



UNIVERSITY OF  
LINCOLN

INTENDED ACTIONS, UNINTENDED CONSEQUENCES: TOWARDS A  
PROCESSUAL UNDERSTANDING OF EXERCISE REFERRAL SCHEMES

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Doctor of Philosophy

2017

## ABSTRACT

Whilst the benefits of physical activity have been well documented, many in the UK population remain insufficiently active to substantively benefit their health, placing individuals at greater risk of developing a range of non-communicable diseases and conditions. As a large percentage of the population accesses primary care, at least on an annual basis, the use of this health care sector to advocate increased physical activity has become widespread. Exercise referral schemes (ERSs) have enabled primary care professionals to refer their patients, typically to a local leisure facility, for supervised exercise. ERSs have seen prolific growth across the UK since their conception in the 1990s and yet their effectiveness has remained in question. Despite a variety of research designs being employed, evidence regarding schemes' effectiveness continues to be inconclusive. Within the existing research literature, the complexity of context within which ERSs operate has remained largely overlooked; specifically, how individual interpretations of ERSs might be co-produced according to the interactions between those central to the service, and how this might influence both service delivery and impact. This study, therefore, aimed to address these lacunae by exploring participants' understanding of ERSs, and how these perceptions contoured ERS service provision.

The research focused on one case-study ERS in the East of England. Semi-structured interviews were employed through a combination of group and one-to-one interviews, with 27 participants (15 patients, 7 exercise practitioners, 5 health professionals) who were central to the ERS at a delivery level, and a further 5 (1

district manager, 2 representatives from the County Sports Partnership and 2 representatives from Public Health) one-to-one interviews were conducted with individuals who represented the strategic management of ERSs. A process sociological lens was adopted to provide novel insights into participants' perceptions of ERSs, their role and their ability to influence ERS service provision. Data were also supported by self-elicited reflections born from the researcher's 'insider' position to the County's ERS.

Thematic analysis generated salient themes that showed conflicting interpretations of ERS service provision, and perceptions of scheme receipt and impact. Data highlighted that the networks of relationships in which individuals were situated not only contoured participant experiences but shaped the delivery processes of ERSs. Individual 'I' identities were situated within interdependent networks of 'we' and 'they' relationships, where identifiable groups were formed according to individuals' perceived role within the scheme. Relationships between individuals and groups were in a tensile state, marked by power balances that had impacted on service provision but also the associated meaning of ERSs, producing interesting, yet unexpected and unintended outcomes. Such findings could prove useful to policy-makers, those responsible for commissioning ERSs, and practitioners, as well as those in similar roles for other multi-agency interventions. By facilitating enhanced understanding of the complexities of this physical activity intervention, findings suggest how the actions and interpretations of those central to a service can fundamentally alter delivery mechanisms and receipt, potentially influencing the very existence of the intervention, or in this case ERSs.

## ACKNOWLEDGEMENTS

I would like to take this opportunity to thank those people who have supported me throughout this process.

First and foremost, I would like to dedicate this thesis to Florence, unbeknownst to you, you have been my inspiration and welcome distraction in equal measure. In the years to come I hope that this may serve as a reminder that you can achieve anything you set your mind to.

For Jonathan, thank you for your endless patience, support and unwavering belief in me.

For my family, Mum, Dad and Becca, words cannot express what your unconditional love and incredible support has meant to me, thank you.

My sincerest thanks go to my supervisors Prof. Niro Siriwardena, Dr. Adam Evans and Prof. Jaqui Allen-Collinson, for your continuous support, encouragement and advice, without which this thesis would not have been possible. Under your supervision, I have grown in confidence and each of you inspire me as a researcher and an academic.

I would also like to acknowledge my colleagues at the University of Lincoln, specifically Donna, Lindsay, Geoff and Cathy. Donna, you in particular have been a source of inspiration and advice and I thank you for this.

My friends have supported me throughout this thesis and prior to the commencement of my studies, I am incredibly fortunate to call you my friends. My heartfelt thanks go to Donna, Gemma, Jo and Pagey.

Finally, I have been privileged to meet and listen to numerous individuals working within and participating in exercise referral schemes. I thank you for your time and your honest perspectives, without which, this thesis would not have been possible.

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## LIST OF ABBREVIATIONS

BASES	British Association of Sport and Exercise Science
BHF	British Heart Foundation
BHFNCPA	British Heart Foundation National Centre for Physical Activity
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disease
CSP	County Sports Partnership
CVD	Cardiovascular Disease
DoH	Department of Health
EP	Exercise Practitioner
ERS	Exercise Referral Scheme
GP	General Practitioner
HP	Health Professional
HSCIC	Health and Social Care Information Centre
HSE	Health Survey for England
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NQAF	National Quality Assurance Framework
ONS	Office for National Statistics
PHE	Public Health England
RCT	Randomised Control Trial

# CHAPTER 1

## INTRODUCTION

### 1.1 Introduction

In July 2011, the headline “Gym sessions on NHS ‘are a waste of money’” (Hope, 2011) was printed in a national daily newspaper. The article claimed that patients who were sent on subsidised gym sessions by general practitioners (GPs) might as well have undertaken more walking. The claim, based on a journal article (Pavey et al., 2011), published at the time, was a damning indictment of a service that had become widespread in targeting poor health (Dugdill et al., 2005). The process of a health professional, such as a GP or practice nurse, referring their patient to a local leisure facility to participate in supervised exercise, is now widely referred to as an exercise referral scheme (ERS) (Department of Health [DoH], 2001). Historically, the concept of ERSs emerged in 1990 after an enthusiastic British GP arranged for his patients to attend a conveniently located leisure centre adjacent to the surgery, believing that it would benefit their health (Taylor, 2001).

Even at the time, however, utilisation of exercise to improve health was by no means a new concept. Indeed, the benefits of maintaining a physically active lifestyle dated back to the seminal work of Morris and colleagues (1953) and their comparison of bus conductors with bus drivers in relation to the development of cardiovascular disease (CVD). In the present day, the benefits of physical activity have been recognised to reduce the risk of chronic conditions such as coronary heart disease (CHD), stroke, type 2 diabetes, some cancers, obesity, musculoskeletal conditions

and mental health problems such as depression (DoH, 2011; World Health Organisation [WHO], 2010). The potential for improved life expectancy and a reduction in all-cause mortality had also been acknowledged (DoH, 2011). Despite these documented benefits, adherence to the British Government's recommended guidelines of 150 minutes of moderate and/or 75 minutes vigorous intensity physical activity over a week (DoH, 2011) have remained challenging for many, with only 61% of the British population meeting the guidelines (British Heart Foundation [BHF], 2017).

The use of primary care became a 'popular' sector to advocate increased physical activity levels (Hillsdon et al., 2002), which took advantage of the opportunities health professionals (HPs) had in encountering the public (Graham et al., 2005). Indeed, GPs were believed to see 95% of the population over a three-year period (DoH, 2001). HPs within primary care were also considered to be an instrumental source of health advice (Riddoch et al., 1998) with the ability to influence behaviour change (Dugdill et al., 2005; Graham et al., 2005). The use of a HP within primary care therefore offered an ideal opportunity for the promotion of physical activity and recommending patients to attend local exercise facilities (DoH, 2001). Yet despite such a valuable opportunity, as indicated by the newspaper headline cited above, the effectiveness of using ERSs remained unclear.

