

Trainee manual

Let's Get Moving

A physical activity care pathway

Module 1



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Welcome

This information pack has been designed to accompany the *Let's Get Moving: a physical activity care pathway* module 1 training. The structure of the information pack mimics the order of the training content that will be delivered by the tutor. However, you will find that this document does contain additional, relevant information which may not be covered directly in the training.

Introduction

Promoting active lifestyles is a simple answer to many of the big health challenges facing our country today. With significant potential to improve the health of the nation by reducing all-cause mortality and improving life expectancy, promoting physical activity can save the NHS money and significantly ease the burden of chronic disease.

The benefits of regular physical activity have been clearly articulated. Achieving 30 minutes of moderate intensity physical activity on at least five days a week can help to prevent and manage over 20 chronic conditions including coronary heart disease (CHD), stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions.

However, despite the multiple health gains associated with a physically active lifestyle, 27 million adults in England alone are not active enough to benefit their health. This level of physical inactivity places a significant economic burden on the NHS for the treatment of long-term conditions and associated acute events (such as heart attacks, strokes, falls and fractures), as well as the costs of social care arising from the loss of functional capacity.

The Secretary of State for Health has called on the NHS to integrate the promotion of active lifestyles *as core business rather than a peripheral concern*. Encouraging healthcare practitioners to adopt physical activity promotion as a key principle of modern healthcare will be key in the forthcoming period where the NHS will be challenged with addressing the burden of 21st century chronic disease.

Let's Get Moving (LGM), a new physical activity care pathway for the NHS, will help to address some of the incipient health challenges. LGM is a behaviour change intervention that has been designed to provide a systematic approach to identifying, supporting and guiding adults (who are not meeting the Chief Medical Officer's (CMO's) recommendation for physical activity) to become more active, for the purpose of both prevention and management of inactivity-related chronic disease.

The information contained in this pack complements the module 1 training and provides you with information on:

- the beneficial effects of physical activity in healthy and unhealthy people alike;
- the principles of LGM and its application in practice; and
- how to assess physical activity levels and guide people towards becoming more active.



Trends in physical activity levels

Physical activity comprises a range of behaviours involving movement, expenditure of calories and raised heart rate. Physical activity can be derived from sport, recreational and occupational activity, active travel (walking and cycling for transport) and heavy domestic activity (gardening and housework).

Although every day we are presented with opportunities to choose to be physically active, only 40% of adult men and 28% of adult women meet the CMO's recommendations for health¹ – that's 27 million adults in England alone. Yet the real challenge is that 75% of men and 67% of women think that they are active enough².

Key health fact

In a practice population of 10,000 (made up equally of men and women), 7,100 believe that they are active enough and yet 6,600 are not doing enough physical activity to benefit their health.

Improvements in technology and the rapid increase in the pace of life have conspired against us. Compared with 1980, in the UK:

- the population now travels 25% less on foot and by bicycle³
- the population watches twice as much television³
- half as many young people play extra-curricular sport³
- half as many people work in physically active employment.³

Over the last 50 years our lifestyles have become physically less demanding and increasingly sedentary, and we now benefit from a plethora of labour-saving devices such as washing machines, dishwashers, lifts and computers. We have become so accustomed to a life of ease and convenience that we now have to consciously choose to exert ourselves and perform a physically active task.

Social patterning

There are also clear and significant health inequalities in relation to the prevalence of physical inactivity for income, gender, age, ethnicity and disability. From figures 1 and 2 we can see that:

- physical activity is higher in men than in women at all ages;
- physical activity declines significantly with increasing age for both men and women; and
- low household income groups are less active compared with high household income groups.

Figure 1. Rates of physical activity at recommended levels in England, 2006, by sex and age¹.

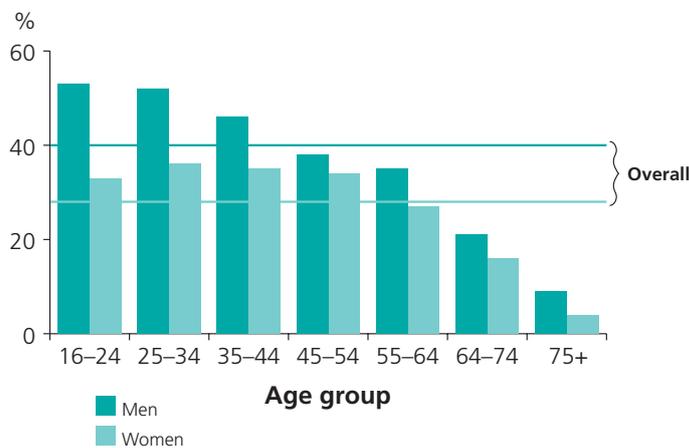
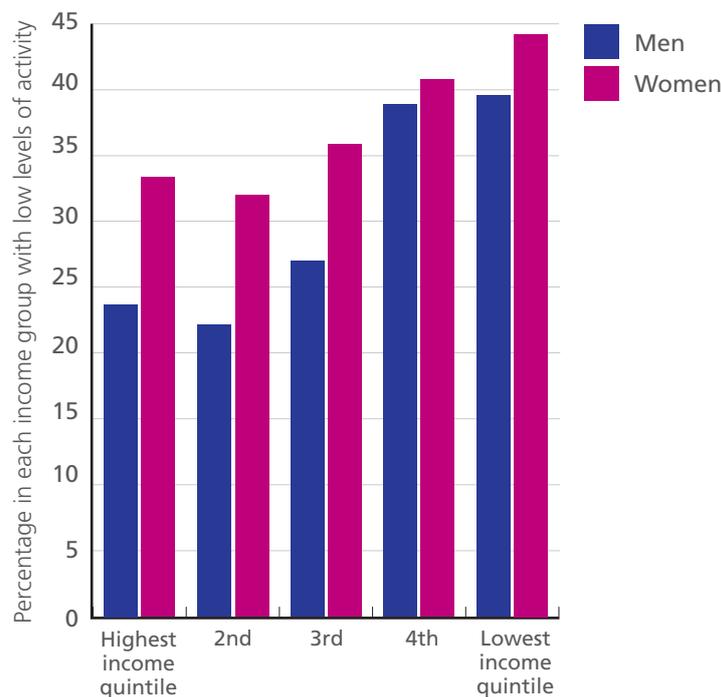


Figure 2. Adults achieving the physical activity guidelines, by ethnic group and gender, England, 2004¹.



