ACTIVE REFERRAL

CARDIOPULMONARY REHABILITATION PROGRAMME

(PART OF THE ACTIVE REFERRAL SCHEME)

STANDARD OPERATING PROCEDURE (V1)

JULY 2021

NEXT REVIEW JULY 2022

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Section 1

Purpose of the Standard Operating Procedure (SOP)

This document provides guidance for Leicestershire Local Authorities delivering level 4 Cardiopulmonary Rehabilitation (CR) programmes. Leicestershire Local Authorities are awarded grant funding by Leicestershire County Council Public Health to deliver CR in the community. This funding does not extend to Leicester City or Rutland. CR is one of many referral programmes within the Active Referral Scheme (ARS) supported by Leicester-Shire & Rutland Sport (soon to be officially known as Active Together).

This document should be considered a minimum County Standard to ensure consistent delivery of CR.

This Standard Operating Procedure was created and agreed following consultation with Leicestershire County Council Public Health, Primary Care Networks (PCN), Active Referral Co-ordinators (ARC), Healthcare Professionals (HP), and Cardiac Rehabilitation Exercise Instructors (CREI) delivering and supporting CR throughout Leicestershire. This document took in to consideration existing National Guidance from British Association for Cardiovascular Prevention and Rehabilitation (BACPR) , Association of Chartered Physiotherapists in Cardiac Rehabilitation (ACPICR), The National Quality Assurance Framework (NQAF) for Exercise Referral Systems, and The British Heart Foundation National Centre (BHFNC)

As a minimum this document shall be reviewed on an annual basis.

1.0 Rationale

Cardiopulmonary Rehabilitation (CR) is an integral part of the care of the cardiac population. Comprehensive CR, combining the key components of exercise, education, psychological and social support, is endorsed by NICE clinical guidance 16-18. CR involves a team of professionals working in an integrated way with the individual, his/her partner and family.

Exercise is a key element within the core components for the prevention and rehabilitation of CVD. The seven components are: lifestyle risk factor management (regarding physical activity and exercise, diet, weight management and smoking cessation), psychosocial health, cardio-protective therapies, medical risk factor management, health behaviour change and education, audit and evaluation and long-term management.

The BACR has summarised the key evidence for supporting the efficacy of activity and exercise-based CR following an MI or coronary revascularisation, including:

Reductions in:

- All-cause mortality by 11 – 26%
- Cardiac mortality by 26 – 36%
- Unplanned hospital admissions by 28 – 56%

Improved:

- Quality of life
- Functional capacity
- Early return to work
- Development of self-management

1.1 Aims and Objectives of CR Programme

To maintain and emphasize a long-term lifestyle change, such as regular physical activity (adopted through Cardiac Rehabilitation Phase III) and assist in enforcing knowledge and confidence of healthy behaviours and habits into everyday life.

The objectives of the programme are to:

- Provide scheme participants with an easily accessible and equitable programme of activities across Leicestershire. Activities may include but not restricted to:

- Fitness/gym based personalised exercise programmes.
- Swimming pool-based activities including aqua aerobics.
- Group exercise classes such as seated exercise or circuits.
- Suitable independent activity such as walking.
- Virtual physical activity sessions where appropriate.

- Offer a 'patient centered' approach whereby scheme participants are offered a suite of options to become more active.
- Ensure individuals referred are equipped with a tailored physical activity programme that is regularly reviewed.
- Continually improve and develop a minimum county standard approach.
- Provide scheme participants with information about local physical activity opportunities and encourage them to increase and maintain levels of physical activity in everyday life.
- Increase the range of non-clinical professionals referring to the scheme e.g., social prescribers.
- To further increase scheme participants knowledge and understanding of how lifestyle changes lower the risk of future heart / lung problems.

The CR Programme will look to contribute to key Public Health outcomes for adults and families who are residents or work within Leicestershire County Council. As well as support to achieve the relevant outcomes in the Leicestershire Joint Health and Wellbeing Strategy 2017-2022.

The CR Programme will help to achieve the vision of the Leicestershire and Rutland Sport (LRS) Physical Activity and Sports Strategy 2017-2021, "Leicestershire, Leicester and Rutland the most physically active and sporting place in England".

2.0 Referral Process

Most referrals into CR Programmes will be made by specialist Cardiac and/or Pulmonary Rehabilitation Healthcare Professionals. Referrals are typically made following completion of a scheme participants Phase III Cardiac Rehabilitation Programme in Hospital. Referrals are made via an editable PDF document. Patient data is manually typed into the Active Referral PDF then securely emailed to the local Active Referral Co-ordinator (ARC). **This form should be used exclusively by referrers who can't access PRISM and can be found here**

GP's may also refer into CR Programmes via NHS Leicestershire Health Informatics Service's Pathway and Referral Implementation SysteM (PRISM). PRISM ensures patient data is securely transferred to local ARC via an encrypted e-mail. **All referrals should be electronically transferred by registered healthcare professionals using the following encrypted email addresses.**