ERSs have come under considerable scrutiny and their effectiveness brought into question (Pavey et al., 2011). Despite strong Government endorsement since the conception of ERSs in the early 1990s and a proliferation of new schemes, evidence

regarding their effectiveness has been varied. This was brought into focus in 2006 when the National Institute of Health and Clinical Excellence (NICE) published its guidance on interventions to increase physical activity, where ERSs were one area of consideration. NICE (2006) concluded that there was insufficient evidence to recommend the use of ERSs to promote physical activity other than as part of a control trial where schemes' effectiveness could be evaluated. Whilst this research was instigated to allay HPs' concerns regarding the use of ERSs, the guidance only served to raise further questions for practitioners, commissioners and policy makers (Sowden and Raine, 2008).

Such efficacy reviews have invited criticism, indeed Beck et al. (2016) suggested that they were an unfair assessment of the potential of ERSs. A systematic review conducted by Pavey and colleagues (2011), referred to in the previously cited newspaper article, identified only weak evidence of short-term increases in physical activity and inconsistent findings for other outcomes such as health-related quality of life, questioning whether ERSs were an efficient use of resources. Yet, Pavey and colleagues' (2011) strict inclusion criteria meant that only randomised control trials (RCTs) were included, which excluded potentially valuable evidence from other evaluation approaches. Although not all systematic reviews have employed such procedures (e.g. Pavey et al., 2012; Williams et al., 2007), this still raised a crucial point regarding the use of RCTs.

RCTs in the evaluation of ERSs have demonstrated mixed findings. A number of the early evaluation studies of ERSs that took a RCT approach (e.g. Harrison et al., 2005;

Harland et al., 1999; Taylor et al., 1998), focused on outcome measures like changes in physical activity levels or immediate health outcomes such as improvements in blood pressure and weight. The findings of such RCTs demonstrated that ERSs could, in the short-term, increase an individual's physical activity levels and improve some health-related indicators such as blood pressure or body fat (Harrison et al., 2005; Harland et al., 1999). More recently, Murphy et al. (2012) identified that the Wales National ERS was only effective for increasing physical activity amongst those referred for coronary heart disease (CHD) risk factors and not for those referred for mental health reasons. Therefore, the evidence continues to be mixed. Wimbush & Watson, (2000) suggested that use of RCTs was typically considered the 'gold standard' method in establishing effectiveness. Yet within the ERS literature, use of a RCT approach has seen manipulation of the ERS delivery mechanisms, such as changes made to recruitment or the support that participants received (Gidlow and Murphy, 2009). By manipulating a scheme's procedures in this way, Dugdill et al. (2005) argued that this form of research led to a limited understanding of ERSs in a 'real world' context and failed to provide a clear indication of the processes needed for effective ERS delivery.

Victoria et al. (2004) suggested that whilst RCTs may have been regarded as the gold standard for clinical decision-making, the evaluation of Public Health interventions should rely on a range of types of evidence. Indeed, Pawson (2013) outlined how outcome evaluations and RCT designs rarely paid due attention to providers' interpretations and the complexity of context. Within the literature, use of different approaches to evaluation have been apparent, with qualitative and mixed method

approaches used. Evaluations that employed qualitative methods provided a useful tool in capturing the perceptions and experiences of all involved in ERSs, which Gidlow and colleagues (2008) considered important to improve the understanding of ERSs' delivery mechanisms. Indeed, previous literature has captured the experiences of the three key groups within ERSs: patients, exercise practitioners (EPs) and HPs. This has been most notable in the exploration of patients' experiences of ERSs alongside the factors that have influenced these experiences. Examples of such factors were highlighted in one such article by Wormald & Ingle (2004), who identified that the level of support provided by the EPs, as well as the gym environment and the perceived potential benefits (e.g. health, fitness and quality of life), all played a part. Gidlow and colleagues (2008) suggested that programme development and delivery were dependent upon the agents who designed and delivered the programme, and therefore investigating their influence was vital. Yet, EPs' perceptions of ERSs have been largely overlooked (Moore et al., 2011) and equally, HPs' views regarding schemes have generally been neglected (Graham et al., 2005).

Within the examples of qualitative studies that have explored the patient, EP and HP groups, the findings from two or more of these groups has been compared but remains limited. For example, Mills and colleagues (2012) employed a mixed method approach to explore patient, EP and HP perceptions of success in an ERS. Yet, overall, there has been little exploration of these groups' collective understanding of ERSs. Furthermore, the perspectives and experiences of those in managerial roles and the commissioning of ERSs have also been overlooked. In order to address these lacunae,



the current study sought to explore these groups further and their collective understanding of ERSs.

With an emphasis on the need to understand ERSs (Gidlow et al., 2008; Dugdill et al., 2005), a range of evaluation approaches have gone some way to address this, with the use of quantitative, qualitative, and mixed methods employed. Yet despite this, some of the evidence-based issues Dugdill and colleagues (2005) raised have persisted and a call for a broader range of evidence regarding ERSs has remained (Oliver et al., 2016). The most recent NICE (2014) guidance suggested a number of areas for further evaluation, with recommendations that included focusing on different models of ERSs and their resultant effects, all recommended to be part of control studies. Other recommendations were concerned with the pragmatics of scheme delivery that influenced uptake and adherence for specific groups as well as the overall cost effectiveness. Further investigation in any of these areas would indeed contribute to the evidence base regarding ERSs, but what these recommendations have overlooked is generating a deeper understanding of ERSs from the perspectives of those individuals associated with schemes and the complexity of a scheme's context. Indeed, Pawson (2013) suggested that the context of an intervention and the circumstances in which it played out was complex and therefore this was worthy of exploration. Arguments regarding approaches to broader evaluation research suggests that instead of considering the effects of interventions, more detailed explorations of how those effects are produced is warranted, which has been referred to as unpacking the 'black box' (Astbury and Leeuw, 2010). Moreover, Astbury and Leeuw (2010) described this unpacking as

explaining why such interventions work or indeed fail to work, in not just different contexts but for different stakeholders, or as described by Pawson (2013) what works, for whom, in what circumstances and in what respects. Yet, with regards to the current ERS evidence base, it can be suggested that the 'what' still requires further understanding.

Gidlow and Murphy (2009) previously suggested that an improved understanding of ERSs in relation to how the process functioned and was influenced by the interactions of those who contributed to it, warranted further exploration and this is still very much apparent. Yet, there is a level of complexity regarding ERSs (Oliver et al., 2016), that Crone and James (2016) described as multi-dimensional in relation to the processes that are employed. Capturing the complexity that schemes operate within has not been fully elucidated and Pawson and colleagues (2005) suggested that the understanding of interventions can be found in the thinking and knowledge behind the reasoning of the actors within such interventions. Therefore, the initial aim of this study was exploratory by design, to seek to understand ERSs beyond what had been presented in the previous literature, by examining the different groups within ERSs, and their understanding of ERSs.

