I have completed all that is asked of me?

You will be made aware that the interview has concluded and asked if there is anything, you wish to add or clarify. You will be reminded that you will be provided with a transcript of the interview within 4-6 weeks of the session so you a can confirm the recorded material is an accurate representation of the dialogue that occurred.

How will my taking part in this project be kept confidential?

You will be allocated an anonymous participant code that will always be used to identify any data that you provide. Your name or other personal details will not be associated with your data. Your consent form and personal details will be stored separately from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic information will be stored on a password-protected computer. All information and data gathered during this research will be stored in line with the 1998 Data Protection Act and will be destroyed 5 years following the conclusion of the study. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed.

How will my data be used?

Any information and data gathered during this project will only be available to the research team. Results from this study will be written up as part of a Doctoral Thesis. If you would like a copy of the thesis, we can arrange for you to receive it as soon as it becomes possible. Should the thesis be presented or published in any form, you will not be identifiable.

Who has reviewed this study?

This project has undergone full ethical scrutiny and all procedures have been risk assessed and approved by the Department of Sport, Health and Exercise Science Ethics Committee at the University of Hull.

What if I am unhappy during my participation in the project?
You are free to withdraw from the project at any time. During the study itself, if you decide that you do not wish to take any further part then please inform the person named in Section 18 and they will facilitate your withdrawal. You do not have to give a reason for your withdrawal. Any personal information or data that you have provided (both paper and electronic) will be destroyed or deleted as soon as possible after your withdrawal. After you have completed the research, you can still withdraw your personal information and data by contacting the person named in Section 18. If you are concerned that regulations are being infringed, or that your interests are otherwise being ignored, neglected or denied, you should inform Dr Andrew Garrett, Chair of the Department of Sport, Health and Exercise Research Ethics Committee, who will investigate your complaint (Tel: 01482 463866; Email: a.garrett@hull.ac.uk

How do I take part?
Contact the investigator using the contact details given below. She will answer any queries and explain how you can get involved. Name: Amy Wilkinson Email: A.M.Wilkinson@2016.hull.ac.uk Phone: 07845756130

Department of Sport, Health & Exercise Science

UNIVERSITY OF HULL

Informed Consent Declaration

Project title	An exploration of East Riding leisure service user's and employee's perspectives of the referral process onto the East Riding of Yorkshire council healthy lifestyle programmes.
Principal investigator	Name: Dr Caroline Douglas. Email address: C.Douglas@hull.ac.uk Contact telephone number: 01482 463345
Student investigator	Name: Amy Wilkinson Email address: A.M.Wilkinson@2016.hull.ac.uk Contact telephone number: 07845756130

Please Initial

I confirm that I have read and understood all the information provided in the Informed Consent Form (EC2) relating to the above project and I have had the opportunity to ask questions. ☐

I understand this project is designed to further scientific knowledge and that all procedures have been risk assessed and approved by the Department of Sport, Health and Exercise Science Research Ethics Committee at the University of Hull. Any questions I have about my participation in this project have been answered to my satisfaction. ☐

I fully understand my participation is voluntary and that I am free to withdraw from this project at any time and at any stage, without giving any reason. I have read and fully understand this consent form. ☐

.....	.....	.....
Name of participant	Date	Signature
.....	.....	.....
Person taking consent	Date	Signature

7.5. Approval Letter

UNIVERSITY OF HULL

University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 463336 | **E:** e.walker@hull.ac.uk
w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Amy Wilkinson
Faculty of Health Sciences
University of Hull
Via email

23rd January 2019

Dear Amy

REF FHS103 - Leisure customers and leisure employee's perspectives of the referral process onto East Riding of Yorkshire council healthy lifestyle (ERoYc) programmes.

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

I wish you every success with your study.

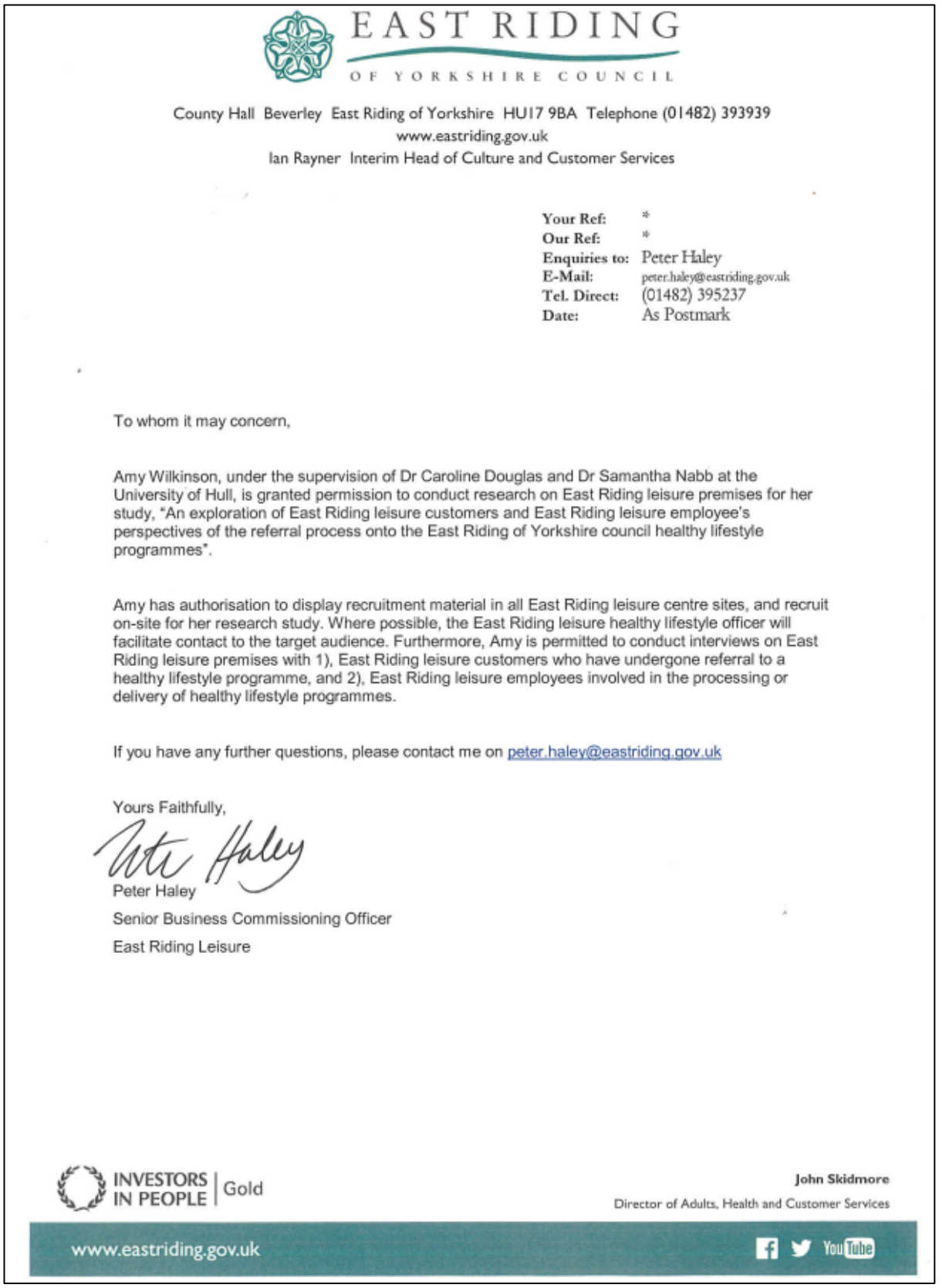
Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY OF HULL

Liz Walker | Professor of Health and Social Work Research | Faculty of Health Sciences
University of Hull
Hull, HU6 7RX, UK
www.hull.ac.uk
e.walker@hull.ac.uk | 01482 463336
@UniOfHull /UniversityOfHull universityofhull

7.6. East Riding of Yorkshire Permission Letter



EAST RIDING
OF YORKSHIRE COUNCIL

County Hall Beverley East Riding of Yorkshire HU17 9BA Telephone (01482) 393939
www.eastriding.gov.uk
Ian Rayner Interim Head of Culture and Customer Services

Your Ref: *
Our Ref: *
Enquiries to: Peter Haley
E-Mail: peter.haley@eastriding.gov.uk
Tel. Direct: (01482) 395237
Date: As Postmark

To whom it may concern,

Amy Wilkinson, under the supervision of Dr Caroline Douglas and Dr Samantha Nabb at the University of Hull, is granted permission to conduct research on East Riding leisure premises for her study, "An exploration of East Riding leisure customers and East Riding leisure employee's perspectives of the referral process onto the East Riding of Yorkshire council healthy lifestyle programmes".

Amy has authorisation to display recruitment material in all East Riding leisure centre sites, and recruit on-site for her research study. Where possible, the East Riding leisure healthy lifestyle officer will facilitate contact to the target audience. Furthermore, Amy is permitted to conduct interviews on East Riding leisure premises with 1), East Riding leisure customers who have undergone referral to a healthy lifestyle programme, and 2), East Riding leisure employees involved in the processing or delivery of healthy lifestyle programmes.

If you have any further questions, please contact me on peter.haley@eastriding.gov.uk

Yours Faithfully,

Peter Haley
Senior Business Commissioning Officer
East Riding Leisure

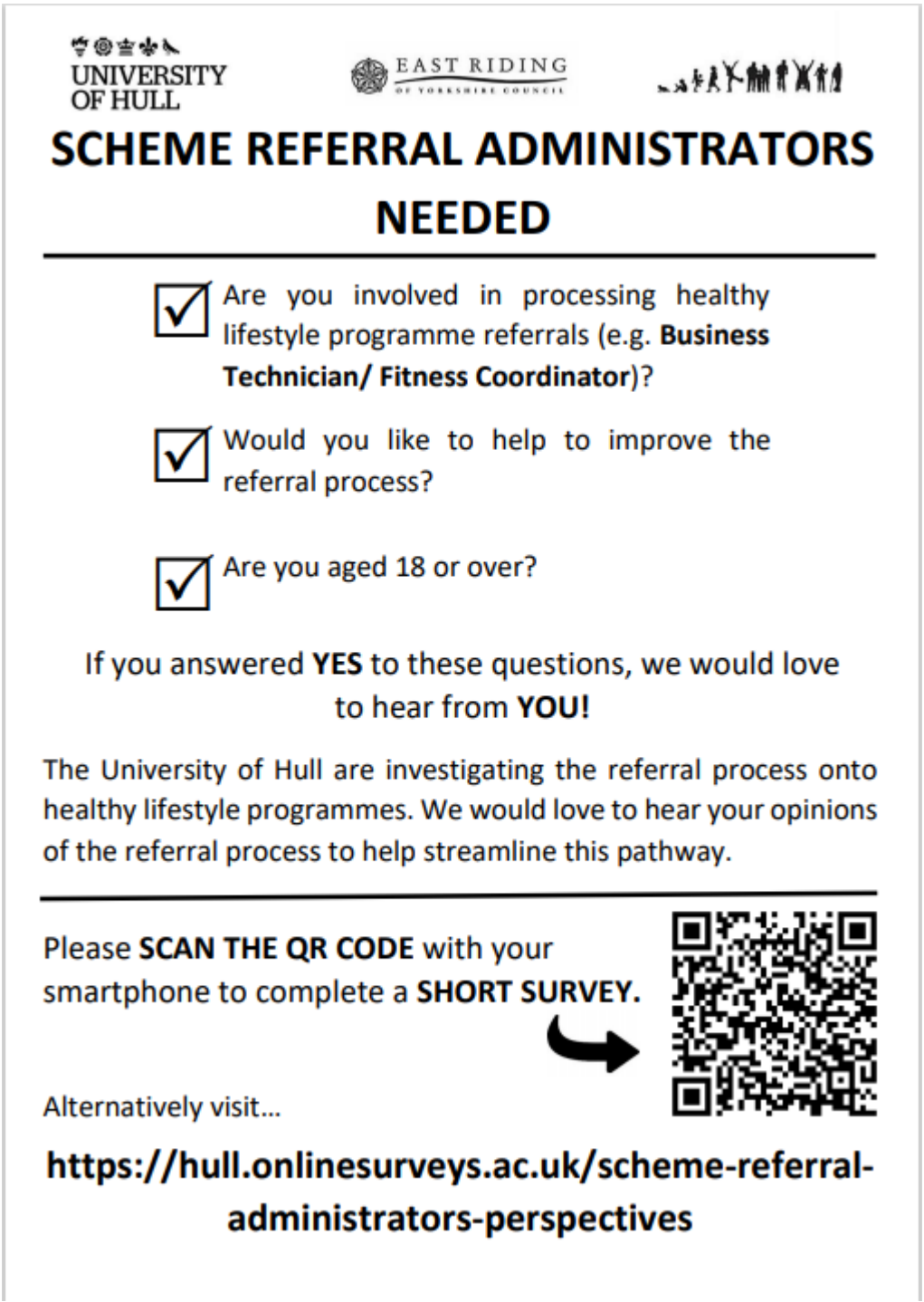
INVESTORS IN PEOPLE | Gold

John Skidmore
Director of Adults, Health and Customer Services

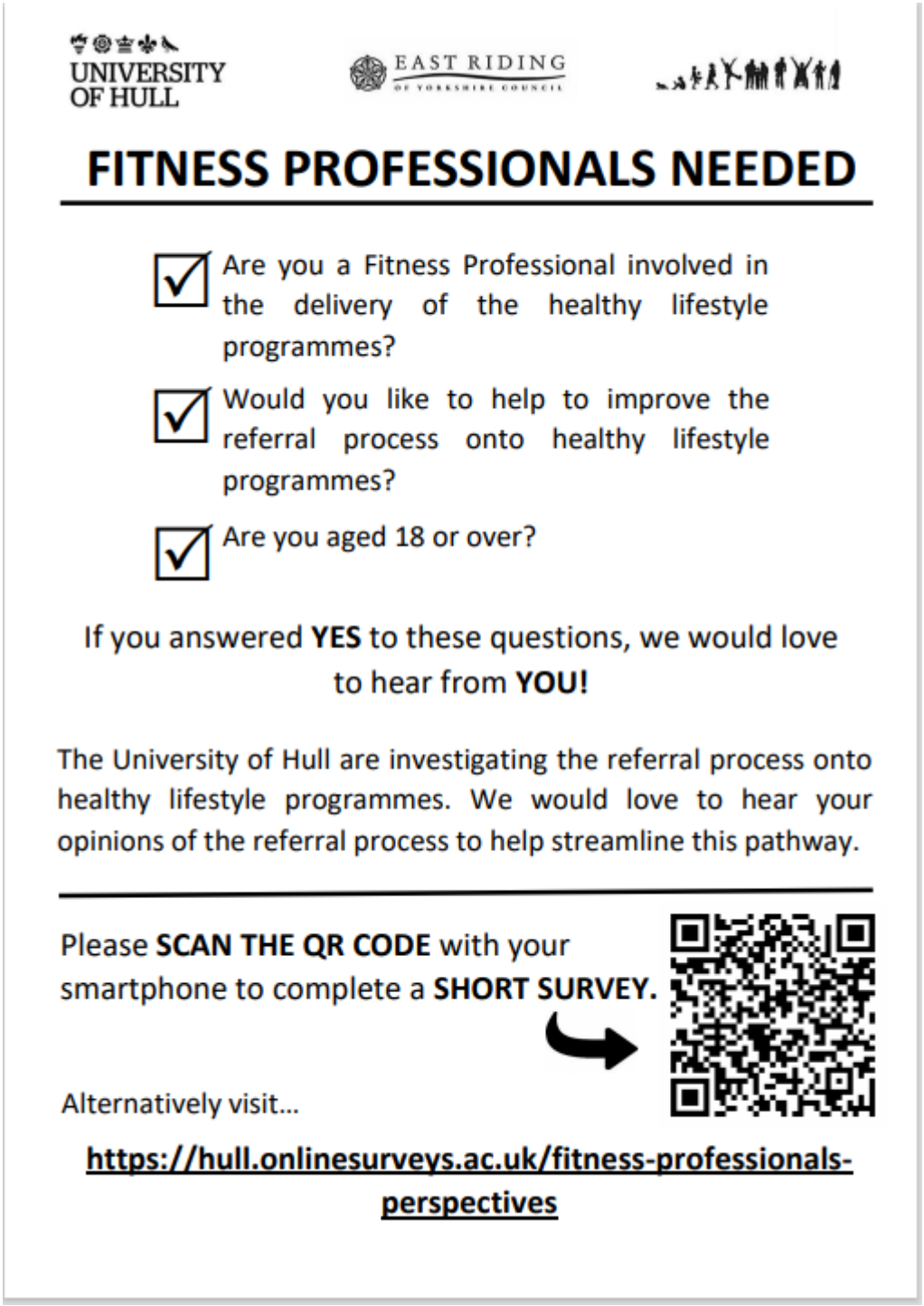
www.eastriding.gov.uk

Appendix 8: Recruitment Material for Research Phase II

8.1. Referral Scheme Administrators



8.2. Fitness Professionals



UNIVERSITY OF HULL

EAST RIDING OF YORKSHIRE COUNCIL

FITNESS PROFESSIONALS NEEDED

- ☑ Are you a Fitness Professional involved in the delivery of the healthy lifestyle programmes?
- ☑ Would you like to help to improve the referral process onto healthy lifestyle programmes?
- ☑ Are you aged 18 or over?

If you answered **YES** to these questions, we would love to hear from **YOU!**

The University of Hull are investigating the referral process onto healthy lifestyle programmes. We would love to hear your opinions of the referral process to help streamline this pathway.

Please **SCAN THE QR CODE** with your smartphone to complete a **SHORT SURVEY.**

Alternatively visit...

https://hull.onlinesurveys.ac.uk/fitness-professionals-perspectives

8.3. Customers

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EAST RIDING OF YORKSHIRE COUNCIL

PARTICIPANTS NEEDED

- ☑ Have you attended a healthy lifestyle programme such as Live Well or Exercise Referral?
- ☑ Would you like to help to improve the patient journey onto healthy lifestyle programmes?
- ☑ Are you aged 18 or over?

If you answered **YES** to these questions, we would love to hear from **YOU!**

The University of Hull are investigating the referral process onto healthy lifestyle programmes run at East Riding leisure centres. We would love to hear about your experiences of referral, which will help us develop the referral process to improve the patient journey for future participants.

Please **SCAN THE QR CODE** with your smartphone to complete a **SHORT SURVEY**

OR alternatively visit...

https://hull.onlinesurveys.ac.uk/customers-perspectives-of-the-referral-process

Appendix 9: Online Survey Schedules and analysis information for Research Phase II

9.1. Referral Scheme Administrators

Theme	Question *(type of question)*		Data Obtained	Analysis Conducted
Consent	Q1	By clicking the 'yes' button, I therefore give my full informed consent to take part in the online survey. I have read and understood the participant information sheet, I fully understand my participation in this survey is voluntary, and I fully understand that I am free to withdraw from this survey at any point without having to give any reason. *(multiple choice)* Yes / No	Qualitative Data-Nominal	None
Demographics	Q2	What is your gender? *(multiple choice)* Male / Female / Non-binary / Prefer not to say	Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q3	What is your age in years? *(open-ended question)*	Quantitative Data-Discrete	SPSS Descriptive Statistics-frequencies and descriptives
	Q4	Which East Riding Leisure site do you work in? Select all that apply. *(multiple choice)* Beverley / Bridlington / Driffield / Francis Scaife / Goole Haltemprice / Hornsea / Withernsea / South Cave / South Holderness	Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q5	What is your role? *(multiple choice)* Business technician / Fitness co-ordinator / Other (please specify)	Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q5a	If you selected Other, please specify: *(open-ended question)*	Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q6	How many years have you worked in your current role? *(open-ended question)*	Quantitative Data-Discrete	SPSS Descriptive Statistics-frequencies and descriptives

	Q7	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply. *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Live Well	Young Live Well	Exercise Referral Scheme	Health Optimisation Scheme	H.E.A.R.T Cardiac Rehab		
	Q8	Within your leisure site, who is responsible for processing the healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Business technicians	Fitness co-ordinators	Other (please specify)				
	Q8a	If you selected Other, please specify: *(open-ended question)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
Referral information provided by PCP	Q9	How do you receive healthy lifestyle referrals? Tick all that apply *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Electronically via email	Electronically via fax	Electronically via ER referral system (BEARS)				
		Paper based referral forms	Telephone referrals	Other (please specify)				
	Q9a	If you selected Other, please specify: *(open-ended question)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q10	Which means of receiving referrals are easier to process? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Electronically via email	Electronically via fax	Electronically via ER referral system (BEARS)				
		Paper based referral forms	Telephone referrals	Other (please specify)				
	Q10a	If you selected Other, please specify: *(open-ended question)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q10b	Please explain why you feel this way. *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
	Q11	Are all healthy lifestyle referrals (e.g. Live Well referrals and Exercise Referral Scheme referrals) processed the same way? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes	No					
	Q11a	If no, please explain how different healthy lifestyle referrals are processed. *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
	Q12	How often do referral forms from primary care sites (e.g. general practice sites) Include all required referral information? *(likert-scale question)*					Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies

		Always	Very often	Sometimes	Rarely	Never		
	Q13	Are you able to get hold of primary care sites (e.g. GP surgeries) easily? *(likert-scale question)*					Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Always	Very often	Sometimes	Rarely	Never		
	Q14	Are you able to gain access to missing referral information from primary care sites easily? *(likert-scale question)*					Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Always	Very often	Sometimes	Rarely	Never		
	Q15	What are the common challenges you face when processing a healthy lifestyle referral? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
Initial Patient interactions (telephone conversation	Q16	During your initial telephone conversation with referred customers, what information do you typically provide? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
	Q17	During your initial telephone conversation with referred customers, are they well informed about the programme they are being referred onto? *(likert-scale question)*					Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Always	Very often	Sometimes	Rarely	Never		
	Q18	During your initial telephone conversation with referred customers, what are the common concerns they raise? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
The Feedback Loop	Q19	How important do you feel it is to provide customer feedback back to primary care sites (e.g. general practice sites)? *(likert-scale question)*					Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Very Important	Important	Moderately Important	Slightly Important	Not Important		
	Q20	Do you provide feedback back to primary care sites? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes		No				
	Q20a	If yes, what information do you feedback to primary care sites? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
Suggested improvements to HLP referral processes	Q21	In your opinion, how could the referral process be improved? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis

Interest for interviews	Q22	Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of processing referrals? *(multiple choice)*		Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes	No		
	Q22a	If yes, please leave your name and contact number *(open-ended question)*		Qualitative Data-Nominal	None

9.2. Fitness Professionals

Theme	Question *(type of question)*					Data Obtained	Analysis Conducted
Consent	Q1	By clicking the 'yes' button, I therefore give my full informed consent to take part in the online survey. I have read and understood the participant information sheet, I fully understand my participation in this survey is voluntary, and I fully understand that I am free to withdraw from this survey at any point without having to give any reason. *(multiple choice)*					Qualitative Data-Nominal	None
		Yes		No				
Demographics	Q2	What is your gender? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Male	Female	Non-binary	Prefer not to say			
	Q3	What is your age in years? *(open-ended question)*					Quantitative Data-Discrete	SPSS Descriptive Statistics-frequencies and descriptives
	Q4	Which East Riding Leisure site do you work in? Select all that apply. *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Beverley	Bridlington	Driffield	Francis Scaife	Goole		
		Haltemprice	Hornsea	Withernsea	South Cave	South Holderness		
	Q5	How many years have you worked as a fitness professional? *(open-ended question)*					Quantitative Data-Discrete	SPSS Descriptive Statistics-frequencies and descriptives
	Q6	Which healthy lifestyle programme(s) are you involved in delivering? Select all that apply. *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Live Well	Young Live Well	Exercise Referral Scheme	Health Optimisation Scheme			

		H.E.A.R.T Cardiac Rehab	Swim for health	Walking for health			
	Q7	Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? *(multiple choice)*				Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Business technicians	Fitness professionals	Other (please specify)			
	Q7a	If you selected Other, please specify *(open-ended question)*				Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
Information Received at the Point of Referral	Q9	Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply. *(multiple choice)*				Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Name	Age	Body Mass Index	Current health status		
		Previous medical history	Medication list	Other (please specify)			
	Q9a	If you selected Other, please specify *(open-ended question)*				Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q10	Do you feel you are provided with enough information prior to meeting face-to-face with a referred customer? *(likert-scale question)*				Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Always	Very often	Sometimes	Rarely	Never	
	Q11	What additional information would be useful to receive prior to your first face-to-face appointment with a referred customer? *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
Initial Contact with Referred Patients	Q8	How often are you able to contact a referred customer via telephone prior to their first face-to-face appointment? *(likert-scale question)*				Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Always	Very often	Sometimes	Rarely	Never	
	Q12	When meeting your referred customer for the first time, are they typically well informed about the programme they have been referred onto? *(likert-scale question)*				Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Always	Very often	Sometimes	Rarely	Never	

	Q13	What information would you like referred customer to be provided with prior to their first leisure appointment? *(open-ended question)*	Qualitative Data-Nominal	Thematic Analysis
	Q14	When meeting your referred customers for the first time, what are the common concerns they raise? *(open-ended question)*	Qualitative Data-Nominal	Thematic Analysis
	Q15	When meeting your referred customers for the first time, what are the common challenges you face? *(open-ended question)*	Qualitative Data-Nominal	Thematic Analysis
The Feedback Loop	Q16	How important do you feel it is to provide referred customer feedback to primary care sites (e.g. general practice sites)? *(likert-scale question)* Very Important / Important / Moderately Important / Slightly Important / Not Important	Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
	Q17	Do you provide feedback back to primary care sites? *(multiple choice)* Yes / No	Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q17a	If yes, what information do you provide when giving feedback to primary care sites? *(open-ended question)*	Qualitative Data-Nominal	Thematic Analysis
Suggested improvements to HLP referral processes	Q18	In your opinion, how could the referral process be improved? *(open-ended question)*	Qualitative Data-Nominal	Thematic Analysis
Interest for interviews	Q19	Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of referral? *(multiple choice)* Yes / No	Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q19a	If yes, please leave your name and contact number *(open-ended question)*	Qualitative Data-Nominal	None

9.3. Customers

Theme	Question *(type of question)*					Data Obtained	Analysis Conducted
Consent	Q1	By clicking the 'yes' button, I therefore give my full informed consent to take part in the online survey. I have read and understood the participant information sheet, I fully understand my participation in this survey is voluntary, and I fully understand that I am free to withdraw from this survey at any point without having to give any reason.. *(multiple choice)*					Qualitative Data-Nominal	None
		Yes		No				
Demographics	Q2	What is your gender? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Male	Female	Non-binary	Prefer not to say			
	Q3	What is your age in years? *(open-ended question)*					Quantitative Data-Discrete	SPSS Descriptive Statistics-frequencies and descriptives
	Q4	What is your postcode? *(open-ended question)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q5	Which healthy lifestyle programme have you attended? Select all that apply. *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Live Well	Young Live Well	Exercise Referral Scheme	Health Optimisation Scheme			
		H.E.A.R.T Cardiac Rehab	Swim for health	Walking for health				
	Q6	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Beverley	Bridlington	Driffield	Francis Scaife	Goole		
		Haltemprice	Hornsea	Withernsea	South Cave	South Holderness		
	Q7	Which primary care site (e.g. general practice) were you referred from? Please include the name and location of this primary care site (e.g. Beverley). *(open-ended question)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
	Q8	Which professional referred you onto your healthy lifestyle programme *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies

		General practitioner	Nurse (e.g. PN , NP Specialist Nurse	Community Link Worker	Care Navigator		
		Physiotherapist	Consultant	Other (please specify)	Not sure		
Experiences of referral	Q9	At the time of referral, did you know anything about your programme (e.g. Exercise referral scheme)? *(multiple choice)*				Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes		No			
	Q9a	If yes, please can you explain what you knew about your programme at the time of referral *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
	Q10	At the time of referral, how did the professional who referred you describe your programme to you? *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
	Q11	At the time of referral, how did you feel about what you had just been told by the professional who referred you? *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
	Q12	At the time of referral, how ready were you to change your lifestyle? *(likert-scale question)*				Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Not ready to change	Thinking of change	Not sure/ uncertain	Somewhat ready	Very ready to change	
	Q12a	Briefly explain why you chose this answer. *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
	Q13	At the time of referral, were you provided with any information resources on your programme (e.g. leaflets)? *(multiple choice)*				Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes		No			
	Q13a	If yes, how useful were these information resources? *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
Suggestions for improvement	Q14	Now you have completed your programme, what would you have liked more information on at the time of your referral? *(open-ended question)*				Qualitative Data-Nominal	Thematic Analysis
	Q15	Now you have completed your programme, do you feel that the original description of your programme was accurate? *(likert-scale question)*				Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies

to enhance the patient journey		Not at all	Slightly	Moderately	Very	Extremely		
	Q15a	Please explain you feel this way? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
	Q16	In your own words, can you describe your programme? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
	Q17	In your opinion, how could the referral process be improved for future participants? *(open-ended question)*					Qualitative Data-Nominal	Thematic Analysis
Feedback on HLP progress with PCP	Q18	Have you been to visit your primary care site (e.g. GP surgery) since your referral onto your programme? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes		No				
	Q18a	If yes, Has your progress on your programme been discussed with you at your primary care site (e.g. GP surgery)? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes		No				
	Q19	How important do you feel it is to discuss your progress on your programme at your primary care site (e.g. GP surgery)? *(likert-scale question)*					Qualitative Data-Ordinal	SPSS Descriptive Statistics-frequencies
		Not Important	Slightly Important	Moderately Important	Important	Very Important		
Interest for interviews	Q20	Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of referral? *(multiple choice)*					Qualitative Data-Nominal	SPSS Descriptive Statistics-frequencies
		Yes		No				
	Q20a	If yes, please leave your name and contact number *(open-ended question)*					Qualitative Data-Nominal	None

Appendix 10 : Online Survey SPSS Descriptive Statistics Outputs

10.1. Referral Scheme Administrators

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
What is your age in years?	16	24	58	42.56	10.282
How many years have you worked in your current role?	16	0	34	7.50	8.587
Valid N (listwise)	16				

Frequencies

Statistics

		What is your gender?	What is your age in years?	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Beverley	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Bridlington	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Driffield
N	Valid	16	16	6	2	1
	Missing	0	0	10	14	15

Statistics

		Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Francis Scaife	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Goole	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Haltemprice	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Hornsea	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Withernsea
N	Valid	1	1	1	1	2
	Missing	15	15	15	15	14

Statistics

		Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Cave	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Holderness	What is your role? - Business Technician	What is your role? - Fitness co-ordinator	What is your role? - Other
N	Valid	0	1	4	9	3
	Missing	16	15	12	7	13

Statistics

		If you selected Other, please specify:	How many years have you worked in your current role?	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Live Well	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Young Live Well	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Exercise Referral Scheme
N	Valid	16	16	14	14	13
	Missing	0	0	2	2	3

Statistics

		Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Health Optimisation Programme	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - H.E.A.R.T (Cardiac Rehabilitation)	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Walking for Health	Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Swim for Health	Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Business Technicians
N	Valid	14	9	5	3	7
	Missing	2	7	11	13	9

Statistics

		Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Fitness Coordinators	Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Other	If you selected Other, please specify:	How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Electronically via email	How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Electronically via fax
N	Valid	9	5	16	11	3
	Missing	7	11	0	5	13

Statistics

		How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Electronically via the East Riding referral system (BEARS)	How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Paper-based referral forms	How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Telephone-based referrals	How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Other	If you selected Other, please specify:
N	Valid	14	13	1	0	16
	Missing	2	3	15	16	0

Statistics

		Which referrals are easiest to process? - Electronically via email	Which referrals are easiest to process? - Electronically via fax	Which referrals are easiest to process? - Electronically via East Riding referral system (BEARS)	Which referrals are easiest to process? - Paper-based referral forms	Which referrals are easiest to process? - Telephone referrals
N	Valid	7	1	10	2	0
	Missing	9	15	6	14	16

Statistics

		Which referrals are easiest to process? - other	If you selected Other, please specify:	Are all healthy lifestyle referrals (e.g. Live Well referrals and Exercise Referral Scheme referrals) processed the same way?	How often do referral forms from primary care sites include all the required referral information?	Are you able to get hold of primary care sites sending healthy lifestyle referrals easily?
N	Valid	1	16	16	16	16
	Missing	15	0	0	0	0

Statistics

		Are you able to easily gain access to missing referral information from primary care sites sending healthy lifestyle referrals?	During your initial telephone conversation with referred customers, how well informed are they about the programme they are being referred onto?	How important do you feel it is to provide referred customer feedback to primary care sites (e.g. general practice sites)?	Do you provide feedback to primary care sites?	What information do you feedback to primary care sites?
N	Valid	16	16	16	16	16
	Missing	0	0	0	0	0

Statistics

		Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of referral?
N	Valid	16
	Missing	0

Frequency Table

What is your gender?

	N	%
Male	9	56.3%
Female	7	43.8%

What is your age in years?

	N	%
24	1	6.3%
29	1	6.3%
30	1	6.3%
33	1	6.3%
34	1	6.3%
40	1	6.3%
41	1	6.3%
42	1	6.3%
44	1	6.3%
46	1	6.3%
48	1	6.3%
51	1	6.3%
53	2	12.5%
55	1	6.3%
58	1	6.3%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Beverley

	N	%
East Riding Leisure Beverley	6	37.5%
Missing 0	10	62.5%
Total	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Bridlington

	N	%
East Riding Leisure Bridlington	2	12.5%
Missing 0	14	87.5%
Total	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Driffield

	N	%
East Riding Leisure Driffield	1	6.3%
Missing 0	15	93.8%
Total	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Francis Scaife

	N	%
East Riding Leisure Francis Scaife	1	6.3%
Missing 0	15	93.8%
Total	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Goole

	N	%
East Riding Leisure Goole	1	6.3%
Missing 0	15	93.8%
Total	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Haltemprice

	N	%
East Riding Leisure Haltemprice	1	6.3%
Missing 0	15	93.8%
Total	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Hornsea

		N	%
East Riding Leisure Hornsea		1	6.3%
Missing	0	15	93.8%
Total		16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Withernsea

		N	%
East Riding Leisure Withernsea		2	12.5%
Missing	0	14	87.5%
Total		16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Cave

		N	%
Missing	0	16	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Holderness

		N	%
East Riding Leisure South Holderness		1	6.3%
Missing	0	15	93.8%
Total		16	100.0%

What is your role? - Business Technician

		N	%
Business Technician		4	25.0%
Missing	0	12	75.0%
Total		16	100.0%

What is your role? - Fitness co-ordinator

		N	%
Fitness co-ordinator		9	56.3%
Missing	0	7	43.8%
Total		16	100.0%

What is your role? - Other

		N	%
Other		3	18.8%
Missing	0	13	81.3%
Total		16	100.0%

If you selected Other, please specify:

	N	%
	13	81.3%
Admin	1	6.3%
Services officer (covering Fitness-co-ordinator)	1	6.3%
Tone Zone Admin Assistant	1	6.3%

How many years have you worked in your current role?

	N	%
0	1	6.3%
1	1	6.3%
2	1	6.3%
3	2	12.5%
4	3	18.8%
5	2	12.5%
6	1	6.3%
7	1	6.3%
10	1	6.3%
12	1	6.3%
20	1	6.3%
34	1	6.3%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Live Well

	N	%
Live Well	14	87.5%
Missing 0	2	12.5%
Total	16	100.0%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Young Live Well

	N	%
Young Live Well	14	87.5%
Missing 0	2	12.5%
Total	16	100.0%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Exercise Referral Scheme

	N	%
Exercise Referral Scheme	13	81.3%
Missing 0	3	18.8%
Total	16	100.0%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Health Optimisation Programme

	N	%
Health Optimisation Programme	14	87.5%
Missing 0	2	12.5%
Total	16	100.0%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - H.E.A.R.T (Cardiac Rehabilitation)

	N	%
H.E.A.R.T (Cardiac Rehabilitation)	9	56.3%
Missing 0	7	43.8%
Total	16	100.0%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Walking for Health

	N	%
Walking for Health	5	31.3%
Missing 0	11	68.8%
Total	16	100.0%

Which healthy lifestyle programme referrals are you involved in processing? Select all that apply - Swim for Health

	N	%
Swim for Health	3	18.8%
Missing 0	13	81.3%
Total	16	100.0%

Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Business Technicians

	N	%
Business Technicians	7	43.8%
Missing 0	9	56.3%
Total	16	100.0%

Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Fitness Coordinators

	N	%
Fitness Coordinators	9	56.3%
Missing 0	7	43.8%
Total	16	100.0%

Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Other

	N	%
Other	5	31.3%
Missing 0	11	68.8%
Total	16	100.0%

If you selected Other, please specify:

	N	%
	11	68.8%
Administrator	2	12.5%
Fitness Professionals	2	12.5%
Health and Well Being Coordinator	1	6.3%

How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Electronically via email

	N	%
Electronically via email	11	68.8%
Missing 0	5	31.3%
Total	16	100.0%

How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Electronically via fax

	N	%
Electronically via fax	3	18.8%
Missing 0	13	81.3%
Total	16	100.0%

How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Electronically via the East Riding referral system (BEARS)

	N	%
Electronically via the East Riding referral system (BEARS)	14	87.5%
Missing 0	2	12.5%
Total	16	100.0%

How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Paper-based referral forms

	N	%
Paper-based referral forms	13	81.3%
Missing 0	3	18.8%
Total	16	100.0%

How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Telephone-based referrals

	N	%
Telephone-based referrals	1	6.3%
Missing 0	15	93.8%
Total	16	100.0%

How do you recieve healthy lifestyle referrals from primary care sites? Tick all that apply - Other

		N	%
Missing	0	16	100.0%

If you selected Other, please specify:

	N	%
	16	100.0%

Which referrals are easiest to process? - Electronically via email

	N	%
Electronically via email	7	43.8%
Missing 0	9	56.3%
Total	16	100.0%

Which referrals are easiest to process? - Electronically via fax

	N	%
Electronically via fax	1	6.3%
Missing 0	15	93.8%
Total	16	100.0%

Which referrals are easiest to process? - Electronically via East Riding referral system (BEARS)

	N	%
Electronically via East Riding referral system (BEARS)	10	62.5%
Missing 0	6	37.5%
Total	16	100.0%

Which referrals are easiest to process? - Paper-based referral forms

		N	%
Paper-based referral forms		2	12.5%
Missing	0	14	87.5%
Total		16	100.0%

Which referrals are easiest to process? - Telephone referrals

		N	%
Missing	0	16	100.0%

Which referrals are easiest to process? - other

		N	%
other		1	6.3%
Missing	0	15	93.8%
Total		16	100.0%

If you selected Other, please specify:

	N	%
	16	100.0%

Are all healthy lifestyle referrals (e.g. Live Well referrals and Exercise Referral Scheme referrals) processed the same way?

	N	%
Yes	7	43.8%
No	9	56.3%

How often do referral forms from primary care sites include all the required referral information?

	N	%
Always	2	12.5%
Very often	8	50.0%
Sometimes	6	37.5%

Are you able to get hold of primary care sites sending healthy lifestyle referrals easily?

	N	%
Always	1	6.3%
Very often	9	56.3%
Sometimes	4	25.0%
Rarely	1	6.3%
Never	1	6.3%

Are you able to easily gain access to missing referral information from primary care sites sending healthy lifestyle referrals?

	N	%
Always	1	6.3%
Very often	7	43.8%
Sometimes	7	43.8%
Rarely	1	6.3%

During your initial telephone conversation with referred customers, how well informed are they about the programme they are being referred onto?

	N	%
Always	2	12.5%
Sometimes	12	75.0%
Rarely	1	6.3%
Never	1	6.3%

How important do you feel it is to provide referred customer feedback to primary care sites (e.g. general practice sites)?

	N	%
Very important	9	56.3%
Important	7	43.8%

Do you provide feedback to primary care sites?

	N	%
Yes	9	56.3%
No	7	43.8%

Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of referral?

	N	%
Yes	11	68.8%
No	5	31.3%

10.2. Fitness Professionals

Frequencies

Statistics

		What is your gender?	What is your age in years?	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Beverley	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Bridlington	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Driffield
N	Valid	32	32	32	32	32
	Missing	0	0	0	0	0

Statistics

		Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Francis Scaife	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Goole	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Haltemprice	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Hornsea	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Withernsea
N	Valid	32	32	32	32	32
	Missing	0	0	0	0	0

Statistics

		Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Cave	Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Holderness	How many years have you worked as a Fitness Professional?	Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Live Well	Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Young Live Well
N	Valid	32	32	31	32	32
	Missing	0	0	1	0	0

Statistics

		Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Exercise Referral Scheme	Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Health Optimisation Programme	Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - H.E.A.R.T (Cardiac Rehabilitation)	Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Walking for health	Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Swim for health
N	Valid	32	32	32	32	32
	Missing	0	0	0	0	0

Statistics

		Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Business Technicians	Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Fitness Coordinators	Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Other	If you selected Other, please specify:	How often are you able to contact a referred customer via telephone prior to their first face-to-face appointment?
N	Valid	31	31	31	32	31
	Missing	1	1	1	0	1

Statistics

		Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's name	Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's age	Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's current health status	Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's previous medical history	Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's body mass index (BMI)
N	Valid	31	31	31	31	31
	Missing	1	1	1	1	1

Statistics

		Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's current prescription/medication list	Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Other	If you selected Other, please specify:	Do you feel you are provided with enough information prior to meeting face-to-face with a referred customer?	When meeting your referred customers for the first time, are they typically well informed about the programme they have been referred onto?
N	Valid	31	31	32	32	31
	Missing	1	1	0	0	1

Statistics

		How important do you feel it is to provide referred customer feedback to primary care sites (e.g. general practice sites)?	Do you provide feedback to primary care sites?	Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of referral?
N	Valid	31	31	31
	Missing	1	1	1

Frequency Table

What is your gender?

	N	%
Male	20	62.5%
Female	12	37.5%

What is your age in years?

	N	%
23	1	3.1%
24	1	3.1%
25	2	6.3%
26	1	3.1%
27	1	3.1%
28	2	6.3%
29	1	3.1%
30	1	3.1%
31	3	9.4%
36	1	3.1%
37	1	3.1%
38	1	3.1%
39	1	3.1%
40	2	6.3%
41	1	3.1%
42	1	3.1%
43	2	6.3%
45	1	3.1%
49	1	3.1%
50	1	3.1%
51	1	3.1%
53	1	3.1%
54	1	3.1%
57	1	3.1%
59	1	3.1%
61	1	3.1%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Beverley

	N	%
0	28	87.5%
East Riding Leisure Beverley	4	12.5%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Bridlington

	N	%
0	29	90.6%
East Riding Leisure Bridlington	3	9.4%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Driffield

	N	%
0	26	81.3%
East Riding Leisure Driffield	6	18.8%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Francis Scaife

	N	%
0	28	87.5%
East Riding Leisure Francis Scaife	4	12.5%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Goole

	N	%
0	27	84.4%
East Riding Leisure Goole	5	15.6%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Haltemprice

	N	%
0	27	84.4%
East Riding Leisure Haltemprice	5	15.6%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Hornsea

	N	%
0	31	96.9%
East Riding Leisure Hornsea	1	3.1%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure Withernsea

	N	%
0	26	81.3%
East Riding Leisure Withernsea	6	18.8%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Cave

	N	%
0	32	100.0%

Which East Riding Leisure site do you work in? (select all that apply) - East Riding Leisure South Holderness

	N	%
0	31	96.9%
East Riding Leisure South Holderness	1	3.1%

How many years have you worked as a Fitness Professional?

	N	%
2	3	9.4%
3	3	9.4%
4	1	3.1%
5	1	3.1%
6	4	12.5%
7	1	3.1%
8	3	9.4%
10	3	9.4%
11	1	3.1%
12	1	3.1%
15	3	9.4%
16	1	3.1%
17	1	3.1%
20	2	6.3%
25	1	3.1%
26	1	3.1%
34	1	3.1%
Missing -9999	1	3.1%
Total	32	100.0%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Live Well

	N	%
0	2	6.3%
Live Well	30	93.8%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Young Live Well

	N	%
0	6	18.8%
Young Live Well	26	81.3%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Exercise Referral Scheme

	N	%
0	2	6.3%
Exercise Referral Scheme	30	93.8%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Health Optimisation Programme

	N	%
0	6	18.8%
Health Optimisation Programme	26	81.3%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - H.E.A.R.T (Cardiac Rehabilitation)

	N	%
0	22	68.8%
H.E.A.R.T (Cardiac Rehabilitation)	10	31.3%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Walking for health

	N	%
0	26	81.3%
Walking for health	6	18.8%

Which healthy lifestyle programme(s) are you involved in delivering? (select all that apply) - Swim for health

	N	%
0	30	93.8%
Swim for health	2	6.3%

Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Business Technicians

	N	%
0	22	68.8%
Business Technicians	9	28.1%
Missing -9999	1	3.1%
Total	32	100.0%

Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Fitness Coordinators

	N	%
0	4	12.5%
Fitness Coordinators	27	84.4%
Missing -9999	1	3.1%
Total	32	100.0%

Within your leisure site, who is responsible for processing healthy lifestyle referrals sent from primary care sites (e.g. general practice sites)? - Other

	N	%
0	29	90.6%
Other	2	6.3%
Missing -9999	1	3.1%
Total	32	100.0%

If you selected Other, please specify:

	N	%
	30	93.8%
Electronic ones come straight to instructors	1	3.1%
Leisure Admin	1	3.1%

How often are you able to contact a referred customer via telephone prior to their first face-to-face appointment?