Generally physical activity levels are also considerably lower within black and minority ethnic groups and disabled groups.

Physical inactivity and risk of ill health

Physical activity is a significant, independent risk factor for stroke, coronary heart disease and type 2 diabetes. It also impacts on a range of other long-term health conditions affecting society today including obesity, hypertension, breast cancer, colon cancer, depression, osteoporosis and mental health (this is not an exhaustive list).

People who are physically active reduce their risk of developing coronary heart disease, stroke and type 2 diabetes by up to 50%, and the risk of premature death by about 20–30%.⁴

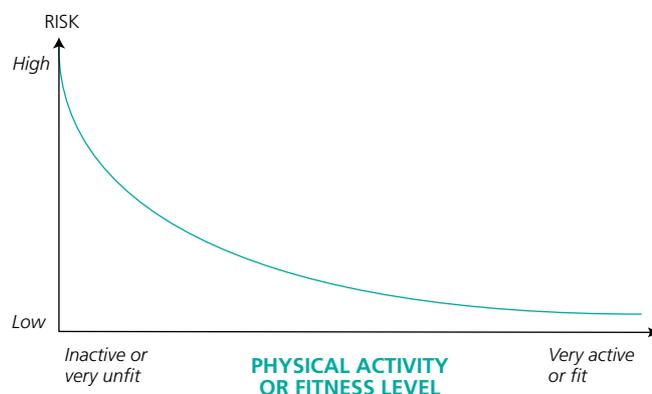
Evidence shows that the health impact of inactivity in terms of coronary heart disease, for example, is comparable to that of smoking, and almost as great as high cholesterol levels.² Considering that inactive lifestyles in England are twice as prevalent as smoking, hypertension or high cholesterol, there is a compelling case for embedding the promotion of physical activity in the NHS.

Key health fact

On average, an inactive person spends 38% more days in hospital than an active person, and has 5.5% more family physician visits, 13% more specialist services and 12% more nurse visits than an active individual.¹⁸

Set alongside the burden of ill health from inactivity, these statistics highlight potentially significant reductions in morbidity and mortality that could be achieved. Furthermore, figure 3 illustrates that those with the greatest to gain by way of reducing their risk of chronic disease are those who are completely inactive. Therefore significant benefits to both the individual and the NHS can be secured if we successfully and systematically encourage sedentary adults to participate in physical activity.

Figure 3. Schematic representation of the dose-response relationship between physical activity level and risk of disease



This curvilinear dose-response curve generally holds for coronary heart disease and type 2 diabetes: the higher the level of physical activity or fitness the lower the risk of disease. Curves for other diseases will become more apparent as the volume of evidence increases.

Source: CMO (2004) *At least five a week*, p10

Counting the cost of physical inactivity

A recent estimate showed that for just five conditions,² in one year in the UK, the burden of physical inactivity caused:

- over 35,000 deaths;
- 3.1% of morbidity and mortality; and
- over £1 billion of the direct health cost burden to the UK National Health Service.⁵

Key health fact

For a practice population of 20,000 the cost of these 5 conditions from physical inactivity is on average £500,000 per year.⁶

Adding the indirect costs to the wider economy, such as working days lost to sickness absence and premature mortality, gives a total bill for physical inactivity that may be as high as £8.3 billion every year.⁶

The health benefits associated with physical activity

Physical activity can help prevent and manage over 20 conditions and diseases including coronary heart disease, stroke, type 2 diabetes and cancer. It also promotes mental wellbeing and helps people to manage their weight.⁴ The clear link between physical activity and chronic disease is set out in table 1 (pages 10–11).

Table 1. The relationship between physical activity and health outcomes

Health outcome	Nature of association with physical activity
All-cause mortality	Clear inverse relationship between physical activity and all-cause mortality.
Cardiorespiratory health	Clear inverse relationship between physical activity and cardiorespiratory risk.
Metabolic health	Clear inverse relationship between physical activity and risk of type 2 diabetes and metabolic syndrome.
Energy balance	There is a favourable and consistent effect of aerobic physical activity on achieving weight maintenance.
Musculoskeletal health	<p>Bone: There is an inverse association of physical activity with relative risk of hip fracture and vertebral fracture. Increases in exercise and training can increase spine and hip bone marrow density (and can also minimise reduction in spine and hip bone density).</p>
	<p>Joint: In the absence of a major joint injury, there is no evidence that regular moderate physical activity promotes the development of osteoarthritis. Participation in moderate intensity, low-impact physical activity has disease-specific benefits in terms of pain, function, quality of life and mental health for people with osteoarthritis, rheumatoid arthritis and fibromyalgia.</p>
	<p>Muscular: Increases in exercise training enhance skeletal muscle mass, strength, power, and intrinsic neuromuscular activation.</p>
Functional health	There is observational evidence that mid-life and older adults who participate in regular physical activity have reduced risk of moderate/severe functional limitations and role limitations.
Cancer	There is an inverse association between physical activity and risk of breast and colon cancer.

Source: Adapted from Department of Health and Human Services (2008) *Physical Activity Guidelines Advisory Committee Report*, Washington, DC: US Department of Health and Human Services.

* These statistics are specific to: Chief Medical Officer (2004) *At least five a week: Evidence on the impact of physical activity and its relationship to health*, London: Department of Health.