Early into data collection however the researcher was presented with conflicting and inconsistent perceptions of the ERS, which was unexpected. In responding to data and the initial findings a theoretical framework was required that deviated from the researcher's own background. Therefore, to generate original and theoretical insights into understanding ERSs, a figurational framework was adopted within this

thesis. Embracing the use of process sociology within a health and physical activity intervention context may have seemed unusual. Indeed, the use of Norbert Elias's process sociology has been more widely recognised for the theory's application to sport. *The Civilizing Process*, Elias's (1994) *magnum opus*, was notably used to describe the development of modern day sport (Jarvie and Maguire, 1994) and yet process sociology has a much wider application. More recent research (e.g. Malcolm, 2016; Evans et al., 2016; Evans and Crust, 2015; Powell et al., 2014) has demonstrated the use of this theory in examining the complex relationship between health and exercise, the experiences and health consequences of physical activity and exercise, as well as the complexity in delivering the physical activity message.

Process sociology is characterised by the use of figurations. Jarvie and Maguire (1994) described this as the interdependency of all humans, whose lives evolve within the webs of relationships, or figurations, that are formed with each other. These relationships are said to be marked by tensile balances of power that engender emergent dynamics that cannot be reduced to individual actions (Jarvie and Maguire, 1994; Quilley and Loyal, 2005). It is these emergent dynamics that fundamentally shape individual processes of growth and development (Quilley and Loyal, 2005), the unintended consequences. The concept of a figuration could be applied to larger groups such as cities or nation states but equally applied to small groups, such as an exercise class (Elias, 1978; Quilley and Loyal, 2005), or in this instance an ERS. Baur and Ernst (2011) suggested that by examining the bonds of association between individuals enables the impact that individual actions have upon the rest of the figuration to be analysed. In the context of ERSs, the use of process sociology offers

an opportunity to explore the power relationships between individuals central to the ERS figuration and how these have influenced the delivery of the scheme. Therefore, whilst the overarching aim of this study was to provide an understanding of an ERS from the perspective of those individuals central to the service, through the use of process sociology as a theoretical framework, three key research objectives for this case-study ERS were developed; to:

1. Characterise the figuration of the ERS by exploring the figuration's power hierarchy.
2. Explore the 'we' and 'they' groups within the figuration and these groups' perceived ability to change the figuration.
3. Explore the 'I' and 'they' balance within the ERS figuration.

This study considered these research objectives in relation to one county's ERS, found in the East Midlands. Through the exploration of this particular ERS, a combination of one-to-one and group interviews were employed, with a total of thirty-two participants. Interviews explored participant's perceptions and experiences of the ERS, and through analysis, examined how these perceptions had contoured the ERS and the way in which the scheme was delivered. This study was not, it should be emphasised, an evaluation of an ERS, and its purpose was not to provide recommendations for how evaluation of ERSs should be conducted or indeed how ERSs could be improved. Rather, the decision to focus on a processual understanding of ERSs was informed by the absence of literature in this area, with the aim of developing new theoretical insights into how the networks of power

relations within ERSs had influenced scheme delivery. This production of knowledge may then assist those working within the ERS field, including policy makers, commissioners or practitioners, in their own understanding of ERSs, supporting scheme development and delivery, in addition to the way evaluation is approached.

## **1.2 Thesis Structure**

In compiling this study, it is important to note that the structure presented here does not necessarily reflect the structure typically employed for a study grounded in sociological theory. Sociological theory is used as a framework to analyse and interpret the data, rather than the study being embedded in theory, therefore the structure identified here reflects this.

This introduction, Chapter 1, has provided an overview of the context for this study by explaining the background to ERSs and the role they play in targeting inactivity and poor health. It has also provided a rationale for this research by emphasising that despite existing research into certain aspects of ERSs, an understanding of ERSs and the complexities in which ERSs operate has been largely overlooked. In particular, the power relationships within ERSs and how these can influence scheme delivery, may be of value to those working in the ERS field. On this basis, the main aim of this study and research objectives were identified.

Chapter 2 details the relationship between physical activity and health and how this has given rise to the use of primary care to facilitate physical activity-based

interventions. A historical overview of the emergence of ERSs is provided, exploring their evolution and widespread use. Previous evidence regarding ERSs and their use are described and critiqued to further illustrate the rationale for this study.

Chapter 3 provides the theoretical and conceptual framework for the study by considering some of Elias's key works that form the basis of process sociology. The chapter examines, in particular, Elias's concept of power and how this was illustrated in his use of game models. Where appropriate, other relevant works of Elias are discussed to present an overview to the framework employed in this study.

Chapter 4 contextualises the chosen ERS for this study. An explanation of the key features that characterise the county in which the study was undertaken is provided and how these relate to the nature of ERS provision. A brief historical account of the county's ERS is also detailed alongside an overview of the current hierarchical structure of personnel.

Chapter 5 provides an explanation of the general methods employed in this study and the philosophical position taken when adopting process sociology. The research design and justification of the measures employed are also discussed. A single ERS was explored, using qualitative methods for data collection. Explanations of how the two phases of the study were conducted are presented and the process for analysis is provided.

Chapter 6 uses the data collected to explore the key themes from each of the two phases of this study. The key themes derived from the data are explained and considered to present a processual understanding of the chosen ERS. Sociological theory is drawn on to analyse the data and where appropriate findings are also compared to existing ERS literature.

Chapter 7 draws together the key findings from both phases of the study to present a holistic interpretation of the key themes and how this addresses each of the three research objectives concerning the ERS figuration and the power hierarchies at play, the 'we' and 'they' groups and their perception of their ability to change the figuration, and finally the 'I-They' balance within the figuration. Themes are applied to the theoretical framework of process sociology, where the overall implications of these findings are finally considered.

Finally, Chapter 8 concludes this thesis by summarising the key findings from the study in relation to the overarching aim and the three research objectives identified in the introduction. The contribution of these findings to existing literature is explained, in addition to the implications for the ERS context. The limitations of the study and recommendations for future research are also presented, followed by the close of this study.

The chapter that follows contextualises the rationale for this study in relation to previous literature, highlighting the relationship between physical activity and health, the emergence of ERSs and the evidence regarding their use.

## **CHAPTER 2**

### **REVIEW OF LITERATURE**

This chapter addresses and critiques the relevant literature central to the origins of exercise referral schemes (ERSs), their emergence and the evidence regarding their effectiveness. ERSs have been described as the referral of a patient, by a member of a primary care team or allied health professional, to a qualified exercise professional for supervised exercise (Department for Health [DoH], 2001). The origins of such a process begin with establishing a relationship between health and physical activity, which is discussed in the first section of this chapter. The proposed benefits of engaging in regular physical activity alongside the potential risks of physical inactivity are also considered. The use of primary care to deliver this physical activity message is then explored alongside some of the challenges in using this approach. The emergence of ERSs as a physical activity intervention is then considered tracing the widespread use of such schemes across the UK. The concluding section reviews the evidence regarding ERSs and their use, highlighting the limited understanding of a scheme's complexity, which has the potential to be shaped by those who are part of the process itself.