	N	%
Always	5	15.6%
Very often	10	31.3%
Sometimes	8	25.0%
Rarely	4	12.5%
Never	4	12.5%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's name

	N	%
Customer's name	31	96.9%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's age

	N	%
0	1	3.1%
Customer's age	30	93.8%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's current health status

	N	%
0	4	12.5%
Customer's current health status	27	84.4%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's previous medical history

	N	%
0	15	46.9%
Customer's previous medical history	16	50.0%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's body mass index (BMI)

	N	%
0	14	43.8%
Customer's body mass index (BMI)	17	53.1%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Customer's current prescription/medication list

	N	%
0	15	46.9%
Customer's current prescription/medication list	16	50.0%
Missing -9999	1	3.1%
Total	32	100.0%

Before your first face-to-face appointment with a referred customer, what information do you receive? Tick all that apply - Other

	N	%
0	25	78.1%
Other	6	18.8%
Missing -9999	1	3.1%
Total	32	100.0%

If you selected Other, please specify:

	N	%
	26	81.3%
-9999	4	12.5%
Blood Pressure	1	3.1%
medical history, BMI, Medication can be missed off the referral forms at times.	1	3.1%

Do you feel you are provided with enough information prior to meeting face-to-face with a referred customer?

	N	%
-9999	2	6.3%
Always	2	6.3%
Very often	9	28.1%
sometimes	15	46.9%
rarely	4	12.5%

When meeting your referred customers for the first time, are they typically well informed about the programme they have been referred onto?

	N	%
Very often	6	18.8%
Sometimes	13	40.6%
Rarely	12	37.5%
Missing -9999	1	3.1%
Total	32	100.0%

How important do you feel it is to provide referred customer feedback to primary care sites (e.g. general practice sites)?

	N	%
Very important	17	53.1%
Important	12	37.5%
Moderately important	2	6.3%
Missing -9999	1	3.1%
Total	32	100.0%

Do you provide feedback to primary care sites?

	N	%
Yes	16	50.0%
No	15	46.9%
Missing -9999	1	3.1%
Total	32	100.0%

Would you be willing to take part in a short telephone or face-to-face interview to further discuss your experiences of referral?

	N	%
Yes	22	68.8%
No	9	28.1%
Missing -9999	1	3.1%
Total	32	100.0%

Descriptives

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
What is your age in years?	32	23	61	38.63	11.198
How many years have you worked as a Fitness Professional?	31	2	34	10.81	7.931
Valid N (listwise)	31				

10.3 Customers

Frequencies

Statistics

		What is your gender?	What is your age in years?	AGE_RANGE	What is your postcode?	IMD_SCORE
N	Valid	20	20	20	20	20
	Missing	0	0	0	0	0

Statistics

		QUINTILE	Which healthy lifestyle programme have you attended? (select all that apply) - Live Well	Which healthy lifestyle programme have you attended? (select all that apply) - Young Live Well	Which healthy lifestyle programme have you attended? (select all that apply) - Exercise Referral Scheme	Which healthy lifestyle programme have you attended? (select all that apply) - Health Optimisation Programme
N	Valid	20	20	20	20	20
	Missing	0	0	0	0	0

Statistics

		Which healthy lifestyle programme have you attended? (select all that apply) - H.E.A.R.T (Cardiac Rehabilitation)	Which healthy lifestyle programme have you attended? (select all that apply) - Walking for Health	Which healthy lifestyle programme have you attended? (select all that apply) - Swim for Health	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Beverley	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Bridlington
N	Valid	20	20	20	20	20
	Missing	0	0	0	0	0

Statistics

		At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Driffield	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Francis Scaife	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Goole	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Haltemprice	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Hornsea
N	Valid	20	20	20	20	20
	Missing	0	0	0	0	0

Statistics

		At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Withernsea	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure South Cave	At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure South Holderness	Which primary care site (e.g. GP surgery) were you referred from? Please include the name and location of this site (e.g. Beverley)	Which professional referred you onto your healthy lifestyle programme? - General practitioner (GP)
N	Valid	20	20	20	20	20
	Missing	0	0	0	0	0

Statistics

		Which professional referred you onto your healthy lifestyle programme? - Nurse (e.g. Practice Nurse, Nurse Practitioner, Specialist Nurse)	Which professional referred you onto your healthy lifestyle programme? - Community Link Worker	Which professional referred you onto your healthy lifestyle programme? - Care Navigator	Which professional referred you onto your healthy lifestyle programme? - Physiotherapist	Which professional referred you onto your healthy lifestyle programme? - Consultant
N	Valid	20	20	20	20	20
	Missing	0	0	0	0	0

Statistics

		Which professional referred you onto your healthy lifestyle programme? - Not sure	Which professional referred you onto your healthy lifestyle programme? - Other	At the time of referral, did you know anything about your programme (e. g. Exercise Referral Scheme)?	At the time of referral, how ready were you to change your lifestyle?	At the time of referral, were you provided with any information resources on your programme (e. g. leaflets)?
N	Valid	20	20	20	20	19
	Missing	0	0	0	0	1

Statistics

		Now you have completed your programme, do you feel that the original description of your programme was accurate?	Have you been to visit your primary care site (e.g. GP surgery) since your referral onto your programme?	Has your progress on your programme been discussed with you at your primary care site (e.g. GP surgery)?	How important do you feel it is to discuss your progress on your programme at your primary care site (e.g. GP surgery)?
N	Valid	20	20	15	20
	Missing	0	0	5	0

Frequency Table

What is your gender?

	N	%
Male	9	45.0%
Female	11	55.0%

What is your age in years?

	N	%
31	1	5.0%
54	1	5.0%
56	1	5.0%
58	1	5.0%
59	1	5.0%
61	1	5.0%
62	2	10.0%
66	2	10.0%
67	1	5.0%
69	3	15.0%
70	1	5.0%
71	2	10.0%
74	1	5.0%
78	2	10.0%

AGE_RANGE

	N	%
25-34	1	5.0%
45-54	1	5.0%
55-64	6	30.0%
65-74	10	50.0%
75 or older	2	10.0%

What is your postcode?

	N	%
DN14 6JU	1	5.0%
DN14 6JZ	1	5.0%
HU12 0SF	1	5.0%
HU12 8DF	1	5.0%
HU12 8FJ	1	5.0%
HU12 8UW	1	5.0%
HU16 5LL	1	5.0%
HU17 7NH	1	5.0%
HU17 8YG	1	5.0%
HU17 9RG	1	5.0%
HU19 2DY	1	5.0%
HU19 2LE	1	5.0%
HU4 7BZ	1	5.0%
YO15 2BW	1	5.0%
YO16 4NG	1	5.0%
YO16 6EV	1	5.0%
YO16 6TQ	1	5.0%
YO25 4BA	1	5.0%
YO25 5YW	1	5.0%
YO43 3QW	1	5.0%

IMD_SCORE

	N	%
1.60	1	5.0%
5.50	1	5.0%
5.67	1	5.0%
7.22	1	5.0%
8.57	1	5.0%
9.10	1	5.0%
9.48	1	5.0%
9.98	1	5.0%
10.54	1	5.0%
13.14	1	5.0%
14.18	1	5.0%
15.60	1	5.0%
20.48	1	5.0%
22.58	1	5.0%
27.29	1	5.0%
30.09	1	5.0%
36.81	1	5.0%
47.88	1	5.0%
47.90	2	10.0%

QUINTILE

	N	%
1st	4	20.0%
2nd	6	30.0%
3rd	3	15.0%
4th	3	15.0%
5th	4	20.0%

Which healthy lifestyle programme have you attended? (select all that apply) - Live Well

	N	%
0	14	70.0%
Live Well	6	30.0%

Which healthy lifestyle programme have you attended? (select all that apply) - Young Live Well

	N	%
0	20	100.0%

Which healthy lifestyle programme have you attended? (select all that apply) - Exercise Referral Scheme

	N	%
0	8	40.0%
Exercise Referral Scheme	12	60.0%

Which healthy lifestyle programme have you attended? (select all that apply) - Health Optimisation Programme

	N	%
0	20	100.0%

Which healthy lifestyle programme have you attended? (select all that apply) - H. E.A.R.T (Cardiac Rehabilitation)

	N	%
0	17	85.0%
H.E.A.R.T (Cardiac Rehabilitation)	3	15.0%

Which healthy lifestyle programme have you attended? (select all that apply) - Walking for Health

	N	%
0	20	100.0%

Which healthy lifestyle programme have you attended? (select all that apply) - Swim for Health

	N	%
0	20	100.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Beverley

	N	%
0	17	85.0%
East Riding Leisure Beverley	3	15.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Bridlington

	N	%
0	16	80.0%
East Riding Leisure Bridlington	4	20.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Driffield

	N	%
0	18	90.0%
East Riding Leisure Driffield	2	10.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Francis Scaife

	N	%
0	19	95.0%
East Riding Leisure Francis Scaife	1	5.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Goole

	N	%
0	18	90.0%
East Riding Leisure Goole	2	10.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Haltemprice

	N	%
0	18	90.0%
East Riding Leisure Haltemprice	2	10.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Hornsea

	N	%
0	20	100.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure Withernsea

	N	%
0	15	75.0%
East Riding Leisure Withernsea	5	25.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure South Cave

	N	%
0	20	100.0%

At which East Riding Leisure centre did you attend your healthy lifestyle programme(s)? - East Riding Leisure South Holderness

	N	%
0	19	95.0%
East Riding Leisure South Holderness	1	5.0%

Which primary care site (e.g. GP surgery) were you referred from? Please include the name and location of this site (e.g. Beverley)

	N	%
Castle hill	1	5.0%
Castle hill hospital doctors referred park surgery driffield	1	5.0%
Church veiw hedon	2	10.0%
Cottingham medical centre	1	5.0%
Fifth avenue mont practice	1	5.0%
GP Surgery	1	5.0%
GP surgery Manor House Bridlington	1	5.0%
Heron group practice	1	5.0%
Manor road heath centre Beverley	1	5.0%
Manor Road Surgery Beverley	1	5.0%
Park surgery driff	1	5.0%
Patrington	1	5.0%
Peeler house surgery	1	5.0%
Practice two station avenue Bridlington	1	5.0%
Scunthorpe hospital	1	5.0%
South holderness medical practices	1	5.0%
St Nicolas withersea	1	5.0%
Station road surgery	1	5.0%
The Old fire Station Beverley	1	5.0%

Which professional referred you onto your healthy lifestyle programme? - General practitioner (GP)

	N	%
0	5	25.0%
General practitioner (GP)	15	75.0%

Which professional referred you onto your healthy lifestyle programme? - Nurse (e.g. Practice Nurse, Nurse Practitioner, Specialist Nurse)

	N	%
0	17	85.0%
Nurse (e.g. Practice Nurse, Nurse Practitioner, Specialist Nurse)	3	15.0%

Which professional referred you onto your healthy lifestyle programme? - Community Link Worker

	N	%
0	20	100.0%

Which professional referred you onto your healthy lifestyle programme? - Care Navigator

	N	%
0	20	100.0%

Which professional referred you onto your healthy lifestyle programme? - Physiotherapist

	N	%
0	19	95.0%
Physiotherapist	1	5.0%

Which professional referred you onto your healthy lifestyle programme? - Consultant

	N	%
0	20	100.0%

Which professional referred you onto your healthy lifestyle programme? - Not sure

	N	%
0	19	95.0%
Not sure	1	5.0%

Which professional referred you onto your healthy lifestyle programme? - Other

	N	%
0	20	100.0%

At the time of referral, did you know anything about your programme (e.g. Exercise Referral Scheme)?

	N	%
Yes	3	15.0%
No	17	85.0%

At the time of referral, how ready were you to change your lifestyle?

	N	%
Not ready to change	1	5.0%
Thinking of change	1	5.0%
Not sure/uncertain	2	10.0%
Somewhat ready	2	10.0%
Very ready to change	14	70.0%

At the time of referral, were you provided with any information resources on your programme (e. g. leaflets)?

		N	%
yes		8	40.0%
no		11	55.0%
Missing	-9999	1	5.0%
Total		20	100.0%

Now you have completed your programme, do you feel that the original description of your programme was accurate?

	N	%
Extremely	4	20.0%
Very	3	15.0%
Moderately	7	35.0%
Not at all	6	30.0%

Have you been to visit your primary care site (e.g. GP surgery) since your referral onto your programme?

	N	%
Yes	15	75.0%
No	5	25.0%

Has your progress on your programme been discussed with you at your primary care site (e.g. GP surgery)?

		N	%
Yes		6	30.0%
No		9	45.0%
Missing	System	5	25.0%
Total		20	100.0%

How important do you feel it is to discuss your progress on your programme at your primary care site (e.g. GP surgery)?

	N	%
Very important	10	50.0%
Important	4	20.0%
Moderately important	2	10.0%
Slightly important	1	5.0%
Not important	3	15.0%

Appendix 11: Online Survey Transcripts for Open-ended Questions used for Thematic Analysis

11.1. Referral Scheme Administrators

Question 10b: Please explain why you feel this way.(in relation to Q10: Which means of receiving referrals are easier to process?)	
Response	**Participant Code**
Difficult to sometimes read paper based referrals. Also telephone numbers often missed off.	A1
The process is very logical and a lot of the lengthier procedures are automated	A2
All information is readily available for us to make the first contact	BT1
Can locate where referral came from/contact info	BT2
We do not have access to bv3 so we can't see the referrals through bears. So we can't see phone numbers of the name of the	BT3

instructor to send the information to and are not able to tell the customer who their appointment is with	
Currently do not have bears 3, so issues looking at bookings to see referral and identify who booking is made with	BT4
secure online, full details, no need to print makes GDPR easier to manage	FC1
At the moment we only have the paper based option but I would prefer electronically if it was available at this centre	FC2
The information is already set up on the computer systems and the cleint has already been made aware of their appojntment time and details of the scheme they are on.	FC3
The system has been in place for years and gives us all relevant medical info.	FC4
Saves time with me not having to make phone calls	FC5
Paper referrals took time and not all info required entered	FC6
Integration with IT and with them are the attached documentation	FC7
Quicker, paper referral can have issues contacting clients	FC8
Safer with Data protection	FC9

Question 11a: If no, please explain how different healthy lifestyle referrals are processed (in relation to Q11: Are all healthy lifestyle referrals (e.g. Live Well referrals and Exercise Referral Scheme referrals) processed the same way?)	
Response	**Participant Code**
Questionnaires for GP Referral are done online using Pharm Outcomes. Live Well still paper based.	A1
HOP referrals are entered onto Pharmoutcomes. Livewell is not	BT1

I only process Live Well & HOP	BT2
HOP is on phsrmoutcomes and the others are not. It is much easier on pharmcomes as we do not have to store paper files	BT3
Only do live well' young live well and hop	BT4
while the process for booking is onto Bears, the way in which electronic and paper slightly vary, also as part of the process there are different forms (paper(ADLW,JLW) and Pharms for the others	FC1
Exercise Referral and HOP are processed via the Pharmoutomes website. Live Well is processed via paper and CRM. There are many similarities such as notes to be added to CRM and also the tracking of clients that Business techs do. The length of each scheme is different and there are different qualifying criterial for each scheme.	FC3
Different staff require certain appointments, based on qualifications etc.	FC4
YLW and LW are paper referrals GP are mainly electronic and GP are done on pharmoutcomes	FC5

Question 15: What are the common challenges you face when processing a healthy lifestyle referral?	
Response	**Participant Code**
Patient not given enough information about scheme.	A1
The client telephone number does not appear within the printable referral notes	A2
Referrals for clients that are not eligible for the scheme, clients being unaware what they have been referred for	BT1

Incorrect contact numbers No GP details	BT2
Patient not being eligible and patient unaware of appointment	BT3
Incomplete information patient not always aware appt has been made by surgery. NHS number is rarely noted on referral. Patients offered 2nd referral for schemes (hop) which is in line with the policy	BT4
have the surgery provided the patient with a letter confirmation when booked online through Bears? paper ones need inputting onto CRM database, before we can book onto bears, this means a card must be issued, if a patient then decline the service or it becomes apparent they are an inappropriate referral at the first appointment we have wasted a resource, and Have Data protected information on someone who is not attending or wants the service (thinking GDPR)	FC1
Clients are often unaware of what to expect, do not understand what the scheme entails. Information can be incorrect on referral form.	FC2
Sometimes the lack of information the client has regarding the schemes they have been referred to. A lot do not know that the have to pay for Exercise Referral which can be difficult and cause them to not commit to the scheme	FC3
Referral being made to the correct schemes.	FC4
Lack of phone numbers Missing medical information Doctors just book people in and don't tell them about their appointments	FC5
Lack of knowledge of the referral the client has been entered onto	FC6
Customer Contact and Suitable Instructors	FC7

Cklients not given much information by GP's (cost, duration, expectations ETC).	FC8
No contact number for referrals	FC9

Question 16: During your initial telephone conversation with referred customers, what information do you typically provide?	
Response	**Participant Code**
Confirm appointment time. Give customer details of scheme requirements, cost, centre information etc.	A1
When and where to come, the nature of the initial consultation, reassurance about the personalised nature of the scheme, duration, required attendance, cost, what to wear	A2
Information about the scheme and why they have been referred. Appointment details and what to expect at the initial appointment. Buddy agreement explained and any questions answered	BT1
Info re referral process Commitment required Appointment date & time Appropriate clothing	BT2
Information about the scheme, the date and time of their appointment	BT3
Info about the scheme, appt day and time, location	BT4
That we have received the referral, who we are what the scheme is and criteria for free places.	FC1
Time and place to come for the appointment, what will happen at the appointment and what they need to bring with them.	FC2

Details of when the y have been booked in for their first appointment. What they should expect to happen during thier first appointment. Also some information on the scheme they have been referred onto and what it entails.	FC3
appointment time/date instructor What to bring Cost (if applicable) format of the scheme (how many weeks, how many sessions) How often you'll be expected to attend.	FC4
How long the scheme is, cost, what is expected of them	FC5
intro, Appointment time, Price, Availibility	FC6
Payment, Car Parking, Attire, Process of 1st Appointment, Instruction for Arrival	FC7
Booking confirmation, cost , location & requirements for first appointment.	FC8
Information about the scheme and cost if any for the scheme.	FC9
done by central	FC10

Question 18: During your initial telephone conversation with referred customers, what are the common concerns they raise?	
Response	**Participant Code**
They are too old for the gym, they are unfit, they are worried about seeming incapable	A2
Why have they been referred, anxiety about using a gym for the first time,	BT1

Whether they can use the gym equipment & if programme is suitable for them	BT2
Not aware of what they have been referred for or why. Sometimes they do not know they have been referred	BT3
Not aware what they are been referred for	BT4
Can I do it with my condition, When do I have to attend, Who will look after me	FC1
They are often worried that it will be more than they can manage, they have never been in a gym environment and are nervous or self conscious. Feel unfit and think they will be surrounded by fit, slim people.	FC2
Having to pay for exercise referral. Not been told much about why they have been referred. A little nervous about comin into a gym environment.	FC3
Not aware of price Live in Hull not ERYC	FC4
Cost, don't know about it	FC5
Price Able to do what is required	FC6
Payment and Commitment	FC7
Cost, flexibility of bookings & non physical type.	FC8
Are the able to take part in the scheme and is the centre full of skinny people.	FC9

Question 20a: What information do you feedback to primary care sites?	
Response	**Participant Code**
Customer results	A1

It very rarely happens, but there are occasions where the primary care site has referred without the consent or knowledge of the client and I feel it is important to relay this	A2
If the referral is inappropriate we advise the GP why	BT1
Pharms is available to GP's to view results, we have written letters on individual cases and spoken directly or via telephone on occasions	FC1
Weight, BMI, Body Fat, well being and general feelings	FC2
Letters are sent to non PharmOutcome schemes Pharmoutcome provided reports to others.	FC4
Pharmoutcomes, all client statistics and questionnaires	FC5
Results, Progress and Commitment	FC7
Pharmsoutcomes now but we used to send a letter to GP when completed or if didn't complete or start.	FC8

Question 21: In your opinion, how could the referral process be improved?	
Response	**Participant Code**
Include the phone number in the printable notes.	A2
Patients to be informed by the referring person what programme they are being referred on to and why	BT1
More info on paperwork	BT2
Patients being given more information and drs making sure the patient meets the criteria as often they can be disappointed if we tell them they are not eligible.Having access to bv3 and if all schemes were processed the same way on pharmoutcomes	BT3

We need access to bear 3. Patients need to be more informed about schemes . Schemes need to be procecessed in the same way. Ensure patients meet the criteria of the scheme.	BT4
An auto mated text to inform the patient the surgery has booked them onto our Bears system. All electronic and no paper referrals. Bears to link with crm database to transfer personal details	FC1
I think it needs to be advertised more as many people never get to find out about the schemes that could potentially save their life. I think there could be a longer term scheme for people on a low income who will benefit from regular exercise but can't afford a membership, often they have done really well throughout the 10 weeks or 20 weeks if they have had a second referral but are unable to continue once the referral ends and slip back into old habits without support and motivation.	FC2
All svhemes should now be processed in the same way. No more paper referrals. All referrals to be adminstered by business techs for first appoointment arrangement. Pharmoutcoes could be a little less complex and user friendly for instructors who are not necessarily computer literate, Instructors can soemtimes find the amount of options quite confusing	FC3
A single referral form that we decide which scheme is best suited.	FC4
Doctors being more informed so clients can be more informed, smoother processes	FC5
Having a tick list for eligibility of each referral option which the GP go's through with the client so fully imformed and what is expected.	FC6
More detail on Referral, All surgeries to be online	FC7

More information for clients at GP surgery.	FC8
The process could be improved if all sites referral understand the schemes they are referring clients onto.	FC9
We have made recent changes which may improve what we have been doing, time will tell	FC10

11.2. Fitness Professionals

Question 11: What additional information would be useful to receive prior to your first face-to-face appointment with a referred customer?	
Response	**Participant Code**
We do not always receive full health condition, lists of meds, any investigations due or if on waiting lists	FP1
A complete list of medication,medical history in the past 3 years	FP2
A standard form/format for all clients, clear & defined 1 week prior to first appointment	FP3
list od medication	FP4
Up to date and appropriate health status details, also full medication lists	FP5
Previous medical history	FP8
Mental health	FP9
1)All medications 2)Previous, full health condition history	FP10
Motivation to exercise How active client is	FP12
Past activity levels	FP14
Other previous ailments All medications	FP16
Fitness levels Requiered assistance	FP17
Why referred, objectives.	FP19
Other relevant information and previous medical history	FP20
Detailed medical history	FP21
All relevant medical conditions	FP22
Previous medical history Medication List Exercise/Physical Activity Experience If they need a Gym Induction	FP23
Prior medical relevant history. Operations Detail re specificity of problem/condition (e.g instead of joint problem, more relevant information would include site of injury/operation such as knee, hip, spinal area etc) Any unusual circumstances (personal/physical)	FP25
Relevant medical history, current activity levels, medication information	FP27
how active they have been recently and current fitness levels	FP28
none	FP29
Medication list, prior medical history if relevanty to current refferal.	FP32

Question 13: What information would you like referred customer to be provided with prior to their first leisure appointment?	
Response	**Participant Code**
Bring list of Meds List of any appointments for procedures or investigations, sometimes people do not know what is wrong with them or why the have an hospital appointment. Any benefit proof for free place criteria	FP1
They should be informed about the scheme including what is expected of them, 10 week programme, appointments with a qualified instructor twice each week, cost and what to expect.	FP2
that they be made aware of their commitment to a program	FP3
price, parking and what the scheme is about	FP4
Correct and full information depending upon the scheme they are coming on	FP5
The procedure of the program/scheme.	FP6
What is it, benefits, costing	FP7
All medical condition, medication. Commitment needed.	FP8
How the scheme works and expectations from the client	FP9
Information on the health programme	FP10
What the first session will involve	FP12
Criteria off the scheme they are referred for.	FP14
Sometimes not a lot of information given by the doctors or Health worker, all think it is free because they have been referred	FP15
That they won't be pushed harder than their ability - to expect to feel the effects of exercise	FP16
Medical conditions and info just in case it has been missed off	FP17
What to expect and how the scheme works	FP19
Details about the scheme. Cost if it applies.	FP20
Cost Expectations of them	FP21
What will be asked of them- weekly commitment to sessions etc	FP22
Duration, Content and Price of the course they are attending.	FP23
The cost of the scheme and more about what the scheme entails	FP24
Name of instructor, payment details, expectations (paper work on first sessions and a guided tour, second session to use the facilities and produce a programme etc), meeting expectations	FP25
exactly what the various schemes entail.	FP26
Cost, length of programme, format of session	FP27
Make sure they understand the there obligations and commitment to the course	FP28

Bullet point information like the cost if it applys, the type of scheme they are on so if a Gp referral they know its over 10 weeks etc.	FP29
Price	FP31
Information about the programme.	FP32

Question 14: When meeting your referred customers for the first time, what are the common concerns they raise?

Response	Participant Code
can I do it (what do I have to do) when do I have to attend Why do I have to attend especially (HOP)	FP1
They may not be fit enough or feel self conscious in front of other customers, some ladies don't like men in the gym.	FP2
That they can actually exercise. Prospective clients should be assessed for exercise capabilities before been reffered.	FP3
not been able to use the gym equipment	FP4
Using the machines in the gym and how hard we will work them. Going into the gym in the first instance.	FP5
Insecuritie/anxieties about the facility/using the gym.	FP6
Unsure as to what the scheme is and don't know about the cost	FP7
Worried about the programme, what is expected of them.	FP8
They will be expected to do things they are frightened by	FP9
1)Apprehensive, 2)Body image pressure, 3) Health condition restrictions to exercise	FP10
How much will this cost I don’t think I can commit for the 12 months	FP12
How much the scheme is, and how long it runs for.	FP13
Time Transport Price	FP14
if the will be able to complete the referral, with their conditions	FP15
That they don’t know if they will be able to exercise and still do daily activities	FP16
Unconfident	FP17
What to wear	FP18
Worried about exercising in a gym for 1st time, and realising they need to amend their diet.	FP19
Time Confidence related issues Money (cost)	FP20
Anxiety of gym environment Not being able to do what is asked of them	FP21

Never been in gyms before - no idea what to exspect	FP22
Those with non-exercise backgrounds can be very apprehensive	FP23
They often feel they may not be able enough to exercise.	FP24
Older generations worry that the gym or leisure centres are not for them. Time management, many people don't believe they can fit it in. People worry about what others think of them and how they look.	FP25
possible costs, and how the schemes work.	FP26
Anxiety re gym environment, expectations re intensity,	FP27
concerned about exercising changing there diet and lifestyle	FP28
Normally aprehensive as have not exercised in a long time in many cases. Sometimes their image, they expect the gym to be full of super fit people who will look down on them but soon realise it's nothing like that.	FP29
Medical conditions that haven't already been given. Then not being prepared for the customer.	FP30
Never exercised Nervous	FP31
Nervous about starting. Intimidated by other fitter members.	FP32

Question 15: When meeting your referred customers for the first time, what are the common challenges you face?

Response	**Participant Code**
I don't really have challenges once they actually turn up, (problems with getting them in, sometimes due to apathy, or multiple appointments at hospitals etc.. as far as gathering information is concerned I personally use a S.O.A.P plan to probe and gather. S - Subjective info O - Objective info A - Assessment info P - agreed plan of action (in principle)	FP1
The clients health issues especially if they are in a lot of pain and have limited movement but need to lose weight.	FP2
mental health problems, extremely low confidence, addiciction issues, unable to read/write	FP3
are they physically and mentally suitable to attend	FP4
Enabling some of them to engage fully with the programme to reach the health benefits attainable. Correcting them on information that he GP has given them	FP5
Understanding of the scheme they are partaking in.	FP6
Cost, time, excuses	FP7
Low confidence, not knowing what to expect	FP8

Convincing them there's a way forward with exercise and activity	FP9
1) They have complex conditions that you are not initially informed about.	FP10
Motivation to attend due to self confidence and esteem	FP12
Availability for appointments	FP13
Confidence levels Ability Changing lifestyles	FP14
Depends on the client, some are motivated	FP15
Can be nervous about exercises	FP16
Getting them to be honest about their limitations	FP17
Fear of the gym How hard are you going to work me	FP18
Change in diet and lifestyle.	FP19
Lifestyle and behavioural change	FP20
Unsure of what is expected of them Mental health and confidence issues	FP21
Ability to used some of the equipment but can usual work round this	FP22
Barriers to participation such as time boundaries. Some customers struggle to fit exercise in with there daily schedule.	FP23
With specific demographics in rural areas - literacy/special needs. Programming and understanding is often hindered. People have preconceptions as to how to affect their health through historic methods of weight loss (not fat loss) such as crash diets. This is where our challenge is to affect their understanding of body composition and safe and effective and modern methods to train and include the holistic approach (the combination of exercise, balanced diet, mental health, persistence, progression and time management, habit forming etc)	FP25
explaing how the schemes work and what is expected of the clients.	FP26
Confidence building, reluctance to change	FP27
coming to the gym if they are unfit and out of shape, there often quite nervous and feel self conscious and worried about exercising	FP28
The willingness to change, mostly in eating or drinking habits.	FP29
Mobility	FP31
Motivating the client in the long term.	FP32

Question 17a: If yes, what information do you provide when giving feedback to primary care sites? (in relation to Q17: Do you provide feedback back to primary care sites?)

Response	Participant Code
written and verbal feedback where possible. Pharms provided opportunity for GPs to see stats	FP1
We use pharmaoutcomes and notes on the CRM which are there for health professional to read.	FP4
Through the pharmoutcomes programme	FP5
results.	FP6
They received the electronic details automatically through Pharmoutcomes	FP7
Results.	FP8
Before and after health statistics e.g. weight, Bmi, Bp, Rhr, body fat%, hip and waist measurement,	FP9
Non starters, challenging clients incorrect data.	FP14
How they have got on and if the have improved their healthy lifestyle	FP15
Nothing	FP18
We do not deal directly with them but assume they get information when we complete pharmoutcomes on completion?	FP19
If a client has not completed on a scheme and the reasons why.	FP20
Through Pharmoutcomes	FP21
Health and Mental Wellbeing statistics via Pharmoutcomes	FP23
When the client has completed/not completed and their health check and well-being results	FP24
Head office provide feedback	FP31

Question 18: In your opinion, how could the referral process be improved?

Response	Participant Code
all electronic and more relevant info on referrals	FP1
I think the scheme should be longer for those on low income to provide a better opportunity for the person to continue their healthy lifestyle rather than revert back to the way they were before starting the scheme. Or there could be another scheme that is longer similar to the HOP scheme but not waiting for surgery.	FP2
by assessing clients for their physical and mental capabilities/suitability to programs before being referred	FP3
I believe our scheme needs more structure or standard guidelines for the exercise prescription from site to site the information/advice/coaching is fragmented. The client would benefit by some structured learning achievements so they reach a certain educational standard on how to eat healthy exercise enough so when they have completed the scheme they go away with the knowledge to be an independent exerciser and has some kind of access or pack that contains meal planning to linking all resources in the NHS etc the outcome would hopefully lead to a person changing and boost the ethos of an individual going down the path prevention rather than the cure!!	FP4
-There are too many schemes for the GP's/ health professionals to know which is the most appropriate for each patient. -Often we get patients booked in from the surgery who don't know they have an appointment. -Gp's are rushed off their feet as we all are, however, I think we are better placed to advise clients as to what the scheme entails to ensure correct information. -If the GP's gave the patient a standard referral form to bring up to the centre, we know that those who come up are wanting to make a change and can assign them to an appropriate scheme. If we are then sent a duplicate of these referrals, we can keep an audit of who has and hasn't engaged with us. We can then call those who haven't made contact to see if we can change their mind to attend	FP5
Ensuring all clients are aware of the scheme they have been referred on.	FP6
Doctors having better knowledge, knowing the schemes better.	FP7
Cooking classes, going off site and helping them in there lifestyle.	FP8
More info on reasons for referral e.g. medication, historical health.	FP9
More information on medication and conditions. Forms for us to feedback to primary care sites.	FP10
N/A	FP12
Scheme explanations to the clients of how things work.	FP13
Giving all clients the full details of the course they are referred for	FP14
Appointments booked while the patient is with the GP	FP16

Instructors to receive training on the Pharmoutcomes system to ensure each client is administered correctly.	FP19
More information to be provided to clients being referred.	FP20
Client medical history on BEARS Having access to clients medical history quickly and easily. Make sure clients meet criteria before being referred.	FP21
Improvements in what info I receive	FP22
Book all sessions (or majority of sessions) on Week 1 providing consistency for instructor and customer.	FP23
More information from the primary sites, i.e informing patients what the scheme involves and more advertisement.	FP24
More involvement and time allowed for instructors to be involved in the feedback and decision making process in developing and delivering programmes. More collaboration with physics, consultants, doctors etc in following through on surgeries, physiotherapist etc. Better and more appropriate equipment in the gyms to aid referral patients (especially when refurbishing tone zones/centres etc). A more coordinated process in tracking patients through the system. Also, when appointments are missed, a process to deal with these. More props in consultation rooms (skeletal mannekins with bones and musculature systems, dietary visual aids etc). I have many more ideas, however I have run out of time to type, therefore meetings to discuss these sorts of issues with instructors as in certain sites, as instructors we don't have meetings and in specific cases , the last meeting will have been four years ago! Being left out of the process isn't great for personal/career development/self actualisation or realisation.	FP25
clear explanation of the sheme to the client so they know what it entails and what is expexted of them.	FP26
Better communication and more information re clients before day one	FP27
Supply as much information for the client as possible	FP28
I think some kind of after care could be introduced as once people are on their own they don't seem to come in as often or simply stop.	FP29
More information on the initial referral form and to make it easier to extend and suspend a clients referral to a site if they have extenuating circumstances, so that they do not miss out on the programmes.	FP32

11.3. Customers

Question 9a: If yes, please can you explain what you knew about your programme at the time of referral (in relation to Q9: At the time of referral, did you know anything about your programme (e.g. Exercise referral scheme)?)	
Response	**Participant Code**
[Fitness Professional name] was telling us there is a live well programme and I asked my go to refer me	C4
I was informed of the programme through a group I am in as part of my retirement. I approached the GP and asked if I was eligible to be referred	C10
Told by hospital in London about scheme	C19

Question 10: At the time of referral, how did the professional who referred you describe your programme to you?	
Response	**Participant Code**
I don't think they did . If you go you will get a lot of benefits .	C1
It's a way of loosing weight and getting fitter.	C2
They told me nothing about live well.	C3
It wasn't by my gp	C4
All he said was did you go to a gym. A said no. He said we can put you on a free trial. I said yes.	C5
Not a lot of detail at all. Just told I could have a Ten free week trial to improve my fitness	C6
Leisure centre told me I could a referral. [Fitness Professional name] and [Fitness Professional name] sorted the referral for me	C7
No information before I turned up at the leisure centre	C8
Physio told me to visit the doctor who would refer me nothing more	C9
I was already aware as I reasearched it prior to approaching the GP	C10
She said it will be exercises centred around the knee and general mobility. I went on escape pain	C11
I don't think he knew much. I think he was aware of the conditions to qualify but not the impression. Not what we do here.	C12
She didn't really. She just said we will try and get you in cuz I weighted 31 stone plus I have a pacemaker	C13
The staff at the gym told me about the live well and advised me to go to the GP surgery and ask about the live well programme.	C14

She gave me a leaflet and said she would sort it. If she had told me more I wouldn't have done it.	C15
Escribed as a programme to become active and lose weight to be eligible for knee replacement	C16
They gave me booklets you've only just had the operation and they give you lots of booklets	C17
no	C18
Told me it would be good to keep moving and exercising	C19
It was leisure who told me at the sports centres who suggested I went and asked for a referral from my GP. My original GP said no because my BMI was not over 35. I came back to the sports centre and they said go back and see another doctor. The second doctor said no problem and referred me. The reason she gave me it was because of my knee replacement.	C20

Question 11: At the time of referral, how did you feel about what you had just been told by the professional who referred you?

Response	Participant Code
I would try anything to get better and the more I sat the worse I was getting. I didn't have any confidence in it but I do now. Person you see at the leisure is more important than the doctor.	C1
I felt happy to do it and give it a go. That was three years ago	C2
Shocked.	C3
I felt Brilliant.	C4
I was quite excited to come.	C5
It was something I wanted to try	C6
Na	C7
Wasn't told	C8
I already knew I should exercise	C9
Just felt pleased that I was being referred	C10
I was quite excited to try anything that would help rather than having surgery . I believe in alternative medicine and was eager to give it a go.	C11
I was nervous and apprehensive	C12
I wanted to lose some weight and I knew I was overweight. I could hardly move	C13
I felt comfortable with everything	C14
I didn't think I would be able to do it.	C15
Unsure if I would be able to do the exercises because of the pain levels	C16
I was happy to get on it . It took me ages to get on because I was waiting for ages for nurse new love to refer me. Then when I get on it that was it.	C17
happy to try anything.	C18
Ok	C19

I was disappointed the first time because I knew that I needed to get myself fit and didn't feel there was much support from the original GP. However the second GP was incredible motivative and understanding. She comes here too.	C20

Question 12a: Briefly explain why you chose this answer. (in relation to Q12: At the time of referral, how ready were you to change your lifestyle?)

Response	Participant Code
I was very much in need of changing. I didn't have much confidence in the schemes at first.	C1
I was happy to do it	C2
Weight problem.	C3
I lacked confidence in my movement as I've got new knees so I needed confidence in my movement.	C4
Because I like to be active and with the pain in my knee I couldn't so I was willing to give anything a try	C5
I'd lost a bit of weight and I wanted to improve my fitness	C6
It's case of having to. I've been through a lot no confidence I needed to do things for myself.	C7
Because I didn't realise how long I had been ill or breathless.	C8
I have always done exercise when from being a young boy	C9
It was because I was ready for the change that I approached the GP	C10
Because I knew it wasn't going to get any better on it's own. I was also diagnosed with type 2 diabetes so I hoped exercise would help that too	C11
I was aware of my son being right	C12
Cuz I wanted to do it. I couldn't move.	C13
I have been a big lady all my life so I knew I needed to do something but I feel right with it in myself.	C14
I did zero exercise due to disability caused by polio and being very over weight.	C15
Because I had been inactive for a long time	C16
I am nowhere as fit as I use to be before my heart attack	C17
to get better diabetes control and get fitter.	C18
All ways tried to exercise , up to falling ill with my back and legs.	C19
Because I have been given the opportunity of a one off procedure that if it works will change my life and the fact that this has been privately funded to st guys Thomas in London. This is me doing my part	C20

Question 13a: If yes, how useful were these information resources? (in relation to Q13: At the time of referral, were you provided with any information resources on your programme (e.g. leaflets)?)	
Response	**Participant Code**
It was pretty helpful. It was saying what they can do. It was very informative.	C5
Good from the leisure centres	C9
It was explained that now I had been referred what the procedure would be and that the leisure services would contact me to make an appointment	C10
I was given a leaflet. It wasn't very useful. We didn't know nothing until we got here and met the instructor.	C13
I read it and still thought I wouldn't be able to do it.	C15
Yes but a bit daunting at the same time as showed a picture a fit young man on a bike	C16
Very useful	C17
[name] the trainer here talked me through health and nutrition and wellbeing and emotional. At the time I was pretty depressed. He referred me to 5e emotional well-being unit in hull. I hadn't even left here and the emotional well-being had contacted me and booked me in. That's how switched on they are.	C20

Question 14: Now you have completed your programme, what would you have liked more information on at the time of your referral?	
Response	**Participant Code**
It's not really come to end. I still come to the heart classes and I still get looked after after my heart programme even though I pay. They look after me and I wouldn't of kept going if not. It's amazing. You get to 70 and you haven't been in that exercise it's a big change. I get to meet new people. We go for lunch 3 4 times a year. [FP's name] works way over her remit.	C1
The costs I didn't realise the costs.	C2
I just went.	C3
I wish I'd of known about the live well programme in the first place by my gp	C4
Not really from day one everything ran smoothly. Dietician told me all about it. My husband comes to the gym too so I knew how good it was	C5
Definitely more detail of the programme and more explanation. When you first come you put too much expectation on yourself.	C6
Nobleisure told me everything and the health trainer were brilliant . For our age group we are not young anymore so it was great that [Fitness Professional name] helped.	C7

I like direct contact for information	C8
Nothing more	C9
I may have been different to others because I actually researched the scheme so was fully aware of the programme so didn't need any further information	C10
I thought I would be in the gym but it was a room without exercise machines.	C11
It was all explained what I got here at the leisure centre at my induction and my first appointment. what type of exercise to do.	C12
I didn't realise there would be so many referrals here and I have made quite a few friends. I would have liked to have been told there would be more people like me here. I was a little worried.	C13
I had spoken to the staff at the gym so I had a lot of the information from them.	C14
I don't know.	C15
Being told that it's not just young fit people but a lot of people like myself i.e. Older overweight and inactive	C16
Nothing	C17
the staff at the leisure centre beverley were really helpful and had the time to discuss my requirements, targets etc	C18
Not for me but I think others would benifit	C19
That is was not just a one off because with me not working. I am now funding this myself. It would have been nice to have the three months renewed. After three months many people fall off the wagon. 5e sports centre wouldn't allow a second referral.	C20

Question 15a: Please explain you feel this way? (in relation to Q15: Now you have completed your programme, do you feel that the original description of your programme was accurate?)

Response	**Participant Code**
Somewhat accurate in that it would do me good.	C1
They didn't tell me anything.	C3
[Fitness Professional name] gave me all information	C4
Leaflets helped	C5
No description really	C6
Health trainers told me everything beforehand.	C7
Not info provided	C8
Met my expectations and took me through a 10 week programme	C10
She didn't give me any definite expectations except other people had benefitted.	C11
He didn't tell me anything about to expect on the gp referral	C12
Because she didn't tell me anything	C13
The staff at the gym are very good and know their information	C14
I'm surprised I've succeeded.	C15

my instructor took me through each step of the way and was extremely patient and understanding	C16
Pamphlets	C17
I had to do all the "foot work" there is little co-ordination between the gp. other departments of nhs, the gym even though the means are there. I think this is a time/ workload problem.	C18
Be Ouse I used the gym in the past, so I had a good idea about it.	C19
The GP didn't tell me anything as I told them. It's like everything, if you don't ask for things or advice or guidance, no one is going to tell you especially if there's money involved.	C20

Question 16: In your own words, can you describe your programme?	
Response	**Participant Code**
Heart started off with very gentle exercise on machine that [FP's name] knows you can do without doing damage. Over the 10 weeks it's builds up and you start improving and feeling better. Once you start improving its good.	C1
It's a kickstart to getting you on a healthy lifestyle	C2
I find it very exciting and a new challenge in my life.	C3
Very beneficial and I would tell anyone with problems you need to get a referral. I tell a lot of people	C4
We have sold it to other people. All I say is go to your doctors give it a go. There's so many choices that you can do. Gym or chair exercises or pool.	C5
It's all access to the classes and facilities at the leisure centre with tuition and guidance and it's tailored to your needs. All staff are friendly and helpful	C6
It's made me feel better. If they are struggling at any way at all you need to exercise. It takes time but you feel better. It's making that first steps perhaps the doctors should suggest it. Even for depression and things like that. It stops you popping pills. It's brilliant	C7
It was a gradual build up and slow progress. The leisure are brilliant and build you up slowly	C8
By all means do it and work with them but do what they say and listen to them. We had a good talk I thought it were good and I would recommend it.	C9
Severe arthritis of the right hip. My aim was to loose weight increase fitness and strengthen the muscles around the hip. I achieved all these goals. I became so much fitter, lost weight and increased the muscle strength around the hip, as a result I became a member of the leisure centre under the graduate scheme, this was so important as it massively assisted in the recovery of my hip replacement operation that I had later that year.	C10
Initially there was a little session regarding various matters like how to treat pain and healthy eating and then onto the exercise room where we did a circuit of individualised exercises. It has	C11

helped me in subtle ways like getting out the car and general balance. I have felt springier in my step	
I would say get in touch with your gp and explain your situation anD Ask if you qualify. Without a referral I would have not come to a gym and not enquired about a gym.	C12
It is brilliant get yourself here it really helps. The instructors are absolutely brilliant	C13
I described it as an exercise program but you can do classes too, of all varieties	C14
Fun. A big sense of achievement. I'm more able to stand and transfer from my wheelchair. When I stand to transfer my balance is improved. My mental health has improved. I've more confidence. I lost weight but unfortunately put some back on. I've been very fortunate to meet such kind and caring staff and Rob has done An excellent job of thinking of different exercises for me to do from my wheelchair.	C15
At first a gentle introduction to being more active concentrating mainly on strenghting legs but gradually increasing resistance and using more pieces of equipment since being on programme have continued exercising and am off morphine altogether	C16
I'd tell them to come on it. It's helped me	C17
My program was to start to exercise slowly to build up my fitnes to be able to do exercise to a greater level. to get fit enough to exercise without doing myself harm or injury. this leading to building stamina and reducing weight and so improving my health.	C18
It gives you motivation as you're under an instructor to start with but you could still do with an extra push. The phone calls keep you motivated if you don't come as a guilt trip because you feel you're letting them down	C19
Do it. Go and ask your doctor and if they say no, go to the sports centre and get a referral form and go back again and take it to them.	C20

Question 17: In your opinion, how could the referral process be improved for future participants?