Effect size	Strength of evidence
There is an approximately 30% risk reduction across all studies, when comparing the most active with the least active.	Strong
There is a 20% to 35% lower risk of CVD, CHD and stroke .	Strong
There is a 30% to 40% lower risk of metabolic syndrome , and a 35% to 50%* lower risk of type 2 diabetes in at least moderately active people compared with those who are sedentary.	Strong
<p>Aerobic physical activity has a consistent effect on achieving weight maintenance (less than 3% change in weight).</p> <p>Physical activity alone has no effect on achieving 5% weight loss, except for exceptionally large volumes of physical activity, or when an isocaloric diet is maintained throughout the physical activity intervention.</p> <p>Following weight loss, aerobic physical activity has a reasonably consistent effect on weight maintenance.</p>	<p>Strong</p> <p>Strong</p> <p>Moderate</p>
<p>Bone: Risk reduction of hip fracture is 36% to 68% at the highest level of physical activity. The magnitude of the effect of physical activity on bone mineral density is 1% to 2%.</p>	Moderate (weak for vertebral fracture)
<p>Joint: Risk reduction of incident osteoarthritis for various measures of walking ranges from 22% to 83%.</p> <p>Among adults with osteoarthritis, pooled effect sizes (ES) for pain relief are small to moderate, i.e. 0.25 to 0.52. Function and disability effect sizes are small: function ES = 0.14 to 0.49 and disability ES = 0.32 to 0.46.</p>	<p>Weak</p> <p>Strong</p>
<p>Muscular: The effect of resistance types of physical activity on muscle mass and function is highly variable and dose-dependent.</p>	Strong
There is an approximately 30% risk reduction in terms of the prevention or delay in function and/or role limitations with physical activity.	Moderate to strong
There is an approximately 30% to 50%* lower risk of colon cancer and approximately 20% lower risk of breast cancer .	Strong

Exercise is one of the most powerful forms of medicine available to clinicians and primary care teams. A physically active lifestyle:

- has a substantial impact on the risk of major non-communicable disease, including CHD, hypertension, type 2 diabetes, chronic kidney disease (CKD) and some cancers;⁴
- can reduce the risk of stroke, be used to treat peripheral vascular disease and to modify CVD risk factors such as high blood pressure and adverse lipid profiles;⁴
- protects against cancers of the colon, breast (post menopause) and endometrium;⁷
- reduces the risk of and helps manage musculoskeletal health conditions, including osteoporosis, back pain and osteoarthritis;⁴
- reduces the risk of depression and promotes many other positive mental health benefits, including reducing state and trait anxiety, improves physical self-perceptions and self-esteem, and can help reduce physiological reactions to stress;⁴
- has been found to be just as effective in the treatment of mental ill health as anti-depressant drugs and psychotherapy;^{8,9} and
- supports weight management – physical activity by itself can result in modest weight loss of around 0.5–1kg per month.⁴



Current CMO physical activity recommendations

The Chief Medical Officer's Report *At least five a week*⁴ provides recommendations for the amount of physical activity for general health benefits. Specifically, *"adults should achieve a total of at least 30 minutes a day of at least moderate intensity activity on 5 or more days of the week."*

MODERATE INTENSITY: You are able to talk but you notice that your breathing is quicker and deeper, your body is warming up, your face may have a healthy glow and your heart will be beating faster than normal but not racing.

Patients' barriers to participating in physical activity

Not understanding the CMO's physical activity recommendations may influence the ability of an individual to take action. However, for those that do understand the recommendations the reasons why they are not active are well documented. These are some commonly cited barriers to physical activity:

- not enough time/too busy;
- lack of confidence and motivation;
- caring for others;
- already perceive themselves as active (remember this is 75% of men and 62% of women);
- lack of money; and
- poor health.

Key health fact

A study by Clemes¹⁰ reported a reduction in the number of steps walked on weekend days in comparison with week days, with a **2,000 step reduction** reported on a **Sunday** compared with a weekday. If one of the top barriers for being active is not enough time, why is it that we are able to be more active during the working week rather than at the weekend?

Increasing population physical activity levels

To increase population physical activity levels, we need to address both the physical and perceived barriers to being physically active. Therefore we need to:

- create activity-friendly environments; and
- guide, support and motivate individuals in their efforts to become more active.

As the most common barriers cited are lack of time and lack of confidence/motivation, it is likely that, psychologically, people may not be active enough because:

- it is of low perceived importance to them; and/or
- they are not confident enough about doing it.

LGM is designed to help overcome these barriers by:

- helping people to explore the personal importance of a more active lifestyle; and
- building people's confidence about becoming more active.

Key health facts

Around one in four people in England say they would become more active if they were advised to do so by a doctor or nurse.

(Health Survey for England, 2006¹)

54% of patients said that their GP had not provided advice on diet or exercise.

(Darzi, 2008¹⁰)



Brief interventions in physical activity

There is strong evidence to demonstrate the importance of the promotion of physical activity in primary care. The National Institute for Health and Clinical Excellence (NICE) public health guidance *Four commonly used methods to increase physical activity*¹² concludes that brief interventions are effective at increasing physical activity levels:

- in the short term (6–12 weeks);
- in the long term (over 12 weeks); and
- in the very long term (12 months or more).

The guidance recommends:

Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more). They should use their judgement to determine when this would be inappropriate (for example, because of medical conditions or personal circumstances). They should use a validated tool, such as the Department of Health's General Practice Physical Activity Questionnaire (GPPAQ), to identify inactive individuals.