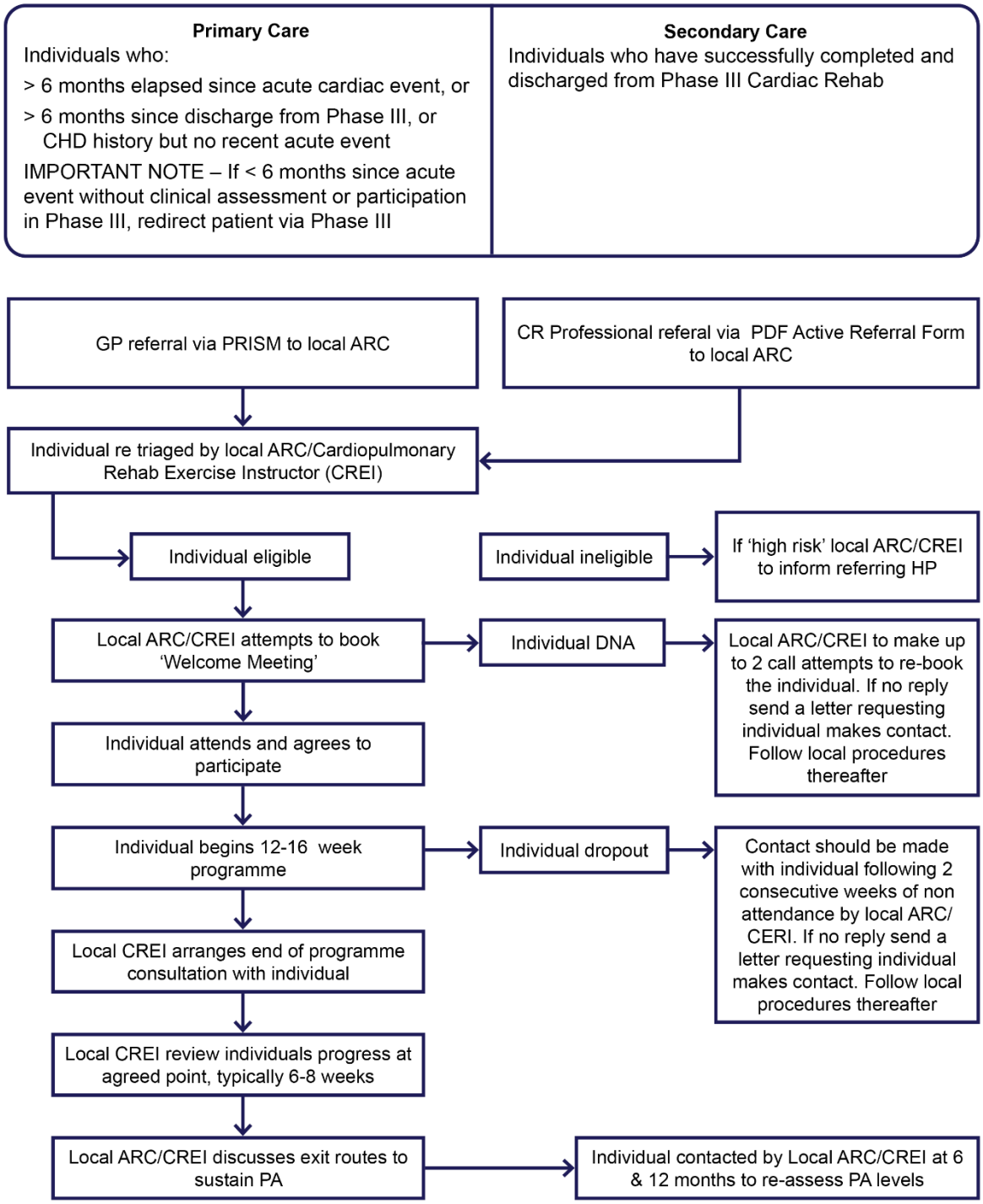
Blaby	exercise.referral@blaby.gov.uk
Charnwood	GPreferral@charnwood.gov.uk
Harborough	exercisereferral@harborough.gov.uk
Hinckley and Bosworth	exercisereferral@hinckley-bosworth.gov.uk
Melton	exercisereferral@melton.gov.uk
North West Leicestershire	exercise.referral@nwleicestershire.gov.uk
Oadby and Wigston	exercisereferral@oadby-wigston.gov.uk
Rutland	activerutlandhealth@rutland.gov.uk

Scheme participants will receive a programme of physical activity at a concessionary rate within a quality assured facility. The lead instructor responsible for assessing a scheme participants clinical information within the referral form, subsequent fitness assessments and exercise prescription must hold a recognised CIMPSA accredited Level 4 Cardiac Disease (Rehab) qualification in exercise and fitness e.g., BACR Exercise Instructor Training.

Local schemes will offer a patient centred programme of physical activity opportunities lasting 12 to 16 weeks. Ideally, the programme should run over consecutive weeks however, a certain degree of flexibility, at the discretion of the local ARC, may be given where periods of unavoidable absence occur e.g., patient illness. On completion of the programme, scheme participants will be invited to attend an exit consultation.

Local schemes are encouraged to follow **BACR EXERCISE PROTOCOL FOR MANAGEMENT OF CHD PATIENTS.**

2.1 CR Programme Pathway



Section 3

3.0 Local Delivery

Leicestershire Local Authorities are provided grant funding from LCC Public Health to deliver ER at a local level. ER is one of many targeted physical activity programmes that forms part of the Active Referral Scheme, supported by LRS.