Response	**Participant Code**
A bit more information from your doctor so you know what to expect. It's very daunting. You feel so out of place. The gp stressing that there are people same as you. Maybe they thought I knew but more background and not to worry when coming. You think everyone is looking at you but people get on with their own thing but that's not what you think at first	C1
It's could be ongoing a little longer for a cheaper rate for those who are committed.	C2

I think it's hard to encourage him. I can't understand why it's for there own benefit	C3
I don't think enough people know about it. You don't see it up at your doctors. There's no information. People need to be made aware of it.	C4
There needs to be more information in the chemist or gp surgery's or library. Any council buildings should be displaying information about the schemes	C5
Raising awareness of it. A lot of people don't know about it. Better promotion	C6
Maybe notices put up but that's difficult. Not many people know a lot of it is word of mouth.	C7
At grass root. Target people in the hospitals after surgery. If there was somebody there to explain face to face then you make up your own mind	C8
More publicity for one. I like the fact that sometimes they have free places that could be explained as well. Tell people who have hip and knee replacements	C9
I believe that to improve the process there should be more publication of the fact this scheme exists. I have met many people with long term medical conditions that in my opinion would benefit from the scheme, none of the people I have spoken to were aware the scheme existed	C10
It would of been good to have a pre visit to an estimating programme to see what it entailed.	C11
I think within the doctor surgery waiting room there are so many leaflets on the wall explaining referrals. Perhaps If theres a leaflet in the gp waiting room which showed who qualifies for the schemes and gives more information.	C12
More information from the doctor because I didn't get get anything	C13
I think the referral progress is very good and very quick too	C14
To talk to somebody else who had done it.	C15
More time taken to give reassurance that I wouldn't be out of place	C16
I wish I'd of been referred faster it needs speeding up	C17
not really sure ads its down to the individual to get their shit together.	C18
The gps need to send more people especially those with weight issues and that leads onto further problems. We need to be pushing more people. Too many people are sitting in front of the tele or on games.	C19
By awareness. More awareness . Not just through the GPS and the sports centre. The obesity in school is horrendous. My consultant says that everybody over the age of 50 should be referred onto this. Prevention is so important.	C20

Appendix 12: Interview Guides for Research Phase II

12.1. Referral Scheme Administrators

Demographics										
Gender	Male		Female		Non-binary		Prefer not to say			
Age (years)										
Leisure site	Bev	Brid	Drif	Francis Scaife	Goole	Halt	Horn	With	South Cave	S/Hold
Role						Can you some up some of your typical roles?				
Experience (years)										
HLP referrals processed	All of them	LiveWell	Young LiveWell	Exercise Referral Scheme	Health Optimisation Scheme	H.E.A.R.T Cardiac Rehab				
Email										

Theme 1: Referral information from primary care sites

- What are the different ways you receive HLP referrals from primary care? Most common?
  - Which type are easiest to process? Why?
  - Which are most difficult? Why?
- How often do you receive referrals from primary care sites that are include all required information?
  - Why do you think that is? Are some surgeries/ PCP better than others?
  - Which sections of the referral form are typically incomplete? Why do you think this is?
  - How could this be improved?
- Can you tell me about your experiences of contacting GP surgeries to retrieve incomplete patient information?
  - How easy or difficult is it to get in touch with primary care sites? Same across sites?
  - How easy or difficult is it to retrieve patient information from primary care sites?
  - Do you have confidence in the information you receive? Why do you feel this way?
  - Approximately, how many surgeries refer to this site?
- How would you describe your relationship with PC sites referring to leisure centre? Why?

Theme 2: Telephone conversation with referred customers

- How quickly are you able to contact referred patients after receiving their referral?
- During your initial telephone conversation with referred customers, what information do you typically provide? How do patients respond?
- During your initial telephone conversation with referred customers, how much do they know about the programme they have been referred onto?
  - Where do they lack understanding? Why?
  - What would be the best way to increase their awareness?
- Are referred patients typically misinformed about anything in particular?
- Are you confident that PCP are providing accurate information to patents prior to referral?

1

- Why do you feel this way?

- During your initial telephone conversation with referred customers, what are the common concerns raised?
  - How do you manage these concerns?
  - What would help alleviate these concerns?
- When speaking with a referred customer, what are the common challenges you face?
  - Can you offer an example?
  - What would help alleviate this issue?

Theme 3: Feedback

- How important do you feel it is to provide customer feedback back to primary care sites?
  - Why do you feel this way?
- Are you involved in providing feedback back to primary care sites?

If yes:

- What information do you provide to primary care sites?
  - Do you always provide this information? Does it differ according to customer/site?
- How do you provide feedback to primary care sites? (E.g. email)
  - What's your preferred method of sending feedback to primary care sites?
- Is there anything additional you would like to FB to PC sites?
- In your opinion, how could the referral process be improved?

Is there anything else you wish to add that you feel is important?

IF DUAL ROLE AS A FITNESS PROFESSIONAL….

- What information do you receive prior to your first appointment with a referred customer?
  - Are you consistently provided with the same info? Why? What's the impact?
- As a FP, how satisfied are you with the amount of information you are provided with prior to your first appointment with a referred customer?
  - Do you have confidence in the information you receive? Why
- What additional customer information would be useful to receive prior to your first appointment with a referred customer?
  - Can you give me an example of when/why this would be useful?
- When meeting your referred customers for the first time, how ready are they to change their lifestyle?
  - How do you measure their readiness to change?
  - How does this affect the programme you devise for them?
- What information would you like referred customers to be provided with prior to their first leisure appointment?
  - What would be the best way to provide referred customers with this information?

12.2. Fitness Professionals

Demographics										
Gender	Male			Female		Non-binary			Prefer not to say	
Age (years)										
Leisure site	Bev	Brid	Drif	Francis Scaife	Goole	Halt	Horns	With	South Cave	S/Hold
Role Experience										
HLP involvement	LW	YLW	ERS	HOP	H.E.A.R.T	Swim for health	Walking for health			
Email										

Theme 1: Referral information from primary care sites

- Can you tell me how the referrals are processed in your leisure site once a referral has been made to a HLP?
    - Who is responsible for processing these referrals? What are the benefits? Are there any negatives?

IF FP PROCESS REFERRALS….

- What are the different ways you receive HLP referrals from primary care? Most common?
    - Which type are easiest to process? / Which are most difficult? Why?
- How often do you receive referrals from primary care sites that are include all required information?
    - Why do you think that is? Are some surgeries/ PCP better than others?
    - Which sections are typically incomplete? How could this be improved?
- Can you tell me about your experiences of contacting GP surgeries to retrieve incomplete patient info?
    - How easy or difficult is it to get in touch with primary care sites? Same across sites?
    - How easy or difficult is it to retrieve patient information from primary care sites?
    - Do you have confidence in the information you receive? Why do you feel this way?

IF FP DO NOT PROCESS REFERRALS…

- What information do you receive prior to your first appointment with a referred customer?
    - Are you consistently provided with the same info? Why? What's the impact?
- How satisfied are you with the amount of information you are provided with prior to your first appointment with a referred customer?
    - How much confidence do you have in the information you receive? Why?
- What additional customer information would be useful to receive prior to your first appointment with a referred customer?
    - How would you like to receive this information?
    - Can you give me an example of when/why this would be useful?
- What happens if you require more information on a referred customer?
    - How easy or difficult is it to get in touch with primary care sites?
    - How easy or difficult is it to retrieve information from primary care sites?

1

- How would you describe your relationship with PC sites referring to leisure centre? Why?

Theme 2: First appointment with customers

- When meeting your referred customers for the first time, how much do they know about the programme they have been referred onto?
  - Where do they lack understanding? What's the impact?
- Are referred patients typically misinformed about anything in particular?
  - How confident are you that PCP are providing accurate information to patents prior to referral?
- When meeting your referred customers for the first time, how ready are they to change their lifestyle?
  - How do you measure their readiness to change?
  - How does this affect the programme you devise for them?
- What information would you like referred customers to be provided with prior to their first leisure appointment?
  - What would be the best way to provide this information? What would be the benefits?
- When meeting your referred customers for the first time, what are the common challenges you face?
  - Can you offer an example?
  - What would help alleviate this issue?
- When meeting referred customers for the first time, what are the common concerns raised?
  - How do you manage these concerns?
  - What would help alleviate these concerns?

Theme 3: Feedback

- How important do you feel it is to provide customer feedback back to primary care sites?
  - Why do you feel this way?
- Are you involved in providing feedback back to primary care sites?

If yes:

- What information do you provide back to primary care sites?
  - Do you always provided this information? Does it differ according to customer/site?
- How do you provide feedback back to primary care sites? (E.g. email?)
  - What's your preferred method of sending feedback to primary care sites?
- Is there anything additional you would like to FB to PC sites?
- Finally, in your opinion, how could the referral process be improved?

Is there anything else you wish to add that you feel is important?

12.3. Customers

An exploration of a customer's journey onto the ERoYC healthy lifestyle programmes.

Demographics							
Gender	Male		Female		Non-binary		Prefer not to say
Age							
Postcode							
HLP attended	Young LiveWell	LiveWell	Exercise Referral Scheme	HOP	H.E.A.R.T	Swim for health	Walking for health
PC site							
Referring PCP	General practitioner	Nursing team	Community Link Worker	Care Navigator	Physio	Other	Not sure
Email							

Theme 1: Primary care visit

- Can you tell me about what brought you to visit your PCP on the day you were referred to your programme?
- Can you recall how you felt that day?
- Who did you have your consultation with?

Theme 2: Conversation with PCP about the programme

- Can you talk me through how the topic of referral to your programme was brought up during your consultation?
    - Who started this conversation?

If PCP:

- What was you told about your programme
    - What were your initial thoughts/ feelings/ emotions?
- What resources were you provided with? (E.g. leaflets)
    - How useful/understandable were these resources?
- Did you feel satisfied with the amount and quality of information provided about your programme?
    - What would have liked more information on?
    - How would you have liked to receive this information?
    - Is there anything else you would have liked to have been told?
- In hindsight, did the information you were provided with match with your experiences of your programme?
- Was there anything that made you feel apprehensive about referral?

1

- At the point of referral, how motivated were you to change your lifestyle?

If patient:

- How/when did you find out about your programme?
- Can you recall what you knew about the programme before approaching your PCP?
- What made you decide to speak with your PCP about the programme?
- In your opinion, did your PCP seem well informed about the programme?
    - Were they happy to refer you?

Theme 3: Process of referral

- Did your PCP complete your referral during your consultation? What did they tell you?

If yes

- What choices were you given during your referral? For instance, were you given the option to select a leisure site? Were you able to select a time for your first appointment?
- Did you feel satisfied with your involvement during the referral process?

If no:

- What happened from there? / Did you have to make a separate appointment?
- How long did you wait before being referred?
- What impact did that have?
- How did you feel about having to wait for your referral?

Is there anything you would improve about this referral process?

Theme 4: Conversation with the ER referral administrator about the programme

- Did your PCP make it clear that you would be contacted by an ER referral administrator within 24 hours?
    - How long did you wait until an ER referral administrator contacted you?
    - Were you happy to be contacted this way?
    - Did you speak with your fitness professional before your first session on your programme?
- Can you tell me about your initial telephone conversation with…?
- Can you recall what did they told you about your programme?
    - What were your initial thoughts/ feelings/ emotions?
- How quickly were you invited to come for your first session on your programme?

Theme 5: Progress discussions

Have you been to visit your PCP since you were referred on your programme?

If yes:

- Has your PCP discussed your progress on your programme?
  - What have they discussed with you?
  - How did you feel?
- What involvement should your PCP have in terms of your progress on your programme?

If no:

- How would you feel if your PCP was able to access FB on your progress?
- What involvement should your PCP have in terms of your progress?
- What information would you be happy for your PCP to access regarding your progress?

Is there anything else you wish to add that you feel is important?

Appendix 13: Interview Transcripts for Research Phase II

AW: Interviewer **Interview date**: 31.01.2019

FC1: Participant Interview **location**: East Riding Leisure Withernsea

AW: 00:01 and within four to six weeks it will be emailed to you just for you to check that it reflects the interview. So, just before we begin, can I take some simple demographics from you? How would you identify your gender?

FC1: 00:11 male

AW: 00:11 yep, and how old are you if you don't mind me asking?

FC1: 00:14 53

AW: 00:15 and is this the only leisure site you work within?

FC1: 00:18 yes

AW: 00:20 perfect and what is your role within this leisure site?

FC1: 00:22 erm tone zone co-ordinator

AW: 00:26 can you sum up some of the typical duties of your role

FC1: 00:31 OK. so, on the gym side I take the cardiac class. Erm, I do GP referrals. I do HOPS. I do LiveWells. I can do Young LiveWells if we are really pushed. I do all my staffing, all my budgets, all the sickness, all the back office stuff. I liaise with the GPs and anyone else who wants to talk as well, as running the, all the gym maintenance side and looking after that and inspections and things

AW: 01:05 a little bit of everything

FC1: 01:07 yeah, dogs body

AW: 01:08 and how long have you been working as a tone zone co-ordinator?

FC1: 01:10 for the council say 2014, so that's what, coming up five years

AW: 01:19 so in terms of the, erm, health agenda programmes, so the healthy lifestyle programmes, you are involved in processing the LiveWell, the young live well, exercise referrals, or GP referrals, health optimisation and the cardiac rehabilitation

FC1: 01:32 yep, yep, yes

AW: 01:32 all of them perfect. And I have your email from the online survey

FC1: 01:36 yes

AW: 01:36 OK so the first theme focuses on the referral information that you receive from general practice sites. Firstly, what are the different ways that you receive healthy lifestyle referrals?

FC1: 01:44 so we get electronic referrals through our BEARS system, and then we get manual referrals through the old-fashioned A5 referral paper. And then we get the occasional email, and then we get the HEART link through the cardiac referral forms which get emailed to us

AW: 02:08 perfect and what is the most common form of receiving referrals?

FC1: 02:11 at the moment now, the most common one is electronic

AW: 02:15 yep. And in your opinion, which is the most, which is the easiest to process?

FC1: 02:18 electronic

AW: 02:19 ok. Why is that?

FC1: 02:20 erm GDPS so all the general data protection it's stored online. I don't need to print if off. I don't need to find a physical folder. I don't need to worry about, is it locked away?

AW: 02:36 so for you it's easier because as you say it's all online

FC1: 02:39 managing it absolutely

AW: 02:38 there's nothing that you have to... and what are the most difficult form of referrals to process?

FC1: 02:45 erm, the difficult ones are, if we get inappropriate ones. So, an email one. Say a physiotherapist might just email with some details and then we've got to email them back and maybe send them a PDF to fill out, and either scan it back to us or they print it back or the post it back, but they are becoming rarer

AW: 03:11 yep. do you tend to get referrals from other places such as physio's

FC1: 03:17 erm we get, yeah, our Young LiveWells come on, they can be referred from anyone non-medical, parent, erm. So, again, they are a little bit awkward to refer because we can't automatically take them. I pass them onto Beverley, let them make the final decision as to who we can and who we can't take on, Young LiveWells

AW: 03:39 ok so Beverley they will decide if the referral is appropriate.

FC1: 03:43 yeah. I just leave that to them because it's very vague

AW: 03:47 so in that case, there's no, Medical Professional giving you that information about their medical history. There is none of that?

FC1: 03:54 the form asks you for it, but there's no, Medical Profession, Professional input into it. They can be referred by a carer, a foster carer, their parent

AW: 04:03 right it could be just ticking, and they might not be as clued up

FC1: 04:09 no

AW: 04:09 ok so how often would you say that you receive referrals that erm, include all the relevant information?

FC1: 04:16 currently, we probably, we are probably averaging about 30-35 a month.

AW: 04:28 OK and do you find the form, however, they are coming through, do they include all the information that you need?

FC1: 04:35 er no, not all the time.

AW: 04:37 can you elaborate on that for me?

FC1: 04:38 so, they always meet the criteria and, I think when they are referring them, it looks like they are just trying to meet the criteria by ticking the boxes. And some, sometimes we do get good information, other times we don't. Erm, for instance, I had one, man just wants weight loss and inactivity. When he came, he had a, he'd had a stroke, well, he'd had a heart attack in hospital and he had a stroke and then I can't remember, something else. And then he put on lots of weight so the doctor said, "oh, you need to lose weight and you're not active", and that's the only information we got. And when he came in, he couldn't hardly walk, he couldn't come up the stairs, we had to use the lift

AW: 05:28 so all this really vital information, you wasn't provided with.

FC1: 05:31 yeah, nothing, nothing we couldn't handle or deal with just… so then it's a case of we, we, we are coaxing it out of them

AW: 05:42 and what's the implications of not having that information?

FC1: 05:45 well, the information is, you might be doing a, some things are obvious, that guy was real obvious. Like I say before we've had one with, came in, was training and you said, to him, everything ok? Yep, fine, I'm just inactive, I've put weight on, blah, blah, blah. Right OK. So, this is the gym, this is the bike. We will start you off nice and gentle. Quarter an hour into it, oh, I'm breathing a bit hard, oh, my chest is hurting a bit. Everything all right? Yeah,

it's, erm, I think it's my scar. Oh, what scar is that? Oh, my bypass! And that was it. So, what we do is, I've learnt from years ago, probing questions. Assume they've got something wrong and probe it and see how they reply

AW: 06:30 yep, to follow-up if there's anything else that you need to know about?

FC1: 06:32 yeah,

AW: 06:34 how do you think we could improve that. So, obviously if GPs are just ticking, as you say the criteria to get them on the schemes.

FC1: 06:41, I think it's a difficult one form the GP because they are under pressure and as you alluded to before, the GP will pass it onto non-clinical staff, non-clinical staff aren't sure. They refer to us. So, I would say to be more sure, I'd say it would come down to us identifying, but we can only identify it, if they report it and then how accurate are they reporting it to us? Or how many, loads of people have said, "oh, well, the doctors said, summit, there is summit wrong with me heart, but, but I dint know what meant". So

AW: 07:20 so you cannot even guarantee that that information is as accurate as...

FC1: 07:21 no, no

AW: 07:23 as what it needs to be. OK and can you tell me about your experiences of contacting GP surgeries to retrieve incomplete information?

FC1: 07:29 nowadays it's very good. We have a very good relationship over here. We have a member of staff who goes into the surgeries once a week.

AW: 07:42 ok. What, what, why

FC1: 07:44 so [Fitness Professional name] at the moment, what she does is, we, we go into the surgeries. We speak with the receptionist, nurses, the doctors, any problems. So, we have a good close working relationship. We can take people in. So, [Fitness Professional name] will go in the waiting room and identify

people who might be suitable for the programme and suggest that they speak to the medical staff to see if they can get approval to come on. Erm, it might be a case of that, if we've got any problems in the centre with somebody, [Fitness Professional name] will go, when [Fitness Professional name] goes into the surgeries, she might raise it with them. They will look on their systems and say, "oh, yes". Sometimes it's usually around medications. We are unsure of what the medication, they think they might be on beta-blockers, they might not be. Erm, cuz obviously that is going to affect maybe the way the train and how they are. And then the surgery will confirm or deny. Nice and simple

AW: 08:36 right, ok. So, you've got that go-to between the surgeries

FC1: 08:37 yeah, yeah, we have got a good working relationship

AW: 08:39 is that unique to Withernsea because I haven't heard that anywhere else?

FC1: 08:42 probably because we push.

AW: 08:46 yeah, that's amazing. Because you push? How did you establish that relationship?

FC1: 08:52 er, well, there was, there was a need for it. So, there's the Withernsea project, diabetes project. They've shut down the hospital, or they've closed down quite a lot of the hospital. Erm, we proved to be a good service that the GP suddenly realised if they were diverting people to us, they were getting seen quicker then sometimes physiotherapy, and we was getting just as good results. So, the GPs have started to take it on board that it cuts down on the number of patients coming back to them, and it's giving them something to do. Because if they just say "well, I'll put you on a list and it might be six

months before you get seen", knowing damn well, that they're gonna come back in in three weeks, "my back's still hurting". Whereas if they send them to us, if gets them out their hair for ten weeks and sometimes we do get good results in line probably with most other centres.

AW: 09:46 yeah. So, GPs are recognising the value of the programmes

FC1: 09:49 yeah, absolutely

AW: 09:51 and in your opinion that's why the relationship's so good here because they're recognising that actually they can pass patients onto you and it, it is having a beneficial effect on them. Perfect... so the second section is about the telephone conversations that you have with referred customers. So, them initial telephone conversations. So, how quickly are you able to contact a referred patient?

FC1: 10:10 OK so erm, we try and contact, so we get the referral through, and we will try and contact them. So, say if the referral comes through on a Monday, this is the downside of electronic, sometimes we've had people, we've had the surgery book on our BEARS system on a Monday evening for a Tuesday morning.

AW: 10:30 right, ok

FC1: 10:32 I've gone home, or my staff have gone home. We've come in at 9 o clock and oh, right we've got a new referral, what time are they in? Oh, 9 o clock

AW: 10:41 OK so that gives you minimal time to prep

FC1: 10:43 yeah, and sometimes cuz the surgery print off the letter and send it out to them. We will ring the person saying, "did you know you had an appointment at 9 o clock this morning?" Well, I've been to the doctors last

night, but they haven't said, out. And then two days letter oh, I've just received a letter! I should have had an appointment two days ago! So, some, it's good, but sometimes it's so quick!

AW: 11:05 so perhaps the booking system is a little bit too, it lets you book a little bit to close...

FC1: 11:10 yeah, well, I, well, I don't think that's a problem., I think where the problem is, it, is the system of how the surgery let the client know that they've booked. If there could be a, an automatic email, or a text so that person, "you have been booked on at blah blah blah…."

AW: 11:30 so it's about how they communicate with the patient

FC1: 11:31 absolutely cuz we are doing it, the surgeries are doing it on letter which is very slow. We've got a small team, real busy just tryna fit it in. You ring the person, no, answer. And then, y, y, you might try it three of four times. We've had it in the past where there's a telephone, mobile number, they've changed the number. They haven't updated the, they haven't updated it at the surgery. So, we are ringing a dead number.

AW: 11:54 do you have much confidence in the information that they are giving you? For instance, the BMI, the mobile number. Do you think it's all up to date?

FC1: 12:03 erm, if the doctor does it, we will get blood pressure and we get a BMI, but that's from their last record. The doctor might not necessarily weight them and check them, so they will just go on file and see what they've had. So, quite often the BMI is out, blood pressure, but blood pressure can vary from day to day

AW: 12:25 absolutely that's very invariable

FC1: 12:26 so yeah

AW: 12:27 ok, but it is not necessarily the most up to date information.

FC1: 12:30 not always we have had, probably more than a few old telephone numbers, but again if people are not telling the surgery

AW: 12:40 then that's a problem on their side

FC1: 12:42 yeah

AW: 12:42 in terms of the BMI, has it ever been a problem in terms of the programme that they are eligible for?

FC1: 12:47 we've had a few issues. Erm, LiveWell, BMI 45, if you're under 45 you can't go on it. They doctors have sent people to us 43, 44. I have taken them on in the past, only to be told by Beverley that I shouldn't have. Then the doctors say, "what do you want me to do? Do you want me to wait until they've got bigger?"

AW: 13:12 wow ok

FC1: 13:13 do you want me to tell them, "the only way you can get treat is to put weight on then start". And so when you get into that close call. I know there's gonna be a cut-off point, but its awkward do you know when you're trying to help people and its, it is awkward

AW: 13:30 what do you tell GPs when they're asking you that?

FC1: 13:34 honestly, if a doctor rings me and says I've got somebody 44. They are going to need another half stone before they reach the 45 mark. I will just say just send them to me. Don't put down their BMI, let me do it

AW: 13:46 right, ok if it is really close

FC1: 13:49 if it is really close and then I will measure them. I might, I might tell them to leave their boots on, coat on

AW: 13:57 to bump that up?

FC1: 13:59 yeah

AW: 13:59 why? Is it because the LiveWell, is a free scheme?

FC1: 14:01 the LiveWell, is a free scheme, but if we get them on the free scheme, if we get them on the, on the LiveWell, scheme, we've got a better chance with them to try and engage with them. The ten-week one isn't really going to help them. It might kick start them, but the problem is if you put them on a ten week one, let's say someone is 44.5 on the BMI. You put them on ten weeks. You've reduced them to 43.9. You come off the ten weeks. There's nowhere for them to go. And then you think well, you can't go on LiveWell, because you've even, you've reduced your BMI a bit more. So, well, what do you do with them? It's alright we will get you on another referral for maybe another 10 weeks if we can, and then people just quite rightly say, "well, I've reached the end of the line, what do I do now?" On paper, join up as a member, but they're still within 20 weeks of trying to change behaviour or within ten weeks and that's a hard job!

AW: 15:07 yeah, so the LiveWell, obviously gives you that opportunity to have that full year

FC1: 15:09 ah it gives, gives you the opportunity. Now whether they engage, cuz the, those people are really hard to engage with, but it gives you the best opportunity. It gives you the best, and the evidence is the more you can engage over a longer period, you're going to get better results

AW: 15:26 and going back to the telephone conversations when you ring people, how aware are they of the programme or the scheme that they have been referred on to?

FC1: 15:32 erm quite often they've got no, information from the doctor or, the, the, quite often the doct, they will say "the doctor has sent me it's for er, oh, it's for, it's for HOP, LiveWell, exercise referral thing where I get something at the surg, at the centre and I do all this keep fit summit, but I don't really know". And that's the real

AW: 15:55 that's the reality

FC1: 15:55 we've put together a little leaflet locally so when [Fitness Professional name] goes in the surgery, she can hand it out to people so they've got a little bit, bit of a better idea

AW: 16:03 ok

FC1: 16:04 and again that's something local we've just done. Not within East Riding

AW: 16:08 right, ok and again you have that go-between so [Fitness Professional name] can spread the word if you like in the surgeries, which I've not heard anywhere else. That's something really unique

FC1: 16:18 she's good .So, she will go in the surgery. just even sometimes just to sit down and engage with people

AW: 16:24 is there any other way that you can think of that might help increase that awareness or make sure that patients are given the correct information from the clinical staff?

FC1: 16:33, I think it's hard cuz you know the pressure they are under. And, I think sometimes if we are asking health professionals to buck up their ideas and improve on how they get things across, will that create a barrier? Will that affect us negatively? So, for instance, if I am asking a doctor to do more, are they just going to go "oh, I haven't got time for that"!

AW: 16:58 you are `quite cautious of ruining that relationship?

FC1: 16:59 yeah, so, so it's all about, our aim, our aim has always been reduce barriers. Just reduce barriers. That's why we got [Fitness Professional name] in. reduce it. [Fitness Professional name] has actually even gone in and sat down with the practice nurses and what not, they are referring somebody online, and she is sat there with them just to make sure they are doing it right and checking things and they are asking queries. Well, I've got this woman and she's... and [Fitness Professional name] can just tell them and oh, right thanks. So, it's very valuable for that

AW: 17:30 absolutely and without that they would probably not have sent that referrals cuz of the uncertainty

FC1: 17:35 yeah, so it, it's a good investment. It takes me time. It's time and re, resource away from me, but, I think it's a good investment for the return

AW: 17:44 you can clearly see the benefit of that

FC1: 17:45 yeah, we can

AW: 17:46 and how many referrals. Are the referrals that are coming in, are they manageable in terms of the workload and capacity?

FC1: 17:53 we, we, break, we are a ruling on one, one-to-one for HOP, one-to-one for LiveWell, we do one-to-one for LiveWell, one-to-one for HOP. And they like us to have one-to-one for GP or a very small group of a maximum of four. Erm, for instance, one of my instructors did a, an aqua gym in the pool, twelve people. So, we break the numbers, but we still find that the quality of service is up. People like it. They engage because they're in a social group environment. But we still do one-to-ones. But if we had to go back to one-to-ones for everything, as per the book, we wouldn't cope!

AW: 18:35 ok, but you've highlighted some of the benefits of being amongst other people so you've said, the social, the fact they're in a social group. They are all bonding together.

FC1: 18:42 absolutely. We've got erm, we've got one group of people who finished it and they actually, they formed their own little group called the water grumpies… I know and they come in the pool, and they come in the pool and they actually wanted to constitute a group and get funding so they can have pool access and just train altogether. So, you know, so it's a good model. It is a good model. It's time-effective

AW: 19:10 absolutely as you say not always necessarily by the book, but it is actually really time effective, it's working in this leisure site. You are getting great results, you are getting good bonds formed amongst customers as well... Perfect and then finally during your initial telephone conversations, are there any challenges that patients raise with you over the telephone

FC1: 19:30 the costs

AW: 19:30 ok in terms in which scheme?

FC1: 19:31 er, GP referral £33, they can't afford it

AW: 19:37 right, ok and how do you alleviate that

FC1: 19:41 if its means, well, at one time we was just giving away free for everything, but we've been told to stop

AW: 19:45 right, ok

FC1: 19:46 because one of the barriers, I went to a GP meeting and a locum GP sat down and he said, right then, oh, where I come from, we use to this all the time, please tell me about it. Picked his pen up was writing down things and I told him its ten weeks, and its blah blah, blah, and it's this, this, this and then I

said, its £33. And he was writing and he just stopped and he went "pardon", I said, it is £33. "What for?" so I said, well, for people to come to the scheme and he just put his pen down, got his bit of paper, threw it in the bin, went "I aren't referring anyone to you". And, and the other doctors were like old, you know, whoa, yeah, yeah, and he said, why would I refer to you when I've got somebody in front of me with high blood pressure, anxiety, and depression, sobbing their eyes, out because they might be getting evicted from their rented house and I'm gonna tell em, pay 33 pound and exercise will lift your mood. He said, why would I do that? And I said, right take your point so we had limited places free. I spoke with the boss and he said, "look we've just got to remove barriers". But I've been told from above that I can't do that. I've got to be in line.

AW: 21:03 is that a recent thing you've been told?

FC1: 21:04 from Christmas so since Christmas I've told eight people, and its if you are on income support or something, fine, no problem, but we do get a lot of working poor people

AW: 21:15 yeah

FC1: 21:15 they're on minimum wage and they are renting a house for 5, 600 pound and that probably, by the time they have paid everything out, they're probably living on like 30 pound a week. And, are they on seasonal work?

AW: 21:29 and that is a really difficult predicament for you cuz obviously, if, if, if you're in more of a dep, a deprived area if you like and there's, there's costs, and obviously if you're use to wavering that cost and not you're not allowed

FC1: 21:41, but then also that impacts on me cuz I've got, I've got targets for my income on health agenda, all my recharges. So, then I've still got to make that money or else my guys are out of a job. It's difficult.

AW: 21:59 absolutely so that's sort of there, you've got their main concerns are, are the cost. Especially the GP referral with it being £33. Is there anything else that they are concerned about?

FC1: 22:10 erm, sometimes you get the oh, I don't, I can't , I can't do, I can't do, I can't do all this marathon running, you know, but, but we are quite good at breaking, breaking down those barriers

AW: 22:21 yeah

FC1: 22:24, but you know, oh, I can't do all like keep fit like green goddess you know, but I, yeah, it's no problem

AW: 22:31 just general sort of anxieties around exercising. And are there any challenges that you face?

FC1: 22:36 erm, challenges. It's tracking, back office tracking. It, its cuz we've got notes to put on for people. We've got, you are part of my team, 34 referral, you might, we might already have 50 people on the books, you might be working 20 hours. You'll see a different person each week. You might not see the same person twice. So, I book a new one in with you, for next Tuesday, they ring up tomorrow to cancel it, to re-arrange cuz it clashes with a hospital appointment and the receptionist says "right I'll try and get you booked in with Amy again. I'll have to ring you back cuz I don't know". You don't even know they exist and then suddenly they've got off the radar

AW: 23:22 right, ok

FC1: 23:23 we've got to track em, get em back in. Just managing that tracking system is a, is a ...

AW: 23:31 so tracking in terms of people who

FC1: 23:34 who's on the system, how many notes have they had. How many sessions have they had. Have they been in for so many weeks

AW: 23:42 how are you tracking them currently?

FC1: 23:42 well, originally, I was tryna do a spreadsheet, so I was tryna do it all, but I couldn't so I've got a little bit of casual back office help now so we have a admin lad, a couple of admin girls who help me for a few hours. They set up a spreadsheet and they go through all the notes that we put on the CRM so they know when they've been in. They try and track down through admissions to see when they've been in and then they will feedback back to the team on our Tuesday meetings. We've had so and so, they started 6 weeks ago, they've had three sessions and they have gone off the radar. Can you ring them and get them in? Sometimes they will ring em and try and get them in. But that, that sporadic back office help I have, I haven't got consistent support.

AW: 24:27 and the CRM is that the system you use.

FC1: 24:27 yeah, that is our database. Our notes on it, memberships things like that so we can track em

AW: 24:36 the final section of the interview is focused on feedback. So, feedback in terms of the feedback you provide to primary care sites. So, how you communicate with them. Er, so first of all, how important do you feel it is to provide that feedback

FC1: 24:50 me personally, I think it's very important

AW: 24:52 ok why

FC1: 24:52 erm, so I always think if the, if the GP, you've got to, you've got to promote it. You've got to let the GPs know that you are doing a good job. If they know you are doing a good job, they are more likely to buy into it. Sometimes the GP will say to erm, Sylvia, "right, ok love, off you go, do a bit of exercise", never see em again so that GP has got no, idea if Sylvia's had a good outcome or anything. I, I suggested a few years ago like a, even if it's just something like a quarterly newsletter back to your local surgery. One side of A4, few little diagrams on it. Few little pie charts. Just to give em some headlines. Few little headline KPI's, but, I think that's really important!, I think having, I think as well, having a point of contact like when [Fitness Professional name] goes in, she knows everybody, get the surgery manage on board, I think that's really important. So, you don't have to, you don't have to see all the GPs, and you don't have to see, see one person who can actually champion your referral scheme in the surgery. When I worked at South Hunsley, we had Doctor Tinker. She was a lovely GP. She was a marathon runner and triathlons and all that lot and she valued exercise. So, I use to see her and then she would, I use to go to their GP meetings and of the GPs use to sit then with a great big glass of port and cigar, and he was in his 70's and he use to go exercise, what's all that about? Medication that's what you want, tablets. But luckily, she was like a young fit doctor who recognised exercise is so important and she use to refer loads of people

AW: 26:42 and as you say if you've got that one person in the surgery who can champion that to everyone else

FC1: 26:45 that champion, yes

AW: 26:47 absolutely and I especially like your idea of the newsletter and just really getting them KPIs out to the surgeries. Do you provide feedback to the surgeries currently?

FC1: 26:55 erm, what we do info, it is informally. If they ask for it, we do. Erm, some of our GPs are older who go to see the GP for the conditions anyways. So, in a way, we are fortunate so they are our advertising. They are always coming back. I was in the GP for me blood, I was telling them how fantastic it is and how much weight I've lost. We have a lot of people losing weight and, and you know, the diabetes score is coming down quite a lot

AW: 27:25 so you can see its having an effect on some of the wider agenda of Withernsea, but as you say if you are giving feedback, it is informal. It is usually done through patients when they visit their GP

FC1: 27:36 yeah

AW: 27:38 what would you like, if there was that feedback loop, what would you like to be specifically telling GPs?

FC1: 27:45 so. It's not always about weight because some people just don't lose weight, but what they do is, they decease pain, they increase self-esteem, anxieties gone, they feel more confident. And it's all these things that are hard to measure and hard to get across. And yet I know you can do all these, you know, Warwick scales and things like that and all these quizzes and tests, but sometimes a GP will just look at a number. Oh, they scored 31 on the Warwick test or whatever and... If the GP doesn't really know what the test is, it is meaningless.

AW: 28:21 exactly so you said, it's not just physical benefits such as pain, its psychological sort of confidence, esteem

FC1: 28:27 yeah, that, that's it and sometimes they are hard to get across

AW: 28:30 yeah, and as you say it has to be understandable to GPs. You can't just say they've scored this score on the Warwick, because they'll be like huh? They are general practitioner at the end of the day not

FC1: 28:39 that's it they are not... yeah

AW: 28:43 they're not experts

FC1: 28:44 so, so, the easiest way probably will be good news stories

AW: 28:47 yeah. Do you take many testimonials here?

FC1: 28:52 erm, we always try. We always, always, always try on our Health Plus, but we also try and get some. We've got lady at the moment, she's come off a programme, off the back of it she's gone to university. Off the back of it she's gonna be a, eventually she wants to be a physiotherapist, but he's got some kind of, she's got some, something now and she's gonna, she's been telling us she will write us a big testimonial about her journey. Er, it is hard. We deal with a lot of people who just ant been, who aren't confident. So, we deal with people who, you know, if you've been through the system and said, could you write me something up, a testimonial, how you feel, and how you've been. You would provide a really detailed structured really good. A lot of these people are "oh, ah" they are not sure. We do get, get a surprising amount of people who can't write

AW: 29:47 right, ok

FC1: 29:48 so we will say tell me how you feel and can I write that down. We don't always have the time to do it to be honest

AW: 29:55 absolutely I assume with all the numbers coming through

FC1: 29:57 yeah, yeah.

AW: 30:00 perfect erm, so I've got sort of general questions to finish and then I might ask you some additional ones because you do have that dual role as a profess, fitness professional as well. So, in your opinion, how could the referral process be improved? So, that could include anything we've discussed today

FC1: 30:16 OK so erm, I think to reduce the barriers on the GP, make a generic referral. So, at the moment, they have got to decide do I go to a LiveWell? Do I go to a GP [referral]? Do I go to a HOP? Whichever way I am doing it. So, they, they struggle., I think we should, in the terms that's been used before, triage people so it should come in and we make the decision which, which referral is appropriate

AW: 30:44 ok so currently, they've got to determine is most suitable, but in your sort of opinion, you think it would be best if you received a generic referral form?

FC1: 30:51 yes, cuz the amount of times we get the wrong ones. When the HOP came out, we got loads of people being referred to HOP, and when you talk to them, they are not even going for an operation! So, they wasn't, so the GP didn't know whatever. The GPs get confused. Erm, we've had people referred to us on GP [referral], and they have been going for an operation so they could of been on HOP cuz... we've had people referred onto HOP who should be on LiveWell. We've had people on GP [referral] who should be on LiveWell. We have had LiveWells referred to us and really, they should be on HOP or just an ordinary, you know. It, it, it, I think they are under that much pressure., I think they're under that much pressure, it's just asking too much. It creates that barrier.

AW: 31:38 absolutely. So, as you say if there was just one generic referral form. You have highlighted all the benefits that is going to bring. Patients are going to be on the correct programme first time and again you've said, it's too much that you're asking now

FC1: 31:50 yeah, we do it day in day out. As soon as we get, even sometimes we, we, we will look at the screen. Right, I can see what they're been referred for and I look at them and I go well, they are on, they are on the wrong one straight away. you can just see

AW: 32:04 how does that impact on your workload?

FC1: 32:06 sometimes if it's a LiveWell, we can't, and they should of been on a GP referral, we can't take em on because there's not a referral, exercise referral. So, they've got to go back to their GP and come back again. If it's an exercise referral, but they're on LiveWell, we can do it that way. Erm, so, so, sometimes it's just a little bit of a, a little bit of a managing it. It's a little bit of an incontinence for us, but I wouldn't say it's massive. It's nothing we can't work around certainly

AW: 32:36 yeah, nothing you cannot work on, but as you say if would just remove that if, if there was that generic referral first of all so you can triage. Perfect and then I have two questions about your role as a fitness professional. So, in terms of the information you are provided with, before devising a programme, are you satisfied with that information that you are given?

FC1: 32:56 yeah, we do. Like I say we, the information you're given no, but we do a lot of probing questions to try and get it out. But then it's only reporting back to you by the patient so you can't guarantee its 100%

AW: 33:12 ok and what additional information would be useful? In an ideal world

FC1: 33:15 well, ideally, we was not to know all the meds, we want to know all the conditions that they've got. Their history, the injury histories, and things. But quite often just having a good, thorough sort of questioning sort of time with them, you can get to it

AW: 33:36 so nothing you can't get from them just by asking them simple questions and probing to see if they've got anything beyond.

FC1: 33:41 yep

AW: 33:42 perfect is there anything else that you wish you add that you feel is important about anything we've discussed today?

FC1: 33:46 no, that's it

AW: 33:47 no, perfect well, thank you very much for your time today

FC1: 33:48 OK brilliant

AW: Interviewer **Interview date**: 31.01.2019

FC2: Participant Interview **location**: East Riding Leisure South Holderness

AW: 00:00 To make sure that's working. Perfect. Would you prefer Patricia, Trisha, or Pat?

FC2: 00:08 Oh, Trisha please

AW: 00:11 No problem and how old are you If you don't mind me asking?

FC2: 00.13 42

AW: 00:14 42. What gender do you identify as? Male, Female, Non-binary...

FC2: 00:19 Female

AW: 00:20 Female, perfect and you're role, unofficially is....

FC2: 00:26 Co-ordinator, Fitness Instructor

AW: 00:32 and how many years have you been in this role?

FC2: 00:34 here I've been 18 months

AW: 00:40 ok. Have you worked previously in another East Riding Leisure site?

FC2: 00:42 I did. I've worked in Hornsea and Pocklington...

AW: 00:51 you've got a good understanding of the different...

FC2: 00:52 and Withernsea, yeah!

AW: 00:58 so how long in total have you worked as a Fitness Professional?

FC2: 01:04 5 years

AW: 01:04 5 years. Which healthy lifestyle programmes are you involved in processing?

FC2: 01:10 GP referral, HOP, LiveWell, and Junior LiveWell, and I do Cardiac Rehabilitation as well

AW: 01:20 ok so all of them.

FC2: 01:24 yes

AW: 01:24 and I have your email so that's fine. Ok, just to start, what are the different ways that you receive healthy lifestyle referral from the general practice sites, or the primary care sites?

FC2: 01:36 generally they come in via the post. Erm, sometimes I'll get them emailed to me, but then they usually come from either the Leisure Technicians at Beverley, or occasionally a referral might have come to Withernsea by mistake and then the Co-ordinators will email it across to me

AW: 02:00 ah, ok. Does that happen quite often with you being quite close to Withernsea?

FC2: 02:05 erm sometimes yeah, I mean sometimes two, three times a month

AW: 02:11 right, ok. So, you've got postal predominantly, and sometimes email. Which of them are easier for you to process?

FC2: 02:19 well, at the moment it's got to be post

AW: 02:24 post. So, I am guessing you are receiving the paper referral forms that way

FC2: 02:28 yes

AW: 02:29 ok. Do you know why South Holderness is not set up on the electronic referral system yet?

FC2: 02:34 we don't have BEARS. BEARS version three is in the pipeline for us erm, I know the technicians have been and they have had a look. Erm, and my manager has said, we can go ahead with that now. So, it's in the pipeline. We are a little bit behind here at South Holderness

AW: 02:59 do you anticipate that will help with your referrals?

FC2: 03:01 yes, it will, and I am sure we will get more as well

AW: 03:05 yep. Are all surgeries round here, are they all set up, do they all sort of refer into here or is it just certain surgeries who tend to refer?