#### **2.1 Physical Activity and Health**

The relationship between physical activity and the potential health benefits have long been established, traced back to the writings of Hippocrates (460-377BC), who recognised the value of physical activity for health:



‘All parts of the body which have a function, if used in moderation and exercised in labours in which each is accustomed, become thereby healthy, well developed and age more slowly; but if unused and left idle they become liable to disease, defective in growth, and age quickly’.

(Myers, 2005, 85)

Hippocrates’ observations have remained as relevant today, as the strength of the relationship between physical activity and health has persisted (DoH, 2011). Yet despite recognition of the benefits a physically active lifestyle offers, a large percentage of the population has continued to remain physically inactive (Lee et al., 2012). A growing concern over the risks posed by leading an inactive lifestyle emerged (DoH, 2011) with physical activity viewed as a major public health problem. Compelling evidence suggested physical activity was a major contributing factor in several chronic diseases and conditions (Blair et al., 2004). Examples included: coronary heart disease (CHD), stroke, type 2 diabetes, cancer, obesity, mental health problems and musculoskeletal conditions (World Health Organisation [WHO], 2010). This was in addition to an increased risk of morbidity and mortality (WHO, 2013).

Chronic, non-communicable diseases (NCDs) are conditions that cannot be passed from one person to another, and are now the commonest cause of death, estimated at approximately 38 million people worldwide each year (WHO, 2013). This umbrella term of chronic disease covered a number of different conditions, the four main conditions being: cardiovascular disease (CVD), cancer, chronic respiratory disorders, and diabetes (WHO, 2013). In 2006 CVD was responsible for more than 200,000 (37% of total) deaths in the UK, with cancers responsible for a further 156,000 deaths (27% of total) (Allender et al., 2007). The Office for National statistics (ONS) recorded similar data in England, with ischaemic heart disease (CVD related condition) being

the leading cause of death for males (15.6% of all male deaths) and second leading cause for females (10.3% of all deaths), whilst cancer (classed as a broad disease group), accounted for the largest percentage of deaths (29% of total) (ONS, 2014).

Lifestyle factors have been heavily associated with the development of chronic diseases and physical inactivity has been identified as a key risk factor (Durstine et al., 2012). Lee et al. (2012) attempted to quantify the effect of physical inactivity on major non-communicable diseases by estimating the percentage of disease that could be averted if inactive people became active and the potential for increased life expectancy. It was concluded that physical inactivity was responsible for 6% of the burden of disease from CHD, 7% for type 2 diabetes and 10% for both breast and colon cancer. This was in addition to physical inactivity causing 9% of premature mortality, death occurring before a person reaches an expected age e.g. seventy-five (ONS, 2006). The overwhelming conclusion from Lee and colleagues (2012) was that if inactivity was decreased (or removed completely) then a substantial improvement in health across the global population would be observed. It was also noted that the study's findings placed inactivity on a par with the risk factors of smoking and obesity.

Evidence suggested that it was not merely inactivity that posed risks to health, there was an emerging body of evidence that indicated 'sedentary' behaviour may be a specific risk factor for a number of health outcomes including mortality (Thorp et al., 2011). It must be acknowledged that the term 'sedentary' has incited much debate and there lacks a clear consensus between researchers regarding the definition (Allen-Collinson et al., 2011). Yet, in relation to Thorp and colleagues' (2011) study,

sedentary was simply described as 'too much sitting' (p.190) and not merely a lack of exercise. Thorp et al. (2011) reviewed the evidence to establish sedentary behaviours in relation to subsequent health outcomes and found that the relationship between sedentary behaviour and premature mortality, specifically all-cause and CVD mortality, was most consistent across studies in men and women. The authors acknowledged that additional studies were needed to validate this relationship. Although the number of studies the authors examined was limited, making it difficult to draw definitive conclusions, it was noted that increases in CVD, symptomatic gallstone disease, mental disorders and hypertension were all shown to be associated with time spent sedentary, regardless of physical activity time. These findings echoed claims made by the DoH's Sedentary Behaviour and Obesity Expert working group (2010), which identified that sedentary behaviour was independently associated with all-cause mortality, type 2 diabetes, some cancers, and metabolic dysfunction. They also claimed that spending large amounts of time being sedentary increased the risks of some health outcomes, even among people who were active at the recommended levels. These findings concurred with the notion that an individual can be active yet also sedentary as Biddle and Gorely (2005) reported in relation to young people, the authors suggested that the two forms of behaviour could co-exist. Despite these conclusions, the exact level of harm to the population has remained unclear (British Heart Foundation [BHF], 2010) but the recommendation to avoid extended periods of sedentary behaviour has endured (DoH, 2011).

Literature presented mounting evidence of the risks posed by sedentary behaviour and leading an inactive lifestyle but the benefits that can be gained by changing unhealthy behaviours has also been established. Understanding the benefits of physical activity is not a new matter; in the 1950s Morris and colleagues' (1953) seminal work examined the relationship between physical activity and chronic disease, specifically examining CVD risk in London's double-decker bus conductors and drivers. The research concluded that the more active conductors were less likely to suffer from CVD when compared with the inactive drivers. Similar themes were later depicted by Paffenberger et al. (1986) in the longitudinal Harvard Alumni study. Paffenberger et al. (1986) followed alumni students aged between thirty-five and seventy-four for sixteen years (1962-1978) and reported that all-cause mortality was reduced for those individuals with higher physical activity levels. Furthermore, the protective effect of physical activity was only apparent for as long as those individuals remained active. Although now dated, both Morris' and Paffenbergers' seminal works raised awareness for the need to become active in order to develop and maintain good health (Durstine et al, 2013). Research has continued to detail the potential benefits that can be gained from being physically active and it has been suggested that physical activity could prevent and alleviate over twenty chronic conditions including CHD, stroke, type 2 diabetes cancer, obesity, mental health problems and musculoskeletal conditions (WHO, 2010). Yet despite such evidence it is well documented that in the UK the majority of adults and many children are insufficiently active to benefit their health (DoH, 2011).

In quantifying physical activity, there has been much debate regarding the characteristics of frequency, intensity, time and type and how each should be disseminated. This has led to numerous different recommendations from both public health and clinical settings (Blair et al., 2004). Prior to 2011, the DoH guidelines recommended thirty minutes of moderate intensity at least five times per week but this was updated in 2011 by the DoH in line with changes made by the WHO (2010). Guidelines have specified that nineteen to sixty-four year olds should aim to be active daily, and over the course of a week activity should amount to 150 minutes of moderate intensity or alternatively seventy-five minutes of vigorous intensity activity (DoH, 2011). In 2010, globally, 23% of adults aged eighteen years and over were reported to be insufficiently physically active, failing to meet the recommended guidelines. Women were less active than men; with 27% of women and 20% of men not reaching the recommended level of activity (WHO, 2010). Compared to those who do at least 150 minutes of moderate intensity physical activity per week, those adults who did not meet the recommendations were said to have between 20 and 30% increased risk of all-cause mortality (WHO, 2010).

