NHS London

LONG TERM CONDITIONS *MY BEST MOVE* PROJECT REPORT

Intelligent Health

go london

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ACKNOWLEDGMENTS

My Best Move in London was commissioned by NHS London within the 2012 Health Legacy Programme. The initiative was managed by Lily Makurah as part of the Long Term Conditions workstream.

Thanks are due to the clinical commissioning groups (CCGs) and general practices in London that have participated in the pilot of *My Best Move*. The work also benefited from guidance and advice from London's Directors of Public Health and London's Physical Activity for Health Leads Network.

Valuable advice was also provided by the members of the Health Legacy Long Term Conditions Steering Group who were:

- Shelley Aldred
- Tracey Baldwin
- Somen Banerjee
- Oliver Berman
- Mark Browne
- Eleanor Craven
- Rachel Flowers
- Sandy Gupta MD FR CP
- Dr Latha Hapugoda
- Shaaz Mahboob
- Kate Melvin
- Hilary Ross
- Helena Wright

Further thanks are due to Paul Stonebrook and Sarah Warby at the Department of Health (Physical Activity) for guidance at key stages of development.

A separate resource *My Best Move – Physical Activity and Long Term Conditions: A Guide for GPs* is also available for primary care teams

For more information on *My Best Move* in London please contact Lily Makurah: lily.makurah@nhs.net

For more information on the NHS London Health Legacy Long Term Conditions work stream and *My Best Move* in London please contact lily.makurah@nhs.net

EXECUTIVE SUMMARY

My Best Move was initiated and sponsored by NHS London and delivered by Intelligent Health, a company founded by Dr William Bird MBE, a General Practitioner (GP) with 20 years' experience of physical activity promotion in primary care. *My Best Move* aimed to increase physical activity in patients with long term conditions by training GPs and other health professionals to deliver physical activity interventions.

Between January and July 2012, training was delivered to 67 GP Practices across London. A total of 314 practice staff had been trained as at 7th August 2012. Of these, 167 are GPs or Lead GPs and 70 are healthcare assistants and nurses. In addition, 26 people from health promotion and 48 administration staff attended sessions.

A range of resources have been developed to accompany the training including the *Guide for GPs – Physical Activity and Long Term Conditions*.

One of the key challenges was that GPs had little understanding of the importance of physical activity in treatment and did not see it as a priority. This made the initial engagement process difficult and slow. However, once GPs had received the training, their viewpoint changed dramatically. GP practices who received training pledged to change their practice and some have already begun running dedicated physical activity clinics with unprecedented levels of patient referrals to walking programmes.

GPs' level of knowledge about the benefits of physical activity or how to use it to treat various long term conditions is very low. Not a single GP knew the current physical activity guidelines. This is because:

- the emphasis has been on obesity and physical activity is simply seen as a way to lose weight making it a secondary problem with less value to healthcare
- there is no training either as an undergraduate or post-graduate
- there is less importance placed on physical activity because it is harder to measure with no adequate cost benefit.

Pre and Post Training measures showed that the training had a significant impact on the importance attached by GPs and health professionals to the role of physical activity in treatment. Post training evaluation also showed that the training significantly increased their confidence in recommending physical activity to patients.

The evidence that had the most impact on GPs was that:

- low fitness was the single biggest single cause of mortality and obesity, in contrast, made very little contribution to all-cause mortality
- getting people who do less than 30 minutes a week to do more than 30 minutes a week is the priority
- increasing physical activity in the elderly is a priority and, for commissioners, has a rapid return on investment
- walking should be the first line treatment for every condition and this may be all that is required: walking has very few contraindications. Gyms, sport and exercise classes offer very little additional benefit and are generally unsustainable
- there is inconclusive evidence to recommend exercise referral schemes
- physical activity is both a potent anti-inflammatory and anti-ageing agent. This information transformed the way GPs viewed physical activity
- obesity is less important than inactivity. Patients only see physical activity as a way to lose weight and yet those who are 'fit and fat' will live longer than those who have a normal weight and are unfit
- physical activity prevents cancer and dementia and is effective in treating cancer, hypertension, diabetes, depression, osteoarthritis and COPD.

Continued demand from Clinical Commissioning Groups suggests that there is still an appetite for training GPs, especially in the light of new and emerging evidence about physical activity.

INTRODUCTION

NHS London was responsible for making sure the NHS in London was prepared for the Olympic and Paralympic Games and also, for capitalising on them to secure a health legacy for Londoners.

This report outlines the findings *My Best Move*, one of a range of projects developed by NHS London, as part of its work to secure a health legacy from the Games.

My Best Move aimed to train GPs to prescribe physical activity to patients with long term conditions. It was as designed to align with *Your Personal Best*, a national campaign developed by GSK, in association with NHS London, to inspire an increase in activity levels among people with long-term conditions aged over 55 through online information for patients and healthcare professionals.

My Best Move was commissioned following research which found that GPs in the capital didn't see the promotion of physical activity as their role but would welcome advice on encouraging patients with long-term conditions to be more physically active. It aimed to raise awareness among GPs of the benefits of physical activity on health and also of the risks of inactivity, building their confidence in recommending physical activity in the management of long-conditions.

A target of recruiting at least two GPs from each borough was set and the project was scheduled to run during 2012 to build on the buzz generated by the London 2012 Games. The project had a significant impact on how important healthcare workers felt it was to recommend physical activity to patients and also, their confidence in recommending it.

BACKGROUND AND CONTEXT

Project partners

My Best Move has been funded by NHS London to equip a pilot sample of GPs and general practice staff in London with the knowledge and skills to improve the use of physical activities as part of the treatment of long term health conditions. NHS London contracted Intelligent Health to design and deliver the intervention during the pilot phases. NHS London is the strategic health authority for London. Intelligent Heath is a company with many years' experience of promoting physical activity in primary care and within schools and communities.

Informing the development of *My Best Move*

My Best Move was developed through a combination of:

1. Social marketing research with GPs in Kingston, Newham and Enfield (undertaken by Kate Melvin)
2. Consultation with the following groups and organisations and individuals:
   - Directors of Public Health in London
   - The Physical Activity Team at the Department of Health who provided advice on alignment with *Let's Get Moving*
   - NHS London Health Legacy Long Term Conditions Steering Group (members are listed in acknowledgements)
   - The first ten practices to be trained who gave their extensive feedback
     - Allenson House Medical Centre, Haringey
     - Star Lane Surgery, Newham
     - Elm Trees Surgery, Haringey
     - Maswell Park Surgery, Hounslow
     - Tulasi Medical Centre, Dagenham
     - Highgrove Surgery, Dagenham
     - Hillview Surgery, Ealing
     - Westbury Surgery, Newham
     - Chiswick Health Centre, Hounslow
     - Lawrence House Surgery, Haringey.

Project aims

There were three overarching aims for the project:

1. To engage 150 GPs with a programme of work designed to help them promote physical activity to patients with long term conditions by heightening their knowledge of the potential benefits of physical activity and building their confidence in recommending physical activity.
2. To complete the design of a social marketing informed project that provides general practices with the tools to become more active.
3. To provide NHS London with a demonstrated model (trialled in at least two GP practices per London borough) that can be presented by NHS London to the London Health and Wellbeing Board, Clinical Commissioning Groups and others for future funding.