FC2: 03:16 well, yeah, they, a lot, they've amalgamated to be fair as far as I understand it. So, the doctors serve all the villages in the, you know, in the vicinity including Withernsea. Erm, but for some people obviously it's closer for them to come here depending on where they live. Erm, so, I suppose you know, it all depends on where their doctor's surgery is.

AW: 03:41 yes, and which leisure site is closest to them?

FC2: 03:43 absolutely yeah

AW: 03:46 how often would you say that you receive referral forms that include all the required information?

FC2: 03:54 most of the time. Erm, they are times where I maybe don't get all the information that I need. For example, I've had one gentleman that came for, erm, bone problems, arthritis, and then I found out that he had angina. So, he didn't tell me, and it wasn't down on his referral form either. That's an extreme, but sometimes I can go to the customer, and I can say, "right I've got down here this, this, and this, is that right?" And they will say "no. I've got this and that". You know? So, sometimes, there are things that are a little bit vague, but obviously, I go through that with the customer

AW: 04:40 yeah. What additional information would you like?... So, you said, it's a little bit vague. Is there anything that you would especially like to know?

FC2: 04:45, I think we need to know everything about that customer, maybe that's happened within the last three years. Er, so if they've had, erm, any heart problem, angina, that really should, or a stroke for example, we need to know that. Erm, you know? You wouldn't want to put someone on a treadmill and then go away and leave them and then find at a later, "oh, by the way did I tell you, you know, I have, I wear this band because I have angina" and they haven't, you know? It's happened so many times to me and it's like, "well, when were you going to tell me that?" Erm, so the more information. Even medication as well, we need to

know the medication that they are on because some medications do affect er, what we might do with them in the gym.

AW: 05:40 absolutely yes. Are you given any information about medication currently?

FC2: 05:45 sometimes yeah, we get a little bit of information, but it's such a small box that er, but some of the GPs or whoever has referred them are really good and they put it on a separate sheet which is very helpful, so it varies

AW: 06:00 depending on whose referring?

FC2: 06:02 absolutely!

AW: 06:03 erm, so is there any sections of the referral form that are typically incomplete. Is there a certain section that you feel most times is missing?. or does it just depend?

FC2: 06:13 erm, quite often as I say it can be vague. So, you've just got tick boxes that the GP or whoever is referring might tick, erm, so it might say weight management or hypertension. I'll just have a look and I can be a bit more specific. Erm, let's have a look here.... so, we've got tick boxes so this one says this lady is not on any medication, but it hasn't said, about her weight loss even though her BMI was high and her blood pressure is quite high erm and it hasn't said, anything about any joint problems. So, you can see, and also it says erm, two or more reasons, well, they've got participant inactive, but not on any medication. You can see that is very vague

AW: 07:33 yeah, yeah

FC2: 07:35 that doesn't tell me much until I actually speak to the person. I mean this lady's blood pressure, 160 over 100 is very high! I wouldn't allow her to exercise if she came in, but they haven't put hypertension so, you can see that... it's not always accurate and we have to do our homework here to get the facts right before we can put them out to the gym

AW: 08:07 would it be fair to say then that you have limited confidence in the information they are giving you? Even when they fill it out correctly? Well, filling out the full thing, it's not always the most accurate information?

FC2: 08:16 absolutely yeah, and I think you know, a lot of my colleagues who work at different sites, I think they would agree with me on that. We don't get enough information, to, for the participants to actually work effectively or safely in some cases, you know? Erm, yeah

AW: 08:39 are there any other problems with paper referrals that you can think of at this moment?

FC2: 08:45 they take a long time

AW: 08:48 in terms of processing them?

FC2: 08:51 yeah, the doctor, or whoever, you know, all it needs is a signature by an authorised person and you know, the gent or lady can come to me two weeks after and say, "have you got my paperwork yet?" And I'll say, "no, it hasn't come through yet". Erm, and sometimes there's a week or two laps before the person can actually start on the programme because I can't start them until I've got their paperwork

AW: 09:25 what affect do you think that has on the person waiting?

FC2: 09:27, I think they get frustrated and to some degree, some of them, not all of them get, you know, sometimes, you know yourself you have to, if you want to do something you have to act their and then. And, I think a lot of these people think yeah, it's a new year I'm going to go for it! Then two weeks, three weeks pass by, I've got more important things to do now then spend a bit of time in the gym you know. I have to look after my husband or I have to look after this grandchild or I have to look after this...and suddenly they have more priorities so, I think it can be off putting for them, you know? They maybe don't have that get up and go that they might have had when they saw the doctor or whoever in the first place

AW: 10:19 absolutely that motivation that they had, as you say in two weeks' time, it's probably diminished, dwindled a little bit.

FC2: 10:23 yeah

AW: 10:25 ok so can you tell me about your experiences of contacting GP surgeries. So, if they've missed something off that you desperately need to know, do you ring the surgeries to retrieve that information?

FC2: 10:35 I never have. Erm, I usually talk to the customer and find out what I need to from them and if I haven't got all the information in front of me, from whoever has referred them, I will get it from the customer and get them to bring in. I like to see their, you know, the bit of paper that they might have from past prescriptions. Doctors don't really like us ringing them

AW: 11:07 ok

FC2: 11:08 erm I did once ring GP for something and I can't remember what It was now because it was quite a long time ago and, I think I got into a bit of deep water for that because erm, maybe I'm supposed to go to somebody in the central team first and then they find out for me. It's almost like it's above my station as it were to try and find that out. Erm, so, I think, erm, we, you know, we never ring the GPs ourselves.

AW: 11:45 right. That is really strange. If you need to know that information and there's that sort of barrier between yourselves and the GPs if you feel you can't contact them that could really I guess, put someone's safety in jeopardy if you need that information.

FC2: 12:04 yeah, I think they ought to be more assessable. I mean I've shared a few emails with some of the, erm, staff in the surgery, you know? Maybe they've wanted to know a question from me, erm you know an answer about a referral and how do we do this or something and I've replied, but never really about a customer.

AW: 12:26 right, ok. I guess it's good that they've got that relationship with you so if they are a bit unsure, they can ask you questions before...

FC2: 12:34 yeah, I mean I wish we had more of a relationship with them because I mean, you know, they, we are taking quite a lot of people that are there, you know, patients if you like

and helping people who are maybe waiting for, say with the HOP scheme, maybe waiting for surgery and helping to build that persons confidence or helping them in whatever way we can which obviously takes the pressure off the GPs hopefully. But we don't seem to have this connection. I know it goes via the technicians and the central team, and that is passed on to us, but I do sometimes feel that we are detached in some way. We should all be, you know, working from the same hymn sheet or whatever

AW: 13:36 absolutely I agree. If you need to contact the GP surgery's, they should be accessible and as you say there should be them relationships established. It would make your job easier and as you say, you are helping the GPs and alleviating some of their pressures

FC2: 13:50 absolutely

AW: 13:51 so you've said, about you take quite a lot of referrals. What is your most popular scheme? Where are the referrals aimed towards? Is there one scheme that is favoured over another?

FC2: 14:02 GP referral is accessible for pretty much everybody because of the, you know, the health, things that it covers. It's everything from weight management so you know obviously it, it really does cover a wide variety of health issues for people erm so people can be referred for 10 weeks for 33 pound, and it benefits them. They can have two referrals, so the GP referral is definitely the main one.

AW: 14:43 the most popular

FC2: 14:43 yeah, yeah. The HOP [health optimisation] scheme, I know that, obviously it is popular. That hasn't been around quite as long, but again it's becoming more popular for people waiting for non-emergency surgery. And the live Well, scheme, I didn't have many here, but in the past, I'd say 4 to 6 weeks I must have doubled the amount that I had. But the LiveWell, scheme is a free scheme and I find that, you know, I don't want to go off topic here, it's just to help you, but basically, we don't have much success with it. Now I don't

know if it's because it doesn't cost people anything. They haven't invested any money into it, but I do find it's very hit and miss. People are not dedicated enough. They want to lose weight, whether it's because they want to look better or because they are, you know, borderline diabetic or obviously, at risk of other health issues, but in my experience so far there's always something that's more pressing. Usually work or family or I've got a bone in my leg! I don't know they give me all sort of excuses and you know? Just er, in the past couple of weeks I got an email from one of my managers from the central team and there as a list of, I think probability six LiveWell, people, all ladies, that had been and had a session because its recorded in the notes. They see that these people haven't been since I don't know the last three, four, five, months so they all had warning letters. Some people I've rang up and I've said, if you don't come back, you're going to get a warning letter. And I think I got two or three people attending again, but by and large for whatever reason, I just can't seem to get them to be dedicated. You know? Maybe if we charge them something, then they might think twice about taking it so flippantly.

AW: 17:09 so you think there would be more of a commitment if they have to contribute towards the scheme?

FC2: 17:11, I think so yeah

AW: 17:15 they've got that buy in because they've paid for it, so they are less likely to not come?

FC2: 17:18 I mean you think about, you know, the membership scheme that we run. If you were paying 20, 21 pound a month, you would come as many times a week as you could. You know, you'd use all the facilities. You would go swimming. So, if there was some kind of charge for that, maybe they would be more committed and because it is a waste of our time and a waste of the scheme.

AW: 17:42 absolutely, yes. So, you said, the LiveWell, has doubled in terms of who's coming on. Why do you think the popularity all of a sudden?

FC2: 17:51 erm, I think, I think, probably, well, one, one young man, his mum is on the LiveWell, scheme, so erm, I think from talking to mum and she's told me Well, my son is this and could you help him? Erm, and also, he is erm, under the Health Trainers so obviously they have probably directed him to us as well. Erm, some of them again is probably what we had last year that have started again. Other than that, I don't know. Erm, unfortunately, I think society and you know, you go in the shops and people look at the packets of foods and it says healthy., I think a lot of it is education. They are not educated. They don't know good from bad. They think a good pile of pasta is healthy. It's just lack education, erm, so

AW: 18:59 so there's the education side. As you say word of mouth from people who have been on the scheme and then also the health trainers who are directing so it seems something is happening. The words getting out there and you are getting more referrals

FC2: 19:10 yeah, I think on that note, I think, and I don't know, my doctors in Hull so I don't know about East Riding, but do you have any notices up on the walls to alert the patients to the schemes? Out there, I have three notices, what is HOP, what is the GP referral, what is the LiveWell, scheme. People sit on the bike, and they can see that and they can think "oh, you know am I eligible for this?" Erm, but we've already got them here. Maybe I, I think personally like, I mean I haven't got a notice in here, but the NHS health check for checking cholesterol, erm, I know that erm letters went out in the er, the peoples council tax, a letter went out if you are between 40 and 72, I think it is, you are eligible for a free NHS health check. So, they can come here, I can do it for free. So, what's wrong with having something similar where you know, do you know about this scheme? Are you waiting for a non-emergency operation? Do you think your BMI is over 45? They could come here they could see me or any of the centres at the East Riding. We could do a free health check which just means height, weight, BMI. Oh, yeah, your BMI is 46, you're eligible for the LiveWell, scheme, you know?

AW: 20:48 absolutely so you feel there should be more advertisement externally.

FC2: 20:51 people don't know about these schemes erm and, I think, I know, you know we don't want to be over-running with it, but our staff are getting more and more educated you know? So, there are more people who are qualified to see the people on these schemes, erm and I, and I just think you know, there's a real lack of knowledge for the general public that these schemes even exist!

AW: 21:19 yep, I agree and that was one of my arguments coz I started this research focused, I'm going off topic a little bit, but in the GP surgeries, and every single GP surgery I went to, there were no, posters. There were the health trainers, plenty for the health trainers, but none for the East Riding leisure programmes and that really shocked me. I thought if you're referring to these, surely if there were out, patients would see them and approach the GP rather than the GP saying, "oh, do you know about this scheme?"

FC2: 21:49 cuz do they even advertise it, you know? If a member of the public goes and says, "well, I'm really trying to lose weight". I mean yeah, they might do some tests, they might do a thyroid check or whatever. How's your diet? But the doctors don't have a lot of time to spend with their patients that's not what they're there for, but that is why we are here. Erm, so, I think if someone goes with ' oh, I've got backache' or ' my shoulder hurts' or I've got you know, they might send them for some tests if they need it you know, oh, you've got arthritis you know? I don't think I dare walk outside, so they come into a controlled environment where we can keep an eye on them and give them a structure programme of exercise

AW: 22:41 absolutely it's that link again between the surgeries and you as well

FC2: 22:43 yeah, I think doctors need to advertise it, not advertise it, but I think if they told more of the public that this is available for them, would you like to try this? "Oh, I don't know about the gym, I've never been in the gym before, aren't they all trendy people all slim with

lovely you know, all their makeup on and everything?" Well, no, we are not you know. Not at all. Erm, 90 percent of my customers are older with health issues you know?

AW: 23:18 and again it's just that awareness. If they knew that, they probably would be as intimidated

FC2: 23:21 absolutely, absolutely yeah

AW: 23:23 ok so the next thing I wanted to talk about it is the telephone conversation you have with referred customers. So, how quickly are you able to contact somebody once you receive their referral form?

FC2: 23:35 right so if I receive a referral form on my desk on a Monday morning, I will get the phone and try and contact that person that morning. Erm, sometimes if people are at work, I might contact them the next day when I am on shift until eight o clock at night. Erm, but I will always try and contact them within a day or two.

AW: 24:00 yeah, so relatively quickly

FC2: 24:04 I'm on it really

AW: 24:06 and during that conversation, what information do you provide to people who have been referred?

FC2: 24:11 so I tell them what the scheme is about, like I'll say do you know what the scheme is? Erm, generally they say no, because they don't know. Erm, so I'll say well, it's ten weeks of controlled exercise, don't worry, it's not going to be any more than you can manage. Er, I let them know what we do here, what to wear erm, what's going to happen on their first appointment, so I'll be doing their height, weight, BMI. We put information into a programme, which is shared with their doctor. It costs £33 and that gives them 10 weeks

AW: 24:56 and this is the exercise on referral?

FC2: 24:58 exercise referral yes. If it was LiveWell, then obviously I would explain about that

AW: 25:03 yeah, the different programme

FC2: 25:04 erm and, and the HOP [health optimisation] scheme, the same so it really is just as easy. Sort of this is what it is, this is what you need, whether it costs you anything or whether it doesn't.

AW: 25:16 just a nice introduction

FC2: 25:16 just basic information and then they come in, it lasts about an hour erm if you want to exercise on that you day you can just bring the right clothing otherwise, we will just sit and have a chat. We might talk about nutrition if that's relevant

AW: 25:31 yeah, so it just depends on where they are at?

FC2: 25:32 yeah, food diary you know

AW: 25:36 do you find that the referrals that are made, do they tend to be to the correct scheme? So, the ones that you get through for exercise on referral for instance, are some of them mixed in with LiveWell. Do they get confused or generally are the referrals correct?

FC2: 25:49 erm, generally I'd say that they are right. I've only had one gentleman recently that, that should have been on the HOP scheme because he is waiting for knee surgery, but he came in on the 10 week GP referral instead. But that was fine because we've done that and he's nearly finished that and now, in fact just today, I got his HOP paperwork through so he is set up for that from the 5th of February, so he's actually got something extra, but that's all good

AW: 26:24 perfect

FC2: 26:27 so to answer your question no

AW: 26:30 it's generally the rights one, yeah. And you've said, about the patients so you've said, most of the time they know nothing at all. Is it that they are not informed at all about the programmes or is it a case of being told the wrong thing? Are they under the impression it's something else?

FC2: 26:44 I just don't think they are told. I don't think they are told much of anything. Erm, I think they might know that its ten weeks, but they don't really know what to expect when they get here. I, I, I don't really know what they expect at all. Erm... I'd like to be a fly on the wall when whoever is telling them about it. I mean sometimes we get people you know who have been to a physio and the physiotherapist have referred them and depending on how much knowledge the physio have got themselves, they might give that person the right knowledge about the scheme and then they do know what to expect, but generally from the GP, no, not really. I don't think they know enough

AW: 27:36 and what are the common concerns that patients raise on the phone. So, when you tell them about the programme and what to expect, do they raise any worries or concerns that they have?

FC2: 27:46 erm, I think their main concerns are well, I'm not very fit. I've never been in a gym before. One chap said, he was a walking disaster, you know. And I think their main concern is that they're not going to be able to do it or a lot of ladies are self-conscious and worry that people are going to look at them. Obviously, I put them, don't know about that because sometimes you might be on, there might be three other ladies in there that are all on the same scheme. So, they are the main concerns really erm

AW: 28:37, but as you say you try to alleviate them by saying, look there's other people in your shoes. As you say, it's not all trendy people. It's, majority of the people are older, and they have their own problems and stuff

FC2: 28:49 absolutely

AW: 28:50 and is there any challenges that you face when you are speaking with them? So, they have their own sort of challenges, worries and anxieties. Are there any issues that you face?

FC2: 29:01 not really erm only if they put up barriers erm or if they're not willing to try. Or maybe they are willing to try, but… for example, with the HOP scheme I had one gentleman

that could barely walk, never mind do any exercise and yet he was under pressure to lose weight before he could have surgery. His diet was good, he was looking after his elderly wife who had also had, I believe hip surgery recently. So, he had a lot on his plate, but he came religiously. And I got him to the stage where he could walk form the car, into the building without a stick. And on the bike, you could see that he was in a lot of pain when he was cycling, but as he worked through it, he worked through the pain. We did a lot of exercises just seated with resistance bands and foam balls and very light weights and he really tried, but my problem was being able to give him enough to be able to erm, allow him to burn enough calories. To burn calories so he was in deficit. That was a challenge, and it wasn't happening. And unfortunately, in the end he came to me, and he said, "I've really tried, and I really thank you for all your effort, but I can't continue". He's done a good ten weeks or so and that was a challenge and that's only the only challenge, I think I've face is not being able to reach the goals that we'd like to reach

AW: 30:59 yeah, absolutely

FC2: 30:59 and people come on and saying, "well, I can't exercise" so we have to try and do it through diet and if you've got somebody who's maybe in their 70's, and their wife cooks, and she likes to give him a big plate of food, you know? We are not there we can't see what they're doing, and they think that sausages and mash is a good meal you know? So, that's the challenges for me that we are up against, I think and erm, it's out of our control, unfortunately.

AW: 31:31 yeah, absolutely. So, the last section is just about feedback. So, I'll ask you about feedback and then ill double check my interview schedule for Fitness Professionals because you do have that dual role. In terms of feedback, how important do you feel is it to provide that patient progress feedback back to the general practice sites?

FC2: 31:51 oh, I think it's absolutely important. I do get people to write testimonials as well. Erm, and I scan them in and email them to Beverley, to the central team. Erm, I don't know if they reach you

AW: 32:06 I've not seen them. I've been heavily involved in the GP surgeries if I'm honest. You're only my second interview do you know in the leisure centres. I'm slowly seeing it all, but I haven't personally seen any testimonials yet., I think it is brilliant to really showcase their success

FC2: 32:23 well, you know I've got a pile maybe that big. Erm, I've got probably a few hundred that I've saved because I have to email them every month to, do you know [Fitness Professional name] ?

AW: 32:33 yeah, yeah,

FC2: 32:33 I email them to her erm, and it shows how many we do a month. So, I can share them with you if you would like, or some of them with you if you would like to read them if that would help your survey. So, that information tells yourselves and [Fitness Professional name] and hopefully it gets back to other people how valuable the schemes are and how much it helps people. I mean obviously I see it on a day-to-day basis. I mean for example I did a little V blog, and it went up on East Ridings' Facebook page and I had this lovely gentleman, he's 85 years old, and he came to me with intermittent claudication which pain in his legs, could lead to thrombosis. He had had, I think a triple or a quadruple heart bypass several years ago erm. And in a nutshell, when he started, he could do two minutes on a treadmill and two minutes on a bike and then he was breathless. But after the end of his ten weeks he would come to me and say, "I've done, I've been on there 31 minutes and I've done however, many kilometres and then 30 minutes walking" .... seven kilometres!

AW: 33:58 that's fantastic

FC2: 34:00 and he's so pleased and then he goes, and he does just some lightweights. And erm that is fantastic progress. So, he went to his vascular clinic for his check-ups, and I don't think he has had his results yet, but there must be improved and that is such a good, you know, testimonial to the job that we do and erm the referral scheme. It's fantastic and he will join. He will take out a membership otherwise you're not keeping up your good work you know. So, that is one really good erm, yeah, its good news. So, yeah, the feedback is absolutely important because it means that the scheme is going to keep going. Maybe other schemes will come out. I sometimes think that maybe the referral scheme could be a bit longer. They are only allowed two in a year. I know from a business point of view, we want people to join and take out a membership, but when they are on a GP referral, they are looked after by us if you like. I'm not saying, we don't look after them when they just become a member, but

AW: 35:16 they have more one-to-one time with you?

FC2: 35.16 Absolutely so I don't know if that's something that could be developed you know? Erm, I'll leave that with you

AW: 35:26 yeah, yeah. That's really interesting. So, do you provide any feedback directly to the referring surgery?

FC2: 35:30 other than Pharmoutcomes, erm, obviously, I record you know, but it would be up to them to say that "oh, Mrs S lost so many kilograms, or her mental health has improved", or "this is better or worse", you know? That would be up to them, it's not in black and white on Pharmoutcomes

AW: 35:56 oh, ok so they would have to go on there and have a look?

FC2: 35:57 I mean obviously, I write notes on our system. I don't know that they have access to that, but I don't know how much is passed onto them after we've finished

AW: 36:11 how valuable do you think that would be if they were able to see evidence of the schemes working?

FC2: 36:13, I think invaluable really., I think they should know what their patients… I mean I know they have so many patients and, but, you know, at the end of the day it keeps them in a job and, I think that the more they know about their patients, I mean obviously if they went for tests, they would get the results of the test so why wouldn't they get the results from the good work that they have done here?

AW: 36:44 yeah, I absolutely agree and, I think it would give them more confidence in the effectiveness, I think a lot of the time they are referring, but they don't actually know if that patient has done well, done not so well. So, I think if they did know, I think if it was, if they saw these fantastic testimonials, they would think well, that was really good for that patient, I'll refer my next one. It might just encourage them to refer a bit more...

FC2: 37:04 definitely

AW: 37:04 perfect. So, in your opinion, is there any way that the referral process could be improved? In terms of you receiving the referrals, anything we've discussed. Any way that you can that may make it easier for you when you're receiving the referrals for any of the schemes?

FC2: 37:21 making it easier...erm, I think it will be easier once, I mean this has got nothing to do with the schemes, but once we are online and the doctors. Because, I think at the moment, this particular centre gets bypassed a little bit and they all go to Withernsea. Erm, I'd probably have twice as many (laughs) I'm not sure if that's good or bad, but we'd probably have twice as many if we were online. But that will be easier for the doctors surgeries or whoever is referring

AW: 37:52 and I guess you as well, because you don't have to read all the handwritten notes

FC2: 37:57 yeah, and people are not waiting for it to be posted to me. Erm, other than that. Other than, as I said, you know, maybe the scheme being extended in some way. I mean I can't understand how a LiveWell, they can have six months with a six month extension for free and yet somebody who's got something more serious. I know, I know there's this fine line between you know, obviously the weight management is important because its preventing other health issues down the line, erm, but I see people with, obviously other conditions, and I don't understand how a person who is already diabetic say, erm, with other complications can only have ten weeks when a LiveWell, is allowed up to a year

AW: 39:07 yeah, and they might just be morbidly obese

FC2: 39:07 yes, and that, and that might be unfortunately, something that they have brought on themselves whether its hereditary or brought on though you know, inactivity, or the parents not feeding them the right food when they were young and then growing up with that knowledge. Whatever that might be. If it's a health problem, erm, that's different, but I just don't see how people, do you see what I mean?

AW: 39:36 yeah, absolutely how they can have a year on a free scheme, but those who may have very severe erm conditions

FC2: 39:45, I think there needs to be… I know the HOP scheme is kind of an in-between, but still they have these conditions where they can't come on the scheme unless they are waiting for a non-emergency operation, or their BMI is over 35., I think there needs to be something else or something else done to that GP referral scheme

AW: 40:04 to your knowledge, is this the only leisure centre that doesn't use the electronic referral

FC2: 40:09 it is yes. It's just, I mean others, South Cave, they don't, but I don't even know if they have anyone there who does referrals.

AW: 40:19 ah, ok so you're not actually sure if that leisure centre is used for the schemes?

FC2: 40:24 South Cave apparently is really small. Erm, so and I've never been, but I know that all the other centres definitely do. Erm, so, and they're all, have Bears as well, so...

AW: 40:41, but not this one yet. So, did you use to receive, when you worked at Withernsea and...

FC2: 40:48 Pocklington

AW: 40:47 yeah, Pocklington, Hornsea, did you use to process them electronically?

FC2: 40:49 well, no, because when I was there, that scheme hadn't yet happened. So, the process of them coming on direct has only been very recent like the last six months or so and obviously I've been here in post nearly two years. So, that's obviously, they use to always come in the post, or they emailed or whatever

AW: 41:17 yeah, and for you that's still how it happens so for you it's not like you've gone form electronic to paper

FC2: 41:23 no

AW: 41:23 because that would be disastrous (laughs)

FC2: 41:23 it would absolutely it's good to have that knowledge. Obviously, when the time comes fingers crossed you know, it will be an easy transfer for me

AW: 41:34 hopefully. Perfect so that's all I wanted to ask in terms of erm, a Fitness Co-ordinators or a business tech. I'm just going to quickly read through the Fitness Professional's interview guide. A lot of it is pretty similar... yeah, we've spoke about all that... no, to be fair a lot of it we've already covered so I won't go into that. Could I just ask one favour? Because you've got the dual role of a Fitness Co-ordinator and a Fitness Professional. You've filled out the Fitness Co-ordinators survey, could you also fill out the Fitness Professional once with you having that dual role?

FC2: 42:17 online? Yeah, yeah,

AW: 42:18 I might have to send you the link separately because I asked [HLO's name] to distribute the surveys and she basically, sent all the Fitness Co-ordinators one survey and all

the Fitness Professionals another survey. So, the one you have been sent is the Fitness Co-ordinators one so I will send you a link to the Fitness Professional one and it's very similar. So, a lot of it is still like what is your age, which surgery..., but some of the questions are just slightly different and they are more aimed towards what you do with someone on their first appointment. So, they one you filled out was more about how do you process referrals, what information is missing, whereas this one is focused towards, ok so when a patient comes in for the first time, what information do you get? What information would you like? So, it's slightly different. But [FC's name], I don't know if you know [FC's name]

FC2: 43:01 yes, I know [FC's name]

AW: 43:01 he's also got a dual role so he is a coordinator and a Fitness Professional so I asked the same of [FC's name] and said, can you fill out both for that purpose so I will send you that link if that is, ok?

FC2: 43:11 that's fine yeah, absolutely

AW: 43:13 well, thank you so much for spending the time today. I know we've chatted a long time. What I will do I am going to type out our interview word for word into a transcript on a word document. You can expect that within 4-6 weeks hen if you just confirm is it or it isn't an accurate representation and then we will go from there

FC2: 43:33 ok

AW: 43:33 so I'll stop this recording...I really should wear my glasses

AW: Interviewer **Interview date:** 14.02.2019

FC3: Participant **Interview location:** East Riding Leisure Goole

AW: 00:03 so is it ok if I take some simple demographics before we begin?

FC3: 00:05 yeah, that's fine

AW: 00:07 how would you identify your gender?

FC3: 00:08 male

AW: 00:08 male and how old are if you don't mind me asking?

FC3: 00:11 41

AW: 00:12 41. Is this the only leisure site you work in? Goole?

FC3: 00:17 mm yeah

AW: 00:17 perfect. And what's your role in Goole leisure centre?

FC3: 00:20 I'm the Fitness Co-ordinator

AW: 00:24 and how long have you been working as a Fitness Co-ordinator?

FC3: 00:27 as a Fitness Co-ordinator, ten years

AW: 00:30 yep, any roles prior to that?

FC3: 00:32 yeah, I've worked at Goole for twenty years in total

AW: 00:37 ok

FC3: 00:38 various roles

AW: 00:40 right. And can you sum up what it means to be a Fitness Co-ordinator?

FC3: 00:43 erm, basically, I'm responsible for the management of the gym and exercise classes. Erm, all gym staff, memberships and sales, the exercise class programme, er, all the health agenda that we do. So, managing Exercise Referral LiveWell, HOP, erm and all the administration that goes along with that, er and all the special promotions. Quite a lot!

AW: 01:10 a little bit of everything

FC3: 01:11 yeah,

AW: 01:14 absolutely. So, you've mentioned a few there in terms of the health agenda. So, the healthy lifestyle programmes. You've said that you are involved in the processing of the LiveWells, the Exercise Referrals, and the HOPs. Any more healthy lifestyle programmes?

FC3: 01:25 Cardiac Rehabilitation

AW: 01:28 yep, Cardiac Rehab as well

FC3: 01:27 erm, I actually teach a class there once a week. Erm, Young LiveWell

AW: 01:36 right so all of them?

FC3: 01:37 yeah, all of, all the health agenda work that we do

AW: 01:41 perfect. And then you've got that additional role and you take on some of the Cardiac Rehab classes as well

FC3: 01:47 yeah. I not only administrate the schemes, I also have clients of my own as well.

AW: 01:53 right, ok. So, do you have a dual role of a Fitness Professional as well?

FC3: 01:56 yeah, yeah.

AW: 01:59 ok. So, what I will do, I do actually have a separate interview guide for Fitness Co-ordinators, Business Techs, and then I also have one for Fitness Professionals so it might be that I ask you a few questions on the other one as well, just because you've got that dual role. OK? Does that makes sense?

FC3: 02:14 yeah, yeah.

AW: 02:16 perfect so the first theme is about the information that you receive from primary care

FC3: 02:19 yep

AW: 02:20 so can you talk me through the different ways that you receive referrals from primary care.

FC3: 02:23 we receive it three different ways. We receive referrals through the post, er paper referrals. We can receive referrals directly from primary care sites and we also receive referrals from the central team in Beverley

AW: 02:44 ok when you say directly from the primary care sites, what do you mean by that?

FC3: 02:46 GP surgeries. So, Practice Nurses, Physiotherapists, people like that

AW: 02:51 is that electronically?

FC3: 02:53 electronically yes, via email.

AW: 02:55 yep. And that's the most common way that you receive referrals?

FC3: 03:01 to be honest at the moment I would say it's around 50:50. Its use to be, it's gone more towards electronic referrals er, so about a year ago I would have said, it was mostly paper referrals, but now it's about 50:50. The direction of travel is getting, well, becoming paperless so going 100%

AW: 03:20 yep, so 50:50 between the ones that are coming through paper and the ones that are coming through electronically. And in your opinion, which way are easiest to process?

FC3: 03:29 the electronic referrals

AW: 03:32 ok why is that?

FC3: 03:34 erm, with a paper referral, er, I do a lot of work. So, I have to go onto the computer, what name, date of birth, ring the client up, arrange a date with erm, what date would be best for them. Input all the information in the database so that the booking is actually made. With the electronic, well, there's two lots of electronic referrals. With electronic referrals from the GP surgeries, I do exactly

the same as the paper referrals. So, it's me actually administrating it. With referrals directly from the central team in Beverley, they do a lot of work for us, so they actually ring the clients, they make the bookings, put all the details onto the database so we just basically, ring the client

AW: 04:25 and that's the easiest one when the Business Techs do that

FC3: 04:29 that's the easiest yeah, yeah

AW: 04:30 so as you say, when they are coming through from the primary care sites electronically you've still got work to do. You've still got to book that appointment.

FC3: 04:36 yeah, yeah

AW: 04:39 so which are the most difficult to process?

FC3: 04:42 er, [phone rings]

AW: 04:43 you can take that if you like, it is fine

FC3: 04:44 no, no, it's fine

AW: 04:44 ok

FC3: 04:46 erm the most difficult to process, the paper referrals are most difficult yeah. We occasionally, instead of them being sent through the post, they get, they get given to the customer who walks in off the street, and we have to deal with it there and then. No matter where I am in the building. That's a problem

AW: 05:08 when people come from the street

FC3: 05:08 yeah, yeah, and they are wanting an appointment right there

AW: 05:11 yeah. And are all sites, primary care sites in the area set up to refer electronically?

FC3: 05:19 not all no. More are coming online at the moment, but we have got, I think two at the moment, with a third coming online soon. Er, so again that's 50:50

AW: 05:30 yep, is there roughly six...

FC3: 05:32 erm yeah, I would say so

AW: 05:37 about six referring primary care sites

FC3: 05:38 Howden, two in Goole, Snaith, Gilberdyke

AW: 05:43 yep, and how often do you receive referral forms that include all the required information?

FC3: 05:51 how often? How many per week would you say? Quite a lot. Ten a week maybe. Sometimes more. Sometimes less

AW: 06:02 ok and do they tend to be correctly filled out, the paper ones?

FC3: 06:07 the paper ones not always. Erm, cuz when we transfer the data onto the, the er, database for booking people in, we are missing things, silly things like erm, postcode, date of birth, sometimes they are missing.

AW: 06:21 ok

FC3: 06:22 as I say, if we have not got a postcode there, you've got to google the address and see what the postcode is, so it just takes a little longer.

AW: 06:27 so again just something else that makes that process a little bit longer and can you tell me about your experiences of contacting GP surgeries to retrieve any information that is missing.

FC3: 06:39 erm, I don't usually contact them. Like I say, it's only, to be fair it's only the er postcode, I can google that. And if I am contacting the patient, I can ask them their date of birth. So, I don't generally go back and get that from a GP surgery, I wait until I call a client and I get the information next.

AW: 06:59 ok. So, you are able to get that by either doing a little bit of a google search or by talking to the patient

FC3: 07:05 yeah, yeah,

AW: 07:06 perfect. And in terms of the information that you are provided with on the form, are you satisfied with the amount of information that you are provided with?

FC3: 07:13 er, on the electronic, the new electronic ones, yeah, they are a lot better. The paper referrals tend to be a little vague. Erm, sometimes you get a lot of options, and just tick a certain box with that option so it's usually generalising what they are being referred for, but not specific.

AW: 07:35 ok. So, what is the difference with the electronic one? What additional...

FC3: 07:37 the electronic one, there seems to be a box to explain the actual medical condition. So, you still get that tick box, but you tend to now be erm, a little bit explaining in more depth why this person has been referred.

AW: 07:52 yep. So, that little bit of free text so they can explain

FC3: 07:55 yeah, a little bit more

AW: 07:57 and is there any additional information that would be useful to receive upon a referral?

FC3: 08:01 erm, the client's readiness for exercise I would say

AW: 08:10 ok. Does that tend to be a stumbling block?

FC3: 08:11 yeah... sometimes you will get a client and it's just "my doctors told me to come here, I don't know what I am doing here, I can't exercise". So, a bit more information from the GP to the client on what the schemes are actually involved with?

AW: 08:34 ok. How do you get around that when they are turning up and a little bit reluctant to change?

FC3: 08:38 er, customer care basically. Meet and greet a customer. See why there are here. Give them a summary explaining exactly what the scheme involves and just being really friendly and approachable to them and before long they are signing up.

AW: 08:58 yeah. So, it's all about how you engage with that, with that customer when they are coming in. But in your opinion, it would just help if you had just a little bit more insight on how ready they are to change

FC3: 09:07 yeah, their readiness to change

AW: 09:12 absolutely. And how would you describe your relationship with the primary care sites that are referring into, into this site?

FC3: 09:18 erm, quite good I would say yes. We've got erm, one Health Trainer that works at the Goole health centre. She, erm, she talks to me quite a lot

AW: 09:32 ok. So, you've established relationships with Health Trainers

FC3: 09:34 with Health Trainer's yes

AW: 09:36 and are they in the surgeries the Health Trainers?

FC3: 09:36 yeah, they are at, the Health Trainers for Goole are at Goole health centre erm, but as far as Doctors, Practice Nurses go, I would maybe get the occasional phone call once now and again, but there's not a lot of relationship there, it's just referrals coming

AW: 09:53 ok. So, it tends to be a stronger relationship with the Health Trainers, but not so much so with the GPs and Practice Nurses. Why do you think that is?

FC3: 10:03 I suppose they are so busy and got so many clients. Er, you know they fill out the referral form send it to us and that's it. That's the end of the process for them and we don't have a lot of interaction anyways. So, we are not on the phone to each other

AW: 10:19 yeah. Minimal interaction and once they are sent that referral, that's their part done in their view.

FC3: 10:26 yeah

AW: 10:26 ok. Er, so the next section is about the telephone conversations that you have with referred customers. So, how quickly are you able to contact a person once they have been referred to you?

FC3: 10:37 I try, well, it depends on how busy my day is. As soon as I get a referral form, I will try to contact them that day. Erm, I always, if I cannot, if it goes to answer phone I leave a message, and I record that I've left a message on the referral form. Erm, I will contact them back within a couple of days and then try to contact them again. Erm, but usually I try either on the same day or the following day, I'll try to contact them

AW: 11:07 you try and have a same day policy, but you audit that anyways so if you have left a message, you're able to jot that down

FC3: 11:15 yeah, yeah

AW: 11:16 and during these conversations, what information do you provide to customers?

FC3: 11:19 basically, I er, I explain who I am, why I've called, the reason why, why I have called. Er, I explain that they have been referred for one of the schemes. Er, I'll book them in for their first appointment. Erm, we, we arrange dates and times, and we will go through a little information er. I ask them how much they already know about the scheme they've been referred to. If they've no, or very little, or the GP has not told them very much, I will go through the scheme with them, and how many weeks it is, what is expected of them, what they can expect of us. Erm, and basically, the rules and regulations of the scheme.

AW: 12:04 does it tend to be the case that patients don't really know about the schemes or are they well, informed?

FC3: 12:09 a lot of time it is, yes. A lot of the time, yeah,

AW: 12:15 is that problem for you if they are not really aware?

FC3: 12:18 er, it would help if they were aware of what each scheme entails, but on the other side, it gives you a conversation starter, so you can establish that relationship up at the start... But sometimes, especially, one of the worst things is, a lot of, some of our schemes are free like LiveWell, and HOP are free. Exercise Referral costs £33 unless you're on say some benefits. So, as soon as you mention to the client "oh, by the way this costs £33", that's a negative straightaway cuz they think they are being referred by the NHS, everything is free and say, "They never told me that I had to pay anything". And we do get some clients who say, "In that case, I'm not coming onto a scheme". So, it would be nice for them to know beforehand that that is what's happening.

AW: 13:13 yeah. So, there's a negative perception that they've got to, they expect I guess everything to be free, and then when it is not free that can cause a bit of tension

FC3: 13:23 yeah

AW: 13:23 how do you think we could increase that, that awareness and understanding?

FC3: 13:25 it, it's just, the knowledge or the information going from the GP surgeries, Practice Nurses, Health Trainers. And I, I, I am well, aware how busy the GPs and Practice Nurses are, but if they could just say, "Oh, by the way, you will have to pay for GP referral", and then they can make their decision then and there. Do I want to go on the referral, or do I want to try something else?

AW: 13:52 absolutely. So, if there was that little bit, really little bit about the costs so there's a...

FC3: 13:57 yeah, and I can be quite confusing because like I said, some of the schemes are free and the other schemes you have to pay for, so it's not a universal scheme, all our schemes.

AW: 14:07 that can be a bit of a confusing time for GPs

FC3: 14:11 yeah

AW: 14:12 are you confident in the information that they are providing to patients about the schemes?

FC3: 14:18 what the GPs are providing to their patients?

AW: 14:20 yeah, or the Practice Nurses, or whoever is referring

FC3: 14:22 er, the Practice, again, the Practice Nurses tend to be a little bit better than the GPs. If it a referral straight from the GP, er, I don't think the client, the customers get a lot of information. They just get told "right we are referring you to the leisure centre for exercise" and that's basically, it. Not much more information than that.

AW: 14:46 right, ok. As you say, the Practice Nurses are a little bit better

FC3: 14:53 a little bit better

AW: 14:54 and the Health Trainers are a little bit better than them as well

FC3: 14:56 yeah

AW: 14:57 and do you have confidence in the information that they are writing down on the form? So, in terms of the BMI, do you have confidence in that information?

FC3: 15:03 er, yeah, oh, yeah, of course. Occasionally, for LiveWell, they may overestimate the BMI cuz with LiveWell, you have to have a BMI of 45 to qualify. So, some, I have had it borderline where the GP has wrote they have a BMI of 47 let's say. Then when we do our initial measurements, it's more like 43.2 or something. So, occasionally, that can happen, but I think that's because they want you to get them onto the LiveWell, scheme.

AW: 15:37 because it's a free scheme?

FC3: 15:39 yeah

AW: 15:39 are you able to take that person on in that instance?

FC3: 15:40 I clarify it with er, the central team at Beverley, but in most cases yes

AW: 15:47 ok. So, there's a little bit of leeway?

FC3: 15:48 if they've reached the point where they have actually been referred by the GP, they've got here, we've done the health check, and they are actually in the building, it's very difficult then to say well, actually your BMI is actually not 45, we can't do it. But I, I do try and get clarity from the central team saying, can I accept this referral. If it's just under 45, they usually accept it. I mean most cases they say yes

AW: 16:11, but you do try to accommodate for that. Like you say, if they have made the effort to come into the gym er, you try your best to try to not turn them to the Exercise Referral

FC3: 16:22 yeah, yeah, yeah,

AW: 16:24 where they have to pay. Ok. And during your initial telephone conversations, are there any concerns that clients tend to raise with you?

FC3: 16:32 erm, a lot of people have not exercised before so they, they are a little bit ap, apprehensive about coming into a gym environment. Erm, especially some of the older clientele that we get. So, it's just a case of reassuring them and saying, it's a public facility and we get all ages, all shapes, all sizes coming into... cuz people have preconceptions of what a gym will be. It is all skinny girls and leotards and big hunky men, that sort of thing. So, it's about reassuring them that its normal people of the community, especially in a public leisure centre.

AW: 17:14 absolutely. So, they are little apprehensive about coming into a gym environment. As you say, they have preconceptions. Is there any other concerns that they tend to raise with you?

FC3: 17:25 erm, occasionally, it all varies. Not one major concern that anybody has, that was the main one.

AW: 17:33 yeah, and the other ones are individual

FC3: 17:35 yeah, individual. Can I ask why we are not getting more information about what the scheme is, and what I am expected to do? That sort of thing. That is generally the...

AW: 17:45 right, ok. And in terms of erm, the conversations that are you having, do you face any challenges or concerns or are you faced with any difficulties?

FC3: 17:55 erm, with the conversation with a client?

AW: 18:00 yep

FC3: 18:01 erm, the barrier that you have to pay £33 to come to the GP referral that is a main one. But no, no, no, I have no, real concerns. I am happy to talk to them about what the schemes involve and things like that. So, no, major concerns

AW: 18:19 yeah, none on your side, but again in terms of cost, again I guess that will serve a challenge

FC3: 18:25 and again with, with "how ready are you to exercise", readiness to change, you can't really gauge that over the telephone. You maybe need to see them one-on-one in their first appointment and have more of an in-depth conversation to see where they are in terms of how prepared they are to change their lifestyle.

AW: 18:43 how do you measure their readiness to change?

FC3: 18:46 there are questions on the questionnaires that we do, do. Erm, on some of them, it depends on what scheme it is, one of the questions is" how ready are you to change your lifestyle through exercise"? So, it's on LiveWell, it's on GP referral., I think it's on HOP now as well.

AW: 19:05 so the questionnaires are slightly different depending on which scheme you go to?

FC3: 19:08 yeah

AW: 19:11 and do all the referrals come in the same way depending on which programme they are referred on to?

FC3: 19:18 er, well, no, not really. We get a lot of Exercise Referral paper bookings, and we also get, now I got LiveWell, and HOP and junior LiveWell, should get sent to central team in Beverley to process and administer, but we are still getting a lot of referral, paper referrals coming through to us, which I don't think should be happening at all. What I do is, I just scan that to the central team, and they take over

AW: 19:53 right, ok. So, how it should work is the LiveWells, Young LiveWells and HOPs should go to Beverley, central team, and the Exercise Referrals....

FC3: 20:00 come to us

AW: 20:01 ok. What about the Cardiac Rehabilitation?

FC3: 20:02 Cardiac Rehabilitation gets referred to us by email from a cardiac specialist at Castle Hill

AW: 20:12 right, ok. And why do you think the Exercise Referrals are still coming to site?

FC3: 20:15 it, because it's the oldest scheme that we run and it's been running for, well, since I started working here. Er, whereas the other schemes, the LiveWells and the HOPs are more recent commissions so, I think your GP is so use to handing out paper referrals that it is taking them a little bit longer for them to realise they can do it electronically that way. And Exercise Referral does come to us anyways, it

doesn't go through central team at Beverly. They don't process the Exercise Referrals, that's done by me

AW: 20:45 you do all those ones

FC3: 20:49 yeah, but the central team should process adult LiveWell, HOP, and Young LiveWell

AW: 20:54 ah, ok. So, because they are used to sending the Exercise Referrals here, they assume they can send the LiveWells?