Ideally, local schemes shall provide a variety of physical activity opportunities including but not limited to, gym sessions, aquatic activities, group exercise classes and a digital offer.

Provision is offered in accordance with local leisure providers and private instructor timetables. Local schemes should discuss the most equitable timetabling of physical activity opportunities for scheme participants with their leisure provider and private instructors.

3.1 Staffing

Local schemes **MUST NOT** operate without qualified instructors. Where a scheme offers physical activity specialist whole classes for clients with any of the conditions covered by the Level 4 fitness National Occupational Standards, they should ensure instructors designing, agreeing, adapting, and reviewing programmes for participants, have successfully completed an appropriate CIMSPA accredited Level 4 qualification (e.g., BACR Level 4 Exercise Instructor Training) and hold a Level 4 CIMSPA membership.

The use of instructors who do not hold an accredited level 3 Exercise Referral qualification and not members of CIMSPA **DOES NOT** represent national policy. **Local schemes operating without suitably qualified instructors should look at the legal implications of this model.**

It is considered best practice for new scheme participants to undertake a fitness assessment prior to exercise prescription (NQAF,2001), which may include identification of functional capacity e.g., walking at 3-4mph, prior to acceptance onto scheme. This should only be carried out by an appropriately qualified Level 4 instructor as detailed above.

3.2 Fees and Charges

Typically, local schemes will charge a concessionary fee to particate in their programmes. This will vary from scheme to scheme. Discounted ‘graduate’ memberships may also be available for scheme participants who fully complete a 12-16-week programme.

In some circumstances local schemes may operate a booking system. This will vary from scheme to scheme. Scheme participants are expected to adhere to local guidance when booking activities.

Local schemes will adhere to an agreed pricing policy in place with their leisure/private providers, ensuring individuals are aware of discounted charges and associated fees.

3.3 Welcome Appointment

Once a referral has been received, the local ARC/CREI will contact a referred individual within 7-10 days to arrange a 'welcome appointment'. Appointments typically take place in leisure facilities local to the referred individual. The appointment will be conducted by the local ARC/CREI depending on local operational practices.

It is the responsibility of the local ARC/CREI's to ensure all relevant paperwork is handled and stored securely following local GDPR practice.

As a guide, the local ARC/CREI should make a minimum of 2 call attempts to arrange a welcome meeting, leaving messages as appropriate. The local ARC/CREI may wish to follow up with a letter (see appendix 9) to the referred individual should calls not be returned. As a guide, if a referred individual does not respond, one month on from the first call attempt, the local ARC/CREI should inform the referring HP and follow local operational practices thereafter.

The 'welcome appointment' carried out by the ARC/ERI provides an opportunity to:

- Review referral paperwork – transfer form, consent.
- Carry out pre-exercise screening – PAR-Q9 or equivalent.
- Carry out pre-exercise fitness assessments – procedures for conducting tests, how to interpret the results, how to present results to the referred individual.
- Carry out motivational interviewing - assessment of readiness to exercise, barriers, activity goals and preferences.
- Discuss risk stratification tools with the scheme participant.
- Carry out any required gym inductions.
- Development an exercise programme with the scheme participant.
- Discuss the scheme participants' responsibilities – attendance, following programme advice.
- Discuss programme monitoring – how to keep a record of the exercise programme, monitor exercise intensity.
- Discuss relevant leisure facility protocols – evacuation, emergency.
- Discuss leisure centre membership subscriptions where appropriate.
- Book further appointments if necessary.
- Discuss COVID-19 guidance ensuring it is fully explained and understood (See Appendix 4).

3.4 Follow up appointments

Scheme participants should be invited to attend a mid-programme review around 6-8 weeks. Ideally done face to face to discuss the individuals progress, gather data and re-assess any goals. All data should be collected and stored in accordance with local GDPR practices. It also provides an opportunity to prevent dropout from the programme. Earlier steps should be taken if an individual is showing signs of dropout (missing sessions, apathy with their programme) before a mid-programme review.

Scheme participants should be invited to attend an end of programme consultation, not to be carried out during an exercise session. An exit strategy is key to supporting long term behaviour change for each referred individual. The local ARC/CREI should discuss physical activities the client has enjoyed and identify opportunities for continued participation. All end of programme monitoring, and evaluation data should be collected and stored in accordance with local GDPR practices.

Scheme participants may be contacted 6 and 12 months after completing their 12-week programme at the discretion of the local ARC.

3.5 Monitoring and Evaluation

LRS request relevant, anonymised scheme participant data be submitted on a quarterly basis using a consistent reporting template. Links can be found to each locality password protected template in appendix 6. Localities have the freedom to collate this information using their own locally agreed methods and operational practices. LRS reserve the right to introduce and request the use of a consistent resource for data collection at any time

Section 4

4.0 Guide to responsibilities

Referring Health Care Professionals

- Make themselves familiar with the guidance document which includes the inclusion and exclusion criteria (See appendix 1).
- Ensure there is a meaningful transfer of relevant information to the person who will be conducting the exercise intervention.
- Ensure all relevant clinical information about scheme participants is detailed in PRISM or the Active Referral PDF and securely emailed to local ARC.
- Respond to any queries scheme participants may have regarding CR.
- Liaise with local ARC over any referral queries.
- If the referrer is a registered HP, they are clinically responsible for the patient they refer.