When providing physical activity advice, primary care practitioners should take into account the individual's needs, preferences and circumstances. They should agree goals with them. They should also provide written information about the benefits of activity and the local opportunities to be active. They should follow them up at appropriate intervals over a 3 to 6 month period.¹²

The delivery of a brief intervention should help people to:

- understand the likely impact of their behaviour on their health;
- feel positive/optimistic about changing their behaviour;
- make a personal commitment to change;
- set goals to undertake specific actions over a specified time;
- plan changes in terms of easy steps;
- plan for events or situations that might get in the way of change; and
- share their behaviour change goals with others.

Key health facts

The evidence for the impact of health professionals encouraging physical activity continues to grow.¹⁸

A study of the effects of three brief sessions of lifestyle counselling from practice nurses, in patients with risk factors for CVD, also led to significant increases in physical activity at four months.¹⁹

Physical activity behaviour change

Critical to the delivery of brief interventions is the manner in which they are implemented. The NICE behaviour change guidance¹³ recommends the selection and implementation of interventions that motivate and support patient to think about:

- the consequences of their current behaviour;
- the positive consequences of changing; and
- how to plan behaviour change in small steps.

One approach that can assist a practitioner in achieving the above points is the application of motivational interviewing (MI). MI is a patient-centred behaviour change methodology that elicits and strengthens people's intrinsic motivation to change their behaviour. It is currently being used by a variety of healthcare professionals to deliver improved outcomes across a range of settings, including primary care¹⁴.

A review of MI intervention studies promoting health behaviours has shown that MI can have a positive effect on a range of health behaviours including diet and physical activity¹⁵.

Let's Get Moving: a physical activity care pathway

Overview

Based on the recommendations of the 2006 NICE Public health guidance,¹² LGM is a behaviour change programme that incorporates a physical activity care pathway designed to help inactive adults aged 16–74 become more active.

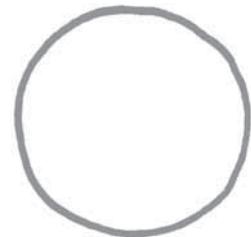
This physical activity care pathway can be used by service deliverers to systematically recruit patients and screen for inactivity (using a validated questionnaire). Then for those patients identified as not meeting the CMO's recommendations for physical activity, offer a patient-centred brief intervention (drawing on motivational interviewing techniques) which:

- highlights the health benefits of physical activity;
- works through key behaviour change stages; and
- concludes with a clear, patient-set physical activity goal, identifying local opportunities to be active including exercise on referral schemes where appropriate.

Participating patients are then followed up at regular intervals over 3, 6 and 12 months after the brief intervention to check progress, encourage and re-set goals.

LGM has been developed to support:

- primary prevention of disease;
- improving health and wellbeing; and
- increasing patient choice.



A practical option

LGM has been tested in a feasibility trial in 14 surgeries by the British Heart Foundation National Centre for Physical Activity and Health at Loughborough University. The results of the evaluation demonstrated that LGM is feasible for delivery in primary care and (subject to a number of specific refinements, which have been implemented) is suitable for wider-scale implementation. The evaluation report is available on the physical activity section of the DH website www.dh.gov.uk/en/Publichealth/Healthimprovement/PhysicalActivity/index.htm.

Case study

NHS Haringey was part of the LGM physical activity care pathway pilot. As a result of being involved in the pilot, staff at Pandya Practice recognised the importance and value of physical activity, and realised the potential of the pathway for improving the health of their patients.

Both Dr Sejal and Nurse Practitioner Sharon Seber were involved in delivering LGM. They found the pathway to be particularly useful in opening up a dialogue about physical activity with patients and for supporting patients in making these important health behaviour changes. To support the care pathway, a health walk from the practice was also established which continues to be well attended by patients.



Introduction

The following sections guide you through LGM and show, step by step, how to implement the intervention.

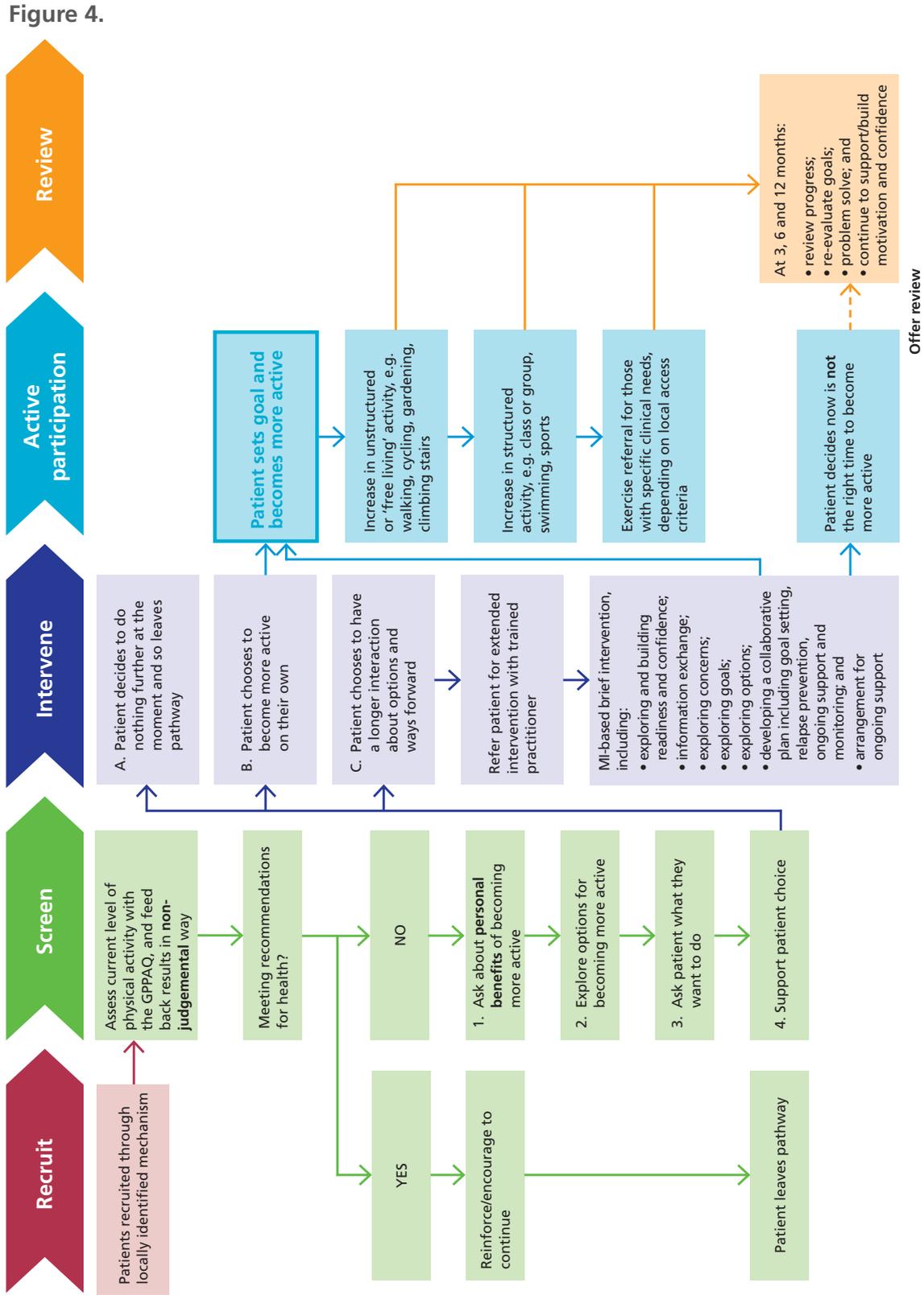
The LGM physical activity care pathway has five stages, which can be seen in more detail in figure 4:

- 1. Recruit**
- 2. Screen**
- 3. Intervene**
- 4. Active participation**
- 5. Review**

The intervention is designed to be cyclical in nature to reflect the fact that many people will benefit from ongoing support and encouragement in their efforts to become and remain sufficiently physically active to improve their health and wellbeing.



Let's Get Moving: A physical activity care pathway

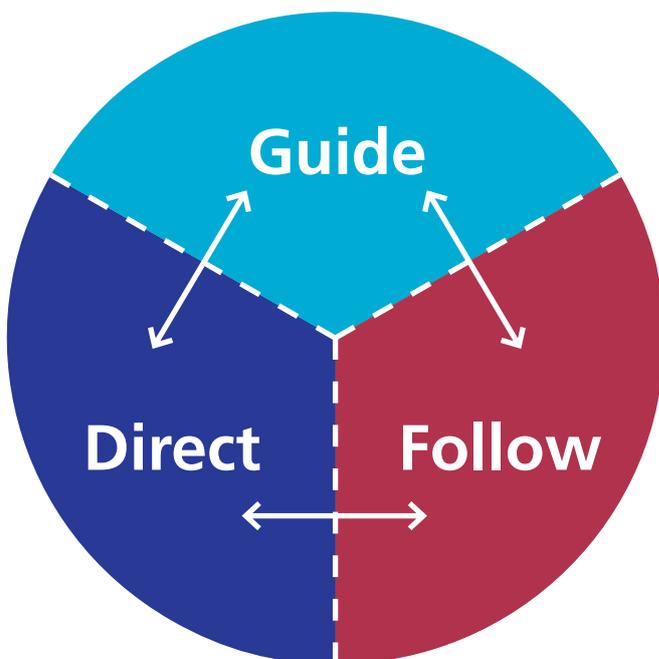


The spirit of the Let's Get Moving approach

The style and approach we take in affecting health behaviour change are crucial to the outcome that is being sought. Telling people what to do can sometimes be very helpful; for example, 'This medication is to be taken once every five hours for the next seven days.'

However, in complex health behaviour change, a telling approach can sometimes get in the way. The evidence suggests that, rather than taking a direct/telling approach, adopting a 'guiding style' can be more effective and helpful in getting people to think about, start and persist with lifestyle change, as it helps to draw out motivations and possible solutions from the patient.

Figure 5. The principles of motivational interviewing



When information needs to be shared, it is shared in a neutral, non-judgemental manner.

Rather than telling the patient what to do, LGM recommends that a guiding style be used, drawing out intrinsic motivation from the patient. This can be done briefly in primary care settings, using an MI informed approach:

Motivational interviewing is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.¹⁶

An MI approach aims to help people explore and resolve their ambivalence about changing behaviour. It selectively elicits and reinforces the patient's own arguments and motivations to change, rather than imposing reasons for change on them. When done well, MI can assist an initially ambivalent patient in increasing their motivational readiness to change, and help them develop a plan for change and commit to it.

Effectiveness is enhanced when MI is provided with fidelity and skill. Research in providing training on MI shows that health professionals can become proficient MI practitioners, although gaining proficiency is not easy. A series of steps for developing proficiency has been identified that includes initial training followed by ongoing supervised practice¹⁷. As with any new skill, over time, a combination of practice and coaching produces a competent and confident practitioner.



Stage 1: Recruit

Effective patient recruitment is key to the successful local implementation of LGM. The primary aim of this physical activity care pathway is to gradually increase the physical activity levels of adults (16+) not meeting the CMO's recommendations for physical activity. There is a range of possible entry routes for patients onto this care pathway, including:

- new patient registrations;
- existing and new clinical pathways, for example NHS Health Check, the adult obesity care pathway;
- existing disease registers or other practice records;
- existing condition-specific clinics, for example weight management, diabetes management and stop smoking clinics; and
- opportunistic entry from routine clinical consultation.

Stage 2: Screen

Step 1: The first step in the screening element of LGM is to use the General Practice Physical Activity Questionnaire (GPPAQ). The GPPAQ is a rapid-completion, validated assessment of a person's physical activity levels. It classifies people into one of four categories:

- inactive;
- moderately inactive;
- moderately active; and
- active.