FC3: 21:00 yeah, yeah

AW: 21:01 how do you see the future in terms of the referrals that are coming in? Do you think it will go completely paperless?

FC3: 21:08 that is a long-term goal yeah., I think it will do eventually. It will be a long process, but the more the surgeries get online onto our computer database, and learn the systems, we will get less and less paper referrals

AW: 21:26 and what benefits do you see from it being completely paperless?

FC3: 21:29 er data protection for one thing. We are not having to store paper referrals in files and locking them in cupboards. It's all on computer, not under lock and key, but under password protections and things like that. It just makes less clutter around the office, and everything in one place.

AW: 21:48 absolutely. Perfect. So, the final section of the interview is about the feedback. So, how important it is to provide that patient progress feedback back to the primary care site?

FC3: 22:02 er very important. Especially with things like HOP or LiveWell. They could be waiting for an operation so it's important. We have a notes system on our CRM and each session that we do, we record a note on how each session went. Er, and so that can be sent to the primary care trusts to see if they deserve to have an

operation, or gastric band or whatever it is that they might need. Erm, with HOP, they are waiting for non-urgent surgery. It could be a knee replacement, hip replacement, er so our notes let them know, look they have come on here to try to lose weight for their operation and I believe they have been successful, can they have their operation. So, quite important to give feedback

AW: 22:48 ok. How does the CRM system link with the GP surgeries? How do you transfer that information across?

FC3: 22:55 I'm not sure that's something that central team, er pinpoint [HLO's name]. I know, we input the data onto CRM, how that gets transferred across to primary care systems. I am not really sure.

AW: 23:11 right, ok. Not a problem at all. Are you aware of the information that you provide to primary care sites or are you not aware at the moment?

FC3: 23:17 erm, I know that I've been told that the notes that we write do get taken into consideration for decisions for the clients future, so I know that that is important, but I don't know how it gets transferred across to them.

AW: 23:34 that's ok and in terms of the information, is there anything you feel is especially important to communicate back? So, you've said, about whether they still need an operation

FC3: 23:44 er attitudes. Attitudes to exercise. Er...

AW: 23:49 what do you mean by attitude to exercise?

FC3: 23:50 how they embraced the scheme. Whether they have really given it a good go. You know, taken on board the advice that we've been giving then. yeah, basically, have they really tried hard on the scheme

AW: 24:06 yeah. Why do you feel that's important?

FC3: 24:08 er just because er it gives them a gauge of how ready they are to change their lifestyle and stay on a healthy lifestyle for the future

AW: 24:22 so in your opinion, it's really important not just to send back how well, they've done physically, but also how well, they are doing psychologically and how motivated they are and how ready they are

FC3: 24:34 yeah, yeah

AW: 24:34 perfect. And in your opinion, how could the referral process be improved? So, that could be to do with anything we have discussed today

FC3: 24:39 er, it can, we've got so many schemes now it can be quite confusing. Erm, the rules of one scheme are different from the rules of another, from the rules of the other. It could, it would be better if everything was just streamlined. All the schemes have the same questionnaires that you have to fill in. The same health assessment to fill in. The same process to follow, how many weeks it has to follow, cuz it's different. We have a thing called Pharmoutcomes where we record all patient data and all the schemes that we have on there, have different questionnaires, different health assessments so it everything could become less complex that would be good

AW: 25:32 yeah, so standardisation across the schemes

FC3: 25:36 for all schemes

AW: 25:36 you feel would be helpful

FC3: 25:39 I mean I, like I say, I've been the Fitness Co-ordinator for ten years and we've got so many different schemes, not just health schemes, everything going on. Sometimes you've got to think, right so he's on LiveWell, he's allowed this, you get a LiveWell, buddy. On GP referral, they can come in at this time, they can go to classes. If everything was standardised then there's no, hesitance straight away.

AW: 26:00 absolutely so it's not only difficult for the people that are referring to the different schemes, you've also got to remember all the different schemes and all the different rules

FC3: 26:10 yeah, yeah

AW: 26:11 anything else that you feel would help streamline the referral process or improve it in any way?

FC3: 26:14 er, if all the referrals came directly from the central team. So, central team receive all the referrals like GP referral, LiveWell, HOP, er and they all, they did all the, the initial inputting onto the computer database. Just send us with the referral and basically, let's go, appointment one, do a health assessment and then go in the gym. We don't have to worry about any of this.

AW: 26:45 yeah. So, to remove that administration burden so one access point. So, the Business Techs or those in Beverley. All the referrals going to them and then they distribute the referrals to each, to each leisure site

FC3: 26:58 yeah, yeah. I mean I'm a Fitness Coordinator, so I am quite good with administration and things, but I am responsible for the gym team as well. And some of the gym team are really, really good Instructors on the gym floor, absolutely fantastic, but not all of them are good with IT. So, a lot of the stuff that has to go on IT, it's a lot of hard work for them to understand what's going on. So, that's something that could make a change

AW: 27:29 yeah, and by changing that it's going to take some of the pressure off them to remember how to do all that sort of things. So, does your gym team also have to book appointments or do you purely do that?

FC3: 27:40 I do, I do the appointments, but I'll book them, the client in with the instructor so on their first appointment, that's when the instructor goes onto Pharmoutcomes for the questionnaires and health assessment

AW: 27:55 ah. So, the Instructor on that first appointment, the first time they will see that client, they will do all the first week questionnaires, health assessments

FC3: 28:00 yeah, yeah, er make sure, er, they are on the CRM, whether they have got a card assigned to them

AW: 28:07 ah, ok. And should that assigning of the card be done by the person processing. So, if you process it, do you put them on CRM?

FC3: 28:15 mmm, the central team put them on CRM, but we have to process their card. We get a membership card, and we process that onto their membership, and they come in

AW: 28:24 ah, perfect. And then final question, is there anything that you would like to add that you feel is important?

FC3: 28:36 er, I think that all schemes are really, really good. er, and from a personal perspective, I enjoy having the clients that I have got. I wish I could take more on, but it is not possible with my role, but just if, yeah, it's just the admin and everything you do on the computer. If that could just be simplified a little bit. Not for me per say, but for some of the instructors that I have. There has been a lot of changes over the past year or two, erm and a scheme could be just a little bit simplified on the computer for the instructors, that would be good

AW: 29:18 is that in terms of everything? In terms of CRM, in terms of Pharmoutcomes?

FC3: 29:19 CRM, all the rules for the different memberships. Pharmoutcomes, yep

AW: 29:24 all of them.

FC3: 29:27 it's really good. The schemes are really good. We do have a lot, one other thing maybe would be, we have a lot of referrals. We've only got so many Instructors and I don't know whether they've looked at a, a cap for how many referrals each site could take, but it just seems to be a constant stream generally. There's only so many referrals one Instructor can have

AW: 29:57 how are you managing the capacity at the moment?

FC3: 29:58 it's difficult. Er, some Instructors are better at managing that capacity than others. So, when I am doing the refer, booking people in for referrals, I try to signpost them to a certain Instructor, but it does become more difficult. Erm, we are trying to get group sessions up and running. But even with the group sessions, if you've got four people on the GP referral at one time, ok you may be able to go round the gym with them, but then you've still got to find the time to do four lots of admin for those people so it there's issues with that as well.

AW: 30:31 is that to write the notes on the CRM?

FC3: 30:31 to write the notes on the CRM, any concerns that they've got. So, I know some of the instructors do think "oh, God how many, how many clients have I got!" Er, and I know there's no, cap on the amount of referrals that we get, but if we could get more Instructors that would help

AW: 30:57 yeah, more Instructors or at least a, a sort of limit to how many they should have

FC3: 31:01 yeah, yeah

AW: 31:04, but you're quite good at sharing that out

FC3: 31:03 yeah. I'm quite good at streamlining people. Of course, the health agenda isn't the only thing that my instructors do. They go and teach exercise classes, do social media promotions. Now we've got 2000 normal memberships and they need

a lot of looking after as well. Erm, inductions, health checks, Boditrax appointments. So, there's a lot of things to do

AW: 31:33 and do find this takes up, the health agenda, does it take up most of their time?

FC3: 31:35 it does take up a lot of time yeah, a lot of time

AW: 31:41 as well, as, like you say the social media, the gym inductions they've got to do, health checks. Everything else that they've got to do as well

FC3: 31:45 yeah. Er from a selfish, purely selfish perspective as well. The scale point that I am at is the same scale point that my instructors are on whenever they take a health agenda client as well. Erm, but I am still expected to supervise them on the same rate of pay and that is just a selfish thing, but it's just something that you know?

AW: 32:09 yeah, it's still, sort of if you're in a supervisory capacity...

FC3: 32:13 yeah, if they, if they, if, if, if, a complaint or a comment or someone's unsure about anything, they all come to me. But I am on the same pay scale

AW: 32:22, but you have that additional responsibility

FC3: 32:25 I have that additional responsibility yes

AW: 32:27 right, ok

FC3: 32:28, but I know that has been discussed in the past. I am happy with it, but it just seems a little bit unfair.

AW: 32:35 yeah, absolutely. Ok so that's all the questions that I wanted to ask today. So, if there's any, not anything else you would like to add...

FC3: 32:43 erm no, no, that's it

AW: 32:45 perfect. Well, thank you for giving me the time today

FC3: 32:47 no problem. That's fine

AW: 32:46 I'll stop this recording

AW: Interviewer **Interview date**: 01.02.2019

FC4: Participant Interview **location**: East Riding Leisure Haltemprice

AW: 00:01 there we go. Am I ok to take some simple demographics before we begin?

FC4: 00:06 yes

AW: 00:07 how would you identify your gender?

FC4: 00:08 male

AW: 00:09 male and how old are you if you don't mind me asking?

FC4: 00:11 29

AW: 00:12 29 and you're situated at...

FC4: 00:17 I'm at Haltemprice. Halt

AW: 00:19 ah yeah. I wrote this and I still can't find where I wrote this (laughs). And what is your role within Haltemprice?

FC4: 00:23 so I'm currently Fitness Co-ordinator

AW: 00:27 any previous roles within this site?

FC4: 00:28 yeah, so I was a Gym Instructor before then. Gym and Class Instructor

AW: 00:34 yep. And how long have you been working as a Fitness Co-ordinator?

FC4: 00:35 Around six years

AW: 00:40 and previous to that, how long was you a Fitness Professional for?

FC4: 00:42, I think it's around five or six years with that as well

AW: 00:47 so all in all around twelve years?

FC4: 00:49 twelve year I have been here yes

AW: 00:51 and can you briefly sum up what it means to be a Fitness Co-ordinator?

FC4: 00:54 in terms of the job role? What I do? Yeah, so it's erm the staffing of the gym and fitness classes, the management of hat they deliver. It's also sort of all the training side of things and sort of being a link between, if you're looking at the

health schemes, the link between the central team which will decide how the health schemes will be ran, we will then make sure that they are ran correctly on the, on the shop floor if you like.

AW: 01:23 perfect, and in terms of the healthy lifestyle programme referrals, which ones are you involved in the processing?

FC4: 01:29 so all of them in essence. So, I, yeah, yeah, all of the schemes, yeah.

AW: 01:35 perfect and I have your email through the online survey

FC4: 01:39 yeah

AW: 01:40 ok so the first theme is around referral information that you receive. But first of all, can you talk to me about the different ways that you receive healthy lifestyle referrals?

FC4: 01:49 yeah. So, we'll get them sort of the old way if you like so by paper. We will get a form through from the medical professional, hopefully filled out fully and we will receive that in a file. We will also get it, through the online booking in. So, that's your BEARS online, online portal if you like. What the Medical Professionals can use. And we do get some referrals that are, it, it, it, it's sort of in our, from our side of things it appears like it's a blend of the two. So, it's probably being a paper form that has been to the central team at Beverley who will then use the online portal to book them in. So, it's sort of like a conglomeration of the two if you like

AW: 02:30 a bit of everything

FC4: 02:30 yeah

AW: 02:32 and which one is the most common type of referral that you receive?

FC4: 02:34 for us it's definitely the paper one. For the way the surgeries around our areas engaged. It's just how, the see it as easier

AW: 02:44 are all the surgeries in the area set up to refer electronically?

FC4: 02:45 not all of them I don't think., I think there's a bit of resistance around some of the, some of our surgeries to take part in it.

AW: 02:52 why do you think that is?

FC4: 02:53 knowing a little bit from the booking side of things, I think that a lot of the NHS operate from a, a portal called SystmOne where they get all their information. They will have forms that are directly interlinked into that, and our IT isn't, isn't linked with that. It would be a separate way of referring which they are maybe not as erm, accommodating to take that on, you know? It's, it's just a different way of referring to them as opposed of what they do for everything else. Every other referral, it seems that goes through SystmOne.

AW: 03:22 right OK. So, there's no, a link between their systems and your system

FC4: 03:25 they can't talk to each other I don't think, yeah. I don't think within our profession, we don't have the rights or the access to all medical records is what I believe. So, we can't have that access to SystmOne is what it looks like.

AW: 03:39 yep, that makes sense. So, the most common are the paper referrals. In your opinion, what do you think is the most, the easiest to process?

FC4: 03:46 I mean because we've done it for a lot of time, the paper one is nice and easy to process. I can definitely see that a, an electronic one would be better in the future. I just think there's a few loopholes within the system at the moment which aren't quite, they don't quite piece the IT side of things with what the instructors need on the shop floor

AW: 04:09 ok. What do you mean by that?

FC4: 04:08 so if we, if we get an electronic referral, say if we were to say that we are paperless, we would need that form to transfer to every single booking made for

that client because the instructors need to know their ailments, they need to know their medical conditions. So, currently, we would get that electronic referral, but still then print it out and put it in a file as if it was a paper referral cuz then you've got it to reference at any point. As much as an instructor may remember their ailments, if they are ill, or if they have to get passed to another instructor, it is just a way of transferring that information

AW: 04:42 yep, absolutely. And earlier on, you said, about the paper referrals, so said, hopefully if they are filled in correctly.

FC4: 04:48 yeah

AW: 04:48 what do you mean by hopefully?

FC4: 04:49 so you'll get referral forms that aren't filled in, you know fully. They maybe have things missing, signatures missing, things like that. It might even be that we've got them in and done a BMI, I've had that before and it is nowhere near the BMI that's on the form, which is quite relevant to some of the health schemes because they are BMI related. So, if the GPs have taken an incorrect or maybe an old BMI reading from their information, and we take a current one, it can decide whether somebody comes or doesn't come on to our health schemes

AW: 05:22 yes, so sometimes the signatures are missing. Other times, some of the referral measures aren't correct. Like you've said, with BMI and you've found that it's actually not

FC4: 05:30 yeah, it's probably really rare that. It's probably really rare, but I can, it's something that sticks quite clear in my mind because I was like right now this person now doesn't fit in this health scheme because we've been given the wrong information.

AW: 05:37 do you find that often, are the referrals erm, are they going to the right destination. What I mean by that, are they completing an exercise referral form for a LiveWell, client or do they tend to be...

FC4: 05:50, I think well, over 90% of people that come in our referrals are getting the right scheme. It's, if they are getting the wrong scheme, it is very rare. And, I think in some respects, the customer, if they are getting help in some way. They are just coming to Haltemprice for a health scheme, you know. Depending on what it is, they are getting helped the same way it's just what we sort of funnel them out into different funding pots if you like from our side of things

AW: 06:21 so in terms of the client they are still getting something

FC4: 06:21 they're still getting a service yes

AW: 06:21 it's just which service is most appropriate

FC4: 06:24 yeah,

AW: 06:26 perfect. So, in terms of the referral form and missing information, you've said, about the signature. Is there anything else that tends to be missing from the…?

FC4: 06:36 not from, not from my mem, you know from instant sort of things like that. They're the first things that come, come to mind. There might be the odd bit of medication, but we are only asking for relevant medication so as much as somebody might have a long list of medication, it might be that, you know, the medical professionals just include the relevant medications so

AW: 06:54 do you think it's easy for them to differentiate what is relevant and what is not relevant?

FC4: 06:56 probably not, no, probably not. Its erm, even for the staff they need to know what, it's probably best to know everything as opposed to just being given some of the information

AW: 07:06 I bet it's hard as well, if your face with all those medications and you're not sure what they are

FC4: 07:11 they will have to do some research around it yeah, and if they can do that prior to their appointment, because the form has got it there, at least they've got a little bit of insight

AW: 07:19 before that person comes.

FC4: 07:20 yeah

AW: 07:20 absolutely. Can you tell me about your experiences of contacting GP surgeries to retrieve any information that you are missing or clarify anything?

FC4: 07:29 yeah. Erm, generally it's been ok. Sometimes, obviously, I think we just sit and wait like anybody else would, so I don't think we have quite that sort of, "Haltemprice are ringing, let's see what they are after". It's, it's quite, we will sit on the waiting list, get through to the reception like anybody would. Once you get through, I think as long as you put yourself across well, on the phone, I think you generally do get the information as long as you can give them a surname, date of birth, that sort of stuff. They are OK. Erm, but I don't know if the relationship is good enough really, for, I don't think we are quite getting the full respect of the services that we offer

AW: 08:03 what do you think may help that relationship?

FC4: 08:05 I don't know really., I think if we get better maybe at reporting how well, people do, we'll maybe get a little more respect on this side of look these people are doing wonders for some of our patients, let make sure we remember what the

health schemes are, remember what they're offering, if they can get the right form for the right person, that sort of stuff. Remembering who is applicable for what. So, cuz at Haltemprice we sit on the Hull and East Riding boundary so sometimes it gets a little bit political about who can and can't come onto our schemes. So, if the surgeries can get that right by referring the right people in. So, if they are an East Riding surgery...

AW: 08:44 does that tend to be an issue with the patients and the boundary?

FC4: 08:47 it, it comes up every now and again. yeah, it can do. So, it's mostly sort of, you get LiveWell, clients that are maybe live in the East Riding, but go to a Hull, go to a Hull GP because it's funded by East Riding GPs, they are applicable for that scheme. So, occasionally you get the odd one you have to let down, but it's, it's few and far between really.

AW: 09:06 OK, but in your opinion if you were able to just build that relationship, perhaps by as you say providing that feedback about how well, people are doing on the schemes, you feel that might improve that relationship a little bit

FC4: 09:17 yeah, and just repeating it because, I think we are easily forgotten about, you know? Its staff turnaround. I'm sure it happens in the surgeries as well. So, as much as we preach to some people one year, the next year, it might be different nurses in there and you've got to keep sounding that message out to make sure that we are still remembered and still current in their mind.

AW: 09:35 yep. Perfect so next, actually I'd like to ask, in terms of the different schemes, how many referrals roughly are we looking at? Per month or per quarter, out of curiosity.

FC4: 09:48 as in people coming through as new referrals or total on the schemes? You're looking at, so with exercise referral we get between 10 and 20. Erm, it's easy for

me to break it down thinking about the figures that we do. So, for the cardiac rehab scheme, we would get maybe between two and five referrals

AW: 10:08 is this per month?

FC4: 10:09 per month sorry yeah. Erm, LiveWells, maybe less, you'll be looking between nought and three maybe you would get a month of referrals and that's probably a collaboration of the Young LiveWell, and the Adult LiveWell

AW: 10:22 so in terms of the most popular scheme, it is definitely exercise referral

FC4: 10:26 exercise referral by far yeah, and then your HOP scheme is probably sitting in between those maybe with like, you know, three to five, maybe something like that

AW: 10:36 why do you think the exercise referral scheme is so popular?

FC4: 10:39, I think it's more established. It's a broader spectrum. So, we are not aiming at people who are waiting for an operation, people who have had a heart problem, people that have a BMI over a certain number. It is erm, it's a broad scope if you like for what people can come in. And it's, it's been around for the most years, so it is probably the most, the most remembered, the most known.

AW: 10:57 so it's got a wider eligibility criteria for that

FC4: 11:00 exactly, exactly that yeah

AW: 11:02 OK so the next phase of the interview I would like to talk about the telephone conversations that you have with people that have been referred.

FC4: 11:08 yeah

AW: 11:09 so first, how quickly are you able to contact a person once they have been referred?

FC4: 11:12 so if it comes paper, we tend to, so I have like a, a, a team around me if you like within the exercise referral team and there's a health and wellbeing co-

ordinator and somebody will do some administration for the health schemes. The administration is done once a week so it could be dependent on what, what day that comes in they would get rung. So, no-one, nobody would wait longer than a week for a call.

AW: 11:37 right, ok

FC4: 11:38 that's the ideal for the calls. Erm, ideally it would be done in a shorter time than that, it just depends on workloads

AW: 11:47 and what information do you typically provide during these phone calls?

FC4: 11:51 we will be letting them know, obviously, a little bit about the schemes so like an overview. If there's a cost. How many sessions they get? If there's an amount of sessions, they need to attend cuz obviously, we want to see that we perform well, on the schemes so we want to see that the people know what they are in for. You've got to, say exercise referral, its ten weeks, ten sessions ideally more. So, they need to know that they are committing to that. Talk about the times, obviously when they are going to get booked in, so we are looking at those, availability of getting their first appointment. What things to wear, those sorts of things. Maybe, cuz there's paperwork to fill out, reading glasses, what to bring with you. That sort of stuff... and, some people will ask more questions, and they'll maybe want to know a little, but more about it, you know, what facilities have you got? What, I've not heard a lot about it, I have just been sent on it. Can you tell me about what I will be doing? So, you can say it can be gym-based or pool-based

AW: 12:48 so when you say, they've just, they have not really been told, they've just been sent on it, what do they tend to know? Do they tend to know much about the scheme they have been referred on to?

FC4: 12:56 it really varies. It varies on who has referred them. It's getting better. I don't get many conversations now where they say, "No I have been told absolutely nothing". But previously it has happened, like, where you have really got to sort of let them know what they're in for. So, the main one is, they know they are coming in for exercise because they've been referred to a leisure centre, so, I think they get that much. Exercise and maybe the nutritional help side of things. It is just the price, you know, like, what could be a sticking factor is the price. How many times do I have to attend? Those sorts of things.

AW: 13:30 and when you say it depends on who has referred, are some surgeries better than others or is it a certain group like nurses?

FC4: 13:36 I would have to say it is probably just down to the individual, whoever is referring. So, if it's a physio, if it is a nurse, if that individuals done their research and knows about our schemes then...

AW: 13:46 so it just depends on their awareness of the schemes

FC4: 13:49 yeah, it's probably boiling down to that. I am sure some surgeries will put more effort in than others to know about all the schemes collectively, but I think it's just down to that individual

AW: 13:56 do you tend to get surgeries that refer more than others in this area?

FC4: 14:02 erm yeah, we get a fair few from the Springhead down the way, Springhead surgery. There's Anlaby surgery, which is literally right next door, within our building. We like to see more from them because it's so easy. It should be, it should be more than really what we get from that surgery. Willerby surgery are quite good, and we do stretch a little bit into the Cottingham area. Some clients, some clients will prefer to come from, to us instead of Beverley from Cottingham depending on what their arrangements are.

AW: 14:32 Are does it get complicated, if, if there's under the impression, they are coming in for Exercise Referral, on the Exercise Referral Scheme, and then when you actually see them, their BMI a lot more and they are eligible for the LiveWell. Does that cause complications if the GPs or whoever has made that decision

FC4: 14:50 yeah, not so much because that's a positive in a way cuz they've got from a pay four scheme that's ten weeks long to a yearlong scheme that's free. So, the other way round, yes, because they've come in for what they thought was going to be free, and they get a gym buddy so I can come to the gym for a year with my friend and then they come in and it's the other way round. That could be an issue. Erm, when it does need tackling, it just needs to be done nice and early so they've not, maybe less experienced instructors have maybe gone along with it, thought it must be right cuz they referral form is here and you know, I don't want to go against that. They've been told all this information whereas those with a bit more confidence or a bit more experience are happy to breach that straight away and let them know that they've been put on the wrong scheme.

AW: 15:31 yeah

FC4: 15:32 it gets more awkward if they've done a session or two and we think right I've got to go back on it

AW: 15:35 absolutely then you're like oh, actually, you need to be on a charged sch...

FC4: 15:37 yeah

AW: 15:38 what do you think might prevent that from happening in the first place?

FC4: 15:40 well, it starts with who has referred them doesn't it? That's great, training the staff would help at our end so it's, it's sorted out nice and early. The screening of the form that comes through. So, at our end, East Ridings end, whoever is

screening that form, whether if it be on site or at central if they can just make sure that whatever BMI is quoted is correct for what scheme

AW: 16:02 so does every scheme have a separate referral form currently?

FC4: 16:07 yeah, they do., I think three of the schemes you could pretty much just change the header, so the information is there. It is not as if we have to go back to the GP and say, we need a new form, you have referred them incorrectly. We don't want to put that barrier in the way or someone who is coming into our building and raring to go. We sort of say right we will use that form, but we will put you on this scheme.

AW: 16:28 right, ok

FC4: 16:29 the cardiac form is a bit different because that needs a lot more information on that, a lot more history about what, what event they have had. What surgery they've had. What medication they are on. So, we need a bit more, a bit more insight on that.

AW: 16:40 right. Do you think it would help if there was, like you say, if they did change the header and there was one form and then maybe a separate one for cardiac

FC4: 16:48 yeah, yeah. It sounds like it something they are looking at and, I think it's the answer really. Let us deal with what scheme they are going on and get them to refer in on one form

AW: 16:57 yeah, that's going to prevent all the information wrongly given out as well

FC4: 17:00 yeah, yeah, yeah.

AW: 17:02 perfect. Erm, so, sorry I've lost were I am now. Do patients come up with any sort of barriers or concerns during your telephone conversations? Is there anything that, any anxieties that they have?

FC4: 17:19 yeah, they could be. it could be money related it could be the amount of sessions they maybe have to attend or if they, if they are on a short scheme, say it's a ten week referral scheme, if they are going away or they have something planned within the next ten weeks, that could be a " oh, well, I don't want to start it then cuz I want to do ten solid weeks. I will wait until I come back from where ever I am going" or... whatever they've had done and then you might, they might have lost that motivation by that months' time or whatever so that could stop, stop somebody taking up one the schemes

AW: 17:52 yeah, so as you say, money. Sometimes the sessions if they've got something booked in. A whole host of things

FC4: 18:01 yeah, yeah. It could be that. It could be location, do you know if they haven't realised that you know, they're going to have to travel across town to get to our site. Some people think because we are so close to Hull that they could go to Albert Av or something like that. It is rare, but they might think that the Hull sites can cater for it whereas obviously we are just the East Riding

AW: 18:17 yeah, and are there concerns that you face when you are speaking to customers on the phone

FC4: 18:24 no, not particularly as in problems I might have?

AW: 18:28 or any challenges

FC4: 18:31 erm, no, I feel all right with it really, erm...I think... no

AW: 18:37 that is fine. So, the last section is about Feedback. So, how important do you feel feed backing to the general practice sites is?

FC4: 18:45 yeah, really important as I mentioned before it sort of shows how well, their patients are doing on our schemes. So, if we keep the feedback strong and it looks good then that's going to help with the amount of referrals that we get through.

AW: 19:00 and as you say it's going to improve that relationship between here and the different surgery's

FC4: 19:05 yeah, definitely and we, we've got more time to spend with the, with the patients as they are. So, we can do like, more blood pressures, and heights and weights, and spend a bit more time and maybe not rush them in and out as much as the surgeries have to do to get people through their appointments. So, they might get a little bit more info. If it's social anxiety, or any mental health issues, they are going to get a lot more of our time on a scheme than they are of anyone within a surgery.

AW: 19:35 absolutely. Currently do you provide feedback back to general practice sites?

FC4: 19:40 yeah, so previously, before we have Pharmoutcomes which is an online portal for us feeding back our results, prior to that we would have letters that would be sent back. So, we had them sort of written up on site, whether that's done around the East Riding I am not sure, but within our site we had a standard letter that we would sent to say you know, this patient has completed, this is how they have done. That would go off to the surgeries. But in maybe the last few years we now use Pharmoutcomes which is a way of us sending across our health check results, questionnaires outcomes, all on an online portal and that covers most of the health schemes. There's only LiveWell, that doesn't fit on there at the moment

AW: 20:21 so LiveWell, is not on Pharmoutcomes

FC4: 20:23 LiveWell, is not on there currently

AW: 20:25 how does Pharmoutcomes communicate with the surgeries? Do they have to sign on to Pharmoutcomes?

FC4: 20:29, I think it goes through via an email from what I believe. So, we occasionally get the odd surgery that isn't set up for these emails and it will bounce back saying,

"this surgery does not accept these emails" so we have to then print those results out and send them manually

AW: 20:43, but that automatically, when it does work, sends that email with all the results

FC4: 20:48 yes, as soon as we submit and send at the end it will send it through

AW: 20:52 so what specifically does it give out in terms of the results? The results in terms of Pharmoutcomes, do it give everything in terms of every single measure you've recorded?

FC4: 21:02 yeah, so I am not sure how it collates it at their end, but we have like a starting questionnaire normally that will include, you know, like if they are committed to change, or you know, if they are wanting to exercise, these sorts of things, what their diet looks like along with their health check results. And then that same questionnaire is near enough repeated so you can test one against the other. So, whether, I am not sure whether the surgeries receive those in a pack at the end to say there's your questions, week 1 questionnaire, week 10 questionnaire as it would be, or if they get one and then get another one later on. I am not sure how that goes through

AW: 21:35 right, ok. Perfect. In your opinion, how could the referral process as a whole be improved? From start to finish so, anything from the GPs end to you receiving that referral.

FC4: 21:47 yeah, yeah. So, I do think if, if it can be done more online. So, if we can get surgeries involved online for our site that would definitely help. It means you can't, evade information if we have boxes that are mandatory, you can't miss a signature, you can't miss any information so that's gonna help on that front. It maybe becomes a little bit more recordable if the IT can do that, so we don't have form

that sit in files. That won't, maybe go missing or maybe just get moved about in files and don't get tracked properly. And if it can have this single form., I think a single form would work for most of the schemes, but I just think the cardiac scheme is a little, we need a bit more information so that one might be a little bit more specific if someone is coming onto a heart scheme., I think that is going to need, a bit of a different route into it.

AW: 22:39 so if there was just one single referral form that takes the pressure from the GPs and the Nurses to remember all the different schemes, so what would you like them to tell patients prior to them coming?

FC4: 22:50, I think if they can see that a patient will benefit from exercise in any capacity. If we just become a, like a brand or a name that's you know, you are going to East Riding leisure sites for exercise, I'm going to refer you and they will let you know what best course they can do for ya. And then we would just offer them the right information at that time

AW: 23:13 yep, so if they could just say look you would benefit from exercise, I am referring you and then you undertake that triage and determine what programme is the most suited for them

FC4: 23:21 yeah, and then that just comes down to resource on who's going to do that. If it is done centrally, we've got the negative of not knowing what the teams expertise are as well.

AW: 23:32 what do you mean?

FC4: 23:32 so centrally there's an office in Beverley that sort of have admin staff that do the, some of the bookings so for the HOPs

AW: 23:39 ah the Business Techs?

FC4: 23:39 Business Techs. So, so they do the booking fully for the HOP scheme which is fine. On the exercise referral because it's such a broad spectrum, we might have people that are specialists, cancer specialist, diabetes, so it, it, I don't think an IT system is quite going to have that decision making process built into in at any point. So, there is a short fall of doing it centrally because the teams on the site know who is best to see what client.

AW: 24:10 yep, so how do they determine, the Business Techs, so you said, they do the HOPs and the Exercise referrals....

FC4: 24:18 yeah, just HOPs mostly, they do a few exercise referrals, but they will do all the HOPs

AW: 24:24 does that just depend on capacity? So, if you don't have the capacity, they will just go centrally?

FC4: 24:26 no, it is more on just where the form has gone to. If the form has gone to them, they will refer them into us. If the form comes straight to us, we will deal with them straight away whereas all HOPs are returned to the central, or the Business Techs.

AW: 24:38 yep, how do they get sent to two different places? If that through the letters, the paper referral forms?

FC4: 24:44 yeah, so, I think they must have a conversation to see which site is best for them. So, is the central site are doing that then they will have to decide which site is best based on the location and then after that it's just a case of a booking system that finds the, the, an instructor available for the date and the morning or afternoon or what they are looking for.

AW: 25:08 and in terms of capacity, booking the appointments in, are you finding you have enough capacity to manage the referrals that are coming in?

FC4: 25:16 yeah, we do OK. Er it's just that, because we have like maybe three, four instructors in at a time, it's just that it might be lop sided. So, online referrals don't know who to book in with, who's got loads of clients, and who's got very little, so it doesn't know, it just works on a sort of left to right, who's available then you've got that appointment in at that time

AW: 25:36 right, ok

FC4: 25:37 so there is a little bit of juggling that we have to do on site just to make sure the workloads are a bit fairer

AW: 25:41 make sure it all fits

FC4: 25:44 yeah,

AW: 25:45 absolutely. Er, that is all the areas I wanted to address today. Is there anything else that you want to add that you feel is important in addition to anything we've discussed today?

FC4: 25:51 no, no, that is all right

AW: 25:55 yeah, yeah, perfect. Thank you very much

FC4: 25:57 no problem

AW: 26:00 I'll stop this recording now as I say I'll type...

AW: Interviewer **Interview date:** 20.02.2019

FC5: Participant **Interview location**: East Riding Leisure Driffield

AW: 00:01 is it ok if we take some simple demographics before we begin?

FC5: 00:06 yep

AW: 00:08 how would you identify your gender?

FC5: 00:08 female

AW: 00:09 and how old are you if you don't mind me asking?

FC5: 00:11 24

AW: 00:12 24. Is this the only leisure site you work within? Driffield?

FC5: 00:15 yeah

AW: 00:16 perfect. And what's your role within Driffield leisure centre?

FC5: 00:18 Fitness Co-ordinator

AW: 00:22 how long have you been working as a Fitness Coordinator?

FC5: 00:23 er about two years

AW: 00:26 and can you briefly sum up some of your role or duties as a Fitness Coordinator?

FC5: 00:32 er, yep. I oversee all the health agenda schemes. So, GP, LiveWell, Young LiveWell, HOP. Er so I just have to make sure that the right people completing, that they've all got the right amount of notes, erm, on CRM. I just overview all of that. Check that all my staff are happy, all my instructors are happy with what they are doing and what they are delivering. Er, I send letters out contacting people if they haven't been in. I chase them up with phone calls, things like that. Erm, and then just general wellbeing of all my instructors, things like that.

AW: 01:08 yep, little bit of everything?

FC5: 01:09 yeah, all the rotas, things, yeah, a lot.

AW: 01:12 and er, you've indicted on the survey that you have that joint role as a Fitness Professional. So, you do undertake that role as well

FC5: 01:19 yeah

AW: 01:19 in terms of the healthy lifestyle programmes which ones are you involved in delivering?

FC5: 01:25 all of them

AW: 01:25 all of them as well. Does that include the cardiac rehabilitation?

FC5: 01:28 so I'm, yeah. I assist with that at the moment. I am just training so I am halfway through my course now. But I do assist on a Thursday with [FP's name]

AW: 01:37 and you process the referrals for them as well?

FC5: 01:37 yeah, yeah

AW: 01:39 lovely. So, the first section of the interview is focused on the information that you receive form primary care sites. So, from the primary care practitioner. First of all, could you tell me about the different ways that you receive healthy lifestyle programme referrals?

FC5: 01:51 yep, so they come through either the BEARS system, our electronic booking system, that's direct from physios or GPs. And then we also, I also receive them via secure email as well

AW: 02:03 ok. So, secure email or the online booking system BEARS

FC5: 02:05 and very, very occasionally post, but not really much now

AW: 02:09 the paper referral forms?

FC5: 02.11 yeah, yeah, it's changed to email now

AW: 02:15 and which type of referral is easiest to process in your opinion?

FC5: 02:22 I would say the electronic ones because it saves time with ringing however, what we've noticed is the GPs just book a random appointment and they don't tell

the client. So, we have had loads of no, shows so it has been a massive problem for us. So, I am, having to ring them all anyways now

AW: 02:36 so that system that intended to take that burden off you....

FC5: 02:41 (laughs) yeah, hasn't!

AW: 02:42 actually not working in practice. Why do you think the GPs are booking the appointment without the patient?

FC5: 02:47 because the assistants do it. So, the GPs see a client and they just send messages to their assistants and it's always the Doctor assistants that book them, but they don't ring the client to tell them. They just book them randomly. And I think they actually send them a letter, but often the letter doesn't get to the client before the appointment. So, it's....

AW: 03:06 ok. So, that's pointless because they are not being forwarded that appointment

FC5: 03:09 yeah

AW: 03:09 what's the alternative in your opinion? What could stop that from happening?

FC5: 03:14 if the actual GP booked in there and then with the client sat there cuz the system is so effortless. It is so easy now. All they have to do is their name, their address, tick all the medical stuff and then choose an appointment, that's it. I know they haven't got a lot of time, but it is quite easy so that would help massively

AW: 03:32 you feel it has been made as simple as possible to enable that it happen

FC5: 03:34 yeah

AW: 03:34, but what you're finding is they are actually passing that onto, onto somebody else to do that.

FC5: 03:37 or at least the assistants making sure that they've actually got hold of them like not just booking a random appointment in. They've actually to gain contact with the client

AW: 03:51 and which is the most difficult to process in your opinion? So, in terms of, out of the, so you said, electronic is easiest, and you've got your secure emails and post very occasionally...

FC5: 04:01 yeah, the secure email and the post would be, they are the same thing basically. The paper thing that comes through the post is what I get through on secure email so, erm, between them yeah, they are about the same. Erm, that's just if there's that missing information. So, if there's no, phone number, I have to try and contact the surgery, but with GDPR they won't just directly give me their number over the phone so then it has to go all through email, through the Practice Manager and through myself. So, it's a long process to gain just a phone number, which is a pain. That would be the biggest problem.

AW: 04:32 so if they are not giving you that information speedily,

FC5: 04:35 well, then the clients doesn't get booked in a reasonable time. I like to get them book in within, from receiving a referral to getting them booked in, I like it to be around three days. I do them quite quickly. So, it means they are not booked in and then if I don't get that information then they are never getting booked in, so they are gonna just drop off. They are never going to get booked in

AW: 04:55 so GDPR rules are, the regulations are restricting that communication between yourselves and the GP surgeries.

FC5: 05:04 cuz they won't give me a contact number over the phone, which is fair enough. They can't prove that's me, but it's, it's quite hard. If we had something, I

don't know, that a code, something where it would be like, oh, it's definitely me, blah, blah, blah, then it would be a lot easier.

AW: 05:20 just to confirm

FC5: 05:22 yeah, that it is me and not, yeah

AW: 05:25 ok. And how often do you receive referrals that include all the required information on the referral form

FC5: 05:33 that have it all on?

AW: 05:32 yeah, so everything in terms of phone numbers, patient information, medical history, etcetera

FC5: 05:38 it's quite hard because, it's hard to answer that because we do have the odd one where we don't have phone numbers which is the most frustrating thing. Erm, but if medical information is missing, we don't always know until it comes out from the client. And because I don't see every single client, I can't really answer that in terms of, do you know what I mean? From my point of view.

AW: 06:00 yeah

FC5: 06:00, but most of the time to me they are actually quite good at putting all the info on, but you don't always know. If medical information is missing, you don't have a clue until the client tells ya

AW: 06:11 so how satisfied would you say you are with the amount of information typically that is provided?

FC5: 06:14 er, yeah, it's alright

AW: 06:17 and is there anything additional that you would like to receive prior to making that telephone contact or booking that appointment in?

FC5: 06:24 er, just maybe sometimes a little history cuz they often put like stress-related illness, but what is that? That is very vague. Er, just a little bit more detail so you

know exactly what you are dealing with. Erm, like some of the circumstances sometimes. Like if a, I don't know, like, I can't think of an example now...

AW: 06:51 do you tend to, when that person comes in, do you tend to have an idea of what they are going to be like from the referral form or are you quite often surprised?

FC5: 07:01 it can totally vary. Some of them like, you have a rough idea and it's not too bad. Some of the are totally, totally surprising.

AW: 07:11 perfect. To the second, oh, one more question actually, how would you describe your relationship with the different primary care sites in this area?

FC5: 07:18 not great actually, because we never get the opportunity to go into, to go into the sites. Like it's always done by the, like the Healthy Lifestyle Officers are the ones who go into the sites, but they are not the ones who technically directly have to communicate with them, it's us. And I have asked previously if I can go into site, and they won't allow that. So, that is a little bit frustrating because it's like, one lady that I speak to a lot at one of the surgeries, it's very hard to communicate over telephone sometimes, and things can get miscommunicated so if I could go in and see her face-to-face, just now and again, it would just eradicate that. So, it would be quite nice to be able to do that …

AW: 08:07 just to build that rapport

FC5: 08:09 yeah, it would just be a little bit nicer. Just then, you know who you are dealing with as well. I am not a big fan of telephone anyways so to me, from dealing with someone face-to-face, then you know who you are dealing with and it's just a bit nicer. Bit more personal.

AW: 08:19 and you said, there is that link between the Healthy Lifestyle Officers and those in primary care, but they are not the people on the ground

FC5: 08:26 no, they are not the ones doing it yeah

AW: 08:29 what do you think the benefits would be of you going into them surgeries and speaking with them?

FC5: 08:34 erm building a relationship first and foremost., I think that's quite vital when you are dealing with people every day. Erm, and then there's no, like, if someone misses something out of an email or something there's no, like animosity or anything. It's just, you know who they are, you know who you are dealing with so it's just easy

AW: 08:53 yeah, absolutely. And how many surgeries roughly are referring into this site? Do you encompass a wide range of primary care sites?

FC5: 09:07 er, we have two in Driffield, one Beeford and Leven, one Naffleton. We occasionally get a couple through from like Bridlington, but cuz if some people maybe live there, but want to come here or work or whatever. We have four main ones and a couple of physios that refer in. So, four main surgeries and then two physios. yeah, that is usually it. And then we've got like our Link Workers, but they work within the surgery anyways

AW: 09:34 right, ok. So, some Link Workers that are based in the surgeries are referring in

FC5: 09:37 yeah, yeah, one at each surgery

AW: 09:39 are you finding in terms of the referral coming in, are you finding capacity-wise, are you able to manage with the demand?

FC5: 09:46 yeah, we are doing alright at the moment, but we are utilising our groups quite a lot. So, our group sessions, we use them quite a bit. Er, because yeah, yeah, we are not doing too bad actually

AW: 10:01 is that for all the schemes?

FC5: 10:00 yeah, we are managing it quite well, but we do have periods where, like not so long ago, it was very busy and we were struggling, but at the moment we are doing quite well, with it

AW: 10:13 so it just fluctuates depending on the time of year

FC5: 10:16, but now we've gone to this electronic and it's really kicked in now. We are getting quite a lot of referrals in

AW: 10:23 have you found the electronic has boasted the amount of referrals coming in?

FC5: 10:24 oh, definitely! Yeah, yeah

AW: 10:28 so the next section is about the telephone conversations that you have with a person who has been referred. So, can you tell me about your experiences of contacting somebody via telephone to book them in or to tell them about the scheme?

FC5: 10:39 yep. Well, it can be a bit of a pain because it depends on, cuz I work quite a few different shifts, I can try people at different times, but obviously, if people are working, it can be a bit of a pain to get hold of them. People often put, Doctors often put home telephones down. Most people nowadays work off like mobiles, so that can be a bit of a pain. Sometimes they don't even know they have been referred as well, so you're ringing them, and they are like, "what?" So, that, that can be a little bit tricky. Not often, but I've had, I've had quite a few

AW: 11:14 what do you do in that instance if they have got no, idea at all that they've been referred onto a programme?

FC5: 11:17 er, I explain what the programme is about and see if they still wanna come or not

AW: 11:20 ok. Do you they tend to still want to follow that up or not?

FC5: 11:24 a couple haven't, but a few have so yeah, it's been alright actually

AW: 11:28 and during that initial conversation, what information do you typically provide to a customer?

FC5: 11:34 the first thing I usually say is about the cost because they never get told

AW: 11:39 are we just on about the Exercise Referral Scheme here?