Active Referral Coordinators/ Physical Activity Development Officers

- To receive referrals and ensure individuals meet the inclusion criteria.
- Arrange and deliver ‘Welcome appointments’ in accordance with local operational practices.
- If required, take appropriate steps in accordance with local GDPR practices to ensure paperwork is securely transferred to local CREI.
- Organise cover for physical activity sessions where necessary.
- Ensure CREI have undertaken and passed any appropriate training courses.
- Ensure CREI have signed relevant contracts if they undertake courses provided and funded by LRS and/or districts.
- Ensure all staff (e.g., receptionists, duty managers, exercise instructors) are kept informed of scheme procedures, session details, cost changes etc where appropriate.

- Ensure any ‘new guidelines’ regarding disease specific exercises are circulated and communicated with instructors.
- To promote their local scheme at every opportunity (e.g., displays, GP protected learning time).
- Provide locality specific operational updates to LRS prior to their bi-monthly meeting with Glenfield Cardiac Rehab Team.
- Attend ARC Operational Meetings on a quarterly basis.
- Use this SOP as a best practice minimum county standard guide in the delivery and development of their local scheme.

Cardiopulmonary Rehabilitation Exercise Instructors

- Communicate all COVID-19 procedures where appropriate.
- Discuss scheme participant goals and design a safe an effective, patient centred exercise programme, offering a variety of physical activity opportunities where possible.
- Carry out initial consultation using motivational interviewing techniques.
- Supervise scheme participant functional capacity fitness assessments prior to their commencement in the programme.
- Book client in for mid programme if appropriate.
- In conjunction with local ARC be proactive to identify scheme participants with high dropout risk by contacting scheme participants who miss 2 consecutive weeks.
- Be available, wherever possible based on local delivery, to offer support and guidance for scheme participants.
- Complete scheme participant gym inductions if required.
- Complete mid and end of programme consultations. Review scheme participant goals and identify opportunities for continued participation.
- Promote and signpost to other relevant health and wellbeing lifestyle services e.g., health checks and local physical activity opportunities (where appropriate) e.g., health walks.
- Ensure scheme participant paperwork is managed in line with local GDPR practices.
- Provide scheme participant monitoring and evaluation data to the local ARC as and when required.

Leicester-Shire & Rutland Sport

- Provide support and guidance to local schemes delivering CR.
- Act as central liaison between Cardiac and Pulmonary Rehabilitation Departments within University Hospitals Leicester (UHL) Leicestershire Partnership Trust (LPT) University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) and local schemes to ensure clear and consistent programme updates and developments are shared.
- Encourage the use of consistent branding, paperwork and referral mechanisms.
- Maintain and expand new referral routes by collaborating with local health services.
- Develop strategic relationships with key stakeholders e.g., CCG, Public Health.
- Provide training grants for local schemes to enhance their provision.
- To be responsible for developing the Standard Operating Procedure.
- Submitting quarterly monitoring and evaluation data to Leicestershire County Council Public Health Team.
- Chair ARC Operational Meeting.

Section 5

5.0 Medico-legal Considerations

Registered Healthcare Professionals assume clinical responsibility and duty of care for referring appropriate individuals to the CR Programme. The decision to refer must be based on the HP clinical judgement alongside the CR Programme inclusion / exclusion criteria.

It is the responsibility of the local ARC/CREI to re-assess eligibility of all scheme participants once they receive a referral form from a HP. Local ARC/CREI are advised not to accept responsibility for a referred participant until all relevant clinical information is available.

Local schemes are then advised to follow the 'best practice' guidance within this Standard Operating Procedure alongside their own operational practices. It is the responsibility of appropriately qualified Level 4 CREI to ensure the safe and effective management, design and delivery of scheme participants exercise programme.

5.1 Suitability of Referrals

Initially, the referrer should assess a potential scheme participants suitability for CR based on a set of agreed eligibility criteria and their own clinical/professional judgement.
On occasion, local triage may uncover one or more scenarios presented below.

Scheme participant is ineligible because they have been regularly active (>30 minutes per week) during Phase III Cardiac Rehabilitation

Typically, patients who are regularly active would not be considered eligible for the CR Programme. Scheme participants referred through primary care i.e., haven't completed Phase III in the previous 6 months or ever, are perhaps less likely to be regularly active and meet inclusion criteria.

Whereas those referred via secondary care i.e., recently completed Phase III will have been regularly active for at least 8 weeks. In this case, local schemes should accept participants providing they are safe to do so. Local discretion is advised on a case-by-case basis.

Scheme participant declines support following initial referral from HP

Consider understanding the referred individuals' barriers (see FAQ's).

Potential scheme participants with any absolute contraindications should not exercise until such conditions are stabilised or adequately treated. Local schemes are advised to inform the referring HP.

Scheme participant is no longer compliant with their medication

Potential scheme participants not compliant with their medication should not exercise. Local ARC/CREI should be confident scheme participants have become compliant with their medication before allowing them to participate. If in doubt, please consult the referring HP.