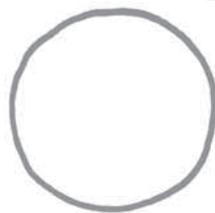
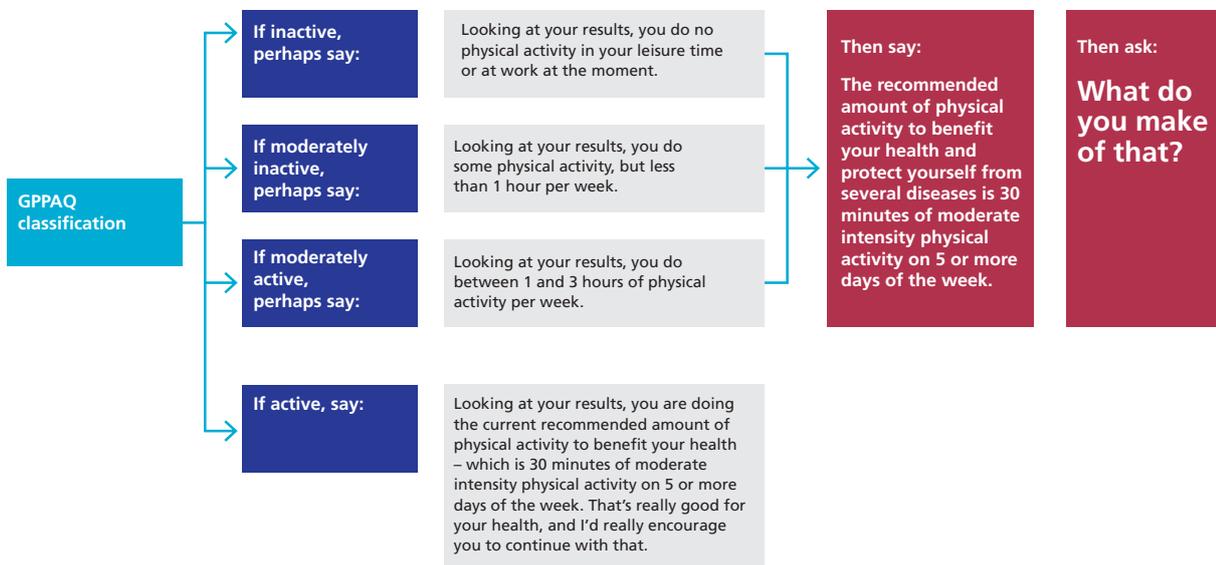
This classification is predictive of a person's all-cause mortality risk.

Step 2: The second step in the screening element of LGM enables practitioners to raise the subject of physical inactivity, provide feedback and move on to explore personal meaning.

Having completed the GPPAQ, ask the patient: "Would you mind if we spend a few minutes talking about physical activity?"

This provides the practitioner with an opportunity to provide the patient with non-judgmental feedback regarding their current physical activity status. Some examples of what you might say, depending on the patients GPPAQ classification, are provided in figure 6.

Figure 6. Providing non-judgemental feedback



Step 3: Having provided the patient with feedback and listened to the patient's response you can move on to explore the benefits and options for changing their behaviour. To do this, ask the following two open questions:

"What would be the benefits to you personally of becoming more active?"

"If you did decide to become more active, how would you go about it?"

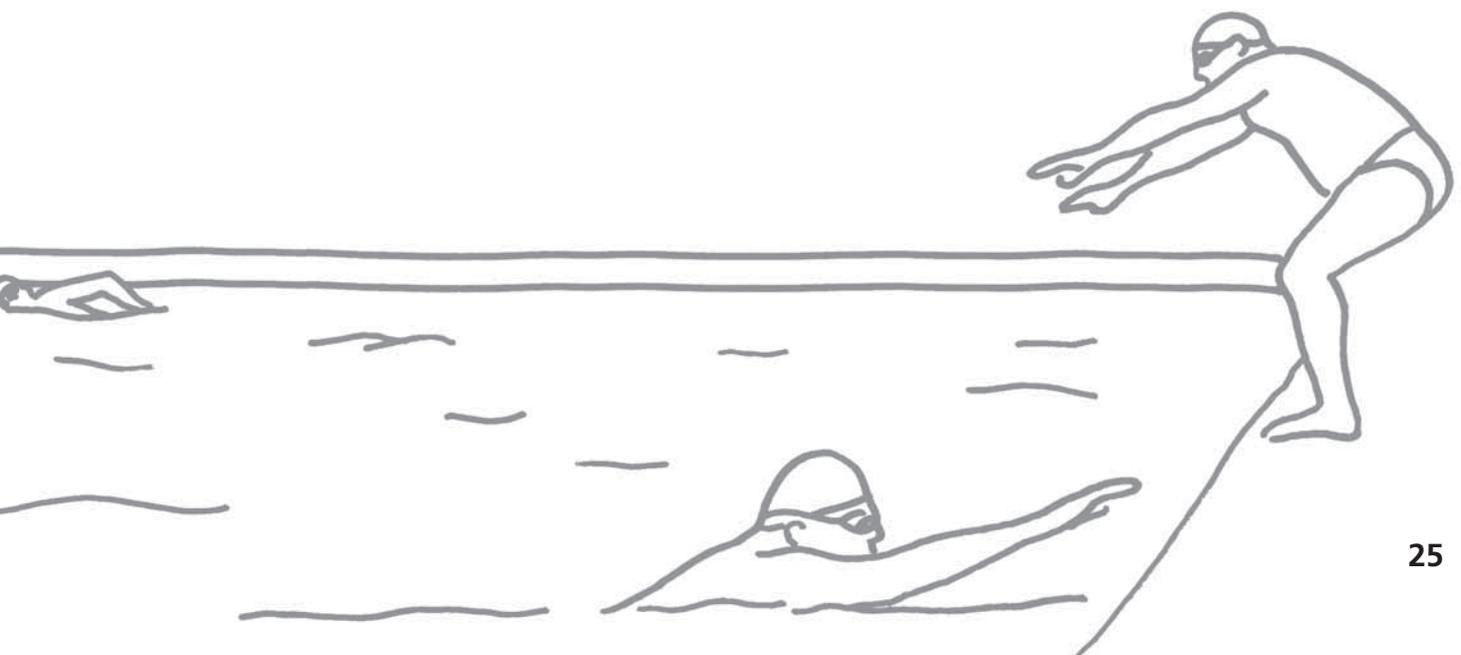
As the patient responds to these questions make sure you:

- listen actively and with curiosity;
- resist the tendency to jump in with advice; and
- let the patient do most of the thinking and talking.