Rationale for the *My Best Move* pilot

The social marketing research supporting *My Best Move* indicates that some previous physical activity initiatives have attempted to embed physical activity in primary care with limited success. The pilot was intended to align with *Let's Get Moving*, an evidence-based physical activity care pathway. *My Best Move* was designed to bridge the challenges which the implementation of *Let's Get Moving* has faced, in particular slowness to develop in primary care. The reasons for this, as highlighted in the research are as follows:

- many GPs do not see the promotion of physical activity as their role
- the pathway was seen to be bulky and difficult to implement in primary care
- to deliver it in house it relied on staff undertaking a two day motivational interview course
- the communication between primary care and local authority is often poorly established.

The pilot was intended to highlight the benefits of incorporating physical activity as part of the treatment plans for a number of chronic health conditions. The pilot design took into account the release of the first set of UK wide physical activity guidelines produced by the Chief Medical Officers for England, Scotland, Wales and Northern Ireland. The pilot took into account the new and growing body of evidence that physical activity has clinical as well as social benefits for people with long term health conditions.

The investment was made after considering the economic case provided by the potential benefit to improving the health of people with long term conditions. By timing the pilot to coincide with the national *Your Personal Best* campaign, which GSK developed in partnership with NHS London, the scheme was tailored to address gaps in GP skill/knowledge highlighted by the national work.

The design of the pilot emerged after review of the findings of the social marketing research with GPs. In addition, the preparations considered the successes and challenges of existing GP referral and *Let's Get Moving* initiatives along with informal recommendation and use of Dr William Bird's prior experience of promoting physical activity in primary care. The need for a simpler and more pragmatic approach was supported by the steering group as the route to creating a more effective approach.

PROJECT DEVELOPMENT

Engagement of Clinical Commissioning Groups and Recruitment of GP Practices

During the scoping phase of the project, we identified that that Directors of Public Health felt that the endorsement of the Clinical Commissioning Groups would be crucial to *My Best Move* success and its long-term sustainability. Clinical Commissioning Groups are the likely future commissioners of this work and, at the beginning of the project, there was still an expectation that physical activity would be included in the Quality Outcomes Framework (QOF) under hypertension and that this would also be a driver for future roll out.

The first step in the recruitment process was to secure a slot on CCG meetings in as many of the London boroughs as possible to introduce *My Best Move* to the group and ask for their endorsement and support and suggestions for which specific GP practices to approach to take part. The CCGs also have representatives from public health and local authorities, meaning that multiple partner buy-in could be secured at an early stage in the local project roll out.

Fig. 1 This chart gives a typical picture of the average timeframes between the various contact points with the surgeries from initial contact to training booking

LESSONS IDENTIFIED **1**

In retrospect, it emerged that securing a slot on a CCG meeting agenda was sometimes difficult, mainly due to many competing priorities in this time of great change within the health sector and the long lead in times required. Also, as a small team, we found that meetings frequently took place on the same day in multiple boroughs.

The NHS London Health Improvement Legacy lead wrote to all CCG leads explaining the rationale for *My Best Move*, including a summary of the objectives and proposed physical activity treatment pathway which is included at Appendix 1. The request was that they provide an opportunity for Lily Makurah (NHS London) and Dr William Bird to present in more detail about the project at a forthcoming CCG meeting. This method secured a slot at CCG meetings in 15/33 boroughs.

Without exception, the project was received enthusiastically by CCGs where it was introduced and a commitment was secured from them to find at least two GP practices to receive the training. However, this enthusiasm sometimes took longer than expected to translate into action. Fig 1 (above) shows the time-lag between initial engagement of the CCG, first contact from a local practice and actual training delivery in a selection of boroughs.

In some cases this happened very quickly, usually where practices volunteered themselves at the CCG meetings which they were attending. Three boroughs have asked for

My Best Move to be offered to more than two practices and have requested larger training events to ensure that the messages are received by the majority of GPs in their boroughs. We are currently exploring the value and usefulness of this approach and tailoring the training session for delivery in this different setting.

LESSONS IDENTIFIED **2**

We have learned that capitalising on the momentum built at the initial engagement of the CCG is important as the enthusiasm soon wanes once other agenda items take precedence. How the programme was introduced to GPs also needed to be tailored to the local cluster's agenda, for instance non-Olympic Boroughs were less interested in the link with 2012 and many CCGs, whilst sympathetic for the need for branding, felt that GPs and nurses would feel that the brand would only have credibility to the scheme. These CCGs were more convinced by the intrinsic value of the approach of *My Best Move.* The brand of NHS London added impartiality and was received well. London 2012 attracted attention but was seen to opportunistic and GSK was seen to be neutral as professionals felt that GSK was delivering an area of health that was under-represented and this they appreciated. A clear explanation of the strategic fit of the project is important, however, the most salient driver for the CCGs proved to be the value of the programme for their patients and its ability to help them deliver better healthcare.

Many patient organisations have been associated with *My Best Move* and this was seen to be helpful in maintaining credibility although GPs would not see the number of brands as a measure of success of the scheme.

LESSONS IDENTIFIED **3**

We have learned that the person who speaks to the CCG needs to be assertive and informed and be respected in this field of work.

Lead-in times need to be realistic to reflect the logistical constraints of securing multiple bookings with GP practices. For instance, to ensure the attendance of the majority of the practice staff, we recognised the importance of delivering in situ, to tie in with existing practice staff meetings. These often occur at the same time of day (lunchtimes) on the same days of the week or month across practices and boroughs, meaning that we could deliver no more three training sessions per week. This led to the programme being extended by four months to try reach the original target of 65 practices across 33 boroughs.

Devising and structuring the training and manual

The initial scoping exercise highlighted the areas of learning that would benefit GPs. In particular, these included a review of new evidence on the benefits of physical activity for prevention but in particular for the treatment of long term conditions. A chief concern was the 'how to' implement a physical activity intervention and how to sustain that intervention. The training was therefore devised to consist of four key components:

1. Information for GPs that explains how physical activity can be promoted for each long term condition including mechanisms and contraindications.
2. Consistency about how to diagnose physical inactivity
3. How to deliver a brief intervention to encourage the patient to change their behaviour
4. How to signpost the patient to suitable activities near to the GP practice.

A pragmatic approach to devising the training was adopted in recognition of the limited time that GPs would have available – in most cases 60 minutes at the most to fit in with usual practice meeting time allocations. This meant that the content needed to be presented in as succinct a format as possible and supporting information and references provided for post-training reference. The format for the training was a Powerpoint presentation, frequently presented informally and with discussion and questions encouraged throughout. (An example presentation is shown in Appendix 2). We also used the 9 minute video titled *23½ hours* by Professor Mike Evans (www.youtube.com/watch?v=aUaInS6HIGo) as an ice-breaker and a simple way of conveying key messages to come. Its popularity as a You Tube hit with 2.3 million views and its engaging style mean that it has proved to be a useful tool for conveying key messages on this topic and it is suited to a mixed audience.

LESSONS LEARNED **4**

The training evolved over the first 15 sessions away from an emphasis on the physiology of exercise and towards a simpler and more pragmatic approach, tailored to the audience. The need for flexibility in the delivery of the training was crucial and time allocated to the training was frequently cut short because of GP commitments or the need to adapt to the limitations of the physical space available (often the training was held in the surgery waiting room).