Scheme participant referral paperwork is older than 3 months and following consultation and risk stratification they are deemed to be 'high risk'

Best practice would be to consult referring HP for a review/clinical assessment. Scheme participants should not exercise until a review/clinical assessment has been completed and the referring HP is happy they can exercise safely providing appropriate recommendations are followed. Any transfer of scheme participant clinical information should be in accordance with local operational GDPR practices.

Scheme participant is no longer ready or willing to commit to the programme

Consider understanding the referred individuals' barriers (see FAQ's) Local schemes should encourage individuals to return when they feel ready and committed to change.

5.2 Re-referrals

Best practice is to only allow scheme participants to access the CR Programme once in a 12-month period and not be referred for the same condition twice. Local ARC are encouraged to use their clinical judgement, discretion and follow local operational procedures.

5.3 Quality Standards

The CR Programme follows the guidelines recommended in the Standards and Core Components (2017) of the British Association for Cardiovascular and Prevention Rehabilitation (BACR) exercise protocol for management of CHD patients . This document provides guidelines for community-based Phase 4 Cardiac Rehabilitation programmes with the aim of improving standards among programmes.

It is recommended local schemes adhere to the guidance within the Association of Chartered Physiotherapists in Cardiac Rehabilitation (ACPICR). ACPICR standards for physical activity and exercise in the cardiac population.

Responding to the provision of Cardiovascular Rehabilitation Programmes during the COVID-19 pandemic, BACR has issued further guidance for exercise professionals entitled Delivery of the Physical Activity and Exercise Component of Core Cardiovascular Rehabilitation during the COVID-19 Pandemic A Guidance Document from the BACR Exercise Professionals Group (EPG) 2nd Edition November 2020.

Localities may wish to share and continually refer to these documents for guidance, in conjunction with their own operational procedures, to ensure best practice is maintained.

5.4 Confidentiality/Data Protection

Local schemes assume full responsibility for scheme participant data, and it should be managed in accordance with local GDPR procedures. Scheme participant data should be stored securely and wherever possible electronically. Paper-based data should be securely destroyed if no longer required in accordance with local operational procedures.

Retention of scheme participant records should follow local operational policy. Localities may wish to refer to the Information Governance Alliances Document *Records Management Code of Practice for Health and Social Care 2016* embedded below.

Local schemes shall ensure data protection protocol is understood and adhered to by all. Leicester-Shire & Rutland Sport are legally hosted by Leicestershire County Council and adhere to GDPR principles and the Data Protection Act 2018.

Section 6

6.0 FAQ's

How do you define a scheme participant who completes a 12-week programme?

Ideally, scheme participants should commit to attending a physical activity session at least once per week for the length of the programme. Where scheme participants, can't commit to this, due to holiday or illness, they should be encouraged to make the local ARC/CREI aware of their forthcoming absence. Where appropriate, scheme participants should be encouraged and supported to remain active during this time to avoid deconditioning.

Local ARC/CREI may wish to discuss how scheme participants can 'make up' a missed week/s. Some local schemes may operate a minimum attendance policy, as part of the scheme participants activity agreement discussed during their initial consultation. This can often assist with programme adherence. For the specific purposes of monitoring and evaluation, LRS state scheme participants with 75% (i.e. attend at least once on 8 out of 12 weeks or equivalent) or higher attendance complete the programme.

How can we reduce our dropout rate?

The scheme participants readiness to change behaviour should be assessed to screen out those likely to drop-out before the end of the scheme. Referring HP should also be reminded to assess a potential scheme participants readiness to change prior to making a referral. Some scheme participants often feel an obligation to 'do as they are told' by a HP in a medical environment, however, change their mind when contact is made by local scheme ARC/CREI. Local schemes should continue to work closely with LRS, UHL, LPT and UHDB to raise awareness of their schemes to ensure quality referrals are received.

Local schemes should Identify and address scheme participant barriers as early as possible, ideally during the initial consultation. Some scheme participants may be apprehensive entering a leisure centre or new environment for the first time. This initial visit should 'set the tone' for all future visits and leave scheme participants feeling safe and cared for.

Local schemes should encourage participants to inform them of known future absences (e.g., holidays, medical appointments). Where possible they should be encouraged to remain active to avoid deconditioning. Local schemes may allow participants to repeat missed weeks in some circumstances at the discretion of the local ARC. Appropriate SMART goal setting should be considered as an additional retention strategy.

Activities should be enjoyable and appropriate to the fitness level and health condition of the scheme participant to encourage adherence. These activities may need to be modified throughout the programme to avoid staleness and push through fitness plateaus. Local schemes should consider how this is best achieved.

Operationally, local schemes may want to consider the following process to reduce dropout. If a scheme participant does not attend for two consecutive weeks, without informing the local ARC/CREI of their absence, an attempt to make contact via telephone should be made. If repeated attempts to make contact via telephone fail, a letter should be sent to the scheme participant requesting they make contact.

Local ARC/CREI are encouraged to be mindful of scheme participants at high risk of dropout, wherever possible. Anecdotal data suggests dropout is most likely during the first month. Where possible and appropriate local ARC/CREI may wish to consider contacting scheme participants who do not attend their first physical activity session following their initial consultation or offer more support to those demonstrating a general apathy with the programme.

What happens if referral forms are incomplete or missing clinical information?