Then summarise what you heard the patient say, and ask:

"What do you think you will do?"

Step 4: Having asked the patient "What do you think you will do?", you will find that some patients may be able to tell you exactly what they intend to do, there and then. Other patients may find it difficult to decide, therefore you may need to share some options with them and help them to choose.



For those patients needing further support in choosing what to do, it may be helpful to share with them several options.

You might say something like:

“Would it be helpful to explore the options? You could decide to:

a) stay as you are or go away and think about it a little more;

b) have a longer chat about becoming more active with a trained practitioner; or

c) set a simple goal for increasing your physical activity levels.

Can you think of any other options?”

“What do you think you will do?”

With the patient having identified their choice, you will need to take appropriate action. Table 2 below identifies the next steps for the practitioner following each potential patient choice.

Table 2: Summary of practitioner actions following patient choice

Patient choice	Suggested practitioner response
Stay the same – not ready to become more active yet	<ul style="list-style-type: none"> • Acknowledge patient decision • Tell them you would be happy to talk again if they become more ready
Go away and think about it some more	<ul style="list-style-type: none"> • Affirm decision: “It’s great you are thinking about becoming more active, it’s one of the most important things you can do for your health” • Offer some reading material to help them weigh up the pros and cons – perhaps the LGM pack • Suggest a date for talking further
Have a further talk about becoming more active	<ul style="list-style-type: none"> • Book session for the patient to have a longer LGM intervention • Arrange follow-up appointment • Provide the patient with the LGM pack
Become more active	<ul style="list-style-type: none"> • Explore options with patient • Help them set a simple physical activity goal • Arrange follow-up appointment • Provide the patient with the LGM patient support pack

Summary: This series of initial steps in the screening stage of the LGM protocol are further depicted in figure 4. To recap, the initial stages involve:

- Stage 1: Recruit;
- Stage 2: Screen:
 - raising the issue of physical activity;
 - assessing the patient's level of activity with the GPPAQ; and
 - feeding back the results in a non-judgemental manner.

And then depending on the results, either:

- congratulate them and reinforce their active lifestyle; or
- explore what the results mean to them.

When exploring what the results mean to them, enable the patient to reflect on the benefits to them of becoming more active. Then explore with the patient their ideas on how they might become more active and help them to choose what they want to do, then agree a way forward.

A practitioner's ability to adopt the above tried and tested approach in the delivery of LGM intervention is integral to the success of the intervention. This short series of initial steps takes a matter of minutes and, done well, can significantly influence the patient's likelihood of behaviour change.

Stage 3: Intervene

The principles and processes imbedded in stage 2 mean that in some ways you have already initiated the 'intervene' stage. Your ability to deliver the initial stages with fidelity and skill lays the foundation for positively influencing a patient to change their behaviour.

As we have already identified, it is possible that some of your patients are already reasonably motivated, confident and interested in changing their behaviour. Subsequently, through the initial series of steps you may be able to quickly assist the patient in setting a personalised physical activity goal.

If, however, the patient's response is quite ambivalent, a fuller intervention will be required. This is illustrated as option C on the LGM schematic (figure 4). This longer intervention continues to utilise an MI guiding style to encourage, rather than direct, and strengthen the patient's intrinsic motivation to change. To deliver this fuller intervention you must have completed the LGM module 2 training or an equivalent specialist MI training and be confident and competent in:

- exploring and building patient readiness and confidence;
- information exchange – in a neutral, patient engaging style;
- exploring patient concerns;
- exploring patient goals;
- exploring options;
- developing a collaborative plan including setting goals, relapse prevention, ongoing support and monitoring; and
- making arrangements for ongoing support.

Let's Get Moving patient support pack

If the outcome of the screening and intervention stage is that the patient has identified a personal physical activity goal, then you should provide them with one of the LGM patient packs. The majority of the pack includes motivational tools and decision aids that can be used during or after the intervention. It also provides patients with examples and experiences of other people who have become more active.

Furthermore there are inserts on physical activity opportunities in parks and green spaces and in facilities centres. These inserts can be customised to reflect local opportunities.

If the patient has chosen not to change their behaviour, or to go away and give it more consideration, it is recommended that they are provided with a generic physical activity leaflet and **not** an LGM patient pack.

Stage 4: Active participation

This stage does not directly require your involvement – but some patients will benefit from an amount of ongoing support, for example from a health trainer.

It represents an up to 12-week period between the 'intervene' and 'review' stages of the pathway where patients work towards their physical activity goals set during the 'intervene' stage. Physical activity goals will include 'unstructured' activity (for example walking, cycling, gardening, taking the stairs, etc), and 'structured' activity (for example walking groups, exercise classes, etc) that suits the patient's needs and interests them.