In relation to global figures, data from the UK suggested the problem of inactivity was more prevalent. The Health Survey for England (HSE) found that 61% (66% men 56% women) met the guidelines for moderate and/ or vigorous physical activity (Health and Social Care Information Centre [HSCIC], 2012). These figures were believed however, to be nearer 59% (65% men 54% women) when re-analysed to be compared with the HSE 2008, due to additional occupational activity questions added to the 2012 version, when compared to the 2008 version (HSCIC, 2012).

Overall data demonstrated that approximately three in five adults aged nineteen and over had met the new guidelines for physical activity that were released in 2011. The HSE claimed data had remained stable since 2008 but the HSE also assumed that compliance appeared to be higher (HSCIC, 2012). This was attributed to the more flexible definition of physical activity, which had allowed individuals greater flexibility in ways to accumulate physical activity throughout the week. Only recently, the BHF (2017) confirmed that the population's activity levels has remained similar, with 39% of the British population insufficiently active to benefit people's health.

Against this backdrop of reported physical inactivity, the risk of developing chronic diseases and premature mortality has continued to be problematic and the prevalence of both were recognised in the ONS (2014) data presented earlier in the chapter. Despite this, the hazards of sedentary living and the benefits of physical activity have been well documented (Blair and Morris, 2009). Indeed, some years earlier Fox (1997) claimed that physical activity had become the preventative vehicle with which to target chronic disease and in many ways this viewpoint has been upheld. Haskell et al. (2009) also suggested that there was now sufficient evidence to develop strong preventative medicine policies. Approaches to the delivery of this physical activity message however have appeared less clear, where effective, sustainable interventions to increase physical inactivity have remained elusive. Previous evidence suggested that effective interventions to increase participation were yet to be found (Morgan, 2005; Dugdill and Graham, 2005; Hillsdon et al., 2002). Despite the uncertainty of physical activity promotion, strategies via the use of primary care have been employed, a sector which became 'popular' in the UK to

increase individuals' physical activity levels (Hillsdon et al., 2002). The use of physical activity in primary care is now explored in the following section, alongside the challenges this has presented.

## **2.2 Physical Activity in Primary Care**

Physical activity research (e.g. Lee et al., 2012; Allender et al., 2007) established the link between physical inactivity and poor health status in populations, but Dugdill and Graham (2005) argued there was still some way to go in understanding how to design, develop and implement physical activity interventions that were effective in not just initiating but sustaining behaviour change. The authors suggested that it was the DoH white paper in 1999, *'Saving Lives: Our Healthier Nation'*, that generated interest in using a settings-based approach for increasing physical activity, such as the workplace, schools or primary care. Indeed, the white paper went some way to highlight the potential of these settings and how they could be utilised. The use of settings to encourage physical activity was considered to be important, as it enabled the general population to be reached and involved them in the health intervention itself (Dugdill and Graham, 2005).

It had become increasingly popular in the UK for primary care organisations to advocate increased physical activity levels (Hillsdon et al., 2002), which took advantage of the opportunities health professionals (HPs) had in encountering the public (Graham et al., 2005). Evidence highlighted that primary care professionals or as they will be referred to, HPs, came into frequent contact with the general public.

For example during 2007/ 2008 it was estimated that 292.4 million consultations in primary care were undertaken (Hippisley-Cox and Vinogradova, 2009), yet by 2014 this figure was estimated to be 340 million, where the average member of the public saw their general practitioner (GP) six times a year (British Medical Association [BMA], 2014). Furthermore, the DoH (2001) estimated that approximately 95% of the UK population visited a general practitioner (GP) over a three-year period. It was not just access to the patient population that supported the use of primary care, indeed GPs were also considered to be a 'powerful' and credible source of health and lifestyle advice (Riddoch et al., 1998; Stathi et al., 2004), with the ability to influence behaviour change at every consultation (Dugdill et al., 2005; Graham et al., 2005). Primary care therefore offered the potential to be an ideal environment for the promotion of physical activity to those individuals who sought healthcare, with an opportunity to target those with existing diseases or those with an increased risk of disease (Simons-Morton et al., 1998). Whilst the patient population could have been considered a limited group, with approximately 95% of the population accessing a GP over a three-year period (DoH, 2001), this remains a large target audience.

The potential for using primary care has been recognised, historically, by a number of national health policies that have placed emphasis on the primary care setting for the prevention of disease. Fox and colleagues (1997) highlighted policies such as *'Health of the Nation'* (DoH, 1992) and *'More People More Active More Often'* (DoH, 1995), which had identified use of the primary care setting. Whilst Government may have changed, the use of the primary care setting to encourage physical activity has remained prominent, evidenced in more recent publications such as, *'Start Active,*



*Stay Active*' (DoH, 2011) and *'Everybody Active, Everyday'* (Public Health England [PHE], 2014). *'Start Active, Stay Active'* (DoH, 2011) made reference to the options GPs had available to them, whether that was providing advice to encourage individuals to increase their physical activity levels or maintaining close links with community-based opportunities to recommend local activities. The National Institute for Health and Care Excellence (NICE), had previously provided recommendations on the use of different types of physical activity interventions within primary care, one of which was providing 'brief intervention', which referred to clinically delivered advice on physical activity (2006). NICE (2006) recommended:

'Primary care practitioners should take the opportunity, whenever possible, to identify inactive adults and advise them to aim for 30 minutes of moderate activity on 5 days of the week (or more)'.

(p.4)

NICE (2006) guidance had led to the inclusion of brief intervention in combination with other recommended strategies, to form central components of the *'Let's Get Moving'* (DoH, 2009) physical activity care pathway. This had been a systematic approach to integrating physical activity into primary care for all patients regardless of their risk (Bull and Milton, 2010). GPs signposting patients via this pathway had demonstrated some evidence of effectiveness (Bull and Milton, 2010; 2011) but whether GPs were the most suitable to facilitate these recommendations had remained unclear. It was outlined by Bull and Bauman (2011) that doctors were neither trained, experienced nor confident to effectively promote physical activity. Particularly in relation to keeping up with the rapidly increased number of both clinical and public health guidelines. Perhaps this was unsurprising considering the training that doctors received in the area of physical activity, as Weiler and colleagues

(2013) identified. Weiler and colleagues (2013) discovered that only 56% of medical schools in the UK had included the Chief Medical Officer's physical activity guidelines as part of their undergraduate curriculum. It was also found that time spent teaching physical activity sciences and promotion was minimal, averaging approximately in total 4.2 hours. This evidence suggested that despite GPs being expected to promote physical activity to patients it would be unfair to do so if there was a lack of education at entry level medical training, which then persisted through to chosen medical specialities and general practice (Ward, 2014).

Gould and colleagues (1995) undertook an investigation of GP trainers and practice nurses, which focused on their knowledge and attitudes towards the health benefits of physical activity. Participants were unanimous in their belief that physical activity was a 'good thing' however their knowledge regarding the benefits was vague. Participants identified that they had received no training on physical activity nor had they received any support in how to encourage patients to become more active. The authors did suggest that this may be due to the participants' National Health Service (NHS) grade (Band 3), and that less developed knowledge might be expected at this particular level. Lord Darzi (2008), however, found that the problem was more widespread, where 54% of patients had reported that their GP had not provided advice on diet or exercise. Ward (2014) also suggested that a lack of knowledge undermined GPs' confidence and ability to fulfil a role that they viewed as having 'potentially harmful and legal consequences' (p.27).