Local schemes are advised not to accept responsibility for referred individuals until all relevant clinical information is available (National Quality Assessment Framework 2001) Local schemes should contact the referrer to obtain any missing information.

Who is legally responsible for an ATARS scheme participant?

Once all the relevant medical information has been transferred to the ARC/CREI, “the responsibility for safe and effective management, design and delivery of the exercise programme passes to the exercise professional.” (National Quality Assessment Framework 2001) Clinical responsibility remains with the referrer, and it is essential the ERI recognises this from a medico-legal and professional perspective. (Wright Foundation 2019)

What should I do if a referral form is older than 3 months?

HP are at risk of being overwhelmed by hundreds of requests for re-referrals because of the backlog caused by National Lockdowns. As an interim measure, local ARC should use an enhanced PARQ (see Targeted Programme Recovery Plan Appendix 7) during consultations, along with the latest ACSM guidance of preparticipation screening (Appendix 3).

High risk scheme participants with referral forms older than 3 months, should be returned to the referrer. This ‘interim measure’ will be reviewed at regular intervals by the ARC Operational Group and adjustments subsequently made to this SOP if required.

The Cardiac Rehabilitation Team at UHL Glenfield are happy to support and offer advice to ARC/CERI as and when required.

I'm not sure if I should accept a scheme participant because they have an unfamiliar cardiopulmonary condition and/or it wasn't covered in my Cardiac Rehabilitation Qualification? Therefor I don't feel 'qualified' or confident to support this participant.

CREI should complete all required CPD to supplement their knowledge on new and emerging topics and guidance not covered in the Cardiac Rehabilitation Exercise Instructor qualification. LRS are working closely with other specialist cardiac departments based at UHL to support CPD updates for CREI e.g., Cardiac Rhythms and ICD.

Local ARC/CREI are encouraged to utilise the experience and knowledge of other CREI for exercise prescription advice and support for conditions they've not encountered. Involve scheme participants in the decision making process as they will be able to provide further insight relating to symptoms and physical limitations.

It's important to reiterate Instructors should only operate within their professional role boundaries. In cases where there are any objectives, physical activities or risks that fall outside their professional boundaries or that they do not feel competent to deal with, advice should be sought from specialist cardiac rehabilitation nurses or equivalent. In most cases, this will be the referring HP.

This SOP is not exhaustive and will be regularly reviewed and updated where appropriate by Andrew Harris (Sports Development Officer – Leicester-Shire & Rutland Sport.)

Appendix 1

CR Programme Inclusion Criteria

(i) > 6/12 elapsed since acute cardiac event, or
(ii) > 6/12 since discharge from Phase III, or
(iii) CHD history but no recent acute event
IMPORTANT NOTE – If <6/12 since acute event without clinical assessment or participation in Phase III redirect patient via Phase III

Scheme participants must be:

- a minimum 16 years of age *
- inactive (regularly participating in less than 30 minutes of physical activity per week) *
- ready and willing to commit to a programme of physical activity.
- compliant with their medication.

Condition specific: **

- Coronary heart disease (CHD)
- Individuals with new onset or worsening exertional angina
- Acute coronary syndromes (ACS)
- Before and after revascularisation – percutaneous coronary intervention (PCI) or coronary artery bypass surgery (CABG)
- Other cardiac surgery
- Following any step wise alteration in CHD condition
- Other atherosclerotic disease for example peripheral arterial disease (PAD)
- Stable heart failure (HF) and cardiomyopathy
- Congenital heart disease
- Following arrhythmias and implantable device interventions (implantable cardioverter defibrillator (ICD), permanent pacemaker (PPM), cardiac resynchronisation therapy (CRT))
- Other specialised interventions such as cardiac transplantation and ventricular assist devices (VADs)
- Those at high multi-factorial risk of CVD
- Metabolic syndrome (hypertension/diabetes/obesity)

* Local discretion advised (see suitability of referrals)
** Taken from ACPICR Standards for Physical Activity and Exercise in the Cardiovascular Population 2015. List is not exhaustive.

Appendix 2

CR Programme Absolute Contraindications

- Symptomatic severe aortic stenosis
- Acute pulmonary embolus or pulmonary infarction
- Acute myocarditis or pericarditis
- Suspected or known dissecting aneurysm
- Resting Systolic Blood Pressure ≥ 180mmHg / Diastolic Blood Pressure ≥ 100mmHg
- Uncontrolled / unstable angina
- Acute uncontrolled psychiatric illness
- Unstable or acute heart failure
- New or uncontrolled arrhythmias
- Other rapidly progressing terminal illness
- Significant drop in BP during exercise
- Uncontrolled resting tachycardia ≥ 100 bpm.
- Febrile illness
- Experience's pain, dizziness or excessive breathlessness during exertion
- Stroke <3 months
- Unstable/uncontrolled diabetes
- Unstable/uncontrolled cardiac disease
- Severe rheumatoid and osteoarthritis
- Any unstable, uncontrolled condition

Appendix 3

Risk Stratification

Risk stratification is a multi-factorial measure used to establish prognosis of future major cardiac events and chances of survival. This tool helps the exercise professional to identify relevant information for individual management, appropriate level of supervision and monitoring.