FC5: 11:38 yeah

AW: 11:40 yeah, ok

FC5: 11:41 erm, 33 pound for ten weeks and they are never told that. So, that's the first thing I say because I am not going through all the conversation, then tell them at the end, offer them to turn up and not know, and then it's pointless if they don't want to do it. Erm, so yeah, I do that. I tell them that first. Then I tell em what the schemes about if they want to continue. Erm, some of them need a massive amount of reassurance. Erm, I sometimes tell them about my instructors as well. So, like, cuz certain ones are qualified in certain things as well, erm, like [FP's name] will do quite a lot of aqua work, as will I. Erm, and then like some of the others have like, are good for lower back pain. So, if I can see on someone's referral form, I will talk through their conditions with them and say look "we've got this Instructor who specialises in this". And I check the sort of time of day they want to come and just check that they are happy with everything.

AW: 12:35 so even during your telephone call, you are able to talk about some of the conditions they have and who might be best suited.

FC5: 12:39 yeah, I try cuz I'd rather get them booked in to someone that they are better suited to than... Cuz if you don't know anything about them and you book them in with someone random… they quite like em, cuz some people might just want a female, some people might just want a male, so I do try my best to, to do that

AW: 13:01 to accommodate for that. So, when you talk about the costs of the Exercise Referral Scheme, how do they tend to respond?

FC5: 13:07 they don't usually know

AW: 13:08 right, ok

FC5: 13:10 we've not had many that actually know there's a cost to it so that's quite frustration

AW: 13:14 are they quite happy to pay the costs?

FC5: 13:17 some are, but some really haven't...

AW: 13:20 ok. So, that's the Exercise Referral Scheme. In terms of the LiveWell, or the HOP scheme, do you provide any additional information baring obviously, what the scheme entails?

FC5: 13:31 not really. I just tell em how many weeks it is and stuff. The only thing with HOP is that Doctors automatically tell em its 26 weeks. Well, it's not. You've got to graduate through your three, your ten. You don't just get 26 weeks. You've got to lose a certain amount of body weight to progress onto the, onto the next stage of HOP. So, that's frustrating...

AW: 13:51 so they are not necessarily giving them the correct information

FC5: 13:55 no. People think they've got free membership for 26 weeks sop they are like "winner, winner"! But it's not, it's not like that. As soon as they have their surgery, they don't get it free after as well. They have had their surgery so that's an obstacle

AW: 14:08 how do you think you could get around that cuz obviously the GPs having to know about all the different programmes and the different eligibility criteria. How do we, in your opinion, get around that so they are not giving out that incorrect information?

FC5: 14:19 to me the best way for them to do it would be, the Doctors doing a generic referral and it gets sent to like the central team that work from Beverley. Obviously, they will need more staff, like put some more staff in there and then the staff deal solely with referrals, constantly. So, they ring them, they are trained on what scheme they should be on. So, they Doctor has to provide like your basics, like your BMI, because obviously that is significant for LiveWell, and HOP, and all the medical information, but then, the Business Technicians or whatever, erm, deal with all the referrals, ring all the people and then send the out to site.

AW: 14:54 right, ok. So, it takes that pressure off the different sites

FC5: 15:00 yeah, cuz I physically would not be able to do all that either. Like if they sent them generically to me, I would not be able to, I would have to have support in place to do that.

AW: 15:07 right, ok

FC5: 15:09 so the easiest thing is to do it from a central pot where all referrals go to one place and there would be no, miscommunication via email or anything because it would go to one generic place, which would be easy

AW: 15:19 and they can build that relationship with just the Business Techs

FC5: 15:22 yeah, so say there was like four of them in the team or whatever. They could, they could go around the sites, build that relationship, and then go from there and it would just be easy. Cuz we've already got that relationship with most of the Business Techs so that's fine. Erm, so they can just refer them onto us. It would be so easy that! The they've already been rung. Then all the costs, all the implications, there's no, surprises. The Business Techs would book them in as well, so it would take that totally away from me and anyone else. So, that would be, that would be ideal that!

AW: 15:50 absolutely. And during your initial telephone conversations, how much do they tend to know about the different, well, the programme they have been referred on, whether that be the LiveWell, or the GP referral. Do they tend to be quite...?

FC5: 16:00 no, they are not very clued up. Because the GP referral always use to be twenty sessions. So, you got twenty sessions to use in that, I believe it was a three month period, before I was in post. Er, and they still turn up and say, "Oh, I've got twenty sessions", but it is not that. It's been like ten weeks, unlimited ten weeks, for well, over two years now so they are quite misinformed. Like I say about the twenty-six week for HOP. They just think they've got it free for twenty-six weeks, which isn't the case

AW: 16:29 how do you think we could increase that awareness of the different programmes? Or do you feel it should just be something that solely responsible for the Business Techs to do?

FC5: 16:36 yeah. I just think it should be generic. Doctors, to be fair to them, have a lot to remember. They know a little bit about everything. So, for them to memorise like four schemes, that is a lot of info, so I don't, I am not getting at them at all. I don't blame them, but I think if we made it easier by having that one sole referral route to the Bis Techs, [Business Technicians] would be brilliant. Take it off the Doctors, off us as Co-ordinators and it would be so much easier!

AW: 17:06 many benefits of bringing it in centrally. Do they currently, are GPs for instance, referring patients to the correct schemes are you finding?

FC5: 17:17 mainly. We don't get many that are not on the right scheme. It is sometimes the LiveWells. We get paper ones, they will just write LiveWell, at the top. They are not filling LiveWell, forms out. They are filling GP [Exercise Referral Scheme] forms in and just writing LiveWell, on

AW: 17:29 right, ok

FC5: 17:32 it's a bit strange, but most of the time they have been alight. We get the odd couple, erm, or if their BMI is very borderline. Cuz the Doctors don't always do the BMI there and then. They will take it off the last reading. So, if someone's got a BMI of like 44, they are not technically eligible for LiveWell, send them on a GP [Exercise Referral Scheme], but by the time they get to us and they put a bit more weight on, they are at 45. We will then put them on LiveWell.

AW: 17:56 right, ok

FC5: 17:57, but most of the time, they are pretty good actually.

AW: 17:59 yeah. And sometimes as that information is, as you say, from an old reading so it's not necessarily the most accurate information... Have you got any leeway with the LiveWell, criteria, BMI 45 or…?

FC5: 18:19 at our site we would maybe go down to like 44, but we are not supposed to

AW: 18:24 yeah, no, worries

FC5: 18:25 you've got to look at the needs of the client as well, though. If a client is really struggling and their BMI is 44, but they've got other needs and issues and you think they are going to last the six months to the year then I'd take them on

AW: 18:38 absolutely rather than give them...

FC5: 18:39, but it's very strange. I wouldn't drop below 44 really. I would only do it if they were really borderline. Erm, but I think you just have to look at the needs of the person as well. And equally there's some and they are maybe really borderline, even like 44.8, but you know that they are not really going to complete so keep them on GP, see how they get on with that and then maybe look at something in the future.

AW: 18:59 oh, right, ok. So, maybe try and buy them in that way with the GP referral

FC5: 19:01 yeah, see how they got on. People are not always committed, and you've got to make a judgement on that first appointment. So, if you are committing someone onto LiveWell, it's a big commitment, and we are under pressure. Like, its, for us, it's always about the client, but we are under pressure in terms of money. We are a business so it's, as we complete LiveWells and stuff, you know, we are under pressure to complete people so if we don't think they are going to complete then we do have to take that into consideration

AW: 19:27 complete as in the full 12 month, you have to...

FC5: 19:32 well, six month really, we go on. They are looking at changing it at the moment. So, we have sort of said, if there's one that you are not sure of, tell them it's six months and they can progress to the further six months. They are looking at changing the scheme at the moment so....

AW: 19:45 right, but it's still a big period of time

FC5: 19:46 it's a massive period of time to get someone in every week, consistently. To get your notes on CRM. To make sure you're doing exactly what we have to do to get our payment to cover Instructor payment, to cover completion payment. It's a lot

AW: 20:02 right. So, you only get paid if they complete that full scheme?

FC5: 20:04 half

AW: 20:07 right

FC5: 20:07 we get Instructor payment per week, but only if the notes on

AW: 20:10 as in the notes on CRM

FC5: 20:12 on CRM

AW: 20:12 right. Wow that is, I didn't realise how much of a big sort of commitment that was, the LiveWells

FC5: 20:18 yeah, it is big. Same with young LiveWell, but they are not as bad because they have got an initial sixteen weeks of 1:1 appointments. So, if we get them to sixteen weeks then we still receive payments, but LiveWells...

AW: 20:31 do you see that working for LiveWell? Maybe if there was sixteen weeks initially

FC5: 20:34 yeah, yeah, I think so

AW: 20:38 and during your conversations, those initial conversations, are there any common concerns or anxieties that patients raise with you over the telephone about coming in for their first appointment?

FC5: 20:49 er... no, not really. Obviously, some are quite nervous and anxious in regard to their condition and how they will be in the gym, but we've always got, we've got classes, we've got like chair aerobics, we've got gentle activity classes. We've got aqua. We've got so much now and not solely focused on the gym so for us we can always work around... I usually just encourage them to come to that first appointment, if they really don't think it's for them after that then it's not for them. But I genuinely believe we can work with anyone.

AW: 21:19 yeah, as you say it's not just gym

FC5: 21:20 it's not just about being in the gym

AW: 21:22 there's different classes for different conditions

FC5: 21:23 yeah, it's really good

AW: 21:22 ok. Are there any common challenges that you face? So, you've spoke about not being able to get in touch, well, with the GP surgeries in the first instance and then them not being able to give you that information. Are there any other challenges that you face in terms of processing them referrals?

FC5: 21:40 it's just time for me personally. Like, I have a lot of job roles. So, to be have to ringing people, you can be on the phone with some people if they've got a lot of conditions, half an hour easy! I don't have half an hour in my day to spend on the phone with someone, which sounds awful. With me seeing clients as well, I see twelve a week so it's over twelve hours of my time around clients. So, I've only got you know, not that much more time to be doing all my admin, all my rotas, sorting all the leaving, just everything. So, it is, it is tough. So, time

AW: 22:14 do you find that, are you mostly able to contact them before they come in?

FC5: 22:18 yeah, on the whole. I will always leave a message. I will try and leave messages if not, er, so yeah, it's not too bad

AW: 22:27, but it's just tough to fit it in with the 101 other things that you're doing!

FC5: 22:30 it's a nightmare! It's an absolute nightmare yeah, yeah, impossible

AW: 22:31 so the last section is about feedback. So, are you currently involved in providing feedback back to primary care sites?

FC5: 22:40 only in terms of er Pharmoutcomes, but in regard to a conversation that I had the other day, er, at the surgery, they are not actually that clued up about it so...

AW: 22:50 about Pharmoutcomes

FC5: 22:53 yes, so that's a debateable one

AW: 22:54 in what way?

FC5: 22:57 they are not really aware yeah, I don't really understand the …

AW: 23:01 ok. What do you feel is important to, in an ideal world, to communicate back to primary care sites?

FC5: 23:06 so how they've done on the scheme like they should be, the Doctors should be up to date with if their clients lost a stone, it's fantastic! It's only reducing the work that they have to do with them in the long run. Erm, and with the HOP

scheme, if they are awaiting surgery, they've done six months and the Doctor has no, idea that they've lost three stone or whatever in the six months, then they are not going to get referred for the surgery. Well, that's the point of the scheme so...

AW: 23:34 so feedback in that instance is especially important because it's going to have implications on whether they actually get the surgery that they need

FC5: 23:38 yeah! massively. For HOP it's massive. For the other stuff, it's not as bad, but it's still, I still think it's important in my opinion

AW: 23:47 are all the schemes on Pharmoutcomes currently?

FC5: 23:49 no. LiveWell, and Young LiveWell, aren't, but they are working on it. They are going to be in the near future, but not at the moment

AW: 23:56 ah so it's something that's going to happ….

FC5: 23:56 so LiveWell, never gets fed back which is your biggest scheme in terms of reducing obesity within the community

AW: 24:05 and Pharmoutcomes, is it purely physiological indicators? Is BMI, blood pressure, weight loss...?

FC5: 24:11 no, there's erm, your psychological stuff on there as well. So, we've got questionnaires. Got the Warwick Edenborough questionnaire, the short version on there. Erm, and then attitudes to exercise as well. So, there are some questionnaires as well

AW: 24:24 so you are able to find out what's changing psychologically.

FC5: 24:26 yeah, yeah, yeah, if they wanted to

AW: 24:28 if they contacted Pharmoutcomes

FC5: 24:30 yes

AW: 24:32 perfect. So, this is more a generic question towards the end. How in your opinion, could the referral process be improved or streamlined?

FC5: 24:42 I do just generally think that centralising, I just really do., I think that is the way forward. Erm, I think it's a great scheme. It's a great service. All the schemes are great, and they are great services, but er, just to take that away from, any problems with the Doctors, any problems with us, to me that's just the way forward so, I think that will be the best thing

AW: 25:03 yeah, absolutely

FC5: 25:04, but in terms of how we deliver and stuff here, on site, I am pretty happy with it, and we do quite well, so

AW: 25:10 all seems to be working site-wise, but you just need that little bit

FC5: 25:12 just that extra support because it is hard

AW: 25:15 and if it's taken off you, you can get on with your day. You can do other things that you've got to do without worrying about processing all the referral forms

FC5: 25:21 yeah, definitely

AW: 25:23 and is there anything else you wanna add that you feel is important about anything that we have discussed today?

FC5: 25:27 no, I think that's it

AW: 25:30 lovely. Well, thank you for your time today. I'll just cancel this

FC5: 25:36 awesome thank you

AW: Interviewer **Interview date:** 05.03.2019

FC6/ FP14: Participant **Interview location**: East Riding Leisure Hornsea

AW: 00:01 Lovely. Is it ok if I take some simple demographics before we begin?

FC6/ FP14: 00:05 yeah

AW: 00:04 how old are you if you don't mind me asking [FC's name]?

FC6/ FP14: 00:07 fifty-one at the moment

AW: 00:12 and which East Riding leisure sites do you operate within?

FC6/ FP14: 00:13 Hornsea

AW: 00:15 Hornsea. And you are the Fitness Coordinator?

FC6/ FP14: 00:18 yeah, for the last twenty five years

AW: 00:22 twenty five years. And can you sum up some of your typical roles as a Fitness Coordinator at Hornsea?

FC6/ FP14: 00:30 mine is, gym, exercise classes, health agenda and then delegate out to Instructors to deal with. Err, generating income and customer care

AW: 00:51 little bit of everything?

FC6/ FP14: 00:52 yeah

AW: 00:52 so as well, as processing the referrals coming in, you're also delivering some of the health agenda programmes as well. So, in terms of the health agenda, so the healthy lifestyle programmes, which ones are you involved in processing? The referrals coming in?

FC6/ FP14: 01:07 all

AW: 01:07 all of them yeah. So, LiveWell, Young LiveWell...

FC6/ FP14: 01:10 LiveWell, Young LiveWell, err, HOP, Cardiac rehabilitation. What`s the other one? Exercise Referral

AW: 01:19 yep, that as well. All of them. And I have your email from the online survey so that's fine. So, the first section of the interview is about the information that you receive from primary care sites. But first, could you tell me about the different ways that you receive referrals?

FC6/ FP14: 01:33 right it has only just being recently that Hornsea received electronic referrals. It has always been through the post. Now those referrals, sometimes might only have their name on.

AW: 01:45 as in the paper referrals?

FC6/ FP14: 01:47 yep, which is causing us major problems because obviously, we don't know what we are dealing with. Secondly, we don't know the meds, they're usually missed.

AW: 01:54 ok

FC6/ FP14: 01:55 medications missed and usually and generally BMI, blood pressures and all those kind of things are missed as well. It says there's an attached form, but then there's no, attached form (laughs).

AW: 02:07 ok. So, they are saying, please see attached form and they are not providing anything. So, what do you do in that instance?

FC6/ FP14: 02:13 send it back. We're having to send them back which then effects our completion rates, and occupancy rates because then, it upsets the client as well, because they are having to wait even longer before we can set them up. So, it, it's erm, they're pretty good. They

have got better over the years, but that has been one of our biggest problems

AW: 02:37 right, ok. How many surgeries are in the area of...?

FC6/ FP14: 02:38 err, we tend to have, err, roughly three. We have Beeford and Leven. We have East Gate and, I think there's another one. I can't remember the name of it sorry

AW: 02:50 that's ok. And are some better than others at providing that information or is it general?

FC6/ FP14: 02:53 err, it tends to be general. Err, since we've become electronic it has been a lot better because everything is there. It has always been there on the BEARS system, on the booking system so everything has been great. The only problem we've had, obviously, with the leisure going through a refurbishment, getting the information to them saying, "Please don't send any referrals because we are shutting". If you get what I mean, has been difficult, but we've done it

AW: 03:18 so what are the benefits of the electronic system, the new system?

FC6/ FP14: 03:23 well, the electronic system is this, it automatically saves me having to delegate it to an instructor, it is already done. It is already booked in with a qualified instructor. The information we require is already on the system. If we wanted to print that off, we can for the instructor. If the instructor needs to do any research for any aspect of it, it is there.

AW: 03:43 right

FC6/ FP14: 03:44 so it's err, it helps us out a lot really. I do believe they are hoping to do that, we've only done that on the GP referral at the moment. The HOPs is just coming onto it, and I think in time the cardiac rehabilitation will come onto it as well

AW: 04:02 right, ok. So, currently it is only the Exercise on Referral

FC6/ FP14: 04:06 and HOPs

AW: 04:07 ah, ok. But there's the idea to bring them all electronically? And can you tell me about your experiences of contacting GP surgeries to retrieve that missing information?

FC6/ FP14: 04:16 err, East Gate never been a problem. They have helped us out with quite a few. We have had a couple of bad cases where we had this one guy and he was er, he started his, he did a GP referral. When I looked into him, he had actually done three sites of referral, at three sites and the general rule is you have one referral. There's no, cheap membership it's, just an open gateway to get you exercising. Err, obviously, if they've had a stroke or anything like that than they have more referrals. But, but if it's just general it's a one rule referral within the year usually anyhow. [coughs] Sorry, excuse me

AW: 04:54 no, it is fine. So, East Gate have been quite good with that?

FC6/ FP14: 04:58 East Gate have been brilliant. We've rung them up, any problems on the phone they've dealt with us directly over the phone and they've actually done that and helped the situation. Obviously, again, we've had some roll up and they've asked if I, patients have been waiting to start a referral scheme, but we haven't received the

referral. So, then, then they are chasing, and they have resubmitted the referrals for us as well, so...

AW: 05:24 ah, ok

FC6/ FP14: 05:25 in that sense they have been brilliant

AW: 05:26 so that's been one of the problems with the paper referrals that sometimes they are not coming in...

FC6/ FP14: 05:30 sometimes they can take up to three, four weeks to come through. Well, the patient, cuz you know, cuz people go and see the Doctor, they are all geared up, they are ready and then two days later they are like "Where is my referral?". We are like, "Sorry mate, it takes a couple of weeks"

AW: 05:42 right, ok

FC6/ FP14: 05:43, but with the electronic, we've got it

AW: 05:47 what impact do you think that has on that person who is waiting?

FC6/ FP14: 05:50 err, I think it's a lot better for them. It doesn't give them chance to stay worrying about it coz everybody worries. But the, the thing what, err, I need to really, really stress is that we don't have any free places for the, for the GP referrals. Ours are all £33 for ten weeks. So, and sometimes they don't relay that information, the surgeries to the individuals, so when they come to us, we've got an upset patient because we are asking for money

AW: 06:19 so they are under the impression that the schemes are free, but actually when they come to you, they're not free

FC6/ FP14: 06:26 no. The HOP is, the LiveWell, is, you know. They're certain schemes which are free, but I believe the general term is that all the, all the health schemes are gonna be charged in the end

AW: 06:38 right, ok

FC6/ FP14: 06:39, but they are reduced dramatically., I think it is £33 for ten weeks, which is like £250 off so...

AW: 06:45 really cheap, yeah. How do patients, well, patients, customers, how do they respond when you say to them, "oh, there is a charge, are you aware"?

FC6/ FP14: 06:53 most, 95 percent of them are absolutely fine. The ones what aren't happy, don't start. Simple as. Err, but the good thing about charging them is that it makes them committed as well, cuz they're paid for it. So,

AW: 07:14 so by investing that little bit of money into it, you find that it does

FC6/ FP14: 07:18 they want their monies worth

AW: 07:19 yeah. So, they tend to commit a bit more to the schemes

FC6/ FP14: 07:21 and they tend to take it on board and then carry on afterwards and take memberships out afterwards. Most of our gym, err, gym clients are ex GP referrals, or ex cardiac

AW: 07:34 yep. So, a lot of them are keeping up those good habits and taking up memberships from the programmes. Lovely, so you said, that you are also involved in delivering some of the sessions. So, you've got that dual role as a Coordinator and a Fitness Professional. So, as a Fitness Professional, how satisfied are you with the amount

of information that you receive about a client prior to meeting with them?

FC6/ FP14: 08:01 it has improved over the years. It is a lot better now. So, like I have gone to Beverley, not use to working at Beverley, but I am running the cardiac session, which is full. It is jam packed. It is 37 graduates and there's eight, ten new graduates, err clients. They do eight weeks and they become a graduate

AW: 08:23 ok

FC6/ FP14: 08:24 so, and we try to keep them going. Err, the referral form now has everything I need on that referral form. So, and then I go down, we have a one to one meeting with them. Tell them the training times and the days they're on. Tell them what meds they need to make sure they bring with them and pair with and it, it's everything is there. The electronic ones are far, far better

AW: 08:49 yeah

FC6/ FP14: 08:50 the problem what my instructors have been having is recording it on the Pharmoutcomes

AW: 08:57 right, ok

FC6/ FP14: 08:58 the Pharmoutcomes is a constantly changing database where it lets you record results and blah, blah, blah. But it is, they kind of closed one screen down that you have to go on another scheme to do this and it brings up the week one and it brings it the week six. Where the old system and it use to give you week one then week twelve, you never knew how much they had developed by or reduced. And then

the new scheme brings in the week one and the week six so you can see the reduction by the end of it

AW: 09:32 ah rather than waiting the whole twelve weeks

FC6/ FP14: 09:32, but going through the new format of all that is difficult. It's a bit mindboggling because you can't make your way through. What use to be one tick is now fifteen if you get what I mean. So, the instructors can get lost with it at times

AW: 09:47 yeah

FC6/ FP14: 09:48 so it's just having to do the reporting aspect of it because as the schemes developed, you know, we've had to develop with that. You know, for example, now you write a note on every client that comes in

AW: 10:01 through Pharmoutcomes as well?

FC6/ FP14: 10:01 through Pharmoutcomes and on CRM as well, which is another database, which is our membership database

AW: 10:08 ok. So, you've got the two databases

FC6/ FP14: 10:12 we've got quite a few different databases and then you've got your own individual database, so you know who has had a referral and who hasn't. So, it, you can get a little bit boggling. You can get bogged down with the paperwork on some of it. It's the reporting back as well. I mean luckily the, we just do the ten weeks, we do the reports, they go in, and then central team will collect all our data and then they produce what they produce

AW: 10:39 as in reporting back to the primary care sites

FC6/ FP14: 10:40 yeah

AW: 10:41 yep. So, it's a bit, there has been a few changes and the reporting of data can be a little bit difficult to get your head around.

FC6/ FP14: 10:49 yes. And the training because they give you a training scheme, but if don't make that day you can find yourself left behind a bit. And it's difficult as well, because like all my staff at the moment are all shipped out within the council. But they are still dealing with the health agenda work so they've having to go with how they do it. It's like, instead of the way we do it.

AW: 11:10 so all your staff at the minute are distributed everywhere amongst the East Riding

FC6/ FP14: 11:15 yeah

AW: 11:16 ok. When does Hornsea, when does it plan to reopen?

FC6/ FP14: 11:18 April 2020.

AW: 11:20 wow, ok

FC6/ FP14: 11:21 yeah

AW: 11:23 so they've got a long time to, to learn these systems. What do you think would help, err, help them to become more familiar with the systems?

FC6/ FP14: 11:30, I think simplifying it. Definitely simplifying it. So, you know, you got a name, bin bang bosh. yeah, he's a GP referral so it automatically takes you through to week one. You put your details in, you put your tests in, save. Done. Put the name is next time, it automatically takes you to week six. Do you get what I mean?

AW: 11:51 yeah

FC6/ FP14: 11:52 put the name in again, takes you to the end results with all the results there and then it gives you your report at the end. Because the individuals want to know how they've done as well. When you haven't got the information on the screen, and we aren't allowed paper copies because of data protection. So, you know, they say, "How much weight have I lost"? And you're like, "oh, well, you have lost some, but..." [laughs]

AW: 12:14 I can't tell you what it is [laughs] right, ok. So, making it a bit more simpler

FC6/ FP14: 12:20 and being able to print a report off for them. Then, then they can give them it and say this is what you've achieved. Which is a good incentive and then it keeps them motivated. It keeps them, it gives them pride, and it keeps them on the good habits

AW: 12:31 absolutely. It is their results so perhaps having a hand out that you can give them

FC6/ FP14: 12:37 we do have testimonial sheets which are hard copies and everything else, but then again, that means you're having to not only do the tests for the health agenda work, then you've got your own in house tests on them to get that information to do. If you get what I mean

AW: 12:53 right, ok

FC6/ FP14: 12:54 sorry if I am going too fast

AW: 12:56 no, no, it is fine I am just trying to, I can't remember where I am in the interview if I am honest [laughs] I am just doing a bit of everything. So, is there anything additional that you would like to

know in terms of the information about a client prior to them coming in. In an ideal world, if you could have anything

FC6/ FP14: 13:10, I think it would be always good to know if they have had a referral before.

AW: 13:15 ok. Onto another scheme?

FC6/ FP14: 13:16 yeah. Been on another scheme or even doing the same scheme again

AW: 13:21 ok. Why would that be helpful?

FC6/ FP14: 13:21 because then that way we can distinguish between the guys that this person is just after a, no, disrespect, but a cheap membership for ten weeks, we won't see them again. Or if he's, if, if there, because 95 percent of the clients have some benefit from taking out a healthy scheme. They either reduce blood pressure. They either reduce weight. Mobility increases. Whatever, they usually have something what improves which sustains a better life force. And if we can keep that going that is far better than having the ones what just come for a ten-week fix disappear, come back six weeks later for a ten week fix, disappear. Do you get what I mean? So, you're constantly going over old ground. Where we can actually say unfortunately, you've had three referrals... what can we teach you knew?

AW: 14:17 exactly so then you can invest your effort and time into somebody who you feel is going to sustain that after

FC6/ FP14: 14:21 I don't want to sound negative, but yeah

AW: 14:24 no. no. Absolutely, yeah. There is only so much you can do and as you say if there's someone that keeps coming back and back, what more can you do?

FC6/ FP14: 14:29 yeah, I mean usually cuz the GP referral scheme has opened up for everything now. So, mental health issues, drug addictions, everything. And you know, you're not going to change somebody in ten weeks on drug addiction. So, it's, it's a little bit hard for us, especially with mental health issues as well, because you're not dealing with the physical body, you're dealing with this [points to head]. And, and that's a lot on the LiveWell, scheme. It's a lot on, even in the cardiac groups, they have a sense of doom. They are frightened to do anything. So, you're still having to work with the brain if you get what I mean. And, I think, courses what look in the psychological aspects of all these things and these conditions should be really implemented to all instructors across the board to deal with those kind of.... Cuz you're not just dealing with the physical anymore, you're dealing with the mental side of it all. And you know, you can take a horse to water, but you can't make it drink. You've got to learn how to coax that person and direct them in the right direction. And it's all about trust as well. So, it's always good to make sure that there is time for that client to see, maybe the same instructor, so they're getting the trust built up and everything else, but demand obviously, dictates obviously, how we are going to go through the scheme.

AW: 15:53 yeah. So, correct [knock at the door] ...correct me if I am wrong, but err, you feel there should be more training around mental health for your instructors. More support around that

FC6/ FP14: 16:13 yeah. There has been some, don't get me wrong. I aren't saying, they haven't done any, they have, they have, but you always find yourself in that situation where you're like oh, err. Do you get what I mean? And especially on the LiveWell, side of it

AW: 16:29 and you said, about having the same instructors, so that can help, that consistency. Do you find that you are able to give that client the same instructor every week?

FC6/ FP14: 16:37 well, unfortunately, because of the leisure centre closing, they could only offer temporary contacts so, so nobody is going to give a permanent job up for a temporary. So, we was very restricted on our instructors, so their time came more and more, not dealing with the general stuff, but just dealing with the health agenda work. And it was a case of wherever we could fit that client in

AW: 17:00 yeah, whoever yeah

FC6/ FP14: 17:02 we could fit it in. The council don't pay us any money for us to have a multitude of instructors just say, "Oh. well, I'll put you with [HLO's name] for this ten weeks". We can't do that. We have to work it around the shifts of individuals. So, we have a team, and then we can say that you generally have a team which is better, but I think what would help is again, err, which is something I am looking at when we reopen, is more group-based. So, more social aspects of everything. So, group based activities. Water based activities. In

groups, so they can have a laugh with other people in the same predicament they are in.

AW: 17:39 yep, just putting on them classes so they've got more of that social aspect

FC6/ FP14: 17:43 social aspect because, and then, because the last thing you want them to do is to be too reliant, err, reliant on the instructor and not actually thinking about improving themselves.

AW: 17:52 yeah, absolutely. So, trying to build that autonomy by getting them amongst other people

FC6/ FP14: 17:57 yeah

AW: 17:57 lovely. Err, and when somebody comes into the leisure centre for the first time, on their initial appointment, how informed do they tend to be about the programmes they've been referred on to?

FC6/ FP14: 18:11 unfortunately, they are not. Err, what happens is, we get a referral. We will telephone the individual, book them in an appointment. Then on that first appointment is when we explain of what the scheme consists of, what it is about, what err commitment we are looking for from them, and then the price. And we do that, and we usually do a health check with them, and then start the programme process off. And then bring them in, make the next appointment for their first training session

AW: 18:46 ok

FC6/ FP14: 18:47 and that's how we do it originally, from getting a referral. Err, you tend to find when you get them on that first appointment, they haven't a clue half the time what scheme they are on. Err, the

LiveWell, well, that was for people expecting to go for bariatric surgery or an alternative for bariatric surgery, and it quite shocked quite a lot of people when they realised that what the scheme is actually about and is about weight loss

AW: 19:12 yeah. Why

FC6/ FP14: 19:14 err so when you look at it in that sense, it's a big, you know, it's not here for us to say, well, I aren't going to be training you or we're going to whip you to death until you lose weight, you've got to do your part at home. And they don't realise that aspect of you know, it's about what you're eating, filling in food diaries, controlling that at the time you are having these things, having the drinks. And again, controlling that. And err, and not only that, but then the family. You know, what are you doing for the family? What are the family doing for you? And so, and it's kind of all that gets brought in to it which none of them really expect

AW: 19:52 right, ok. So, they're quite shocked by, when you tell them about all the different aspects and the holistic approach, you're giving them. They are a little blown away by that

FC6/ FP14: 19:58 yeah, most of them will. Don't get me wrong, some of them are brilliant and erm most seem to take it in their stride and do come onto the scheme. But obviously, the ones which cost money, if they are unaware of the money, you tend to have lost somebody before we've got them in.

AW: 20:13 right, ok. So, money can be quite a big issue

FC6/ FP14: 20:13 yeah, especially with the elderly if they aren't working. You know, £33 doesn't seem a lot to us, but to them, it could be. It could be their week's groceries, so it is difficult. But we do have free places, but Hornsea has never had them. But they was looking at, basically, if they are on a benefit, I think the general rule is they can have a free place, but they have to prove they are on a benefit.

AW: 20:38 right, ok

FC6/ FP14: 20:39 and obviously, most people just say they are on a benefit when they aren't [laughs]

AW: 20:44 so there might be changes around that so you can get some free places

FC6/ FP14: 20:48 yeah

AW: 20:48 why do you think, err, patients or customers, however, you wanna describe them, why do you think they're not aware of the programmes?

FC6/ FP14: 20:54 I don't know if It's ignorance., I think most probably they've been told in the Doctors, and they haven't actually picked it up., I think they've misheard, and they just say, cuz they think, a lot of them use to think cuz I use to be called exercise on prescription. And because it's a prescription, they don't pay for their prescriptions, so they always expect it free. That's why we kind of changed it to GP referral. Err, but nothing free on the NHS anymore so... and err you've got to understand we've got, we've got our level three instructors as well, because you have four levels of instructor, and he's got to be a level three or above to deal with any of the health

agenda work. So, you can't just give them a basic instructor so, and they are on a scale point 25 which is about 12 quid a hour whereas 8.50 for a gym instructor. Do you get what I mean?

AW: 21:47 yeah. Yeah, so they are more highly qualified as well, yeah.

FC6/ FP14: 21:49 and then you have to kind of like fit them in to their working pattern. So, it, it can be very difficult. Err, we try and as I say, pair them up with an instructor if we can. You know, if they can make every Wednesday and Thursday, then I've got, or every Wednesday and Friday, I have got this instructor here who works every Wednesday and Friday. There you go

AW: 22:07 so sometimes that really works yeah

FC6/ FP14: 22:10, but erm, sometimes it doesn't. And sometimes they have work. And I'm a GP level three and I've had an instructor level three in, they may be on the days and on the night time I might only have a level two in and they wanna come in on the night and I'm like sorry, but you can't. So, it can be very hard

AW: 22:31 do you find you manage in terms of capacity. So, in terms of the Fitness Instructors that you've got available and the referrals coming in? Do you tend to meet that capacity?

FC6/ FP14: 22:41 we do, but we struggle because it is full

AW: 22:45 right, ok

FC6/ FP14: 22:46 especially as it has been before we shut because I was down to about four instructors

AW: 22:51 right, ok

FC6/ FP14: 22:52 and we still had the full agenda to go ahead with

AW: 22:54 wow

FC6/ FP14: 22:55 yeah. So, err there, we tend to be back to back with health agenda work, which didn't leave us much time for doing general members, programmes, health checks, or new member inductions and so it can be quite a balancing act at times.

AW: 23:13 yeah, because you've not only got the health agenda stuff, as you said, you've got your memberships, you've got your health checks. Everything else, but probably most of your capacity is thrown at the health agenda work

FC6/ FP14: 23:21 we also have a 44-week class timetable to deliver as well

AW: 23:26 wow

FC6/ FP14: 23:26 yeah, [laughs]

AW: 23:29 everything. And earlier on you said, about some of the challenges that clients face. So, when they first meet you, they are a bit apprehensive, a little bit worried. What are the common challenges that they disclose with you?

FC6/ FP14: 23:39 it depends on the situation like cardiac aspects, you've got the sense of doom. They've had a heart attack. They are frightened to do anything. They are frightening to even go back. The think that's it. The times started, the clock is on its way. You know, they've had a heart attack and they are very, very careful about doing anything. So, there's that aspect to it. We are, over here we are a lot better than we are abroad. We have aftercare. We have the phase three. We have the phase four for cardiac. Err, abroad, none of it. You have the operation, you're out, you're done. So, there's big changes in that

aspect. So, you tend to find with the cardiac, they've very, very err, wide open. Very much absorbing what you are telling them because they've only had so much intervention by the hospitals. Some do the phase three at the hospitals, some don't. Some have the operation and come straight to the phase four, so they are very much in your face basically. They want to know everything about their issue they've had, their conditions and how they improve that. So, they are very much easy to work with in one sense because, obviously, you've got to be a level four for cardiac. So, err, when I am delivering them, I've got to go this afternoon, they, they are on the ball, on the ball. Very careful, but they have what you call the Borg scale, I don't know if you've heard of the Borg scale

AW: 25:09 is that the exertion scale?

FC6/ FP14: 25:10 yeah, the exertion scale from zero to twenty. And every exercise I do, they have to monitor it. They get told the reason why they are getting monitored for it. Perceived exertions and then basically, depending on if we get anything higher than a thirteen, we will lower it. If we get anything lower than an eight, we will increase it and that's the general rule basically. But obviously, then you've got your counter indications with medications, so you've got to take those into account as well, when you are setting the programmes. But you tell them what you are doing. You explain to them why you are doing it. You explain what you are looking for and then you explain to them the benefits. And then by week eight, they see that benefit.

And they see that, and they realise, eight weeks out and I have done this. I can do this now. I'll keep it going

AW: 26:04 and it is working, yeah

FC6/ FP14: 26:07 so that's why we have so many graduates in every cardiac group because they all still keep coming. Which is great and we only take ten new ones. But once the eight weeks is up, they graduate, then we get a new one in. So, at the moment, I have got two people to contact this week cuz I've got two finishing this week, or graduating this week should I say

AW: 26:29 brilliant. So, that's the cardiac groups. So, what about your LiveWells and your Exercise Referrals?

FC6/ FP14: 26:32 LiveWells... it has been, I have been involved in the LiveWell, from the very beginning. It was six months. We complained because those who did well, didn't always see great results in six months, even though they had done really well. So, we extended it to a year. But then that left the doors open for those that tossed it off if you know what I mean. Didn't do any changes at all and didn't change their lifestyle. Still carried on drinking near fifteen pints a week and whatever and just wanted a freebie to come now and again. And do you know, when we are expecting three to five sessions a week because it is free. It is every day. And err, so, it was then decided that after a long, long time and because none of the LiveWells really knew what it entailed. They do now, they seem to be a little bit better now, but they didn't then at the beginning. And err, they've kind of like, taken on board what we do, but now we do it for six months and

it is up to the instructors discretion if they get the next six months free

AW: 27:41 ah so then you've got that choice whether they are committed and taking it seriously or if they are not taking it seriously

FC6/ FP14: 27:45 yeah, and you can take them off

AW: 27:47 right, ok

FC6/ FP14: 27:49 which is far better for us because we are not wasting our time. Because there's nothing worse sat in a room when you know they've are blatantly lying to you, and they will [laughs]. And you know, what training have you done today? Oh, well, I've been in the pool for an hour, and I have done an hour and half swimming, and I've done two aqua fit classes. Well, unfortunately, your membership card says you haven't been in the centre at all. yeah, but I have been going where I live. Well, why aren't you coming here, it is free. Why are you paying for where you are going? Do you get what I mean?

AW: 28:17 something just doesn't quite add up, yeah

FC6/ FP14: 28:19 and then you get it. And then you might say to someone, "Have you been on a good diet this week?" "Brilliant, I have not made a mistake". And then, "oh, I went out with the girls the other night". We get chatting later on and they're like, "oh, yeah, yeah, yeah, went for a meal". "Did you now?" [Laughs].

AW: 28:33 didn't mentioned that earlier on [laughs]

FC6/ FP14: 28:34 so yeah. But overall, I think the schemes we do are really brilliant. I do think they are. I just think we just need to tighten up a little bit more on the information we receive. The referral process,

err, it is faster now it is electronic, so that is brilliant because three to four weeks is far too long for anyone to be sat there waiting

AW: 28:59 absolutely. How else do you think it could be improved? So, by, obviously, making it electronic so you are getting the referrals a lot faster. So, in terms of the information that you are provided with, how could we improve that side of things?

FC6/ FP14: 29:07 as I said, to have current blood pressure, current BMI, current medication and if they've had a referral before

AW: 29:19 ok do you have confidence in the BMI, BMI that the GPs are providing for instance. Is it...?

FC6/ FP14: 29:26 no, I don't to be honest with you. I, I put it down there because it is an indication. We always do it ourselves anyhow. But it is not about BMI any more it is about waist circumference. But, in the same context, old school people rely on BMI. They understand it better. But it is actually waist circumference. 30 for a women, 34 for men. Anything above, you are at risk. End of. Makes it a lot easier to understand for them.

AW: 29:50 yeah. Is the, the criteria for the schemes though, they are based on BMI, aren't they?

FC6/ FP14: 29:55 BMI of 47 for LiveWell. HOP, they've got to be waiting an operation. GP referral anything. They could be overweight. Could be blood pressure. Can be anything

AW: 30:07 right

FC6/ FP14: 30:07 err GP referral and what's the other one? Cardiac rehab, you've obviously, got to have a cardiac event

AW: 30:14 yeah, yeah

FC6/ FP14: 30:15 so

AW: 30:17 so the last section of the interview is about feedback. So, feedback in terms of a client's progress and how that is communicated back to the primary care site or that referring practitioner. So, currently, do you send feedback to the primary care sites?

FC6/ FP14: 30:30 not personally. Not direct. The central team send all that back

AW: 30:36 ok the central team in Beverley do that?

FC6/ FP14: 30:37 yeah. They collate all the information from Pharmoutcomes. They check all the notes on the CRM and if anyone is missing notes, they chase us. Or out like that. Err, and then once they've completed, then they report back to the...

AW: 30:57 to whoever has referred on. Is there anything that you feel is especially important to communicate back to the primary care sites or that referring practitioner? Obviously, Pharms is based a lot of statistics. Is there anything additional that you feel would be useful?

FC6/ FP14: 31:13, I think the general, it's all facts. It's all facts. There is no, good wills. There's, if you know what I mean. There is no, mental aspect of any of the reporting

AW: 31:29 so it's all on physical

FC6/ FP14: 31:31 you could say, it is all physical. You know. They want to know your weight. They want to know your blood pressure, body fat percentage. But they don't actually say, how did the person find the scheme? We do have questionnaires, which ask those questions and

also ask if they trained on a one-to-one or there was in a group and all that kinds of thing, on the questionnaire, but I don't know where that info goes on the questionnaires. But at the actual reporting back aspects, on the form, that is just always factual. They are never on good will gestures. You know, loved the scheme, really enjoyed it, keeping it going, taking out a membership. And I just think that would help you guys as well, because you think well, that person has really done well, on there. Where if you had someone who hated the scheme, but attended, you get what I mean? You could say well, I know you did not like that scheme, but did you want to go on it again and more often no. Do you know what I mean?

AW: 32:30 yeah. So, having a little section so you can free type perhaps

FC6/ FP14: 32:31 yeah, or even a suggestion box. And just say, we could say, well, this person has had a stroke so they actually need another referral so we will just transmit it straight through to another referral instead of them having to go back to their GP to get a referral to get sent through again and everything. Can't we just continuously keep going?

AW: 32:53 yeah. Miss out that middle-man, the GP, and you take that on. Do you find the, I keep saying, GP, but I mean the referring practitioner, do you find that they are referring patient to the correct programme first time?

FC6/ FP14: 33:05, I think as the NHS has lost its services, I think we are getting more and more referrals, which don't really suit the scheme they have been referred for. So, a prime example was we had a young guy.

Motorbike accident. Wanted physical manipulation in movement. Referred onto a GP referral scheme. That's, no, way! My guys are not qualified to do that. We can't take him. Well, why has the GP referred me? Unfortunately, I don't have the answer. Do you get what I mean? That was one. The other thing is, I think it's err, not so much a problem, but cuz we have the power to say," Look you've been referred for this scheme, but you'll be better on this scheme". So, we had one guy here, referred for GP referral, was expected one to one, motivation and all that aspect, but on a GP referral scheme we can take up to five clients per group

AW: 34:08 ok. So, a lot more group-based work

FC6/ FP14: 34:08 he wanted it on a one to one, but when I looked at him, looked at his stats, he has a BMI of over 47 and he wanted it free. And I said, to me, no, disrespect, but you'll be better off on a LiveWell, scheme. Your BMI is over 47, it, it's a free course for six months. If you do well, you can get a further six months. We can give you the one to one aspect. So, why has your GP given you GP referral? Do you get what I mean? But I think that's just not understanding the full schemes

AW: 34:45 yeah, perhaps not having the awareness of the different criteria. What do you think could improve that in the future?

FC6/ FP14: 34:48 I honestly don't know to be honest with you. I mean there's so many surgeries what refer into the scheme, and I think to kind of cover every one of the surgeries. I don't think anyone has got enough time in the day to do that

AW: 35:03 right, ok

FC6/ FP14: 35:04 and every Doctors at that surgery who's doing the referral

AW: 35:08 yeah, exactly

FC6/ FP14: 35:09 err unless we could cover the generic, this is East Riding health schemes. This is what you qualify for this. This is what you qualify for this. This is what you qualify for this. And then just have that on a big A3 poster or something or other.

AW: 35:25 ok. Just some more information resources

FC6/ FP14: 35:28 or even when they are referring it electronically, it brings it up there. You're referring for the GP referral, this person must have... You're referring for HOP, this person must have....

AW: 35:38 ok. So, just reminders through the referral system as well. And then again, whilst they are inputting the data, they can triage that patient to which programme is best for them. That's a good idea... Lovely, I think I have covered everything that I wanted to talk about today. Is there anything else that you want to add that you feel is important about anything?