Due to the experimental nature of this project, we decided to develop the training by testing the format with the first 15 GP practices we visited, constantly adapting, changing, distilling and, above all, simplifying the key messages and content. An additional challenge was the fact that the whole practice was invited to the training session, meaning that there was a wide range of background knowledge and skills amongst participants. However, for the whole practice to fully engage with the programme, we learned that it was important to have all staff present and explain their various roles in the process; e.g. GPs 'kick start' the process with their patients by highlighting the importance of physical activity for their condition and commence the behavior change process, Health Care Assistants and Nurses continue to offer support (and sometimes further motivational interviewing) and administration staff ensure that information is made available at the point of decision making by the patient.

Feedback from Training Session, Allenson House Medical Centre, Haringey – Training 17th January

Email from Justin Mason, Practice Manager

"The structure of the training was very well put together. It was contained to approx an hour, it didnt blind anyone with useless statistics, it was to the point and very very informative. So often GPs have these sessions and it becomes pointless or just paper pushing exercises and they just don't have the time to go to those kind of meetings but this was very practical and I know Dr Young and Karen our nurse also found it very useful. A lot of companies and training sessions could learn a lot from you and your team."

Dr William Bird delivering a training session at the West London Medical Centre, Hillingdon

An accompanying manual for the training has been produced with NHS London. *My Best Move – Physical Activity and Long Term Conditions: A Guide for GPs* brings together the latest evidence, contra-indications and recommendations for specific conditions and advice on behavior change in a ready-reference guide for GPs. It is designed to accompany the 60-minute training session rather than replace it. See Appendix 3.

Key learning which resonated with all trainees and which came as a surprise to many were:

1. The fact that physical activity is 'anti-inflammatory'; a fact which places it into the disease process and therefore makes it relevant to treatment and GPs.
2. The first 30 minutes of activity are the most important; i.e. going from doing nothing to just 30 minutes per week will have the most impact at a population level.
3. Fitness is more important than weight loss in terms of population health. This point was often debated at great length and practice staff were reassured that they could 'de-couple' weight and exercise as they often felt patients became demoralised once they started exercising because weight loss was slow. Being able to reassure patients of the 'better to be fit and fat' message was perceived as very useful.
4. Ageing is not a reason to slow down – in fact exercise becomes even more important.
5. The importance of reducing sedentary behavior and the potential damage that sitting for long periods of time may cause.
6. The 2011 Chief Medical Officer guidelines – in particular the new messages about sedentary behaviour.
7. Physical activity is as effective in reducing blood pressure, depression and HbA1C as medication.
8. Cancer patients should continue or start to be active on diagnosis particularly if they are undertaking chemo-therapy or radiotherapy.
9. Increased walking is as good as almost all other activities yet is considerably safer than remaining sedentary.

Many training sessions resulted in practice staff adopting the messages and implementing them at a personal level with several practices pledging to run staff challenges. Many doctors said that they would henceforth collect their patients from the waiting room rather than call them over the tannoy system.

Additionally, it should be noted that there was a total absence of any concerns expressed from GPs or practice staff about liability or legal comeback from patients despite the fact that this is often perceived (by public health) as a barrier for getting GPs to recommend activity.

The training now consists of training notes and supporting resources found in the appendices:

- Background to physical activity and population risk
- Disease specific information: two minutes on each condition at most. Highlighting interesting points and memorable facts (e.g. breast cancer reduced by 23%) but signposting to more information rather than overloading
- Behaviour change – an introduction to motivational interviewing. Explanation of what it is and illustration of a few quick techniques (decisional balance tool, importance/confidence ruler)
- Where to signpost people locally. This section benefits from the attendance at the training of a representative of a local delivery agent, e.g. health walks lead or local physical activity lead.

Training delivery

The majority of training was initially delivered by Dr William Bird with two sessions delivered by Veronica Reynolds from Intelligent Health, a physical activity expert with training experience.

The presence of a representative from public health and, in particular from the local delivery agencies of physical activity (health walks leaders, local authority physical activity leads) was judged to be an essential component of the training. This enabled GPs to understand better what was available for their patients locally and to meet the person who would be helping them on the next part of their journey towards an active lifestyle. However, it was important for that person to understand the limitations of GPs to be able to retain and disseminate large quantities of information about physical activity opportunities so this needed to be distilled and presented in a simple format. The best and most accepted course of action was for that person to provide GPs with one simple leaflet and telephone number which they could then pass onto patients. The local provider could then talk through the options of opportunities with patients rather than over-burdening GPs with this task.

Surrey Docks, Southwark – 27 February

Email from Dr Noel Baxter, Lead GP

"We all felt quite galvanised by your talk. Pat, our senior partner is now busy titrating his daily antioxidant levels.

I myself have discovered two patients this week who have been phobic about activity because of their predisposition to/fear of sweating. I hadn't before really explored this as a blocker before so that was really important learning for me. One of them has taken the step-o-meter on loan for a week.

How do we make it acceptable to sweat a bit? I have noticed over recent years that more colleagues who cycle in London to meetings are now arriving sweating with a mixture of embarrassment and self deprecating humour. The London respiratory team has quite a number who arrive on bikes so it makes this scenario easier now.

We have included all three actions you have proposed on our draft action plan and a few more. Eilidh and I will develop these over the coming weeks and let you know how we are getting on."

LESSONS IDENTIFIED **5**

There was sometimes a misunderstanding between representatives from public health or local authorities who felt frustrated at the perceived lack of GP interest in their programmes and the GPs who, whilst keen to help patients, found the referral method and plethora of activities confusing. There is a need for public health to be more nimble and responsive to the needs of primary care. This might be achieved through either more focus and emphasis on patient treatment and/or through additional training. *My Best Move* training sessions proved to be a useful opportunity to break down some of these tensions and explore new ways for public health and GPs to work together more closely.

Endorsement from experts

This pilot was about understanding the need of primary care to be able to deliver physical activity as effectively as possible. We sought endorsement from experts so that GPs would be assured that:

- evidence is up to date and unbiased
- current local and national protocols are being followed
- any solution is openly available and not restricted to a specific product.

Our experience is that endorsement of other organisations and clinical leaders has very little impact at this formative stage as it is the quality of evidence that is scrutinised by GPs. If this has been reviewed by a reputable medical journal or an organisation representing the Government (such as NICE) then this offers reassurance to those GPs who are less familiar with original studies. There was considerable debate about the evidence suggesting cardio-respiratory fitness being a more

powerful predictor of mortality than obesity. This was mainly because it questions current policy and has major implications in primary care.

My Best Move – Physical Activity and Long Term Conditions: A Guide for GPs

When writing the booklet as a guide to physical activity it is very important that the correct endorsement is received. This because very specific guidance is being given and GPs and nurses have to be convinced that the above four benefits have been covered.

All clinical chapters have been reviewed by clinical experts including GPs consultants and physiotherapists. This is important to ensure that the review is relevant, accurate, unbiased and practical. The endorsement from major patient groups is helpful but not as important as good evidence or a statement from the National Institute for Clinical Excellence. Endorsement or sponsorship from a pharmaceutical company would probably be unhelpful.

LESSONS IDENTIFIED **6**

We under-estimated the time it takes to create the booklet. However, much of the content changed as we received feedback from GPs during training. Each clinical chapter took between two and three weeks to write and get feedback and reviews from experts.
We think it was correct for one person to write the main body to maintain consistency but we could have created a timetable and identified reviewers.