Following Gould and colleagues' (1995) suggestion that GPs were unable to give effective advice due to a lack of knowledge regarding physical activity, Lawlor and colleagues (1999) explored GPs' knowledge, attitudes and self-reported practice towards promoting physical activity, and its potential impact. Lawlor and colleagues' (1999) findings indicated that participants had a good level of knowledge of both the benefits of health and the levels of activity that were required. This was conflicting evidence in relation to findings by Gould et al. (1995), but it was suggested that there was potential for knowledge to have increased since the 1995 study. It was interesting to note the barriers reported by GPs for promoting physical activity centred on time, lack of relevance to that particular consultation and concerns over whether the patient would follow the advice given. The study found that in reality few GPs promoted physical activity in a way that would influence a change in the patient's current activity levels.

This, alongside the aforementioned arguments, made a case for the use of an intervention delivered outside of primary care, with a third party who held the necessary skills, expertise and resources. This effectively described an ERS, which combined the advantages of a primary care setting, to identify participants, but was delivered by a qualified exercise practitioner (EP) (Gidlow and Murphy, 2009). ERSs were an intervention that had been embraced by primary care (Kahn et al., 2002) and had become increasingly popular (Dugdill et al., 2005). The use of ERS presented HPs with an opportunity to refer their patients to qualified EPs for a structured programme of exercise that typically took place in community-based leisure centres. Ward (2014) had suggested that the implementation of ERSs generated similar

problems in engaging the support of HPs, who had cited the same barriers about ERSs as they had for simply recommending physical activity. This evidence suggested that whilst HPs were considered pivotal in encouraging patients to become more physically active and were indeed well positioned to do so, there was some reluctance. Hillsdon et al. (2002) argued that an effective intervention to increase physical activity within primary care was still to be determined, yet following their conception, the use of ERSs saw exponential growth. The concept of ERSs as a public health intervention is now examined.

### **2.3 Exercise Referral Schemes**

In the UK, ERSs have been considered one of the most popular interventions used in primary care to encourage both sedentary individuals and individuals who have presented with long term conditions to become more physically active (BHF, 2010). ERSs have been used as a strategic approach to offer the opportunity for participation in physical activity through increased access to exercise facilities (Kahn et al., 2002). These facilities are generally located in the community in a leisure-based setting, typically a gym environment (Dugdill et al., 2005), however, some facilities are practice-based (Gidlow et al., 2016; Crone et al., 2004). The process is typically characterised by the opportunistic referral of patients by GPs, to a qualified EP for supervised exercise (DoH, 2001; BHF, 2010). It has become apparent, however, that other members of the primary care team, for example, practice nurses or physiotherapists, also identify patients who could benefit (Gidlow et al., 2016). In some cases, patients have been known to refer themselves (Gidlow and Murphy, 2009). On receipt of the patient, EPs utilise medical information and relevant

screening procedures (Dugdill et al., 2005) and devise tailored programmes of activity, whilst monitoring clients closely throughout (Williams et al., 2007). The individually tailored programme could include a plethora of activities such as the gym, exercise classes or swimming (where available), but these opportunities have continued to evolve (Gidlow et al., 2016) with the inclusion of other public health initiatives, for example 'Walking for Health'. Although the length of such programmes has varied, the BHF (2010) has suggested programmes last anywhere between ten and sixteen weeks, which is typically at a subsidised rate for patients or in some areas for free. A typical ERSs will have adopted a model similar to that depicted in figure 2.1 below.

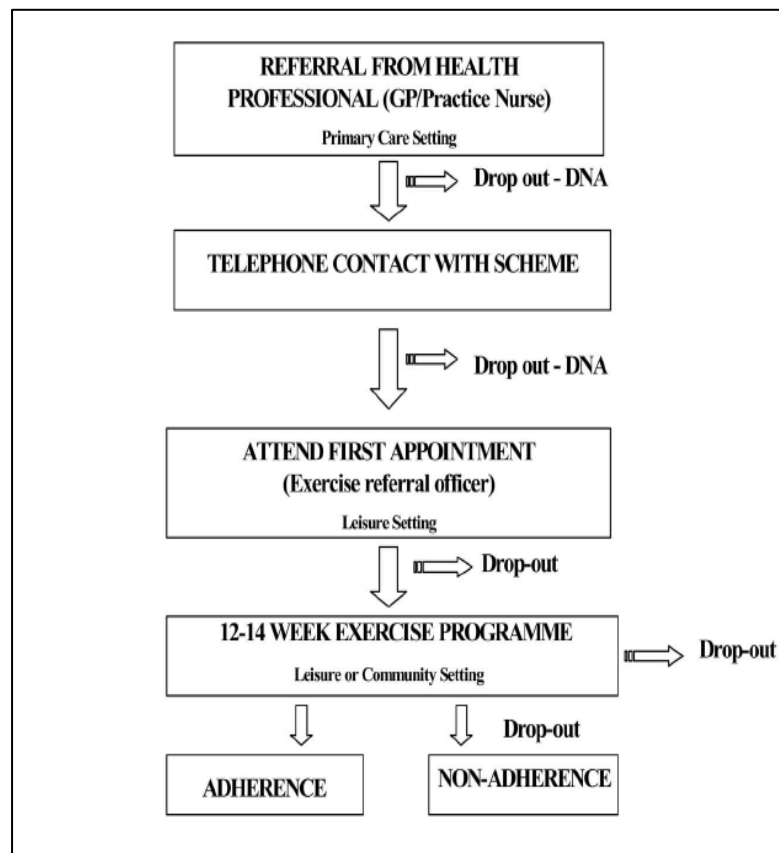


Figure 2.1 Generic referral structure taken from Dugdill et al. (2005).

*\*Where DNA is shown this is referred to as 'Did Not Attend'.*

Advantages are recognised of such a model as it removes responsibility from the HP, where the time available to discuss physical activity is often limited and expertise in exercise programming is not always accessible (Taylor, 2001), as has been described in the previous section. It does however mean that the role of the EP is integral to the implementation and delivery of ERSs. Both the knowledge and effective interpersonal skills of the EP have been viewed as key determinants for patient adherence to exercise (Vinson and Parker, 2013; Moore et al., 2011; Hardcastle & Taylor, 2005; Stathi et al., 2004; Wormald and Ingle, 2004) and are discussed later in this review.

Although the model identified in Figure 2.1 reflects a typical ERS, it has been acknowledged that there are variations in both the models and standards of scheme delivery across the UK (BHF, 2010). Dugdill and colleagues (2005) drew attention to the design of ERSs and highlighted how those responsible for developing ERSs copied other schemes when deciding the content and delivery of their own. Crone et al., (2004) also acknowledged the design of schemes as an issue and believed them to be designed without a standard format. The variation in scheme design could be considered unsurprising when national policy and best practice guidelines have been described as vague and this has perhaps led to continued diversity of scheme delivery (Oliver et al., 2016). Despite design issues, the growth in schemes has not been hindered and at the time of the first NICE (2006) public guidance, this was in the order of 600 schemes operating in the UK and by 2008, Sowden and Raine claimed, that across England 89% of primary care organisations were operating an ERS.