LOWEST RISK - C	MODERATE RISK - B	HIGHEST RISK - A
Absence of complex ventricular ysrhythmias during exercise testing and recovery Absence of angina or other significant symptoms (for example unusual SOB, light-headedness, or dizziness, during exercise testing and recovery) Presence of normal haemodynamics during exercise testing and recovery (i.e., appropriate increases and decreases in HR and SBP with increasing workloads and recovery) Functional capacity ≥ 7 METS Non-exercise Testing Findings: Resting EF ≥50% Uncomplicated MI or revascularisation procedure Absence of complicated ventricular dysrhythmias at rest Absence of CHF Absence of signs or symptoms of post-event/post-procedure ischaemia Absence of clinical depression	Presence of angina or other significant symptoms (for example unusual SOB, light-headedness or dizziness, occurring only at high levels of exertion ≥ 7 METS) Mild to moderate level of silent ischaemia during exercise testing or recovery (ST-segment depression <2 mm from baseline) Functional capacity <5 METS Non-exercise Testing Findings: Resting EF 40 – 49%	Presence of complex ventricular dysrhythmias during exercise testing or recovery Presence of angina or other significant symptoms (for example unusual SOB, light-headedness, or dizziness at low levels of exertion (<5METS) or during recovery) High level of silent ischaemia (ST-segment depression > 2mm from baseline) during exercise testing or recovery Presence of abnormal haemodynamics with exercise testing (i.e., chronotropic incompetence or flat or decreasing SBP with increasing workloads) or recovery (severe post exercise hypotension) Non-exercise Testing Findings: Resting EF <40% History of cardiac arrest or sudden death Complex dysrhythmias at rest Complicated MI or revascularisation procedure Presence of CHF Presence of signs/symptoms of post-event/post- procedure ischaemia Presence of clinical depression
All characteristics must be present for patient to be low risk	**One or more of these findings' places patient at moderate risk**	**One or more of these findings' places patient at high risk**

Appendix 4

Key Terms and Definitions

Active Referral Co-ordinator (ARC)
The Active Referral Co-ordinators are based at Local Authority facilities in their respective areas. In most cases they will have other work responsibilities. The Active Referral Co-ordinators are responsible for the overall co-ordination of the scheme in their area. The Active Referral Co-ordinator may or may not hold a CIMPSA accredited L4 Cardiac Rehabilitation Exercise Instructor qualification.

Acute health condition
Acute illnesses are those that are of short duration. They may be minor, or they may be serious, occurring suddenly, and have immediate or rapidly developing symptoms.

Chronic health condition
Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.

Controlled medical condition
A condition (e.g., hypertension) in which the critical parameter (e.g., blood pressure) is maintained within a target range due to active therapeutic and/or lifestyle intervention.

Cardiac Rehab Exercise Referral Instructor
The Cardiac Rehab Exercise Referral Instructor refers to an individual, working on behalf of the Local Scheme, who holds a CIMPSA accredited L4 Cardiac Rehabilitation qualification.

Healthcare Professional (HP)
The Healthcare Professional refers to any person who has completed a course of study in a field of health, such as a GP, registered nurse or physician. The person is usually licensed by a government agency or certified by a professional organisation and uses their skills and knowledge to treat patients and promote wellness in a clinical environment.

Leisure Provider
The Leisure provider refers to the contractor who manages the local leisure centres. Everyone Active manage centres in Blaby, Harborough, Oadby & Wigston, Melton and North West Leicestershire. Fusion Lifestyle manage centres in Charnwood. Place for People manage a centre in Hinckley and Bosworth. Some areas also partner with independently owned health, fitness and sports centres and fall under the definition of ‘leisure provider’.

Level 3 Physical Activity Programmes/Schemes
Suitable for individuals with low to medium risk, stable and controlled health conditions. Physical activity may need to be adapted by an Exercise Referral Instructor.

Level 4 Physical Activity Programmes/Schemes
Adapted physical activity for individuals with significant physical limitation related to chronic disease or disability. Requires an appropriately qualified Level 4 specialist instructor to lead.

Local Scheme/s
This is a reference to the 7 Leicestershire Local Authorities who provide a Level 3 physical activity intervention for referred populations in their area.

Patient
The Patient refers to an individual who has been referred by their Healthcare Professional.

Primary Care Network
Groups of general practices working together, and in partnership with community, mental health, social care, pharmacy, hospital and voluntary services in their local area, to offer more personalised, coordinated health and social care to the people living in their area.

Physical Activity Development Officer
An officer working on behalf of a Local Authority responsible for a variety of physical activity related initiatives and programmes. In some case they may also be the Active Referral Co-ordinator. They may or may not hold a CIMPSA accredited L3 Exercise Referral or L4 Cardiac Rehabilitation Exercise Instructor qualification.

Scheme Participant
The Scheme Participant refers to the Patient who is actively participating in a Local Scheme.

Stable medical condition
A person's clinical condition is predictable, does not change rapidly, and medical orders are not likely to involve frequent changes or complex modifications.

Uncontrolled medical condition
A condition (e.g., hypertension) in which the critical parameter (e.g., blood pressure) isn't maintained within a target range due to the removal or absence of therapeutic and/or lifestyle intervention.