Patient's Leaflet

The creation of a patient leaflet was not part of this original contract but many practice staff felt that this was required. Whether it is condition specific or generic will have to be decided.

Influence on other projects

My Best Move has been a catalyst to bring together other groups looking into promoting physical activity in primary care. *My Best Move* is working closely with:

- **British Heart Foundation National Centre for Physical Activity and Health** based at Loughborough University who are leaders in promoting physical activity in the UK. They are currently working on a risk assessment called PARQ plus that will help stratify patients into risk groups. *My Best Move* and the British Heart Foundation will work together to ensure that both sets of work can integrate together.
- **Faculty of Sports and Exercise Medicine**. There has been very close working with Sports and Exercise Medicine registrars and the Faculty will sign off the final draft of the GP booklet.
- A team from **Oxford University** is developing an algorithm to help refer patients for physical activity. This will need to be carefully researched as many of these algorithms have failed at the point of being used by the clinician. *My Best Move* will be working with Oxford to ensure that this is a successful initiative,
- **The Royal College of Physicians** are developing a document called *Exercise for Life* and *My Best Move* will ensure that these are integrated together.
- The **Department of Health** have reviewed *Let's Get Moving* and *My Best Move* provided a considerable amount of information to help the department review this. *My Best Move* is also in continuing dialogue with the Responsibility Deal.

PROJECT RESEARCH / EVALUATION

Assessment of general practice understanding of evidence on physical activity and long term conditions

This evidence was collected using post-training feedback forms and based on discussions between Dr Bird and the participants.

Knowledge

All GPs knew:

- That physical activity is a strong risk factor for cardiovascular disease and diabetes. Beyond this the knowledge was mixed.

Most but not all GPs knew:

- That physical activity can be used to treat depression, hypertension, diabetes and can offer secondary prevention in coronary heart disease.
- That it is not necessary to belong to a gym or undertake sport to become more physically active.

Some GPs knew:

- That physical activity was a risk factor for bowel cancer and depression. However few knew about the benefits of physical activity to prevent dementia, breast, prostate and endometrial cancer.
- Arthritis required more not less activity to reduce pain and dysfunction.
- That physical activity is equal to cholesterol and hypertension as a risk factor for cardiovascular disease.

Not a single GP knew the following:

- The Department of Health guidelines. Many were not even close with only about 10% mentioning 5 x 30mins.
- That physical activity is equal to smoking, as a risk factor for cardiovascular disease.
- That physical activity is as effective as medication in reducing HbA1C
- That the main effects of physical activity were anti-inflammatory and creating cellular anti-oxidants.
- That physical fitness was more important than obesity in all-cause mortality.

Current practice

The quantity of referrals to physical activity schemes depended on the local area. However in comparison to other services, GPs referred few patients for physical activity. Many GPs recommend that patients should be more active and some advise walking or exercise classes. However this is almost exclusively for primary rather than secondary prevention.

GPs appear to have no connection with Cardiac Rehabilitation with no GPs we met referring patients directly. Referrals appeared to be entirely generated by secondary care. Pulmonary Rehabilitation was very patchy with few GPs being aware of the service and fewer still referring patients directly. Again this appears to be from secondary care.

Exercise referral was used more frequently but there were complaints about the following:

- Knowing what form to use and for what scheme
- Difficult and long referral forms
- Long waits from referral to the first session
- Feedback about the patient's progress

However, some boroughs were much better than others in streamlining the referral and it was beyond the scope of this project to identify the heroes and villains!

Types of GP Practice

We visited practices of varying size from large polyclinics with up to 14 GP partners to single-handed practices. There appeared to be no difference in size or type of practice in identifying who came forward to take part in the training, knowledge or enthusiasm. However there was a trend in that the more deprived boroughs were keener to be involved (Newham, Haringey, Hounslow etc). Practices in the more affluent areas were more likely not to return calls or say that they were too busy. This is of course anecdotal but there may be an underlying difference in attitude to the so called lifestyle factors by GPs according to the socio-demographics of the population served.

Staff training

In all practices visited the practice nurse was included in the training. In most practices, the practice manager stayed for some of the time. In 30% of practices receptionists and administrative staff were included. These sessions were the most lively with evidence, medicine and local knowledge mixing together to create practical solutions to the problem of inactivity. Many staff volunteered to become more active themselves.

Patient participation

Patients were not included in the training. The suggestion to practices was for the patient participation group to be involved with identifying what activities are ongoing in the very local area.

Some practices were keen to set up local health walks with staff or patients leading them. In terms of other activities, we found that there was no simple way of helping patients identify the local opportunities other than going onto a website or visiting

the leisure centre. On review, the training team found that even bespoke London-wide physical activity and exercise websites were not tailored or comprehensive enough to be used as a 'one-stop shop' for physical activity. This was also a major barrier for the staff in each practice in recommending the most appropriate activity.

Influence of similar GP training projects

Let's Get Moving is an evidence based physical activity referral pathway developed by the Department of Health to ensure consistency in recruitment, motivational interviewing, signposting and a structured review of. The General Practice Physical Activity Questionnaire (GPPAQ) is the main measure of physical activity used by *Let's Get Moving*. The uptake of *Let's Get Moving* has been disappointing with most GPs either unaware of its existence or finding it complicated to use in such a short time. Another barrier is the need for staff fully trained to deliver motivational interviewing.

The motivational interviewing helps to resolve ambivalence in a patient. Staff wanting to deliver motivational interviewing have to receive training over a two-day course. Although it is highly effective in changing behavior, few practices have funded the training for their staff.

General Practice Physical Activity Questionnaire (Appendix 4) The General Practice Physical Activity Questionnaire was created using data from the EPIC (The European Prospective Investigation into Cancer and Nutrition) trial in the East of England. It is based on cardiovascular risk only and excludes walking, gardening and housework but does include cycling, vigorous activity and workplace activity. It is the main outcome measure of physical activity for health checks. We found many GP practices having trouble in using the General Practice Physical Activity Questionnaire because patients need help with the questions and the questionnaire is unable pick up those who are fully active through walking.

Exercise Referral or Exercise on Prescription has been popular amongst GPs and started in the late 1980s. Patients with certain conditions such as hypertension are referred to the local leisure centre gym and supervised by suitably qualified instructors. There have been few high quality studies and the recent systematic review (www.hta.nhs.uk/fullmono/mon1544.pdf) by the NHS failed to find any conclusive evidence that it can sustainably increase physical activity.

Green Prescription originated in New Zealand (www.sportauckland.org.nz/) and allows GPs to "prescribe" a fixed regime of outdoor activity for certain conditions. This is written down in a similar format to a normal medication prescription but the dose and frequency are related to physical activity.

Exercise is Medicine originated from the American College of Sports Medicine and provides a simple template and website (www.exerciseismedicine.org) to encourage physicians to recommend physical activity as part of the treatment for Long Term Conditions. It has been developed in many countries worldwide.

Evaluation and findings

Given the experimental nature of this pilot project, evaluation has focused primarily on process and lessons learned and on monitoring against the delivery objectives of 65 GP practices trained by end August 2012. (Extension from end of April due to logistical constraints – see above). Discussions took place between Intelligent Health and NHS London to identify the potential scope of an outcome evaluation of the project and the possibility of showing impact of the training in terms of numbers of patients receiving a physical activity intervention. However, we soon established that a systematic outcome evaluation of this nature was not appropriate or possible given that the project was still very experimental. It was likely that such an outcome evaluation would not yield particularly useful data and that it was more important to explore how the programme could be further developed to engage a wider audience at this stage.