The number of ERSs has dramatically risen since its earliest example, which became the catalyst for national increases in similar schemes (Taylor, 2001). ERSs quickly became the most prevalent primary care based physical activity intervention (Crone et al., 2004). The rapid expansion led to suggestions that there was a consequent lack of quality assurance and limited evaluation taking place (Hillsdon, 1998), bringing the effectiveness of ERSs into question. Indeed, as schemes grew at a 'grass roots level', drawing and relying upon local initiative and enthusiasm (Crone et al., 2004), concerns mounted that ERSs were being treated as the 'panacea' for physical activity promotion (Dugdill et al., 2005).

Despite the limited evidence base at this time, the growth in the number of schemes was thought in many ways to be fuelled by UK Government endorsement. The Government prioritised ERSs as a means of reducing obesity and tackling disease prevention, and acknowledged the use of ERSs in a number of key health and physical activity promotion strategy documents (DoH, 2001). It was the release of the National Quality Assurance Framework (NQAF) in 2001 that was highly significant in placing ERSs on the public health policy agenda (Crone et al., 2004), in a bid to improve the quality of the delivery of schemes (BHF, 2010). It was a collaborative document forged by the DoH, the National Health Service (NHS) and the British Association of Sport and Exercise Science (BASES). The document reiterated many of the points raised by *'Our Healthier Nation'* (DoH, 1998) in identifying how ERSs provided an ideal opportunity to address health care inequalities, disease prevention and ultimately enhance quality of life (DoH, 2001).

The document targeted policy-makers in developing schemes that would involve everyone, from HPs to EPs, clarifying the processes involved and enabling those partnerships to work to the benefit of the patient (DoH, 2001). Sections in the document included topics such as medico-legal considerations and professional competencies, in an attempt to provide the much-required clarification, but it also aimed to improve standards of existing schemes and guidelines for those still in the development phase (Crone et al., 2004). The NQAF was intended to answer requests for a consolidated model of practice, as the document itself acknowledged there were so many in existence (DoH, 2001) and emphasised the importance of evaluation (Dugdill et al., 2005; DoH, 2001). In spite of the publication of the NQAF, the document came under scrutiny from those involved in the delivery of ERSs and was heavily criticised regarding the guidelines on evaluation. It was believed to have failed to achieve consistency and comparability of audit and evaluation mechanisms between schemes (Dugdill et al., 2005; Sowden and Raine, 2008). Capacity and resource constraints were largely believed to have dictated the extent to which the majority of schemes were meeting these standards (BHF, 2010), which raised questions regarding the real-world application of such guidance (Dugdill et al., 2005; Gidlow et al., 2005).

Although concerns about the quality and effectiveness of ERSs were voiced by researchers and policy makers (Sowden and Raine, 2008), Government policy continued to promote schemes as a popular intervention for increasing physical activity, most notably in the White Paper '*Choosing Health: Making healthier choices easier choices*' (DoH, 2004). Yet questions remained, and consequently in 2005 the



DoH commissioned NICE to undertake a review of the effectiveness of ERSs to increase physical activity levels (BHF, 2010). Despite being conducted to allay HPs' concerns, the review did the opposite and concluded there was insufficient evidence to recommend the use of ERSs to promote physical activity other than as part of a control trial where the schemes' effectiveness could be evaluated (NICE, 2006; Sowden and Raine, 2008). This only raised more concerns and questions for practitioners, commissioners and policy makers, particularly regarding how ERSs should function if, as NICE (2006) guidance suggested, schemes should only be used if part of a control trial. It was a complete shift from the holistic approach to evaluation that had been suggested in the NQAF (Sowden and Raine, 2008) and offered little practical direction on how delivery and evaluation of schemes could be improved (BHF, 2010).

Following the publication of the NICE (2006) guidance, a year later the DoH (2007) released a statement to try and clarify the guidance, in some way offering a reprieve for some schemes (BHF, 2010). It was stated that the requirement to be part of a control study had only applied to those schemes that existed solely for the purpose of promoting physical activity in people with no underlying condition or risk factors; all other schemes could continue as before. This seemed a strange statement to publish as it was unlikely that any ERS existed for solely healthy people. Sowden and Raine, (2008) suggested that the statement allowed schemes to effectively ignore the commissioned NICE guidance.

In further steps to alleviate concerns shown by EPs and other physical activity leads, the British Heart Foundation National Centre for Physical Activity (BHFNCPA) developed a toolkit for ERSs (BHF, 2010). This was designed to be a practical guide for all professionals involved in the delivery, coordination, commissioning and evaluation of ERSs. The emphasis was very clearly placed on the document to be used to aid design, delivery and evaluation and not to replace national policy or to be used in isolation of the NQAF. Indeed, the delivery of ERSs were still very much in use and well supported. This was evidenced in the '*Let's Get Moving*' physical activity care pathway (2009) which saw ERSs embedded into the initiative.

NICE (2014) also offered further reassurance by updating its guidance in relation to the recommendations made in 2006. The guidance targeted primary care practitioners, commissioners, policy makers and any other practitioners with physical activity as part of their remit, whether local authority or NHS based. This appeared largely to be a repetition of the original published guidance but with apparent further clarification. Policy makers and commissioners were still advised not to fund ERSs for sedentary or inactive people who were otherwise healthy, as well as reaffirming that those in primary care should not initiate referral for these people. The second recommendation suggested that ERSs should be funded for sedentary or inactive people with existing health conditions or other factors that placed them at increased risk of ill health. This was with the caveat that the scheme utilised behaviour change approaches, collected data, and made data available for analysis and research, to inform future practice. PHE were also advised to develop and manage a system to collate all local ERS data. Interestingly, the fieldwork conducted by NICE (2014) as

part of the review identified that commissioners through to practitioners found the draft guidelines unclear and unhelpful and the comments made sought further clarification on the proposed guidelines. The general feeling was the guidelines had undermined current efforts, as it seemed to imply that ERSs were ineffective. The only reassurance the document had provided at that time, was that the NQAF was being updated.

Whilst there may be a lack of consensus regarding ERSs, the role of schemes has been acknowledged as part of a bigger model of 'Social Prescribing'. A decentralisation of healthcare decision-making from central to local Government and a Health Service that acknowledged that it was unable to do everything by itself (NHS, 2014), have provided a climate for the development of Social Prescribing (Thomson et al., 2015). Social prescribing is a model that supports the 'prescribing' of non-medical activities to patients (South et al., 2008), which are typically delivered by third sector or community agencies (Husk et al., 2016). Models of social prescribing tackle a range of factors that can directly impact on health including: diet and exercise; social isolation and support networks; mental health and wellbeing; and employment and finances (National Endowment for Science, Technology and the Arts [NESTA], 2013). Whitelaw and colleagues (2017) suggested that the work of Social Prescribing had a history within exercise referral, but this role has now become far more comprehensive with the 'prescription' of a wider range of activities such as: art therapy, reading groups, nature-based activities and volunteering (Husk et al., 2016). ERSs are still viewed as one branch of this multi-component complex model, which has been demonstrated by the inclusion of ERSs in a recent review of Social

Prescribing (Thomson et al., 2015). Thomson and colleagues (2015) identified that encouraging patients to become proactive in decisions about their own health, whilst increasing social contact and support in local communities, had led to reductions in levels of reliance on primary and secondary care.