Unstable medical condition
Clinical signs and symptoms are present in an individual. A registered healthcare professional has determined that the individual's signs and symptoms are outside of the normal range. The individual's signs and symptoms require extensive monitoring and ongoing evaluation of the individual's status and care. Changes in the individual's medical condition are uncontrollable or unpredictable and may require immediate interventions.

Appendix 5

Abbreviations

ACS – Acute Coronary Syndrome
ACSM – American College of Sports Medicine
AMT (score) – Abbreviated Mental Test
ARC – Active Referral Co-ordinator
ARS – Active Referral Scheme
BACPR – British Association of Cardiovascular Prevention and Rehabilitation
BASES – British Association of Sport and Exercise Science
BHFNC – British Heart Foundation National Centre
BMD – Bone Mineral Density
BMI – Body Mass Index
BP – Blood Pressure
CABG – Coronary Artery Bypass Graft
CCG – Clinical Commissioning Group
CD4 (cells) – Cluster of Differentiation
CHD – Coronary Heart Disease
CHF – Congestive Heart Failure
CIMSPA – Chartered Institute for the Management of Sport and Physical Activity
CREI – Cardiac Rehabilitation Exercise Instructor
CRT – Cardiac Resynchronisation Therapy
CPD – Continued Professional Development
CV – Cardiovascular
CVD – Cardiovascular Disease
DBP – Diastolic Blood Pressure
EF – Ejection Fraction
ERI – Exercise Referral Instructor
GP – General Practitioner
GDPR – General Data Protection Regulations
HF – Heart Failure
HIV – Human Immunodeficiency Virus
HP – Healthcare Professional
ICD – Implantable Cardioverter Defibrillator
LRS – Leicester-Shire & Rutland Sport
NICE – National Institute for health and Care Excellence
NQAF – National Quality Assurance Framework (for Exercise Referral)
METS – Metabolic Equivalent of Task/s

MI – Myocardial Infarction
OA – Osteoarthritis
PA – Physical Activity
PAD – Peripheral Arterial Disease
PADO – Physical Activity Development Officer
PARQ – Physical Activity Readiness Questionnaire
PCI – Percutaneous Coronary Intervention
PCN – Primary Care Network
PPM – Permanent Pacemaker
PRISM – Patient Referral Implementation SysteM
RA – Rheumatoid Arthritis
SBP – Systolic Blood Pressure
SOB – Shortness of Breath
SOP – Standard Operating Procedure
TIA – Transient Ischaemic Attack
VAD – Ventricular Assist Devices

Appendix 6

Monitoring and Evaluation

Localities have been provided with password protected excel files to record scheme participant data. Links can be found below.

Blaby
Charnwood
Harborough
Hinckley & Bosworth
Melton
North West Leicestershire
Oadby & Wigston
Rutland

Appendix 7

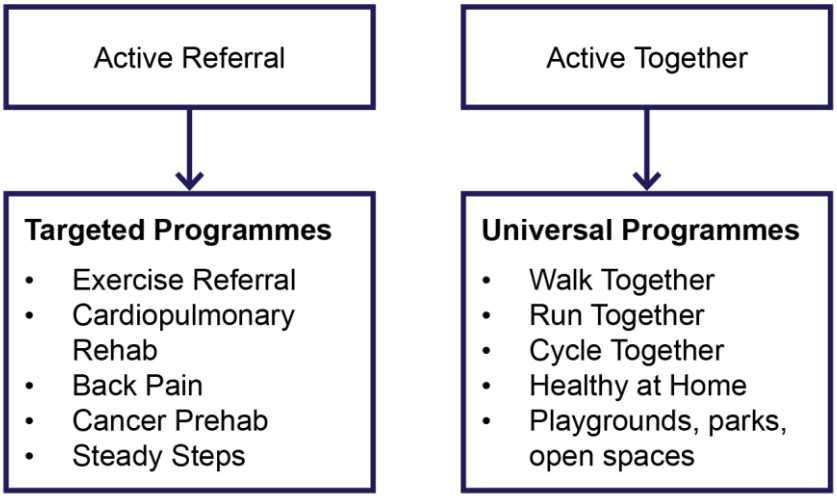
Targeted Programme Recovery Plan

This guidance has been produced by LRS and district colleagues in line with national guidance and serves as a tool to assist in the local recovery and delivery of targeted physical activity programmes. The document can be accessed here

Locality colleagues are advised to keep checking updated Covid-19 national and local guidance. Further guidance and links can be found in the appendices of the document.

Appendix 8

LRS Physical Activity Pathway



Appendix 9

Template Letter to HP/Referrer

(Your name)
(Your local scheme)
(Your address)
(Date)

(Title, forename, and surname of referrer)
(Referrer address)

Dear (title and surname of referrer)

(Your patient's reference number if applicable)

(Patient's title, forename, and surname)
(Patient's address)

Thank you for referring your patient to Exercise Referral, part of the Active Referral Scheme. (Patient's name) has completed the 12-week programme and I am delighted to include the following details of their progress.

(Write details of progress/achievements in the letter as bullet points. Including clinical numbers where appropriate BMI/BP/ etc).

Please don't hesitate to contact me for any further information regarding (patients name).

Your sincerely

(Your signature)

(Your forename and surname)
(Your professional)
(Your local scheme)