Various different instruments were used to monitor the project and record lessons learned:

1. A project planning spreadsheet recording contact with Clinical Commissioning Groups, GP practices and public health representatives and used to record and track engagement, bookings and delivery of training to practices
2. A full attendance register of all trainees and sessions
3. A contact timeline
4. A post-training assessment sheet completed by the training team, recording e.g. demographic information about the practice and staff, pertinent comments from practice staff, unusual experiences or comments and key areas of interest and recording which system (EMIS, Vision1) is currently being used by the practice and whether they have the General Practice Physical Activity Questionnaire installed (see Appendix 4).
5. An importance/confidence ruler to capture trainees degree of importance attached to this subject and their confidence in delivering a physical activity intervention (pre and post training).

Impact on patient care

We initially wanted to track the impact on patient care using the General Practice Physical Activity Questionnaire or tracking patients in the community. This proved both unrealistic and unhelpful for the following reasons:

- The General Practice Physical Activity Questionnaire is not generally liked by most GPs and they are particularly concerned that patients are being graded inactive even if they have been walking considerably. The General Practice Physical Activity Questionnaire is being used as part of health checks so is now familiar but they say that patients do not find it easy to use.

- Following a patient into community activity is both expensive and complex.
- This project is very much a pilot and therefore exploratory. It is unlikely at this stage for a major shift to be seen in GP behaviour.

The evaluation was not designed to capture evidence about the impact that the training had on patients' attitudes to becoming more physically active or on their actual physical activity levels. A study of this type is beyond the scope of the current approach of testing the feasibility of the roll out of a training programme. However, the case study featured below summarises the approach and impact which the training led to in two Newham practices. Without doubt the physical activity clinics set up in the surgeries in Newham have been the most successful intervention seen. These will be studied in more depth to see if the cost benefit analysis is favourable for a general roll out.

Impact on GPs' confidence to recommend physical activity

We decided to use the importance/confidence ruler to give a quick snapshot of GPs and practice staff's experiences of delivering physical activity interventions. As it is a tool which we recommend for use during motivational interviewing sessions, we felt it might be useful to introduce it and use it to capture a measure of the impact of the training session. Initial versions were adapted to make them less ambiguous as it was apparent that trainees did not always understand what they were being asked without a fuller explanation.

Data from 112 participants using the new form was analysed.

Fig 2. Importance/Confidence Rule (Appendix VII)
These results suggest that the training has had a significant impact on GP's and Nurses' confidence in carrying out a brief intervention and the importance they attach to physical activity in primary care

Comparing overall average differences in importance rankings

In the sample of 86 people who answered at both time points, the average importance score was 7.8 before training and 9.3 after training. This was a statistically significant change ($p<0.001$, two sided paired sample t-test to compare means at 95% level of confidence).

Comparing overall average differences in confidence rankings

In the sample of 85 people who answered at both time points, the average confidence ranking was 6.2 before training and 8.5 after training. This was a statistically significant change ($p<0.001$, two sided paired sample t-test to compare means at 95% level of confidence).

There was a statistically significant difference in the changes in confidence reported by various professional groups.. Nurses were slightly more likely to experience a very large degree of confidence change. Healthcare assistants were likely to say they had experienced only very minor levels of change. Some nurses appeared to experience the largest levels of change, but the sample size was small.

Ouputs from *My Best Move*

Detail of the locations of practices that committed to training by July 2012 are contained in Appendix 5. The training has been delivered to 67 practices across 22 of the 33 boroughs as at 6 August 2012. A total of 314 practice staff have been trained as at 7 August 2012 of these 167 are GPs or Lead GPs and 70 are healthcare assistants and nurses. In addition 26 people from health promotion and 48 administration staff attended sessions.

Fig 3. Distribution of various people trained

Telephone follow-up survey

We had initially suggested a follow-up survey with GP practices four to six weeks after the training sessions. An attempt was made to do this with the first ten practices but proved very difficult and resource-intensive. The GPs did not want to be burdened with telephone calls and none returned calls despite several messages. To progress the project, this method was therefore abandoned.

Two successful telephone calls indicated that the training had had an impact on practice staff. Furthermore, the information it was yielding was not particularly surprising or useful. There was inconsistency in the mechanisms used by practices to record patients who had been given a brief intervention and the *My Best Move* evaluation working group decided that this evaluation method was not robust nor particularly useful. However, it is recommended that future interpretations of *My Best Move* do attempt to collect data systematically, from General Practice Physical Activity Questionnaire data where possible, on the number of patients who receive an intervention. This would pre-suppose that all practices visited received support in the installation and continued input into the various systems used. A similar follow-up survey with physical activity leads would be useful in the future to establish the impact of the intervention on their participant numbers.

Perhaps a key outcome of the *My Best Move* project is the fact that three boroughs have already indicated that they would be interested in commissioning additional training. These are Lewisham, Greenwich and Islington.

Discussion and implication of findings (including for legacy)

1. In common with other schemes it was found that a full impact evaluation of *My Best Move* would require significant resource which was beyond the scope of this current pilot. However the impact on health professionals' knowledge and confidence was enough to warrant a continuation of an intervention of this kind as there is clearly a gap in their training when it comes to the benefits of physical activity.
2. Even with local Clinical Commissioning Groups the practicalities of organising training sessions within general practice are often much more burdensome than anticipated and lead in times for booking training sessions can sometimes extend to weeks or even months. Certainly, delivering training in situ in the practices themselves alleviates some of the issues with GPs attending training within their working day, however, future interventions could explore other delivery methods and approaches
3. Undoubtedly, the presence of a fellow GP was helpful in engaging doctors and reassuring them that we understood their agenda, concerns and priorities. However, it is now becoming clear that, due to the value of the messages being delivered and the importance of physical activity in the treatment and care of patients, whilst desirable, the trainer need not necessarily be a GP. A well informed and competent trainer with charisma who understands GPs, the dynamics of general practice and the primary care setting and who knows the subject would be equally well-received.
4. Whilst the optimum length of training session if probably 90 minutes to cover all the elements, in reality, this is probably unrealistic given the time constraints in a busy practice. The training needs therefore to be flexible and complemented with other materials, e.g. the booklet.
5. It is understood that the time that a GP can actually spend on brief intervention with a patient is usually limited, therefore full Motivational Interviewing is probably unrealistic in this setting. However a GP can start a patient on the right path for behaviour change.

Considerations for further pilots and research

This was a pilot which generated a number of ideas for further pilots and research as follows: .

1. To increase the speed with which general practitioners are trained further pilots could consider using online materials and tools to support learning and continuous professional development. Other approaches to explore include 'train the trainer' and franchise models.
2. To consider extending the knowledge base beyond general practice by delivering the training to additional professional groups such as pharmacists
3. To consider developing a whole-city approach to promoting physical activity with training for a more diverse group of professionals such as physical activity leads and podiatrists.
4. To consider using new technologies to help general practitioners raise the subject of physical activity in consultations and also to monitor patients behaviour change.