FC6/ FP14: 36:04 no

AW: 36:04 no

FC6/ FP14: 36:05 only that the schemes are very good, and they do help a lot of people. You know? Over the years that I have been doing this job I have seen people coming in with walking sticks, I have seen them walk out without any. I have seen diabetics come out who are not diabetic any more. You know, seen heart attacks that have done marathons

AW: 36:25 gosh

FC6/ FP14: 36:28 do you know? And it is educational. It is more educational than anything else and having the understanding and the motivation to help those people. Err, as I say the only times that I do get a little bit stuck is the mental aspects what we are dealing now because obviously, the services are disappearing from the NHS, we tend to get more and more referrals coming through which sometimes are really beyond us. And nobody wants to say I am sorry I can't help you.

AW: 36:56 absolutely. You are willing to help everybody, but there are instances where you, it is beyond your capacity to deal with them people

FC6/ FP14: 37:04 yeah

AW: 37:04 do you feel a little bit like you're the outlet for the GP service because they've got nowhere to signpost?

FC6/ FP14: 37:09 at times, definitely. I mean when I did my cardiac rehabilitation, we went to do the phase three at Castle Hill hospital. They had a Nutritionists, they can a Physiotherapist, they had a Nurse, they had a doctor, they had all, there was seven of them. There was seven of them. Went to go to one err, about two years ago, it was reduced to two. No Nutritionists. No-one talking to them about healthy eating at all. So, all this information, they are getting from us at phase four, which is quite a way down when you consider they had their operation. They have had their recovery. They have done the phase three at the hospital, and then before they even talk about nutrition, it's with us at level four

AW: 37:55 absolutely. It's a long process to then be getting nutrition advice right at the end

FC6/ FP14: 37:59 yeah, you know, we had one guy, I remember from Castle Hill, boasting that he had twenty two coffees a day! And I am like, you've just had a triple bypass [laughs]

AW: 38:11 you're going the right way for another one, God [laughs]

FC6/ FP14: 38:13 and he was happy because he was only twenty four

AW: 38:19 it is a long time

FC6/ FP14: 38:18 ok

AW: 38:19 yeah, lovely well, thank you very much. I will turn this recording off and type up the transcript.

AW: Interviewer **Interview date:** 04.02.2019

BT1: Participant Interview **location:** East Riding Leisure Beverley

AW: 00:01, but it purely just so I can reflect on exactly what you're saying, and make sure I don't get anything wrong. Is it ok if I take some demographics before we begin?

BT1: 00:07 yeah

AW: 00:08 would you prefer [BT's name] or [shortened BT's name]

BT1: 00:09 [shortened BT's name] is fine

AW: 00:11 how would you identify your gender?

BT1: 00:13 female

AW: 00:14 female. And how old are you if you don't mind me asking?

BT1: 00:16 34

AW: 00:18 34. So, we are in Beverley and what is your role within Beverley Leisure Centre?

BT1: 00:23 Business Technician

AW: 00:24 yep, and how long have you worked as a Business Technician?

BT1: 00:27 erm, four years now

AW: 00:30 four years

BT1: 00:31 yep

AW: 00:32 and can you briefly describe what it means to be a Business Technician? What you're typical roles are.

BT1: 00:37 so with regards the, the health agenda?

AW: 00:38 yeah

BT1: 00:38 erm, it would be receive the referrals from the GPs, Physio's et cetera. Erm, contact the clients. Check that they have been referred for the right programme.

Get them booked in at the nearest centre and then we forward the paperwork to the instructors and then track the clients progress as they go through the scheme. So, monitor their attendance and...

AW: 01:10 perfect and what healthy lifestyle programmes are you involved in processing?

BT1: 01:13 erm, the HOP, LiveWell, Young LiveWell. Erm, the Exercise Referral, purely track the sessions on that. We don't have anything to do with the booking process

AW: 01:28 ok

BT1: 01:32 and then at the moment nothing to do with the Cardiac

AW: 01:34 right no problem. So, who is responsible for processing the Exercise on Referral referrals?

BT1: 01:38 the sites do them specifically, so the GPs send those direct to each site.

AW: 01:46 right, ok and what's the difference between those referrals? Where do they other referrals go?

BT1: 01:53 all` the others come through to us

AW: 01:53 ok so they come centrally

BT1: 01:55 just to our office yeah,

AW: 01:56 right OK

BT1: 01:58 to the Business Tech office

AW: 01:59 perfect and I have your email from the survey so that's fine. Ok so the first section of the interview will be based on the referral information that you receive

BT1: 02:07 yeah,

AW: 02:08 so what are the different ways that you receive referrals from primary care?

BT1: 02:13 erm we get paper copies, erm email copies and fax

AW: 02:19 paper, email, and fax

BT1: 02:21 yep

AW: 02:22 and what's the most common?

BT1: 02:24 email

AW: 02:25 email

BT1: 02:26 yeah

AW: 02:27 is that the electronic ones?

BT1: 02:29 erm some surgeries will email the PDF of the referral form. Others will book, book the client in directly

AW: 02:40 yep. Is that through BEARS?

BT1: 02:39 yeah

AW: 02:41 yep, and what, in your opinion, what's the easiest type of referral to process?

BT1: 02:46 the email physical referral form

AW: 02:49 right the PDF?

BT1: 02:48 yeah

AW: 02:52 why is that?

BT1: 02:52 er, just because we have all the information there in front of us… and we're, we're sort of seeing the process through from start to finish then. We're, we're making the appointment with the client, getting a time that's convenient. Whereas the ones that have been made at the GP surgery, erm, in a lot of cases, the client don't know that they have had that appointment made. So, we will ring them, "oh, you've got this appointment", "well, no, I can't make that one" so we are having to re-arrange and it's just, not straight forward

AW: 03:27 so do you prefer to make the appointment as opposed to the GP surgeries?

BT1: 03:30 yeah

AW: 03:30 do you know why the patients are not aware of their appointment time?... Do you think they are booking in without...?

BT1: 03:34, I think they are doing it when the patient isn't present. It tends to be when the medical staff have booked it rather than the GP. So, whether they have left the surgery and then gone in

AW: 03:46 and then booked in what they think. OK and what is the most difficult to process? So, you've said, the PDFs are the easiest, which ones are the most difficult?

BT1: 03:54 I'd say as I just said, the ones that are booked in by surgery

AW: 03:57 ok same type, but the ones, which are booked in, but they are not aware of their appointment.

BT1: 04:00 yeah

AW: 04:02 and are all surgeries in the area set up to refer electronically?

BT1: 04:05 not all of them no

AW: 04:06 ok do you know how many roughly are?

BT1: 04:09 no, I don't

AW: 04:09 ok no problem

BT1: 04:11 [HLO's name] would be your best bet for that one or [HLO's name]

AW: 04:16 and how often do you receive referrals that include all the required information?

BT1: 04:22 most of them do yeah. Erm...

AW: 04:26 and is it often that they refer onto the correct programme?

BT1: 04:29 yeah

AW: 04:30 perfect can you tell me about your experiences of contacting GP surgeries to retrieve any information that is missing from a form?

BT1: 04:40 er, they have usually been helpful yeah....

AW: 04:48 how would you describe your relationship with the East Riding surgery's and East Riding leisure?

BT1: 04:52 erm, to be honest, the, the only contact we really have with them is if something is missing on the forms. We would ring erm, obviously explain what we are calling for, and what's missing and they will give us that information. We don't really have any further involvement with them.

AW: 05:08 are they quite happy to release that information on the phone?

BT1: 05:11 yeah, yeah, yeah

AW: 05:15 so the second theme is around the telephone conversations that you have with those who have been referred. During that initial telephone conversation, what information do you provide to referred customers?

BT1: 05:24 erm, so we just ring and say we've received this referral form from your doctor. Are you aware of it? Erm, and then they will usually say, "yeah, they have referred me for LiveWell", or "I am having an operation, they've referred me for HOP". Erm, and then we, obviously run through, just a brief summary of what the programme involves, find out which is the nearest site, and then get them booked in. And then we will send them some confirmation by email. Again just, reiterate what we've said. What they have got to wear and, what the programme involves et cetera.

AW: 06:06 so you said, they tend to know, I've been referred for LiveWell, so do you think they've got a good understanding of the programmes?

BT1: 06:12 er I would say probably about 80% no. it tends to be more the HOPs that don't erm, you know, they will say, "well, I don't really know what I have been referred for". We've had some thinking they have just been referred for stop

smoking. Erm, and then others just "no, well, no, I don't know, I'm not having an operation, I don't know why I have been referred".

AW: 06:37 right, ok

BT1: 06:38 which can be a bit awkward

AW: 06:41 how do you get around that?

BT1: 06:43 I just say well, we've had this referral from your GP. This is the programme, do you want to participate and it's either a yes, or a no. They are a bit more hesitant to start with HOP, I think erm because it's something that they have been, they have got to do this before you can have your surgery kind of thing! Whereas LiveWells, they are more keen to get on and...

AW: 07:07 yeah, so you feel the ones referred onto LiveWell, because they are not so much forced into doing that, they are more keen to get started

BT1: 07:14 yeah

AW: 07:14, but the HOP's...

BT1: 07:16 "well, I don't really want to do it, but I've got to so yeah, I'll come "

AW: 07:21 and what to do you think would be the best way to increase that awareness about HOP to referred clients

BT1: 07:26, I think it would help if they had more information at the point of referral. From their point of view, they are getting someone ringing up from the leisure centre, "well, your doctor has said, this to us", and they don't really know why. Erm, so if it was explained to them at the point of referral, why they're being referred onto these schemes.

AW: 07:49 so more information from the person who is referring them would help

BT1: 07:53 yeah

AW: 07:55 anything else that you feel would help? ... I'm just speculating if there's anything physical we could hand them

BT1: 08:05 maybe if they had like an information leaflet yeah, explaining what the scheme is. I mean, we do, we do run through it with them on the telephone like I say, but whether it goes in one ear and out the other, you don't know do you? Whereas if they've got something physical there, I think

AW: 08:22 it will remind them that you are going to call them. Are they, most of the time, are they aware that they are going to be contacted?

BT1: 08:28 most of the time yeah

AW: 08:31 and how confident are you in the information that has been put on the referral form, in terms of the BMI and the blood pressure? Are you confidence that is all up to date and accurate?

BT1: 08:40 yeah, yeah. I mean sometimes they probably send us too much information. There's been a few instances where we've had the whole medical history from birth, which obviously we don't need. Erm,

AW: 08:56 how do they send that across? Do they attach that with the PDF?

BT1: 09:01 yeah, they attach it to the email, yes. It's like a patient summary. Erm, but usually the BMI's are, yeah.

AW: 09:09 and if you get a massive summary of the medical history, are you expected to syphon through that to find what's relevant or do you just pass that on?

BT1: 09:15 no, we destroy it. We don't need that. We destroy it yeah.

AW: 09:21 ok and during your initial conversation, do referred customers raise any concerns about coming to the leisure centres or the programmes?

BT1: 09:28 erm usually they're a bit nervous. It's kind of an alien environment to a lot of them. So, we just give them that reassurance and....

AW: 09:44 so to get around that you sort of say to them it's fine and reassure them

BT1: 09:47 yeah, just explain what it's about and give them that reassurance...

AW: 09:51 anything that they raise or that they are concerned about before coming?

BT1: 09:57 no, no, no

AW: 09:59 and what do you think might help alleviate their worries and anxieties about coming in?

BT1: 10:06 again, I think it is just being informed. So, if they have that information from the beginning. I mean a lot of them that come in tend to have anxiety issues anyway. Erm... so if they've got that extra bit of information....

AW: 10:31 just so they're aware of what's going to happen

BT1: 10:33 yeah, and then something that they can keep referring back to...

AW: 10:40 absolutely. And are there any common challenges that you face? So, you said, it can be quite awkward when they don't know about the HOP programme…

BT1: 10:46 yeah, the HOPs. If they, well, I don't really want to come, it's kind of well, you don't have to come. If you don't want to come, you don't have to. We are not going to force you to come. Erm, we, we don't, we don't try and push them into it if they don't want to attend...

AW: 11:04 any other challenges that you face? Is it mainly if they're not sure? If they don't really want to

BT1: 11:08 yeah, yeah, yeah

AW: 11:11 that bit of resistance I guess over the phone.

BT1: 11:12 yeah,

AW: 11:14 so the next, the last section sorry, is about the feedback that you provide back to general practice sites

BT1: 11:20 uh huh

AW: 11:20 erm so you said, you are involved in the full process from the monitoring of the progress right through to the end. So, could you just describe about your involvement in the feedback process? Do you feedback back to primary care sites?

BT1: 11:31 yeah, erm. So, going from the beginning erm, any referrals that we can't contact, erm, we'd refer them back to the GP. So, they would just go back, erm, in the post with a letter explaining, we've tried to contact your patient on these occasions. HOP is slightly different cuz that's on Pharmoutcomes, so we refer those back on Pharmoutcomes.

AW: 11:55 ok

BT1: 11:55, but LiveWell.... LiveWell, isn't on Pharmoutcomes yet so

AW: 12:03 right, ok. So, do HOP referrals come through Pharmoutcomes? Or is it just monitored on Pharmoutcomes?

BT1: 12:10 it's just, everything is just recorded on Pharmoutcomes for those. So, the referrals still come in exactly the same way, but we record the information on Pharmoutcomes

AW: 12:21 ah OK. That makes sense. But LiveWell, is not on Pharmoutcomes?

BT1: 12:24 no, no

AW: 12:25 do you know why that is?

BT1: 12:27, I think it's due to go over in April time

AW: 12:28 ok so it's due to, to move over?

BT1: 12:30 yeah, yeah, so like I say at the minute we have to send them back via the post if we are returning them back to the GP

AW: 12:37 does that make it more difficult because it's not on the same system as HOP referrals?

BT1: 12:45 yeah, I mean we kinda got used to it now, but it, it would be helpful if they both follow the same procedure, definitely.

AW: 12:55 hopefully April that will get sorted. Perfect so that is if there is a non-attendance…

BT1: 13:01 yeah

AW: 13:01 can you talk me through the other so if someone has completed the full scheme

BT1: 13:05 so, my personal involvement, I, if, if anybody is removed from the scheme for not attending, I send that information back to the GP

AW: 13:14 the same way through a letter

BT1: 13:18 yeah, it is through a letter. Erm, and then with HOPs again it is just through Pharmoutcomes. And then it's one of my colleagues that deals with any who complete which again it's the same format. It's just a letter out.

AW: 13:36 ok do you know what information is supplied back to the GPs once a patient is completed?

BT1: 13:43, I think it's just how much weight they've lost and what their BMI is at the end of the scheme.

AW: 13:54 weight loss and BMI... Do you think it would be useful to send across anything else? Or do you feel that's enough for the GPs?

BT1: 14:05 erm... I don't know if their level of attendance. Would that be of any use to them? I don't know

AW: 14:14 it's just your opinion, I don't know. I am just wondering (laughs)

BT1: 14:16 well

AW: 14:17 maybe attendance?

BT1: 14:19 yeah, your patient attended 70 per cent of their sessions and lost this weight or gained this weight

AW: 14:28, but you are not involved in giving that feedback. You said, somebody else does that.

BT1: 14:34 yeah, my colleague does the completions.

AW: 14:36 yep, perfect. And finally, in your opinion how could the referral process be improved?

BT1: 14:45, I think having the same process for all the schemes. Like I say, we have got used to doing it the different ways, but you still each time, do I do this one for LiveWell, or is that what I do for HOP? You know, you're sort of double-checking yourself.

AW: 15:03 so with them coming in centrally, that's for all the East Riding sites? Driffield, Beverley...

BT1: 15:07 yeah

AW: 15:07 all of them?

BT1: 15:07 yeah, all of them

AW: 15:10 and once they are in centrally, you book that appointment with the centre?

BT1: 15:13 yeah, although, at the moment, erm, some of the sites are changing onto BEARS version three, which they won't let us have access to BEARS version three. They won't let the business techs access it. So, any appointments that are made at the GP surgeries, we can't see the referral for those. We can just see that an appointment has been made, but we can't see anything else

AW: 15:39 ah how are you expected to....

BT1: 15:40 it's all a bit up in the air at the moment. There's no, set answer yet for that one...

AW: 15:48 ok... and how is the workload? Is it manageable in terms of the referrals that are coming in? Obviously, you do a lot of the schemes and it's only the exercise on referrals that you don't do...

BT1: 15:56 yeah, there is five of us in the office and we do er, two half days each, erm, monitoring the incoming referrals and contacting any that need chasing up

AW: 16:09 yeah, that you need to book in... Why, why do so many of the referrals come in centrally and then the Exercise Referrals go to each site?

BT1: 16:18 I don't know

AW: 16:21 ok I just wondering I'm trying to piece together....

BT1: 16:20 no, no, I don't know., I think they are looking at bringing them all centrally. Erm, we've just got three new healthy lifestyle officers to look after these programmes. Erm, so, I think they are going to all be coming in centrally soon, but at the moment that is how it is done.

AW: 16:39 OK, and is workload OK on terms of the ones that you have got at the moment?

BT1: 16:41 yeah, yeah, like I say we all split it out, so it is manageable

AW: 16:47 lovely. And then final question, is there anything else that you want to add that you feel is important about anything we've discussed today?

BT1: 16:55... I don't think so no

AW: 16:58 OK perfect. Thank you very much. I'll just turn this off. Have you got a full day today?

BT1: 17:03 yeah

AW: Interviewer **Interview date**: 06.03.2019

BT2: Participant Interview **location**: East Riding Leisure Beverley

AW: 00:01 yeah, absolutely. So, it is just the, it is just the healthy lifestyle programmes that you deal with. So, the Young LiveWells, the LiveWells and the HOPs

BT2: 00:07 yeah, that's fine yeah

AW: 00:08 it is ok if we take some simple demographics before we begin?

BT2: 00:09 ok yeah

AW: 00:10 how old are you if you don't mind me asking?

BT2: 00:11 erm 48

AW: 00:13 48 and which East Riding leisure site do you work in?

BT2: 00:17 Beverley

AW: 00:17 Beverley. What is your role within Beverley Leisure centre?

BT2: 00:20 erm, Business Technician

AW: 00:23 and can you sum up some of your typical roles? Or what it means to be a Business Technician?

BT2: 00:27 right, ok. So, I erm processing memberships. Er, er, customers enquiries. Er, dealing with the referrals onto the different health programmes that we offer. Er, completing paperwork and obviously, er, collating information from completed paperwork. Erm, you know, for people that have been on the schemes

AW: 00:52 so when you say the er, health agenda programmes that you deal with…

BT2: 00:56 yeah

AW: 00:56 which ones specifically are you involved in?

BT2: 00:57 so erm the HOP, erm the adult LiveWell, and the young LiveWell. Er, and they've just started a new one. They've just trailed one, which was the Escape Pain. Erm

AW: 01:12 yep. So, the LiveWells, adult and young, the HOP schemes and the new programme, the Escape Pain

BT2: 01:16 yeah, yes,

AW: 01:17 and how long have you worked as a Business Technician?

BT2: 01:19 erm it will be, oh, let's see about fourteen months

AW: 01:27 yeah, just over a year

BT2: 01:30 yes

AW: 01:31 lovely and I have your email from the online survey. So, that's just to send your transcript at a later date. So, the first section of the interview is about the information that you receive from primary care sites

BT2: 01:40 ok

AW: 01:41, but first of all can you tell me about the different ways that you receive healthy lifestyle referrals?

BT2: 01:46 ok. So, er, sometimes we receive a paper copy that comes in through the post or possibly handed in at reception

AW: 01:55 ok

BT2: 01:55 erm, our other one is through our, we have our leisure health inbox. So, they come through, erm, on the leisure inbox and they are dealt with that way. Er, and occasionally, possibly through, fax they just come direct to the copier. They are not, not so many. That's minimum

AW: 02:17 ok, and which is the most common way that you receive referrals?

BT2: 02:20 erm I would say the leisure health box

AW: 02:23 the inbox?

BT2: 02:24 yeah, the electronic referrals

AW: 02:27 and in your opinion, which is the most easiest to process?

BT2: 02:30 er the electronic referrals

AW: 02:31 why is that?

BT2: 02:32 er, because they come in, you've got an email address immediately, if there are any queries er, later on

AW: 02:42 an email address for the surgery that's referred?

BT2: 02:43 yes, or the referring person

AW: 02:46 ok

BT2: 02:47 yes, yes

AW: 02:49 which ones are the most difficult in your opinion, to process?

BT2: 02:53 erm, I would say the paper copies, erm because of them are hand written. Er, sometimes reading handwriting is erm, quite a chore. Er, but I mean obviously, that can be the same cuz some of the electronic referrals are hand written as well

AW: 03:13 ok

BT2: 03:17 and that er,

AW: 03:18 how are the electronic ones hand written? Is that faxed?

BT2: 03:20 yeah, well, say like if, for example, although we have an interactive forms. So, some of them come back and they are typed, but then we also, some of them have got, form where, I presume they've like saved it as word maybe…

AW: 03:30 ok

BT2: 03:32 and then filled it in and then scanned it back to us

AW: 03:34 ah, ok

BT2: 03:35 so it still comes in through the health box, but it might be more a scanned copy then the initial interactive form

AW: 03:39 yep,

BT2: 03:41 yeah, if that makes sense

AW: 03:41 so they are not always using that interactive one. Sometimes...

BT2: 03:44 yeah. We had one the other day and they said, "Oh, can you send it through as a word document?" so...

AW: 03:50 they find it a little easier to do it that way?

BT2: 03:51 possibly yes, yeah.

AW: 03:53, but then as you say it's the handwriting. If they do it that way, you are still struggling to read the handwriting sometimes

BT2: 03:58 sometimes, yes, yes

AW: 03:59 and how often do you receive referral forms that include all the required information on them?

BT2: 04:09 er, well, quite difficult to say really. I would say the majority of forms do have the information on them although it may not be the correct information that we require. So, for example, on the form, it would say er, name of patient, er, name of GP surgery, address and it is actually asking for the address of the clients, but the GPs quite often put their address down

AW: 04:33 right, ok

BT2: 04:33 so them fields are not, sometimes clear to some people so the, the field are filled in, but perhaps not correctly

AW: 04:41, but not necessarily

BT2: 04:43 not the correct information that the form is actually asking for

AW: 04:47 what do you think would help that?

BT2: 04:47 erm, perhaps inserting patients address., I think, I would need to check on the form actually, as to whether it does just say address

AW: 04:56 ok, yeah. So, just a little bit more clarity around that

BT2: 04:58 yes, yeah, on there. Erm, and obviously, there are fields on some of the forms that they don't fill in. So, like on some of them, it does say BMI, er, or blood pressure, and sometimes they come back, and they are not filled in. That does tend to be, I've noticed, more or less on the forms that come in from say a parent that's referring. So, sometimes obviously, they may not have that information. Er, and when we've spoke to the parents and said, you know, "do you have an idea of the height of the child or the weight of the child?" Cuz obviously, we don't ask for the BMI of a child, then they have said, "Oh, I don't know".

AW: 05:38 ok yeah

BT2: 05:39 so we've had to make it clear to them, well, we can book them in for the initial appointment, but obviously, we will be checking the criteria for height and weight

AW: 05:46 yeah, to see if they meet that

BT2: 05:48 to see, yes, yeah.

AW: 05:48 right, ok. So, is that just in relation to the young LiveWell, programme?

BT2: 05:52 erm that one tends to be, yes, yeah

AW: 05:55 and how do you retrieve missing information from referral forms?

BT2: 05:59 erm, so, normally if there is the patients name and a contact number er, we would ring the patient direct. Erm, maybe asking them you know, to confirm their address or confirm their date of birth erm, which we would check anyways. Erm, sometimes it's a case of ringing the GP er, because if they've just put patients name on that they're referring, but they haven't given us a contact number for the patients, Obviously, we then have to ring the GP surgery and ask them

AW: 06:30 because there's no, way in getting that information from the patient

BT2: 06:31 yeah

AW: 06:32 and how easy is it to contact GP surgeries?

BT2: 06:34 err, being in queuing systems, that is what I would say, that you can be in a queuing system for quite a length of time. Er, particularly at peak times. So, obviously, that is something, I know before I've gone to ring up and I've thought, oh, actually, 9 o clock in the morning, it is perhaps not the best time, I'll put that aside and ring them later in the day. Erm, and then I've found some of the surgeries are really helpful. They'll maybe say, "well, what's the date of birth of the clients?", and obviously, clarify their details. We have had one or two that have said, "Oh, well, actually, can you leave it with me, and I'll ring you back". So, I don't know if that's a bit more of a data protection, you know, obviously checking they are speaking to who they say

AW: 07:19 ok. So, some of them are quite happy for you to give that information, but others are a little more reluctant to do that

BT2: 07:21 yes, yeah, yeah.

AW: 07:24 ok. So, you don't have any advantage over patients on that telephone

BT2: 07:29 no, it's just the normal system yes, yes

AW: 07:33 and do you have confidence in the information that they are writing down on the referral forms? So, for instance, the BMI's, err, are you confident that that is the most up to date measure?

BT2: 07:41 err, I would say so. Er, although I know a couple of times when we have rung GP surgeries and we've asked, or you say you've not put the information on and you've rang up and say, "You've missed BMI", and they've looked at the records and said, "Oh, well, actually the last time it was taken was three or four months ago"

AW: 07:59 ok

BT2: 08:00 so, you would think, or I would think, if they were referring them, they would have perhaps just been into the surgery a week or two prior to that, but we always do make it clear that obviously when they do come, that information is checked, you know, to see if they are eligible

AW: 08:19 so they are not necessarily always taking the most recent measure

BT2: 08:23 reading

AW: 08:23 yes, or reading, but they are jotting down the last one of the system

BT2: 08:28 yes, yeah

AW: 08:28 and overall, how would you describe your relationships with the different primary care sites that refer into this leisure centre?

BT2: 08:33 yeah, I would say, I would say they are always really helpful, err, and that. I mean, obviously, because there are so many, it's not as though you are speaking to them on a regular basis and it's like, with us, we are all part time workers. They are as well, but yeah, we've never had any issues with any of them at all. So, you know, they are always willing to err, to give you the information

AW: 08:59 yeah, that you need. So, do you know, because you do the, obviously the young LiveWells, the LiveWells and the HOPs, they've come in centrally. Does that mean you have to contact surgeries not only in this area, but for instance, in Beverley, in Driffield. Are you sort of responsible for contacting all of them?

BT2: 09:12 yes, yes, yeah, yeah

AW: 09:16 oh, ok. So, it's not like you've just got a few around Beverley

BT2: 09:18 oh, right, no. So, it's for the whole of the East Riding

AW: 09:22 oh, ok

BT2: 09:23 yeah, yeah

AW: 09:25 lovely. The second theme of the interview is about the conversations via telephone that you have with customer that have been referred

BT2: 09:33 right, ok.

AW: 09:33 so first of all, how quickly are you able to contact a patient after they've been referred to you

BT2: 09:39 err, as in our time scale for following, for following it up

AW: 09:44 yep

BT2: 09:44 err, we have err, a rota in the office where we all do half a day each on the leisure box. Err, so, within that role, we also err, cover the folders. So, for example, if it was my morning on this morning, err, I'd be taking the referrals off the leisure inbox, err, printing them off, doing the cover sheets, putting them in the folder, and then working my way through the folder. So, it is a continuation process cuz obviously, I would do it until lunch time and somebody else would do it tomorrow. So, you're work your way through the folders. So, sometimes, we are able to ring them on the same day. It depends on the volume that we've got in at the time

AW: 10:25 yeah, there's always somebody continuously working on that

BT2: 10:26 yes, monitoring the, yeah

AW: 10:29 so in terms of workload, do you find it is manageable amongst you all to keep on top of the referral coming in? Coz obviously, you do so many different referral from so many different places. Are you finding it is manageable?

BT2: 10:39 yeah, I mean, there's always, obviously, we've got the memberships and they are our priority because you've got your deadlines and things to meet. So, obviously it is workable. Err, you know, we certainly try to ring them within a couple of days of receiving the referral. Err, and I would say, on the whole that works, works pretty well. Er, but it's like anything, if there's something else that

comes in that needs doing, you know, then obviously you have to prioritise your work

AW: 11:11 absolutely. As you say, it's not just the health agenda stuff, you've got memberships things to do

BT2: 11:15 memberships to do. We've got updates for the tills and things like that so that's another role that we do. Err, but yes, yes. As I say, depending on the volume, you might be on the folder, but you may only get two or three done that morning. So, if there's ten in the folder then obviously it will go to the next person. So, it's just like a rolling programme

AW: 11:34 absolutely. And during the initial telephone conversations, what information do you provide to people that have been referred onto the programme?

BT2: 11:41 erm, so introducing ourselves. Obviously, where we are ringing from, what we are ringing about. Err, so you know, obviously we have been given their details by the GP or the Dietician or School Welfare Officer etc. Err, telling them that we are going to book them in for their initial appointment. Err sorting out a date and a time. Which leisure centre. Err, explaining about the scheme to them. Err, some of the clients have been briefed by the GPs, others haven't got a clue [laughs]. Yeah, basically, no, they've just told me I need to go to the leisure centre, so I don't know anything about it. Err, so obviously, we would tell them, err, about the programme you know, the basic initial information that they need to know at their point. Err, give them an indication of like time scales. So, some programmes like the LiveWell, err, at the moment are for a year. Err, with young liv well, they are expected to do a minimum of sixteen weeks, one to one. So, there's different requirements for each course, each scheme. And like with the HOP it's initially, over four weeks, but then that may get extended, err.... obviously, explaining what

they need to wear clothing wise. Err, and a lot of the time, well, some people as well, it's like reassurance because they are quite concerned that all of a sudden, they've got to go into a gym, perhaps which is alien to then. They've never been before. So, for some people err they don't know what to expect and, err, you know. So, obviously, if they do have any concerns, when we are following that up with the instructor, err, we can actually put you know, the client is very anxious

AW: 13:33 ah so they've got a little bit of insight before they are seeing them

BT2: 13:35 yeah, yeah

AW: 13:35 so you said that sometimes they are a bit concerned about going to the gym. Err, are there any other common concerns that they raise with you over the telephone prior to them coming in?

BT2: 13:43 err, I think for some of them, cuz a few of them on the HOP scheme have been like perhaps early 80's. So, for some of them, obviously, it's a new idea, you know. There's no, point in me going. I won't be able to do anything. So, it's obviously then bringing them around and speaking to them and saying, well, you know, obviously we will discuss nutrition with you, err, we do have equipment that is adapted. Err you know, they will only have you doing something that you are comfortable with and happy doing you know. Err

AW: 14:18 just trying to reassure them again

BT2: 14:19 yes, yeah, and put them at ease yes, yep

AW: 14:21 how do they respond to that typically?

BT2: 14:22 err, yeah, I would think most of them, most of them are actually. Yes, yeah

AW: 14:28 lovely and when you said, err, earlier you said, some of them don't know anything about the programme they've been referred onto, others have been briefed a little bit by the GP

BT2: 14:36 yeah

AW: 14:36 do you find it depends on which programme they've been referred on to, or is it just err, is it random

BT2: 14:41 yeah, I wouldn't like to say there's, yeah, patterns

AW: 14:44 it just depends?

BT2: 14:46 yeah, yeah, yeah, some of them will say, "Oh, yes, the GP said, you would be ringing", you know? And then other people go "Oh, ok then" you know, "I didn't know about that"

AW: 14:58 and is there any challenges you face when you are speaking with somebody for the first time over the telephone? So, they are a little, but anxious about coming to the gym, are there any challenges you've come across?

BT2: 15:09 yes, we've had the odd one or two where they've said, err, "I don't want to do this ", straight away. "It's not for me". Err, I think one of the occasions I had was a guy who was like err, a long distance Lorry Driver and he said, "Well, I can't fit this in to my work schedule because I'm away Monday to Friday. Err, and I really don't want to do it". So, they are few and far between err. So, obviously, if, if they are given a definite no, then we have to go back you know, to the GP and say obviously, they don't want to take this, this scheme up

AW: 15:50 so sometimes there's a bit of a reluctance to, to come to the scheme's other times it's not feasible for them to fit it into their schedules

BT2: 15:57 yeah, yes, yeah, yeah

AW: 15:58 and what do you think would help increase the awareness amongst patients? So, before you telephone then, what do you think might help increase their awareness of the programme?

BT2: 16:05 err, maybe just informing them a little bit more about it. As I say, I would say most people are pretty, pretty on board with it. Er, other people are like, "Thank you so much I welcome the opportunity". Yeah. "I've been waiting for this, and you don't know what this means". But for some people er, I think we had another one where they were like in their 80's and they said, "Well, I can't get to the leisure centre". You know. "I'm not very erm, mobile". Do you know what I mean? So, but they are few and far between I would say

AW: 16:43 some have got their own transportation issues or mobility issues

BT2: 16:45 or somebody might be relying on somebody else to bring them

AW: 16:51 ah, ok

BT2: 16:51 so they are little bit concerned as to, well, if you want me to do it on a regular basis, I'm relying on somebody else, yeah

AW: 16:56 absolutely. Err and the final section of the interview is about feedback. So, feedback in terms of a client's progress on any of the health agenda programmes, and how that is communicated back to primary care sites. So, how important do you feel it is to communicate that feedback back to the referring practitioner

BT2: 17:13 er, really important yeah, err, priority

AW: 17:17 why do you think it's important?

BT2: 17:19 err because obviously, it's a process, err, about that patients health and lifestyle. Err, and obviously now, for example, with the HOP, because they have to go down this route, for some of them, before they can be referred. Some of them obviously have to lower their BMI don't they before they can be considered for surgery and things like that. Err, so obviously, it is a process that you would complete from beginning to end, from referral from informing the surgery whether it's that they've completed the programme, whether it's that they've dropped out

after so many weeks, or they've been removed from the programme because it was non-attendance

AW: 18:03 yeah. So, not only when they've done well, but also if they've dropped out or if they've been removed as well

BT2: 18:05 yes, yes, yes

AW: 18:07 so do you currently provide that feedback back to the general practice sites?

BT2: 18:09 err, with, with the LiveWells, err, [BT's name] does warning letter. So, what would happen is an instructor, if we had somebody for example who wasn't attending. The instructor, err, has done their intervention, which is usually in the form of a phone call. You know, I have not seen you. You've not booked in, or you've cancelled a couple of appointments. So, they would do an intervention cause, which they would log on our system. Err, if there's no, response then they would ask [BT's name] to do a warning letter. She does those

AW: 18:42 right, ok.

BT2: 18:43 to say we've not seen you recently. We've been trying to contact...

AW: 18:46 is [BT's name] a Business Technician?

BT2: 18:45 yes, yes, so, she does those. Err, and then if there's no, response from the letter, er, then the instructor might instruct us to do a removal letter so then [BT's name] would follow that up with a removal letter to the customer. Err, and a copy to the GP so then that would finish that process

AW: 19:07 are you involved in sending any feedback personally to the general practice sites?

BT2: 19:13 err, I've done it if [BT's name] hasn't been there. That's primarily her area so.... However, obviously, we can all do that, or I have covered on holidays. Err, I, I am responsible for the completed ones. So, if a client has completed and we get

the completed paperwork back from sites, err, then I do a completion letter to the client congratulating them. Err, if it's been a weight gain or stayed the same, we will send them a letter, you know, saying, well, done for completing the course. If they've done a weight loss, you know, I might put on your you know, fantastic achievement losing, I've got one this morning, thirty-one kilograms. Err, so and then we just slightly adapt them because I can see that some of them have already taken up a membership. Some of them we say, you know, it's important to continue keeping healthy. We offer a number of memberships

AW: 20:15 ah, so if they have not taken out a membership

BT2: 20:17 yeah. And I do a letter to the GP err, about that patient and it says, "Your patient has lost, say thirty one kilograms and now has a BMI of.... and then if you require any further feedback contact the healthy lifestyle office". So, now it's, it use to be [HLO's name], it's now [HLO's name], yeah

AW: 20:37 so that is for the LiveWell, scheme. What about the Exercise Referral?

BT2: 20:39 err, Exercise Referral we don't do

AW: 20:42 sorry you do the LiveWells

BT2: 20:44 sorry with the young LiveWell, we don't do letters at all. So, basically, we just get the paperwork back, err we've got a database that I put some of the information on, but there's no, follow up letters to GPs or parents. Err, with the HOP programme, err, now because that's done on Pharmoutcomes, err, that's done by the instructors. So, we don't get any completion work

AW: 21:12 ok

BT2: 21:13 in to us. We do the trackers and then if we have queries on the tracker like has this person completed etc., that goes back to the Instructor or the Fitness

Coordinator. Err, but unless we are asked to do occasionally sign offs, that's actually done by the Fitness

AW: 21:31 Pharmoutcomes

BT2: 21:30 yes, Pharmoutcomes. Yes, so we don't send paper copies of letter or anything

AW: 21:38 ok. Why do you think there's not any letters for the Young LiveWell? Do you think that is important?

BT2: 21:40 err, yeah, I would say so cuz again really obviously, they've been referred either through the GP or the parent or like the system of education welfare, Dieticians etc. Err, so yeah, I would personally think that they would want to know the end result.

AW: 22:03 yeah, just like the adult LiveWell

BT2: 22:02 just for their records really. Yes, yes. Err,

AW: 22:08, but for some reason there's not...

BT2: 22:08 yeah, I mean obviously, if it's the parent, because if they've under 16, obviously, they need the parents and they have to be there on certain weeks. So, they would be there say at the final weigh in measurements etc. So, they would know and there is a participation sheet where it's got the measurements with what they started off with on week one and where they are at week sixteen

AW: 22:31 ok

BT2: 22:32 err, but yeah, it isn't followed up with any letters. Well, that's the way it has been since I've been here, but thinking about it, you would think it would be in the GPs interest would you if they've done something. You know, sent somebody on the course, where are they now?

AW: 22:52 yeah, cuz then I guess they can see if it has been a good cause for them or not so good

BT2: 22:54 good or yes, yes

AW: 22:56 cuz I believe at the minute they might not have any idea of, of how well, that persons doing

BT2: 22:59 yes, yes, yeah

AW: 23:01 err, last two questions. So, in your opinion, how could the referral process be improved? So, that could be to do with anything we've discussed or beyond what we've discussed today

BT2: 23:10 yeah, err I just think, err, forms to be completed correctly. Err, so for example, with the HOP form you've got your usual details at the top, your name, address, etc. You've then got a tick box at the side which is, if any of these conditions apply. You know, like depression, anxiety, etc. And then there's a box and it says about err, details of surgery the patients waiting for. Quite often, for example, that could be left blank

AW: 23:41 ok

BT2: 23:42 so then when we get the form in, we are thinking well, are they awaiting surgery, or have they just put them on this scheme?

AW: 23:48 ah, ok. So, they might have been placed on the wrong scheme in that first instance

BT2: 23:50 yes, yes. Whereas if they put err, right hip surgery you know, straight away. So, sometimes when we've ring the client up and said, "Oh, we've received a referral form, are you currently awaiting surgery?" and they go, "No". So, then we have to say, "Oh, right, well, can you leave it with me? We will ring the GP cuz we need to check that" ... You know, because obviously, that might of not be the right

scheme for them. Err, sometimes it is the right scheme because obviously, they need to lose the weight prior to

AW: 24:25 getting the surgery

BT2: 24:25 put on the scheme, yes, yes

AW: 24:26 do you find that…

BT2: 24:28 so just completed fields really

AW: 24:29 yeah, that's one of the issues. Do you find that quite often, are clients or patients referred to the correct programmes first time, or do you have to do a little bit of jumbling around?

BT2: 24:40 err, I would say the majority of times they are, but there's always one or two err, that aren't

AW: 24:47 that you've got to move around

BT2: 24:49 yeah, yeah

AW: 24:50 what do you think would help that, getting sort of patients onto the correct scheme first time?

BT2: 24:52 err, I think, presumably all these surgeries have been briefed on the different schemes and we do actually have a sheet with the health agenda with the different schemes. So, a couple of times, I have forwarded that to a GP surgery if they've asked. You know, cuz obviously, they've got to meet the criteria, errand that. So, a couple of times we have forwarded err that to them, just so they can see

AW: 25:22 just for a little bit more information at the surgeries

BT2: 25:24 yeah, yes, yes

AW: 25:25 so they can look at the criteria and then determine

BT2: 25:28 yes, which one are they

AW: 25:27 yeah, which one to go to

BT2: 25:30 yeah

AW: 25:31 lovely and finally, is there anything else that you want to add that you feel is important?

BT2: 25:32 err, well, obviously, now, like we've raised before about with some of the centre changing over to BEARS version three at the moment. Because we haven't got access to that, if we are making a referral, err, through doctors live. So, we've got the er, referral in front of us, we are making the initial appointments, then obviously, we are not getting the notification through to our health box. So, if you have client on the phone, you're booking them in, say for example, at Goole, ten o clock on Monday. Because we are not getting the notification through, we can't say to them who the appointment is with. And you do get some clients who perhaps ask if they can have a female instructor, you know. Some ladies you know, say, "Well, I would prefer a female instructor"

AW: 26:26 ok. So, are you aware at all that an appointment has been made? So, are you able to follow them up still and give them a telephone call? Or is it a case of...

BT2: 26:35 yeah, so we'd have the referral form. We would ring the customer. We'd book them in. We can do the booking on doctors live, but then we are not now receiving a notification into our health box. Err, so sometimes we've had to put the phone down and then ring Goole and say, "Right I've just done a booking, Monday the eleventh, ten o clock, can you tell me who it is with please?" Because we can't, we can't see that booking. So, and especially sometimes, you know, like if you've, sometimes you make a booking, you've got, and they say, "Oh, sorry I can't make that now, can I change it I've just remembered I've got an appointment". So, just to have that visibility on the screen that the booking has been confirmed and you know. It's useful

AW: 27:17 and previously you've always had access to that in the past?

BT2: 27:18 yes, yeah, yeah.

AW: 27:22 so you can still make the appointment, but you are not able to see who that appointment has been booked in with

BT2: 27:24 yes, we are not getting the confirmation err, email. The notification. Err...

AW: 27:31 and as you say, some people like to have female instructors, or they like to know their name and you're not able to do that now

BT2: 27:37 yes, yeah, yeah.

AW: 27:36 ok. Is there any, err, are they planning, are they intending to put you on BEARS version three?

BT2: 27:43 err, I'm not sure what the latest is. I mean obviously, that's, higher up. Err, but as you saw from that list, each site is going on to BEARS three in the very near, if they are not on it already, they are going on to it in the very near future. Err, so

AW: 28:01 do you feel it is making your job harder because you haven't got access to that?

BT2: 28:04 yeah., I think, it's like, well, if you, if you book an appointment for somebody, you like to know who you are with unless they say it's an open surgery. You like to know who you're with so, I think it's just a little bit more professional if you can give that information at the time. Err so sometimes you have to put the phone down and then I've rung say Goole, and then I've rung the customer back so it's all time consuming. Taking your time which could of been avoided if you just had the visibility of that booking online

AW: 28:35 absolutely. It's just another two steps you've got to make. So, you've got to mess about ringing them, and then ringing the patient back...

BT2: 28:39 yeah, yeah, yeah. And I don't feel it comes across as being professional because you can't give that information out

AW: 28:46 absolutely. Lovely, well, that's all the sections I wanted to speak about today. If there's anything else you want to add, err, if not, we can stop the recording. Is that all right?

BT2: 28:54 yes, no, I think that's fine

AW: Interviewer **Interview date:** 31.01.2019

AD1: Participant **Interview location:** East Riding Leisure Beverley

AW: 00:00 I'll just make sure this is recording. Perfect so I'll leave that over there. Before we begin, can I just ask a few simple demographics?

AD1: 00:08 yes

AW: 00:08 so how would you identify your gender?

AD1: 00:13 female

AW: 00:13 female. I have now...

AD1: 00:14 that's ok yep

AW: 00:16 and how old are you if you don't mind me asking?

AD1: 00:16 erm 53

AW: 00:19 53. What is your role within Beverley Leisure?

AD1: 00:23 erm it's an admin role

AW: 00:29 so could you talk to me a little bit about what it means to be in an admin role? So, what your typical duties are.

AD1: 00:32 erm well, I do one day a week on reception, but when I am in the office, I look after the admin for the GP referrals, and membership admin for existing and perspective clients

AW: 00:49 ok and how long have you been in this role?

AD1: 00:51 erm, in the admin, I've been here 12 years and, I think I've been doing the admin role about seven or eight years, I think roughly. Maybe it might be a bit longer time flies

AW: 01:04 it sure does. So, in terms of the healthy lifestyle programmes referrals, you are involved with processing the exercise referrals, or GP referrals

AD1: 01:12 GP referrals yes, or exercise referrals because they are not always from a GP

AW: 01:20 perfect and I have your email so that's fine. So, who processing the rest of the referrals so the LiveWell, or the young LiveWell

AD1: 01:26 erm Business Techs

AW: 01:28 Business Techs. Ok. Why is there a separation between...?