Examples of activities some patients will choose to set goals around include:

- active travel (walking and cycling for transport);
- recreational walking;
- recreational cycling (e.g. British Cycling-led Skyrides);
- local led walk groups (e.g. Walking for Health);
- dance classes;
- informal/recreational sport (e.g. frisbee in park, football with friends);
- swimming (e.g. free swimming or Blue Gyms);
- gardening and active conservation;
- introductory sports sessions (e.g. Get Back into Netball or beginners' badminton);
- local leisure facilities;
- condition-specific services (e.g. exercise on referral, falls prevention, cardiac rehabilitation); and
- community and third sector class and course programmes.

During this stage the LGM patient support pack can act as a helpful and motivating resource for patients.

Stage 5: Review

The LGM programme guides practitioners to follow up with their patients at regular intervals; 3, 6 and 12 months following the initial intervention (or more if deemed necessary). Ideally, this follow-up should be conducted by the practitioner who undertook the original LGM intervention.

During the follow-up intervention, you should reassess the patient's physical activity levels and check for any changes compared with when the patient started on the pathway. In this consultation you should build on the previous discussion with the patient in order to continue to develop their belief ('self-efficacy') in their ability to become and stay more active.

Following this you will need to re-complete stages two to four, continuing to implement an approach that is guiding and supportive, helping the patient explore the progress they have made towards their physical activity goals, as well as the difficulties they may have encountered and possible solutions to these.

It is important to remember that many people find it hard to become and remain sufficiently physically active to benefit their health, so the need for support and encouragement is to be expected.



Risks associated with increasing physical activity

If you have a patient who is not physically active, ask yourself the question: "Is this patient safe to remain sedentary?" In most cases, remaining inactive will harm the patient.

For practically all inactive patients:

- remaining inactive is likely to be seriously harmful to their health; and
- becoming more active is likely to benefit their health **significantly**.

For most inactive patients, becoming more active will be associated with a very small risk of:

- musculoskeletal injury;
- cardiovascular event; or
- metabolic disturbance.

During your discussion with a patient about becoming more active, you should consider that the risks associated with taking part in physical activity at levels that promote health are low. Higher levels of risk occur predominately among those exercising at vigorous levels, and in those taking part in contact sports and high-volume fitness training.

LGM aims to guide patients to gradually increase their physical activity levels. Therefore the type of activity the patient chooses to undertake is likely to be reflective of their personal interest and daily routine. Subsequently, practitioners may find that patients are more likely to choose activities of a health-promoting intensity (e.g. walking a couple of extra stops before catching the bus) rather than higher-risk vigorous activity (e.g. taking up squash).

Key health facts

The absolute risk of sudden cardiac death associated with moderate intensity exercise may be as low as 1 per 36.5 million hours of exertion.

The increased relative risk during a moderate intensity exercise session may be between 1.6 and 2.5 x (compared with no exertion).

Both these risks fall over time as people become more active.

As a practitioner you can further minimise the small risks associated with a patient becoming more active. By considering the information that you already possess about a patient's medical history, you can identify whether it is safe for a patient to begin or increase their activity levels. The patient's medical history can further assist you in using your judgement when guiding the patient towards appropriate types of physical activity. When guiding a patient towards increasing their physical activity levels, you should encourage the patient to:

- avoid vigorous intensity physical activity;
- start with light to moderate intensity activity;
- build up the intensity (to moderate) slowly; and
- stop exercising and seek advice if they develop new, worsening or uncontrolled symptoms, e.g. uncontrolled angina.

Furthermore, on considering a patient's medical history you may feel that they would benefit from:

- starting with a period of supervised activity, e.g. via an exercise referral scheme; or
- having some further tests, investigations or medication before becoming more active.

All people, irrespective of health, fitness or activity level, should increase activity levels gradually. People with low levels of habitual physical activity, who are unfit or who have existing disease, should pay particular attention to this.

Talking about risk

You want your patients to come to an informed decision about whether or not to become more active. You may have already shared with them the risks associated with being inactive – such as CHD, stroke, obesity and type 2 diabetes.

- How you talk to them about the risks of becoming more active may influence their motivation to become more active. Therefore, you may want to say something like:

“Now we have already discussed some of the health benefits you are likely to experience from becoming more active, but there are also some small risks. Do you know what these are?”

- That is, elicit what they know first. Then, depending on what they say:

“The main risks associated with becoming more active include musculoskeletal injury and heart problems, but both of these can be kept at very low levels by starting slowly and building up gradually. What do you make of this?”

- If the patient is concerned about the risks associated with becoming more active, consider using a double-sided reflection to communicate understanding:

“So on the one hand, you would like to protect yourself from several health problems by becoming more active, but you also don't want to make your health worse as you start the process of becoming more fit and healthy.”

- Then listen to what they say, seeing if they agree or elaborate. You could then offer to provide them with some more information:

“Shall we talk a little more about these risks, and how to reduce them?”

- Depending on what the patient says, you might say:

“The risk of someone like yourself developing a serious health problem while exercising is very low as long as you start slowly and build up gradually – perhaps as low as one serious health problem for every million hours of exercise – while your risk of developing heart disease or having a stroke is greatly raised so long as you stay inactive. What do you make of what I have just said?”

Summary and conclusions

Many common illnesses are caused, or exacerbated, by insufficient physical activity.

Most patients will benefit in multiple ways from becoming more active.

It is possible to increase a person's readiness and confidence about becoming more active quite rapidly by using empirically supported brief interventions.

Starting at low intensity and building up gradually keeps things safe for most unfit and unhealthy individuals.

Further training in motivational interviewing is available to help primary care staff get better at behaviour change.



Appendix A – Exercise: developing an evoking style

- Talker: share with the practitioner something you are thinking of changing (which could be your physical activity levels).
- Practitioner: ask the following simple questions. Listen carefully with a goal of understanding the dilemma. Give no advice.
 1. Why might you want to make this change?
 2. What are the three best reasons to do it?
 3. On a scale from 0 to 10, how important would you say it is for you to make this change?
 4. Why are you at ___ and not a lower number?
 5. How might you go about it, in order to succeed?



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