Recommendations

1. NHS London / Intelligent Health to distribute the *My Best Move* book to all GPs who have received training and systematically gather feedback to understand how the book can be improved
2. Intelligent Health to incorporate feedback and other expert comments about the *My Best Move* book into the second edition that will be published in March 2013
3. NHS London to discuss with Clinical Commissioning Groups funding the training of some local GPs to provide *My Best Move* training to local practices in the Clinical Commissioning Group.
4. Department of Health to set up a working party to assess whether the General Practice Physical Activity Questionnaire is fit for purpose or whether other validated measures are more appropriate.
5. Department of Health to discuss with BMA and NICE whether the inclusion of physical activity in QOF is appropriate for 2013.
6. For NHS London to explore the use of technology to enhance the promotion of physical activity by London GPs.
7. For NHS London to discuss with the London deanery whether physical activity is taught to post-graduate doctors (particularly GP registrars).
8. For Department of Health and NHS London to set up a working party to assess whether the level of teaching about physical activity is being delivered in undergraduate courses.

APPENDIX 1

NHS London

My Best Move

London's Physical Activity Treatment Pathway

There is strong evidence that physical activity can prevent many long term conditions (Table 1).

However there is now growing evidence that physical activity can also **treat** these conditions (Table 2)which in some cases can be as effective as standard medication. NICE recognises this shift in evidence and recommended that physical activity should be included in QOF although after negotiations this was not accepted by the BMA[1] for 2012/13.However physical inactivity remains one of the five big risk factors for long term conditions equal to smoking, obesity and hypertension. Given this increasing importance of physical activity NHS London is inviting interested GP practices to sign up to My Best Move, a short training programme currently being delivered to GP practices across London, to encourage patients to become more physically active. This is based on Let's Get Moving[14], a physical activity care pathway developed by the Department of Health. We hope it will become one of the main legacies of the Olympic and Paralympic Games to increase physical activity throughout London.

Table 1*Physical activity and risk reduction*[3]

Disease	Risk reduction	Strength of evidence
Death	20-35%	Strong
CHD and Stroke	20-35%	Strong
Type 2 Diabetes	35-50%	Strong
Colon Cancer	30-50%	Strong
Breast Cancer	20%	Strong
Hip Fracture	36-68%	Moderate
Depression	20-30%	Strong
Alzheimer's Disease	60%	Moderate

The four stages of My Best Move are:

1) Information for GPs that explains how physical activity can be promoted for each long term condition including mechanisms and contraindications.
2) Consistency about how to diagnose physical inactivity using GPPAQ[2].
3) How to deliver a brief intervention[15] to encourage the patient to change their behaviour.
4) How to signpost the patient to suitable activities near to the GP practice.

What will the practice have to do to be signed up?

There will be one training session of 90 minutes for GPs and nurses to understand;

1) How to use the GPPAQ and offer a brief intervention.
2) How physical activity can be used to treat the main long term conditions.

Table 2: Examples of how physical activity can benefit six long term conditions

Type 2 Diabetes:[4]Physical activity can significantly reduce HbA1C even without associated weight loss.
COPD:[5,6]Physical inactivity is the strongest predictor of mortality in patients with COPD.
Asthma:[7,8]Regular physical activity can help reduce asthma exacerbations.
Depression:[9,10]Physical activity is an effective treatment and can help prevent recurrence. It is often combined with other forms of treatment.
Osteoarthritis:[11,12]Light to moderate activity protects joint cartilage, reduces pain and increases function
Coronary Heart Disease:[13]Patients with CHD have a 30% lower mortality if they remain physically active. At greater intensities, regular activity can reverse plaque formation.

Success will be measured by the number of inactive patients being signposted to new activities. This will be recorded outside the practice.

This work runs alongside a campaign called 'Your Personal Best' which was launched in January, led by the Olympic and Paralympic sponsor GSK in association with NHS London to encourage the 7.78 million people in the UK over the age of 55 with long term conditions to regard activity as a benefit rather than as a threat to their health. This campaign connects with GPs by providing some additional tools. For more information visit www.yourpersonalbestcampaign.co.uk

Dr William Bird, a GP with a special interest in physical activity is leading this work and has already delivered the training to 10 practices across London with a further 40 training sessions planned for March and April. Demand from practices has been high however there are still some Boroughs we are keen to engage. If you are interested in signing up to My Best Move, please contact Veronica Reynolds on veronica.reynolds@intelligenthealth.co.uk

For more information on NHS London's wide plans for an Olympic and Paralympic Games health legacy please contact: Lily Makurah, 2012 Health Improvement Legacy Lead, NHS London on lily.makurah@london.nhs.uk

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NHS London

MY BEST MOVE

Physical Activity Treatment Pathway

A Health Improvement Opportunity Capitalising on

London 2012 Olympic and Paralympic Games

November 2012

Dr William Bird MRCGP MBE
Lily Makurah
Veronica Reynolds

sample

Health Improvement Legacy Context

2009 The ***Go London*** joint framework for action established.

2011 ***Go London*** refreshed.

1 core message targeted at energising the health system to utilise physical activity for health.

3 themes: Healthy Londoners; Healthy NHS; London 2012 Olympic and Paralympic Games Inspired.

2011 Leveraged support from Olympic and Paralympic Sponsors.

Encouraged NHS Trusts, GPs, public health teams and partners to jointly focus on delivering change and to capitalise on unique opportunities the London 2012 Games could bring.

2012 Capitalised on new, refreshed and inspiring health partnerships and collaborations.

Beyond the London 2012 Games

Over 200 examples of campaigns, initiatives , changes to policy and practice.

Multi-organisation buy-in touching every part of London and nationally.

Suite of directories capturing the progress and lessons.

Showcasing of improvements to the health system and our partnerships that are sustainable for the benefit of our future generations.

Improving the health of people with long term conditions a key feature e.g. My Best Move

To add to the evidence base of what works, our stories have been shared in suite of reports.....

Sample

My Best Move

An NHS London 2012 Games legacy initiative to encourage those with long term conditions to become more active

Making the case for physical activity

- Physical activity is an important component in the treatment of Long Term Conditions
- These include Stroke, Diabetes, COPD, etc
- You, as primary health care team play an important part in the process of changing behaviour through the brief intervention.
- There are activities on your doorstep which your patients can access.

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Attributable fractions (%) for all-cause deaths in 40 842 (3333 deaths) men and 12 943 (491 deaths) women in the Aerobics Center Longitudinal Study.

Blair S N Br J Sports Med 2009;43:1-2

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sample

Attributable fractions (%) for all-cause deaths in 40 842 (3333 deaths) men and 12 943 (491 deaths) women in the Aerobics Center Longitudinal Study.

Blair S N Br J Sports Med 2009;43:1-2

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Anti-Inflammatory

Two possible mechanisms:

- the reduction in visceral fat mass;
  - Visceral fat increases inflammatory agents and reduces anti-inflammatory ones creating a permanent state of Inflammation.
- Increased production of anti-inflammatory cytokines from contracting muscle. This reduces the anti-inflammatory state.

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sample

Anti-Inflammatory

Two possible mechanisms:

- the reduction in visceral fat mass
  - Visceral fat increases inflammatory agents and reduces anti-inflammatory ones creating a permanent state of inflammation
- Increased production anti-inflammatory cytokines from contracting muscle.

CHRONIC INFLAMMATION IS THE BASIS OF MOST LONG TERM CONDITIONS. THIS GIVES PHYSICAL ACTIVITY A MAJOR ROLE IN TREATMENT.