AD1: 01:30 erm when I started doing the GP, or the exercise referral there was only LiveWell, at that point and that was done by Laura Hutchinson. There wasn't even Business Techs when I first started doing it. Erm, the way it is at the moment, is the referrals still come to site, but everything else goes central… I don't know why that is, but that is what it is. I don't know if it's because of the quantity., I think I've got about 120 people of the referral programme at the moment and that's without any of new ones that are waiting to start

AW: 02:07 wow so is that typical of the numbers you normally

AD1: 02:09 they've increased. Erm, you go through peaks and troughs. You can have one month where you get 50 plus sometimes and you get another month where you might only get 15-20.

AW: 02:20 wow and that's just for this site?

AD1: 02:22 that's just for this site so maybe that's why. Imagine that times by the ten sites or whatever. It's a lot

AW: 02:28 wow I didn't realise how many there were. Ok, so what are the different ways that you receive healthy lifestyle referrals from primary care sites?

AD1: 02:37 erm it's mainly electronic now. I get the odd paper one still, but very rare. Maybe one or two a month. It's primarily, well, maybe sometimes a bit more than one or two a month, but it's, I would say 95% electronic.

AW: 02:52 and what type is easier to process? Electronic or paper?

AD1: 02:55 electronic

AW: 02:57 why is that?

AD1: 02:58 erm doctors writing (laughs) on the paper ones. And, I think with the electronic ones, it doesn't let them, cuz when they do it electronically, they actually book an appointment as well, and it doesn't let them process it unless all the fields are correct, complete. So, it wouldn't go through without telephone number, or a date of birth. On the paper ones, you can have bits missing.

AW: 03:20 right

AD1: 03:20 so you can end up with no, telephone number and then you've got to call the surgery to find out telephone number and then you've sometimes got an incorrect telephone number and you've got to send them a letter so... yeah, so, the electronic is better

AW: 03:32 ok so you for that sort of stops them from filling it out incorrectly because as you say, it doesn't let them progress...

AD1: 03:38 yes, and also as well, with the paper ones and they write, you know, the medication on, even the reason for referral sometimes under other they will put something else and sometimes you just can't read it.

AW: 03:48 yeah

AD1: 03:49 whereas electronic, especially with the medication on the electronic, customer brings it with them, and it's all printed out nicely and it just get attached to their information then

AW: 04:01 so it ensures you get that information.

AD1: 04:02 yeah, it ensure you've got everything accurately

AW: 04:04 are all surgeries set up to refer electronically?

AD1: 04:07 erm, I think most the Beverley ones are. Maybe not all., I think there may be a couple they are still working on. [HLO's name] would be able to tell you which

ones. I've got a feeling North Beverley still aren't and they are a big surgery so everything we get from them is paper. And I don't think the old fire station are either, but, I think the rest are. I am sure they all are!

AW: 04:29 is there a particular surgery that tends to refer a lot more than other surgeries?

AD1: 04:33 yes, Manor Road. Manor road and the physios. I'd say most of the referrals come from them.

AW: 04:39 where are the physios based?

AD1: 04:42 I'm not sure that they are all at the community hospital or whether they are in some surgeries, but it doesn't tell you. That's another thing on the referral, it doesn't tell you where they are based, but they are all in Beverley., I think most of them are in the community hospital

AW: 04:55 perfect. So, on the paper referrals, we've spoke a little bit about erm, some of the information missing. What specifically tends to be missed from the forms?

AD1: 05:08 telephone number (laughs)

AW: 05:08 telephone number

AD1: 05:09 mainly telephone mainly and sometimes date of birth. I mean nothing that's not retrievable, it is just another hurdle.

AW: 05:18 yep. So, what would you do in that instance, if you needed to give them a call, but they haven't provided a telephone number?

AD1: 05:23 I'd ring the surgery. I mean we get a few referrals from [Dr's Name] at Hull Royal. Erm, he's one of the consultants there, he never puts numbers on, and trying to get hold of his secretary is difficult so I end up writing a letter to the client. Just saying, I've not been able to contact you on the telephone. You've been referred on the scheme. Tell them a little bit about the scheme. Er please can you contact me to

arrange an appointment. If don't hear from you within two weeks, I'll assume you don't want to do it. So, to try and give them a couple of weeks to get back to you.

AW: 06:01 yep, so in the instance that you can't contact the doctor you'll write to the patients

AD1: 06:05 write to the patients yes

AW: 06:06 in your opinion, how easy or difficult is it generally to get in touch with primary care sites?

AD1: 06:12 easy

AW: 06:13 easy, usually easy?

AD1: 06:16 yes, and, I think now because I've been doing it for a while, a lot of them know me now. Not personally, but if I ring up and say it's [name] from the leisure centre, they, they know who I am. They don't need to question why I am ringing

AW: 06:27 and are they happy to give you patient information?

AD1: 06:28 as long as I give them their date of birth or their address, or the NHS number which you've usually got something on the form. And they know, they've got a record that they have sent it to us anyways so...

AW: 06:39 so there's no problems

AD1: 06:40 it's all quite, no, there's no problem with that. Getting through to the surgeries is sometimes difficult (laughs). Especially on a Monday morning! I mean now...

AW: 06:49 do you find that you have to ring a few times?

AD1: 06:51 yes, sometimes and sometimes, some of the surgeries now, like manor road, one of the receptionists there, [name], I don't know her surname, but she knows me by name now and she's got my direct number, so she'll quite often ring me. Not only about, you know, a question about a future referral or to question someone

that hasn't heard from here so it's nice to have that relationship. So, although electronic is nice, it is still nice to have the personal relationship as well, with people.

AW: 07:17 absolutely yeah. And as you say if you are able to advise her before she even sends a referral, it's going to stop a lot of these things from happening

AD1: 07:23 yeah, because sometimes we will recommend a second referral for someone. Erm, only in extreme circumstances. Like some, somebody, if a stroke survivor for instance, it takes them the whole ten weeks so even get little bit of mobility, so they definitely need a second one. So, we'll say right go back to your GP, get a second referrals and quite often the secretary rings, oh, they've asked for a second referral, is it ok? Cuz, they know the procedure. So, it's nice to have that relationship with them

AW: 07:52 so is it two referrals max they're allowed for the exercise on referral

AD1: 07:56 yeah

AW: 07:57 ok so next I would like to talk about the telephone conversations that you have with referred customers. So, from being referred, how quickly are you able to contact referred patients?

AD1: 08:07 I do it immediately

AW: 08:07 immediately

AD1: 08:08 I don't have wait list. You know, within a day or two of receiving it.

AW: 08:14 and what information do you typically provide during these telephone conversations?

AD1: 08:17 Erm, I'd just like, introduce myself and then I'll just say that I've received their referral from the surgery. Did they know anything about the scheme? Quite often they don't (laughs) er, quite often, they don't know there is a cost involved.

So, you know, just explaining the whole procedure really. The requirement that they, know cuz they have a commitment as well, to commit to attending at least 10 time in 10 weeks and having one to ones. Cuz some people think they are being referred and they can just have ten week membership and do their own thing and that's not the aim of the scheme and you've got to try and explain that to the customer that the idea of the scheme is that you've been recommended on it that you need support and that's why it's come as a referral otherwise you would just come along an join. If you don't want, if you don't want the support of an instructor then just come along and do a membership. So, it's just answering the questions really, telling them about the car park. Silly little things like that and like next week I've got a lady coming in, I can't remember where she's from, she's a physio and she's got a client that she wants to put on the scheme for er, she wants it for physio and mental health actually and she's so nervous! So, I've arrange for her to come in with the client before she refers her. And I will just show her around, introduce her to one of the guys [Fitness Professionals]. That's going off, well, it's not going off

AW: 09:41 no, no, it's not at all. It's something additional you do before they are referred

AD1: 09:44 yeah, not very often you quite often don't need to, but if you do get somebody, when you speak to them, they say, "oh, you know I've never set foot in a gym before I'm really nervous". It's just putting them at ease really and offering that. Come in, have a look around, see how you feel, meet someone...

AW: 10:02 yeah, absolutely it's that person-centeredness again. You are going above and beyond to make that...

AD1: 10:05 and that's what I love doing. I love that. I love that, speaking to the person. Cuz even on the electronic referrals, I still ring the person to confirm the appointment, even though they know their appointment. It's just the contact here.

AW: 10:21 as you say it's just putting a voice to a name

AD1: 10:26 yeah, and to just answer any questions the GP, or the Physio didn't answer really.

AW: 10:31 so you've spoke about the costs involved with the exercise referral scheme

AD1: 10:34 yeah

AW: 10:34 how do patients tend to respond to that if they are not aware?

AD1: 10:40 erm, most of them are all right. You get the odd few that say, "Oh, it's a prescription", because a lot of people still call it a erm, a prescription for exercise, which years ago, I think that's what they did call it. And you say well, it's not a prescription it's just a referral and most of them are fine. You get the odd one and if you do get one that is really, really, says, "I just cannot afford it" then I would go to [HLO's name] to see if we could get funding for it, and we do occasionally. Cuz most of the funding goes to Withernsea, and, I think Goole get some funding as well, to put people on it if they can't afford it, but generally we don' get it. But if we get extreme circumstances then I would go to [HLO's name] and she would get approval for it to be funded and, I think, that's happened a couple of times in the last six months. But most people, most people say that's a lot of money and then once you start telling them what a gym session is, and a pool session, and a class, and you're getting all this for £33 in ten weeks and you're also getting your one to one support and they are like yeah,

AW: 11:46 well, actually it isn't that bad.

AD1: 11:46 yeah

AW: 11:46 so how come some other areas have funding and this area doesn't?

AD1: 11:51, I think it's to do with the areas of deprivation really

AW: 11:54 so this is more of an affluent area?

AD1: 11:58 yeah

AW: 12:03 perfect and we also spoke about the scheme so not many people actually know what the exercise referral scheme is. Are you aware of what they are actually told?

AD1: 12:10 no,

AW: 12:11 from the GPs?

AD1: 12:12 no, I don't know what the GPs, I think some, I think manor road are probably very good. A lot of them do come in, but, I think some of the other surgeries don't make it quite so clear. And I know there's the protocol booklet, but I'm not sure how many people see that. I know all the surgeries have got it and there is a healthy lifestyles leaflet. I'm not sure if the GPs give that out., I think they just get told it's an exercise programme and they don't realise just what they can achieve from it

AW: 12:46 So, would you say you are not confident that they are providing the most accurate information?

AD1: 12:50 yes. When you look at the questionnaires, because obviously when they start here, they fill in a week 1 questionnaire and quite often, one of the questions, it use to be, I'm not sure if it's still on there, I would have to check with [HLO's name], cuz that's something the trainers see and that's something they would be able to speak to you a lot more about, I think one of the questions is "how much were you told from the health professional?" and quite often it's not very much.

AW: 13:15 right, ok

AD1: 13:17, but as I say that will be something the trainers will go through with you and you will see from them because they are the ones that are sitting with them, asking them.

AW: 13:23 yeah, and they have the questions

AD1: 13:25 yeah,

AW: 13:25 it's good that they are recording that, so they are able to see what they are being told

AD1: 13:28 I'd say it is getting better because the whole scheme is much more well-known now. Erm, a lot of the referrals as well, are from people that actually walk in off the street, and they will come to reception and say, "I've got this knee problem", or "I need to lose weight" and we sort of say to them go to your GP, tell them you'd like to be referred on the referral programme

AW: 13:49 so the words getting out there in the public as well?

AD1: 13:50 yeah, and a lot of people now, like you can imagine with a hundred, nearly 120 on it, they talk to their, I mean I've got a lady who's just about to finish and next week her husband is starting it, so it spreads, doesn't it?

AW: 14:01 yeah, absolutely. So, can you see in the future, it being self-referral as opposed to GP referral?

AD1: 14:08 erm I can't comment on that

AW: 14:11 yeah, just a thought if people are coming in. That`s really interesting that the word is getting out there

AD1: 14:15, I think it's quite nice that they don't, well, I'm not sure how, if this is changing or not, but up to now we've had the link workers as well, referring in as well, and it's quite nice that the patient, or the customer doesn't always have to go to the GP. It can be the nurse. It can be the link worker. Cuz sometimes it's hard to

get an appointment with the GP and, I think that's getting out there a bit more, but you know, you don't need to go and see the GP you just need the nurse, or the link worker can do it for you.

AW: 14:44 and that's what I found in a lot of my interviews with those from primary care. A lot of the time the GP just doesn't have time to do these things so even if a patient did come in, they would send them to a link worker or somebody else which is fantastic that they have that

AD1: 14:56 well, the GP are there to look after the people who don't know what's wrong. You know? Whereas if people know that they need to lose lots of weight or they're diabetic and they want a little bit of help on what they should do and what they shouldn't do, it's nice they can go to somebody else

AW: 15:12 yeah. Are you confident in the… information that you are given? Do you think it's the most up to date in terms of the BMI and things? Do you have confidence in that information?

AD1: 15:22 Quite often their BMI, they don't even put it on.

AW: 15:25 right, ok

AD1: 15:26, but I don't think that's a major issue because it's one of the first things you do. The only time it becomes an issue is when someone is borderline referral stroke LiveWell. If they came in on a referral and then when they came in for their first appointment, their BMI was over 45 then we'd put them on the LiveWell, scheme.

AW: 15:44 ok. Do you find that patients are referred onto the correct scheme?

AD1: 15:47 most of the time yeah

AW: 15:49 and as you say if there not, you're able to...

AD1: 15:52 yeah, we just point it in the right direction.

AW: 15:55 perfect. So, we've spoke about some of the concerns that referred customers face, you've said, a lot of the time, they are nervous about being in a gym environment. Are there any other concerns that they raise with you over the phone?

AD1: 16:08 erm, not really, it's the financial side which is usually, you know, it ends up not to be a problem and yeah, just the commit... if somebody, if I ring somebody and they really want to do, but they say "oh, I've got this coming up and that coming up and", then I say look, if this isn't a good time for you we will just put it on hold. I wouldn't keep that referral I'd return that one because things change. Quite often, this time of year when you ring elderly in particular, "oh, it's cold, it's icy, I've got transport problems", well, would you prefer to wait until spring. If it's not something on the referral that's, well, they're not life threatening things anyways obviously, but you know, obviously if it's a stroke survivor and they've been referred, it's probably important they come straight in, but some of the other things like a bad shoulder or a bad knee, you know, you say to them well, would you prefer to wait until spring? Ah yeah, that's much better. It's much better to get them in at a time where they are in the right place.

AW: 17:05 yeah, so as you say you try to accommodate for that.

AD1: 17:08 just try and yeah, but I explain to them, you know, I can't keep this referral, you will need to get a new referral. I can't just sit on a referral for three months, we need to turn them around. So, I would just send that back to the GP with a note on it to say the patient would rather wait until spring or feeling too ill at the moment. I had one this morning actually, just had a bereavement and it was her mother so obviously it is not going to be a two week thing

AW: 17:35 not absolutely

AD1: 17:37 so I just refer it back and say when they're ready, we will just get a new referral. And on that point as well, if we have someone who starts the scheme and they've paid their £33 and then something happens two weeks later and they barely do two sessions, if it's something like that we would say "right don't worry, come back when you are ready, we will hold the money and we will just start from scratch again". But you don't charge them again obviously, so we try to accommodate like that.

AW: 18:01 yeah, so for like, exceptional circumstances you are able to

AD1: 18:07 we are flexible

AW: 18:12 and in terms of the appointments, do you find there are enough appointments to accommodate for all the referrals coming in

AD1: 18:16 what we do, we try to get people on a pattern, especially when you are dealing with the elderly and that. They like to have a set time and day. So, what we do is when they come in for their first appointment, we will book two more appointments. So, we always book two weeks ahead. So, when they come the following week, they book for two weeks' time, so they've always got 2 ahead of them. And that, and we have that policy right across the board so nobody can book one two weeks at a time so when they come up at Wednesday at 10 o clock and they've already got Wednesday at ten o clock next week booked. They can always get the following week, so it gets a little bit of a pattern. Every now and then, we get something that messes it up, but generally

AW: 18:59 and a lot of people like that routine

AD1: 19:01 they do yeah, especially the elderly ones. And there's a lot of people that have erm that a friend brings them, so they need to come at exact times, or a family member or something.

AW: 19:13 I know the LiveWell, scheme, you're allowed to have a buddy with you. Is that, do the same stand for the exercise referral?

AD1: 19:17 no, no. I don't know why. Again, that's something higher up. They have never ever had a buddy., I think maybe cuz the LiveWell, scheme is erm, maybe is a lot more mental side in it so they need that person to encourage them to come. Where the exercise on referral is for someone that needs something because they've got a bad knee or… Maybe that's why I don't know

AW: 19:46 they just need that little bit more support

AD1: 19:47 yeah

AW: 19:48 that absolutely makes sense. So, the last them is about feedback. So, how important do you personally feel it is to provide that feedback on a patient progress back to a general practice site or a primary care site?

AD1: 19:59 yeah, it's very important. They never ask for, like we just send erm, the notification goes back to say that it's completed. Erm, I've never been asked, I don't know if [HLO's name] has, for inform, I mean obviously the information is there about the client and it's on our files, it's on our electric system as well, as on pharm. I don't know., I think on pharm actually, they actually see the results don't they anyway?

AW: 20:26 I'm not sure to be honest

AD1: 20:28 I'm not sure how that, I'm not sure what, how it goes back, but on Pharmoutcomes obviously the results are there. The only thing on Pharmoutcomes, quite often it's the physio that refers, but the results go back to the GP, but, I think that's something that they are trying to develop where it's the person who refers gets the results back as well.

AW: 20:49 gets that information yeah, because as you say if the physio can't see it then there's no, point in sending feedback back

AD1: 20:56 no. But I guess, I imagine they get feedback from the client anyways. We are starting to get quite a few referrals from oncology actually, but they've, we haven't had any for the last few months, but we went through a phase last year., I think it was [name] who's one of the consultants there. We were getting a few referrals from her

AW: 21:19 so when you say these schemes are becoming more well, known, what's changed to make that happen?

AD1: 21:25 I don't know., I think that's a [HLO's name] question. I guess it's word of mouth. There's more schemes now, they're bigger and more investment has probably gone it. I mean we've got HOP now and Escape Pain. I don't know how they, how Public Health, I don't know how that side of it, like, how they get that information out there. I'm not sure of who goes to see GPs, or where that all ties in

AW: 21:54, but somethings happening

AD1: 21:54 yeah, somethings happening out there (laughs). Yeah.

AW: 21:55 absolutely. So, the escape pain is a new scheme and HOP hasn't been running that long, do that always come through centrally?

AD1: 22:03 yes

AW: 22:04 right, ok

AD1: 22:06 oh, no. Escape pain, I think that's all though, I think that's all through [HLO's name] at the moment. I'm sure she is dealing with all of those, I think.

AW: 22:12 yeah, it's a very, very new scheme

AD1: 22:14 yeah, it's only like last week, I think it started., I think I've got a four page brief that I've only just sort of looked through briefly, but, I think [HLO's name]

and [FC's name]who's our fitness co-ordinator, he's assistant manager/ fitness coordinator, they seem to be doing that one at the moment

AW: 22:32 and the HOP referrals, they come in centrally?

AD1: 22:35 they're leisure techs, yes.

AW: 22:36 to the business techs?

AD1: 22:37 business techs yeah

AW: 22:38 perfect. When you said that a notification goes to the surgeries, is that, is that an email notification?

AD1: 22:43 erm, I don't know how pharm does it, how pharms send it. We don't send an email. It's all done through pharms

AW: 22:53 ah so it not something you have to do

AD1: 22:52 no, we don't have to do anything it's all done through Pharmoutcomes, and I don't know how that happens in the back somewhere

AW: 23:01 that's fine. I just wasn't sure if after the scheme you had to do anything

AD1: 23:04 we use to before we went on Pharmoutcomes and really, when, I think about it now it would be impossible, everything was done by letter. So, everything was paper. It was urgh! It was horrendous! It was so time-consuming. You used to have to like, every time someone completed you had to send a letter back to the GPs saying, they had completed or if they hadn't committed you had to send a letter or...

AW: 23:27 wow so even if they didn't complete the scheme you had to...

AD1: 23:29 yeah, or if they didn't start, you sent a letter. It was very time consuming, but then there wasn't nearly the amount of people on it that there are now. I mean it has cut my workload down by tons, but not doing letters. And it's so sort of antiquated isn't it to do that nowadays, but now we've got the secure email

anyways so I guess you would do it by email, but when we first started doing it, it was all paper

AW: 23:54 was that roughly 8 years ago that it was all...

AD1: 23:57 yeah, like 6, 7, 8 years ago and it was even the questionnaires were paper. I mean I had filing cabinets full of them

AW: 24:02 gosh

AD1: 24:04, but now everything, all questionnaires are electronic so it's much better

AW: 24:09 so was you expected to go through those questionnaires to formulate the feedback, back when you use to do it through letter?

AD1: 24:13 erm well, no, you use to put the questionnaire with the letter

AW: 24:18 ah and send everything back?

AD1: 24:18 so yeah, and then keep a copy for your file as well. So, well, that all been shredded now with the new GDPR. we only have to keep it for a year so nothing, we haven't got any of that anymore!

AW: 24:28 no, big piles of letters everywhere

AD1: 24:31 no, (laughs)

AW: 24:31 perfect, I think that's all the sections that I wanted to speak about today. Just two final questions. So, in your opinion, how could the referral process be improved?

AD1: 24:44, I think it's improving all the time really so I, I don't think they are working, everything that, like, even this morning me and [HLO's name] sat down cuz it was the, erm first time we'd gone, since Pharmoutcomes started, they've changed the way the whole referral is done on Pharmoutcomes, its all, it's much easier for them from a reporting point of view, but it's very different for us for inputting, but we are used to it now. So, they have just, this is the first time they have run their end

of quarter results using the new Pharmoutcomes. So, we got a few teething problems. So, [HLO's name] came down this morning cuz she sent me a report with some clients that on her report it showed that they were pending, but from my side I had closed them as non-starters, and it hadn't done through. And we identified what the issue is so they're developing it all the time. So, little things like that, but it, its continual work on progress

AW: 25:43 and as you say you communicate with each other so you can through these little teething problems

AD1: 25:47 yes

AW: 25:47 perfect and is there anything you would like to add that you feel is important about anything we've discussed?

AD1: 25:52 no, I can't think of anything

AW: 25:53 no, that's absolutely fine. Well, thank you for your time today. Your insight is very useful for us going forward to keep changing these programmes erm and you're my first interview so thank you very much

AD1: 26:04 oh, I hope I hope did alright

AW: 26:05 and I will stop this. Oh, no, you absolutely did

AD1: 26:06 I hope I didn't do too many um's and ah's

AW: 26:10 it's fine I probably did more than you

AD1: 26:10 no, I think the schemes amazing.

AW: Interviewer **Interview date:** 15.02.2019

AD2: Participant **Interview location:** East Riding Leisure Bridlington

AW: 00:01 so is it ok if I take some simple demographics before we begin?

AD2: 00:04 of course, no problem

AW: 00:07 how would you identify your gender?

AD2: 00:07 male

AW: 00:09 male and how old are you if you don't mind me asking?

AD2: 00:11 46

AW: 00:12 is this the only leisure site that you work within?

AD2: 00:16 yes, it is

AW: 00:17 and what's your role within Bridlington leisure centre?

AD2: 00:21 it's, it has kind of evolved slightly. My badge says I am a receptionist, but essentially my role at the moment is to provide admin support for the gym team

AW: 00:30 right, ok. So, by law receptionist, but you provide that administration support. Sometimes you cover a few gym sessions if need be

AD2: 00:42 exactly, that's fine Yeah

AW: 00:43 so can you sum up some of your typical roles as a receptionist who provides that administrative support

AD2: 00:48 yeah, I mean, I don't, to be honest the receptionist is just in name only at the moment. I did originally, use to do some shifts down on reception, but now I am entirely based up here supporting the gym team. Erm, most of my role is based around the GP Referral Scheme, which is obviously what you came to see me about. Obviously, cuz, cuz the instructors gets so many GP clients here which we really, really do, they don't always necessarily have time to receive the paperwork, make the phone calls, do the bookings etc., so I kind of do that side of things. So,

once the instructor is actually seeing that client, their details are fully recorded on the system, they've been telephoned, they know what to expect and everything is ready to go. That's my majority of my role. I also do a little bit of sales retention work. Erm, we do promotions, three of four times a year and we are always given a target of how many promotions we have to sell and then how many of those promotional memberships we have to try and convert into full membership. And essentially, I am always fully responsible for the retention side of things once the promotion has finished.

AW: 01:49 right little bit of everything then

AD2: 01:51 yes

AW: 01:51 little bit of the sales retention and promotion, but as you say predominantly because of the number of Exercise Referrals, it's really supporting the gym staff and getting them set up before...

AD2: 01:59 yeah, I mean there's another little bit of a back office as required. I do help a lot with the rotas and things like that, but yeah

AW: 02:06 definitely a bit of everything (laughs)

AD2: 02:07 absolutely

AW: 02:07 and how long have you worked at this leisure centre?

AD2: 02:08 since it opened so since er May 2016.

AW: 02:13 ok. So, in terms of the healthy lifestyle programmes, the health agenda, is it purely the Exercise Referrals that you are involved in processing?

AD2: 02:21 I have very little involvement in any of the others

AW: 02:23 right predominantly Exercise Referral

AD2: 02:26 yeah

AW: 02:26 perfect and I have your email from the online survey so that's fine. So, as I said, the first section is about the information that you receive from primary care sites. So, can you first of all tell me about the different ways that you receive referrals?

AD2: 02:40 it's now 85% electronically. So, by, by email. Erm, the GP surgery would have used the sort of front-end software that automatically sends the booking through to us. Erm, so when I receive it, typically the patient has already actually had a slot booked on the system and I just receive the patient details. Erm, the other 15% still come by paperwork either because it's a, it's a smaller service which haven't been set up on the electronic system yet. For ex, for example the East Riding Pulmonary Rehab service are registered to refer clients, but they have not been set up yet.

AW: 03:20 right

AD2: 03:20 and the other one, for some reason one of the local doctor surgery, their system is not working properly at the moment, so they have gone back to paperwork

AW: 03:30 Ah ok. So, originally, they were set up to refer electronically, but it's not, for some reason not working

AD2: 03:32 for some reason it doesn't transmit the bookings across when they make them. We, we, we can't really understand why that's the case, but just one surgery, so they've gone back to using paper referrals

AW: 03:41 and in your opinion, which is the most easiest to process?

AD2: 03:45 the electronic one is by far the easiest to process., I think the paper system currently gathers slightly more information

AW: 03:54 right, ok. Why do you feel it is easier to process electronic ones?

AD2: 03:58 because one stage if the job has already been done for me. Because what happens when the paperwork comes in, if we get a paper referral, I then go on and use the electronic system the same way that the doctors do to actually book the appointment in. So, in effect, when I am doing the paperwork system, I am adding a first step

AW: 04:18 so you're duplicating what they would do

AD2: 04:19 what the doctor would do yes. That's right, yeah

AW: 04:22 and you said, about the paper, er there's more information on that, so what do you mean by that?

AD2: 04:29 there are specific questions on the paperwork, and I personally feel that when they are actually there on the paper, they are all filled in by the Doctor. The medical information, the drugs information, everything like that., I think, quite often, when it's not the Doctor themselves, but another member of the team at the surgery, that then asking to input that information into the electronic system. Because you don't have to input everything, not all the fields are mandatory if that makes sense, you don't often get it, that they've entered all the information. The most common one is you don't get a list of drugs or medication

AW: 05:02 right, ok

AD2: 05:03 very, very regularly because that's not a mandatory field on the electronic system, we quite often miss that information.

AW: 05:07 what's the implications of not being given that information, so the drugs and the medication?

AD2: 05:13 it would mean that the instructor would have to find that information when the client arrived for their appointment

AW: 05:18 ok how do they do that?

AD2: 05:20 by verbal questioning

AW: 05:22 ah, ok

AD2: 05:22 yeah, yeah,

AW: 05:25 right, ok. I wasn't aware that is wasn't mandatory to input that information

AD2: 05:28 no, no, it's not. Are you happy were we are, or do you want to go get a coffee and carry on down there?

AW: 05:32 erm I'm easy. Could we go downstairs where it's a bit quitter, just to save my sanity when transcribing later on. What I'll do, I'll just pause this. I am sure I can pause this... there we go. Erm, so you said, about sometimes the medication is missing from the referral forms…

AD2: 05:52 yeah, it is unusual. The electronic side of things, er, it won't let you proceed without entering the customer's name, date of birth, address, er, the medical condition they are being referred for, it will let you proceed as soon as you click something. So, again it is possible to miss something there. Because you are supposed to give the reason for referral, whether or not that is their only current medical situation. If it's not you list the others and also what their medical background is. But if someone was, not lazy, but if somebody was in a hurry or something like that, it will let you progress as soon as you've chosen something. And then the next box is just a free-text box where it asks you to list any medication, and again it will let you progress without entering anything. And I personally believe that if you look at the things that people get referred for, I think it would be very unusual for someone to come who wasn't on any kind of mediation, but the majority of electronic ones that come through don't list any

AW: 06:49 right, ok. What do you think would help improve that electronic referral system, so you are given all the information that is needed?

AD2: 06:54 just literally making that free text box so you couldn't proceed until you put something in that box

AW: 07:02 in terms of their medical conditions and

AD2: 07:05 mainly the medications

AW: 07:07 medications are wrong

AD2: 07:07 yeah, yeah. It's just completely a free-text box, you know, they don't have to type anything

AW: 07:13, but making that mandatory so you have put something

AD2: 07:13 so there has to be something in there

AW: 07:17 erm and are some surgeries or referring er, sites better than others at providing that information?

AD2: 07:23 they now are all very, very good. Erm, there were teething troubles at first. One of the things I found most frustrating was there was at least one, sometimes more surgeries who were making a retrospective decision that somebody would benefit from a referral. So, then they were making that referral to us with no, knowledge off the patients. So, then when I made my initial phone call, "oh, I'm from the, your surgeries booked you on for Exercise Referral", they didn't have a clue.

AW: 07:52 wow so they were making those referrals without even informing the patient

AD2: 07:54 yes. Doesn't happen anymore, I think we've got a handle on that point now, but that was an initial frustration

AW: 07:58 and how are surgeries, how do they find moving from paper referrals to electronic referrals. Has that been well, received do you think?

AD2: 08:05, I think so, yeah. It seems to have increased the number of referrals because, I think it has reduced the workload., I think it has made it easier for them to refer a patient

AW: 08:15 and you said, earlier on about how many referrals you are getting on Exercise Referral, can you give me any rough numbers of the figures you are seeing

AD2: 08:23 erm, there are days when I will receive upwards of ten in a day

AW: 08:29 wow ok

AD2: 08:30 that would be the busiest. That would very rarely happen more than one day in a row. But I would say on a busy week I would receive 20 in a week.

AW: 08:40 wow ok and in terms of capacity. Do you have the capacity to manage those referrals coming in?

AD2: 08:47 we've never actually reached the point where we couldn't manage it, although, I think sometimes, we have to be aware of our limitations a little bit. I mean that's one of the reasons it is good to have me doing the admin side of things so obviously the instructors keep themselves going

AW: 09:01 and just relieve some of that burden of the admin role

AD2: 09:03 yeah, yes

AW: 09:05 and can you tell me about your experiences of contacting GP surgeries to retrieve any information that is missing on the forms?

AD2: 09:10 90 percent of the time it is great. It really, really is easy. Er, the surgery will tend to cover themselves by making sure I am who I say I am. So, if I say, “Oh, you've not given me a phone number for Mr Smith”. They will say, “Oh, can you tell me Mr Smith's address, date of birth, and the name of the doctor who referred them”. So, then they have covered themselves. I have got one surgery who takes

data protection, I personally think rather too seriously, and they might refer a patient to come in tomorrow and not given me a phone number. And I will ring the surgery and say, “can you provide me the phone number”, and it doesn't matter how much information I give them, they simply won't do that. What they will insist on is them ringing the patient and asking the patient to ring me. And if they can't contact them then obviously, their receptions are an awful lot busier than I am sometimes. And it sometimes results in the patient not being contacted before their first appointment and turning up completely blind or occasionally, they are not being informed that their appointment is there at all

AW: 10:16 Right ok. So, sometimes that does pose a little bit of a challenge if they are not allowing you that information

AD2: 10:21 exactly yes, yes

AW: 10:24 and as you say the implications of that is patients are either not coming, not knowing their appointment, or they are turning up without any knowledge...

AD2: 10:28 of what's going to happen. Yeah, exactly

AW: 10:31 absolutely, but that's just one surgery. On the whole are you happy?

AD2: 10:36 on the whole yeah. Generally speaking, we have quite good relationships with the surgeries. They are getting to know me a little bit now and yeah, it is good

AW: 10:46 Do you have confidence in the information that you receive in terms of the patients BMI? Do you feel that information is all up to date and relevant?

AD2: 10:54 I would say it is correct enough for me at the time for me to be able to say, yes, I've got faith in it. I couldn't look you in the eye and say mistakes never happen, but...

AW: 11:04 on the whole yeah

AD2: 11:03 on the whole yeah.

AW: 11:06 and do they tend to, the referring practitioners, do they tend to signpost people to the correct programme? So, what I mean by that, are you getting BMIs over 45 that really should be pushed towards the LiveWell, programme?

AD2: 11:16 that is the one stumbling block I would say. That very, very specific issue you've just mentioned. We will get, sometimes get people on the 10-week GP referral, er, where their surgery has put down weight loss as the reason for referral and when they turn, turn up, they actually have a much bigger BMI than expected and would be eligible for the LiveWell, programme. Conversely, we sometimes get people referred for the LiveWell, scheme that I end up having to bring onto the GP referral. And that of the two is the more difficult situation because these people will turn up thinking they are getting a year's free membership and they find they are not eligible for it. They're only actually eligible for sort of ten weeks at £33.

AW: 11:57 and how do patients respond to that? How do you get around that issue?

AD2: 12:01 generally obviously they find it fairly frustrating. Er, the perception from the public is not always great in terms of that one. Er, some people almost feel, if you tell somebody "I'm sorry, your BMI is actually 40, not 45, you're therefore not eligible for a year's free membership, but you can have GP referral". There is very much a perception out there that we are rewarding people for being overweight, if you see what I mean. I have heard that comment made so many times. "Oh, I am penalised for not being fat enough. You're rewarding the people who are overweight"

AW: 12:31 yeah, and do they tend to take up the Exercise Referral from there

AD2: 12:36 they generally will I would say, yeah, but yeah. I don't think the perception...We could maybe work on that, but I also think you know, obviously there's a bit of frustration there., I think it's definitely a stumbling block that the

amount that you get on the LiveWell, scheme is perceived by people on the referral scheme [Exercise Referral scheme] as people being rewarded for being overweight

AW: 12:57 yeah. What would maybe prevent that from happening in the first place, do you think?

AD2: 13:01 erm, I think possibly making it clearer that twelve weeks gym membership isn't a gift. It's, you know, people have still got to come in and work hard you know? We are not just, people see if as a free gym membership, oh, we can go in and do all these nice things, but if you actually get it into people's minds that it's, it involved working and exercising rather than being given something for nothing

AW: 13:29 yeah, absolutely. So, giving them clarity about what actually the programme is about.

AD2: 13:31 yeah, yeah. The fact of the matter is we're a really nice centre. We have got lovely pool and we are lucky we have a sauna, steam room and Jacuzzi as well, which people on both GP referral and LiveWell, scheme are allowed to use

AW: 13:45 oh, ok so they can use all leisure facilities

AD2: 13:47 and, I think there are some people who play the system a little bit to try and get a year's free use of the Jacuzzi. Do you know what I mean? Yeah, so in that sense it is perhaps perceived that we are rewarding people a little bit. We try to avoid that.

AW: 13:59 yeah, yeah. And earlier you said, you had a good relationship in your opinion with the GP surgeries

AD2: 14:06 yes

AW: 14:06 why do you think the relationship is so established and good in this area?

AD2: 14:10, I think it's because, I mean, Bridlington is a town with quite an elderly population., I think a lot of the GP surgeries in Bridlington are probably quite

overstretched and, I think the fact that we can now offer something er, that benefits them and their patients. Erm, I'm not going as far to say because I don't think like that at all, but they are using us to get patients off their hands cuz I don't believe that at all, but I just think the way the schemes works is a really, really good opportunity for the GP surgeries and as such they are really happy to be involved

AW: 14:46 yeah. And you think they recognise the value of the programmes?

AD2: 14:49, I think so yes

AW: 14:50 they are not just using it as somewhere to dump their patients

AD2: 14:52 well, I don't think so. I don't think they really do. It's like I say, Bridlington has got a very old population. I don't know if it's ever occurred to you, but we are not only by the seaside, but we are also completely flat. It's a nice place to live and it's an easy place to live if you are older and you've got less mobility. You know Scarborough and Whitby are full of hills

AW: 15:12 absolutely yes

AD2: 15:13 so a lot of people do retire here.

AW: 15:17 and the next section is about the telephone conversations that you have with people who have been referred onto the programmes. So, how quickly are you able to contact referred customers once the referral has been processed to yourself?

AD2: 15:29 usually, first attempt. Erm, but certainly within a couple of days

AW: 15:36 and what information do you tend to provide?

AD2: 15:39 er what the nature of the first appointment is. Basically, that it is mainly a consultation. Then how the scheme will progress after the first appointment. Tend to advise them that initially their exercise will be supported, but as the scheme progresses, it is very much the intention that they become more and more independent. So, that towards the end if they wanted to move onto a main

membership, they are confident to work out on their own. Erm, obviously always make them aware of the cost of the scheme.

AW: 16:12 so you're quite clear from the outset that it is going to be a supervised programme, but you are planning to build that autonomy and get them to be…

AD2: 16:17 as the scheme progresses yes. By the tenth week, they should really be able to come in and work through the programme on their own.

AW: 16:23 yeah

AD2: 16:24 we don't make them do that, but we like to say that you know, we feel they should be able to

AW: 16:29 yeah, and that's the intention of the programme. And how do patients respond to the costs?

AD2: 16:34 the only time people tend to respond is when I get people who are receiving benefits that express concern about being able to afford it, but obviously in that case we do have a limited number of funded places that we can offer

AW: 16:47 ok so this area does have a few free places for people who are not able to afford the programme

AD2: 16:56 yes, that's right, yes.

AW: 16:55 and how much do customers tend to know about the Exercise Referral Scheme generally? Do they seem to be well, informed about the scheme?

AD2: 17:02 not, they are aware of how long it lasts. Usually aware of how much it costs, and they are aware that it involve exercise. And I would say those three points are what they know.

AW: 17:16 right. Is there anything else you would like them to know prior to, at the point of referral? Anything else you would like them to be aware of?

AD2: 17:22, I think it would maybe allay some initial fears if they were made clear that it is very much an individualised programme, which is targeted uniquely towards that person. Erm, a number of sort of older ladies we get, that when I first phone them, they are quite nervous because they literally think they are going to be dropped in a gym, thrown onto a treadmill, and told to run as fast as they can. Do you know what I mean? That's what their perception of a gym is. Erm....

AW: 17:51 and that leads nicely onto my next question. I was actually going to ask about the common concerns that people raise over the phone

AD2: 17:56 sure

AW: 17:56 so you've said, there some negative perceptions of what is going to happen in the gym. Is there any other sort of common concerns or anxieties?

AD2: 18:04 the main anxieties come from people who don't really know how a gym works. Erm, a lot of people think it's a gym where young people in the teens, and twenties come wearing small sports bras and show off their bodies a lot and use it as a place to pose. Do you know what I mean? That perception is still very much engrained into people. Erm, and I encounter that one quite a lot. So, sometimes there's quite a lot of reassurance. I mean you see around yourself, I don't know if you noticed whilst you were up there, the mix of people we have in the gym. You get everything from sort of very young fit people here to do a cardio workout. We get a lot of people sort of body building and using weights. But we do have a massive number of older people who are just trying to benefit their health so... and, I think if you say to someone who has never used a gym and never being interested, if you use the word 'gym', I think it does conjure up that mental image and, I think people could be quite frightened. Both for what they are going to do and what other people they are going to find there.

AW: 19:03 do you tend to use an alternative word to gym? Or how do you get around that to reassure them?

AD2: 19:08 I really deliberately use the word gym, but then bring in a lot of reassurance just to dispel that myth., I think if you avoid the word gym then in later situations if they go somewhere else, that word gym crops up again and you are back to square one. So, what I very much try and do is make people aware that its, here in particular, it's a friendly place. It's very open. It's, everything is very unique and tailored. I always make the point that we use the word Gym Instructors, but they are a long way beyond Gym Instructors. They have a background in sort of medical and health conditions and everything like that and stress. You know?

AW: 19:46 just again to reassure them that they are qualified to deal with their conditions

AD2: 19:51 exactly

AW: 19:50 cuz I, I guess a lot of them, with it being an older population, they have many chronic conditions

AD2: 19:56 yes

AW: 19:57 many all inter-related as well. So, I think it's just that reassurance that somebody does know what they are doing

AD2: 20:01 yes.

AW: 20:04 perfect any other concerns that they tend to face? So, you said, they are a bit nervous, particularly around the gym, around coming in. Is there anything else that they raise with you over the telephone?

AD2: 20:14 er we mentioned cost and everything.... no, I don't think so. Maybe a small one that I hear quite regularly is people who haven't physical been to this building before and nervous about being able to find their way around once they get here

AW: 20:27 absolutely

AD2: 20:28 it's just an unfamiliarity thing. I mean

AW: 20:30 absolutely it's an alien environment to them if they haven't been before

AD2: 20:33 yeah, if they've never been at all, they will ask, "oh, where do I park?" and "do I need to go to reception, where is reception? How do I find the gym"?

AW: 20:39 right, ok

AD2: 20:41 just small things

AW: 20:41 generic yeah,

AD2: 20:42 yeah

AW: 20:43 perfect and in terms of the conversation you have, do you face any challenges or with the referral process. So, you said, earlier on sometimes the medication is not on there. There's a little bit, er, a few hurdles in the electronic referral process.

AD2: 21:01 yeah

AW: 21:01 is there anything else that you find difficult? Not difficult, but something that isn't as streamline as it could be? If that makes sense?

AD2: 21:12 I don't think so to be honest., I think I have learnt over time to give the information the way we've just described to take it beyond the three points they initially know, which is er, it's £33, it's ten weeks, we are exercising so...

AW: 21:26 and the days were you are having maximum ten a day, do you find you are able to manage that alongside your additional roles as well?

AD2: 21:34 yeah, I think so. I mean, depending on the customer, I think the initial part of the work for me, cuz if, basically, what I will do first when it comes in, I will check whether that person is already registered on our system as an existing customer. Er, if they are not, then I will then set them up on the system, so they are

ready to go. Allocate a membership card. Then I will make the phone call to them. Talk through everything they need. Then I will file the paperwork in the relevant place for the instructor to find. And depending on how much the customer wants to ask, each one of those customers will take me, I would say a minimum of fifteen minutes, maximum of 30-40 minutes

AW: 22:15 ok so not too long and unmanageable if you do get an influx of them at once

AD2: 22:17 no, no. That's it

AW: 22:19 ok and so the final section is about feedback. So, the feedback loop from the people who are referring, so from the primary care sites, to here. And that's about the patient progress so how well, a patient has done either throughout a programme or at the end of a programme. So, how important do you feel it is to provide that patient progress feedback back to the primary care sites?

AD2: 22:40 this is more of a difficult one for me to answer because once the client is in the hand of the instructors, I don't have as much to do with it. So, it’s, I mean, I can tell you I do think it is important, but I am not really involved in the process of it happening.

AW: 22:54 yeah, no problem. That is fine. Absolutely,

AD2: 22:57 ok

AW: 22:58 lovely so erm there's just two last questions then. In your opinion, how could the referral process be improved? So, that could be to do with anything we've discussed today or any other ideas you have around improving the referral process

AD2: 23:11 what I've said, before., I think the actual body of the information could be more consistent.

AW: 23:17 yep. The information coming from primary care sites to here?

AD2: 23:25 yes, could be more consistent. Not every patient can remember the names of all the tablets they are on when they've showed up, so, I think, I think we need full and consistent information

AW: 23:36 yes. As you say, you can't really rely on that patient to remember everything that's going on. Lovely. And is there anything you wish you add that you feel is important beyond anything we've discussed today?

AD2: 23:45 I don't think so to be honest

AW: 23:47 no. Well, lovely.

AD2: 23:46, I think the scheme is going well., I think it is working well, for us and yeah, still good.

AW: 23:52 well, thank you for your time today.

Appendix 14 : Mindmap of Covergence Coding Matrix