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Anti-ageing effect

- Increases Reactive Oxidative Species (Free Radicals)that stimulate the production of antioxidants in the Mitochondria
- This is a powerful anti-ageing mechanism that protects the cell from DNA damage.
- In fact taking antioxidants orally interferes with this mechanism and can shorten life-span and increase disease.

PATIENTS CAN UNDERSTAND THAT PHYSICAL ACTIVITY IS MORE TO DO WITH ANTI-AGEING THAN WEIGHT LOSS

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sample

APPENDIX 2

CVD Mortality risk Factors Modified by Physical Activity

Risk factors modified by physical activity [illegible] percentage [illegible] contribution they each [illegible] to reducing CVD events. i.e the [illegible] behind how [illegible] activity benefits [illegible] mortality.	
Inflammatory [illegible] (CRP Fibrin [illegible])	33%
Bl[illegible]	27%
Additional Lipi[illegible] (Cholesterol, LD[illegible] H[illegible])	19%
N[illegible] (Lipoprotein [illegible] Lipo[illegible]ein)	[illegible]
BMI	10%
HbA[illegible] [illegible] diabetes	9%
All risk [illegible] above	59%

WEIGHT LOSS ACCOUNTS FOR ONLY 10% OF THE CARDIOVASCULAR BENEFITS OF PHYSICAL ACTIVITY. 90% IS THROUGH OTHER MEANS.

Mora S, Cook N, Buring J, Ridker P, Lee I-Min
Physical Activity and Reduced Risk of Cardiovascular Events: Potential Mediating Mechanisms. Circulation 2007, 116:2110-2118

© 2012NHS London/ Intelligent Health

Risk of cardiovascular disease mortality by cardiorespiratory fitness and body mass index categories, 2316 men with type 2 diabetes at baseline, 179 deaths.

Blair S N Br J Sports Med 2009;43:1-2

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APPENDIX 2

Risk of cardiovascular disease mortality by cardiorespiratory fitness and body mass index categories, 2316 men with type 2 diabetes at baseline, 179 deaths.

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Cardiorespiratory Fitness and Body Mass Index as Predictors of Cardiovascular Disease Mortality Among Men With Diabetes

Timothy S. Church, MD, MPH, PhD; Michael J. LaMonte, PhD; Carolyn E. Barlow, MS; Steven N. Blair, PED Arch Intern Med. 2005;165:2114-2120

179 CVD deaths during a mean (SD) follow-up of 15.9 (7.9) years and 36 710 “manyears” of exposure.

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Sample

Importance Confidence Ruler

"On a scale of 1-10, how important is physical activity "

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My Best Move

- Training up GPs within their practice with PA lead. Booklet written to support learning
- Where clinics established 150% increase in referrals
- Significant increase in GPs confidence and 'importance'
- Future use of technology to monitor and motivate

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sample

GPs have very little knowledge about physical activity.

This is because:

- The emphasis has been on obesity and physical activity is simply seen as a way to lose weight making it a secondary problem with less value to healthcare.
- There is no training either as an undergraduate or post-graduate.
- There is less importance placed on physical activity because it is harder to measure with no adequate cost benefit.

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Primary Care has poor communication with physical activity schemes in the local area.

This is because:

- The physical activity schemes are often changing due to change in budgets and staff.
- There is no reliable central point of contact
- They are complicated to understand. i.e. who is eligible for what.
- They are often not local enough

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sample

There is no established method of monitoring physical activity in Primary Care.

This is because:

- DH chose GPPAQ that is not designed to show change
- There is a dearth of evidence to demonstrate a good way to monitor activity
- The new evidence demonstrates that fitness is as important and this is hard to measure.

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Health budgets allocate a relatively small amount of funding for physical activity.

This is because:

- Inactivity is perceived as less important than obesity or smoking cessation.
- There is much less evidence around successful ways to promote activity.
- There are no good accepted cost benefit models currently being used.

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sample

APPENDIX 3

MY BEST MOVE – LONDON'S TREATMENT PATHWAY			
GP Training Session (note: session can be delivered using booklet alone – slides are optional. Timings may vary depending on setting. Time total : 90 minutes			
Time	**Resources**	**Content/method**	**Training notes**
Introduction: 10 minutes			
10 minutes	Slides 1 – 2 HAND OUT IMPORTANCE-CONFIDENCE EVALUATION TOOL	Trainers Introduction Background to project/ NHSL/YPB	• Personal relevant experience • Outline of session/breaks/ housekeeping • How fits with QOF
Making the case for physical activity: 27 minutes			
7 minutes	23 ½ hours video	Show video	• Ask GPs/health professionals whether info is new to them? What was most surprising fact?
5 minutes	Introduce slides 4/5 on CRF Slides 6/7/8	Ask trainees which is most important? Levels of p.a.	• Attributable risk – not individual • Doing something from nothing has greatest impact • What is moderate/vigorous? Show examples of activities
5 minutes	Slides 9/10/11/12	Physical activity guidelines. Discussion / gauge awareness of current guidelines	• What is CRF? Why is it important?
5 minutes	Slide 13	How does p.a. work?	• Show examples for CV/Cancer
5 minutes	Slides 14/15/16/17	Weight loss and p.a.	• Key message: Fat and fit is better than thin and unfit. Obesity is independent of fitness
Physical activity prevention and treatment: 5 minutes			
5 minutes	Slides 18/19/20	Risk reduction by condition. QALY's	• Financial argument for promotion of p.a. in primary care.
Recommendations for physical activity and Long Term Conditions: 20 minutes			
20 minutes	Slides 21-32	Prevention/Treatment and cautions for main conditions. Ask GPs about a particular case that they have seen recently and how they might advise them on p.a. for their condition.	• Emphasise few contraindications. Walking is fine in most cases. Emphasise that evidence you are presenting has been endorsed by key medical charities/medical experts

Time	Resources	Content/method	Training notes
Putting it into Practice: 21 minutes			
10 minutes	Slide 33	Introduction to screening question/ GPPAQ. Discussion about systems and templates	• Identifying inactive patients and data capture
6 minutes	Slides 36-37	Overview of Brief Intervention	• Emphasise need to elicit and empower, not judge. • Emphasise just a brief introduction to MI. Takes practice. • Spirit of MI • Goal-setting needs to be incremental and realistic. Encourage GPs to praise and encourage and follow-up at next visit
5 minutes	Slide 38-39	MI-based techniques to start the process of change talk Importance confidence ruler	• Decisional balance tool: A useful technique to start 'change talk'. Use in order 1–4 • Emphasis MI takes practice and full MI may be available locally – ask p.a. lead? • Talk about this in context of using it with them
Signposting and wrap up: 10 minutes max			
7 minutes	Contact name of p.a. provider/Booklet/ supporting timetables	Give one name/contact number for GP to give to patient	• Give examples of what is available locally • Explain LL map in surgery • Who is involved locally?
	HAND OUT IMPORTANCE-CONFIDENCE PAPER	Explain evaluation follow-up and survey	

APPENDIX 4

GENERAL PRACTICE PHYSICAL ACTIVITY QUESTIONNAIRE

Date	
Name	

Please tell us the type and amount of physical activity involved in your work. Please tick one box that is closest to your present work from the following five possibilities:

		Please mark one box only
A	I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
B	I spend most of my time at work sitting (such as in an office)	
C	I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, childminder, etc.)	
D	My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
E	My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

During the *last week*, how many hours did you spend on each of the following activities?
Please answer whether you are in employment or not

		Please mark one box only on each row			
		None	**Some but less than 1 hour**	**1 hour but less than 3 hours**	**3 hours or more**
A	Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
B	Cycling, including cycling to work and during leisure time				
C	Walking, including walking to work, shopping, for pleasure etc.				
D	Housework/Childcare				
E	Gardening/DIY				

How would you describe your usual walking pace? Please mark one box only.

Slow pace (i.e. less than 3 mph)		Steady average pace	
Brisk pace		Fast pace (i.e. over 4mph)	

APPENDIX 5

LOCATION OF PRACTICES THAT COMMITTED TO TRAINING BY JULY 2012		
Postcode	Practice	Borough
RM8 2ES	Highgrove Surgery	Barking and Dagenham
RM8 3XU	Tulasi Medical Centre	Barking and Dagenham
N20 0QQ	Derwent Medical Centre	Barnet
N3 3NR	Mountfield Surgery	Barnet
DA6 7LP	Albion Surgery	Bexley
DA6 8DZ	Crook Log Surgery	Bexley
SE2 9LH	Lakeside Medical Practice	Bexley
DA8 2HS	Slade Green Medical Centre	Bexley
NW10 9HP	Church End Medical Centre	Brent
HA0 4UZ	Harness Wembley GP Access Centre	Brent
BR6 6HD	Chelsfield Surgery	Bromley
BR7 5AQ	Chislehurst Medical Practice	Bromley
NW3 2QU	Hampstead Group Practice	Camden
NW5 1TR	Parliament Hill Surgery	Camden
N1 5HZ	Lawson Practice	City of London
CR7 8LY	Parchmore Medical Centre	Croydon
UB6 0RA	Allendale Road Surgery	Ealing
UB5 4SR	Barnabas Medical Centre	Ealing
W3 0AA	Cloister Road	Ealing
W5 2HS	Corfton Road Surgery	Ealing
W7 3EY	Cuckoo Lane Surgery	Ealing
UB6 0PA	Elm Trees Surgery	Ealing
HA0 2EN	Grove Medical Centre	Ealing
UB6 7HQ	Hillview Practice	Ealing
W3 8QH	Mill Hill Surgery	Ealing
W13 9QP	Northfields Surgery	Ealing
UB6 8RA	Oldfield Family Practice	Ealing
EN3 6NS	Freezywater Primary Care Centre	Enfield
SE18 6PZ	Ferryview Health Centre	Greenwich
SE3 0EN	Manor Brook Medical Centre	Greenwich
SE7 8TX	The Fairfield Centre	Greenwich
E5 8BY	Nightingale Practice	Hackney
W12 7PH	White City Health Centre	Hammersmith & Fulham
N8 9TB	Allenson House Medical Centre	Haringey
N17 9DL	Dowsett Road Surgery	Haringey
N10 2PS	Dukes Avenue Practice	Haringey
N8 0PH	Hornsey Park Surgery	Haringey
N15 4JR	Lawrence House Surgery	Haringey
N17 8NW	Somerset Gardens Family HC Centre	Haringey
N17 8AH	Tottenham Health Centre	Haringey
N8 8SU	Vale Practice	Haringey
HA3 7LT	Circle Practice	Harrow

APPENDIX 5

LOCATION OF PRACTICES THAT COMMITTED TO TRAINING BY JULY 2012		
Postcode	Practice	Borough
HA7 1JP	Honeypot Medical Centre	Harrow
HA5 3EE	Pinn Medical Centre	Harrow
RM12 4EQ	Maylands Healthcare	Havering
UB10 9JN	Acorn Medical Centre	Hillingdon
HA4 9LZ	Cedars Medical Centre	Hillingdon
UB3 4JE	Dr Kanthan	Hillingdon
HA6 2RG	Mountwood Surgery	Hillingdon
UB8 3NG	West London Medical Centre	Hillingdon
W4 1RX	Chiswick Family Doctors Practice	Hounslow
TW3 1NL	Firstcare Practice	Hounslow
W4 2BD	Glebe Street Surgery	Hounslow
TW3 3ET	Hounslow Medical Centre	Hounslow
TW3 2DY	Kingfisher Practice	Hounslow
TW7 4HQ	Thornbury Road Centre for Health	Hounslow
KT6 6EN	Central Surgery	Kingston
SW4 6EB	Manor Health Centre	Lambeth
SW16 2XT	Valley Road Surgery	Lambeth
SE12 0DS	Baring Road Medical Centre	Lewisham
SE12 9TH	Chinbrook Road	Lewisham
SE6 1BQ	Muirkirk Surgery	Lewisham
BR1 5NJ	Oakview Family Practice	Lewisham
SE16 2SP	South Lewisham Group Practice	Lewisham
E16 4QH	Star Lane Medical Centre	Newham
E7 8BU	Westbury Road Medical Practice	Newham
E12 6SU	Wordsworth Health Centre	Newham
IG3 8LF	Doctors House	Redbridge
SW13 0DR	Glebe Road Surgery	Richmond
SE16 7JX	Albion Street Group Practice	Southwark
SE16 6NP	Surrey Docks Health Centre	Southwark
SW16 3NY	Church Lane Practice	Sutton & Merton
SW19 4DL	Francis Grove Surgery	Sutton & Merton
E14 8JU	Barkantine Practice	Tower Hamlets
E14 9WU	Dockland Medical Centre	Tower Hamlets
E11 1BN	Allum Medical Centre	Waltham Forest
SW11 5TU	Lavender Hill Group Practice	Wandsworth
W9 2AF	New Elgin Practice	Westminster

APPENDIX 6

MY BEST MOVE: POST TRAINING EVALUATION			
Name of trainer			
Date			
Practice name			
Borough			
Time allocated for session and actual time taken			
Attending:	Lead GPs		1,2
	GPs		
	Trainee GPs		
	Nurse Practitioners		
	HCAs		
	Admin/Reception/Practice Manager		
P.A. Lead present?	Yes	No	Name:
What happened?	**What did I learn?**		**How will I change what I did in the future?**
Key areas of interest			
System used by practice:	System 1 Emis Vision		GPPAQ installed? Yes No
Comments re GPPAQ			
Follow up			
Action by practice			
Action by p.a. lead			
Action by NHS/IH			
Other comments			
Thank you email sent?			

APPENDIX 7

MY BEST MOVE: POST-TRAINING SUMMARY EVALUATION

1. What are the three most important **things [or topics]** you learned during this training?

2. Was an appropriate **amount of material** covered? If not, was too much material covered or too little?

3. To what extent do you expect this meeting will make a difference in the way you do your job?

1	2	3	4	5
No difference				Tremendous difference

4. Has the practice installed GPPAQ onto its GP system as a result of My Best Move? Yes No

Comments

APPENDIX 8

MY BEST MOVE: IMPORTANCE CONFIDENCE RULE									
Date:									
Practice name:									
On a scale of 1-10, how important do you feel it is to tell your patients about the benefits of physical activity?									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
0 = not at all important									10 = very important/essential
On a scale of 1-10, how confident are you right now that you could advise your patients about the benefits of physical activity for their condition?									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
0 = not at all important									10 = very important/essential

NHS
London

NHS London
Southside
105 Victoria Street
London SW1E 6QT

020 7932 3700
www.london.nhs.uk

November 2012