Therefore, as guidance appeared to play catch up with both the development and recognition of schemes, this presented some idea of the complexities of ERSs. Oliver and colleagues (2016) suggested there was a level of complexity regarding ERSs. Indeed, schemes were considered to provide both treatment and preventative roles (Riddoch et al., 1998) in improving patients' health, which suggested schemes were far more complex than simply providing advice on physical activity (Sørensen et al., 2006). Dugdill and colleagues (2005) explained the referral concept had surpassed the simple delivery of exercise based classes but demonstrated '...complex multi-stranded physical activity programmes', which strived to facilitate a change in lifestyle (p.1395). Moreover, Crone and James (2016) described ERSs as multi-dimensional in relation to the processes that were employed. This complexity was more widespread than the design of the scheme itself, however. Schemes encompassed collaborative partners interacting at a number of levels, operating under what appeared to be conflicting guidance between advising organisations and an evidence base that continued to scrutinise ERSs. Therefore, it was perhaps unsurprising that the need to better understand effective methods of physical activity promotion and the delivery of these interventions (McKay et al., 2003) was a reoccurring theme. Dugdill and colleagues (2005) argued that there appeared to be

little underpinning evidence upon which to assess/evaluate the effectiveness of ERSs and whilst the evidence-base has grown, many of the issues have persisted.

Whilst it has already been stated that the focus of this study is not to evaluate ERSs, in order to establish what is not known about ERSs, it is necessary to consider what is known. Such literature has mostly taken the form of evaluative research, and therefore a critical examination of the existing evidence regarding ERSs is presented in the following section.

#### **2.4 Evaluation of Exercise Referral Schemes**

NICE (2014) highlighted the uncertainty regarding the effectiveness of ERSs and this, in the main, was attributed to the evidence-base regarding ERSs. NICE (2006) had previously suggested that schemes should only be delivered as part of a controlled trial and yet only the year previously Dugdill and colleagues (2005) had argued that the understanding of ERSs in a 'real world' context was limited. Therefore, there appeared a disjuncture between the type of evidence that was required, in relation to the understanding of ERSs that the existing evidence actually provided. Victora and colleagues (2004) suggested that the evaluation of public health interventions required a range of types of evidence, and the commentary that follows considers these different examples regarding the use of ERSs, and highlights where some areas are yet to be addressed.

### **2.4.1 Quantitative Evidence**

Use of quantitative approaches to evaluate ERSs has been varied. Randomised controlled trials (RCT), as one example of a quantitative approach, have typically been considered the gold standard method in determining effectiveness and for clinical decision making (Victoria et al., 2004; Wimbush and Watson, 2000), indeed, early evaluation studies of ERSs took this approach when investigating schemes. Studies of this nature (Harrison et al., 2005; Harland et al., 1999; Taylor et al., 1998) drew on outcome measures that included changes in participants' physical activity levels but also other measures such as blood pressure and weight. Harrison et al. (2005) and Harland et al. (1999) found small increases in physical activity levels in users of ERSs in the short-term compared to controls, while Taylor and colleagues (1998) observed some improvement in health-related indicators such as blood pressure and skin-fold measurements for those with high attendance. More recently, Murphy and colleagues (2012), considered the Wales National ERS and identified the scheme was effective for increasing physical activity amongst those who had been referred for CHD risk factors but not for those who had been referred for mental health reasons. Each of these studies provided some insight into the general effectiveness of ERSs to improve physical activity and health outcomes, but for only a single set of patients at that time.

Limitations of the RCT approach have been highlighted within the ERS literature. Using a RCT approach saw manipulation of the ERSs' operational process, such as changes to recruitment or the support that the participants received (Gidlow and Murphy, 2009). Indeed, Crone and James (2016) suggested; 'participant selection,

attrition rates, group matching, control of independent variables and bias' (p.249) were all potential problems having employed such a design. By manipulating the programme's procedures in this way, it was argued that this form of research led to a limited understanding of ERSs in the 'real world' context (Dugdill et al., 2005) and failed to provide a clear indication of the processes needed for effective ERS delivery. This suggested that this particular approach presented challenges in contributing to the shaping and development of existing and new ERSs.

Use of RCTs have also formed a key part of systematic reviews that have been conducted in an attempt to establish the effectiveness of ERSs both historically and more recently (Biddle et al., 1994; Riddoch et al., 1998; Morgan et al., 2005; Gidlow et al., 2005; NICE, 2006; Williams et al., 2007; Pavey et al., 2011; Pavey et al., 2012). For some reviews, changes in physical activity behaviour were primarily focused on, where a number of the studies determined that physical activity increased but only in the short term (Riddoch et al., 1998; Morgan, 2005; NICE, 2006; Williams et al., 2007). Williams and colleagues (2007) also questioned whether such a small benefit was an efficient use of resources. Pavey and colleagues (2011) evaluated similar outcomes but identified only weak evidence for short-term increases in physical activity and inconsistent findings for other outcomes such as health-related quality of life. The authors ultimately questioned the effectiveness of ERSs.

Such reviews have invited criticism, Beck and colleagues (2016) suggested that they are an unfair assessment of the potential of ERSs. Indeed, in conducting these reviews existing evaluation studies are typically excluded by researchers for failing to

meet the strict inclusion criteria, typically those that deviate from the RCT model. For example, this applied to those reviews conducted by Pavey et al. (2011) and NICE (2006). Other more recent reviews (Pavey et al., 2012; Williams et al., 2007) have been more holistic in their approach and included both observational and population cohort studies (Crone and James, 2016). Gidlow and colleagues (2005) conducted a review that compared RCTs with other evaluation studies to examine characteristics of those patients who attended and why some dropped out. It was revealed that the way in which studies defined the referral uptake (those patients who commenced the ERS programme of exercise) contributed to the overall attendance levels recorded. This demonstrated an argument for the use of observational studies as an alternative, where routinely collected data related to actual practice (Gidlow et al., 2008). Hanson and colleagues (2013) also identified that routinely collected data was preferable, in their evaluation of an ERS that considered the changes in patients' physical activity levels over a six-month period. Indeed, such quantitative studies have provided some insight into those population groups who are most suited to the processes of ERSs (Gidlow and Murphy, 2009). Examples have included identifying poorer adherence for younger people (Gidlow et al., 2007; Moore et al., 2012) and mental health patients (Moore et al., 2012; Crone et al., 2008).

Alongside the quantitative research that has been identified here it is also worth noting the use of studies of cost-effectiveness, which have provided further quantitative insight into ERSs. Indeed, Edwards and colleagues (2013) suggested that in times of financial constraint, consideration of the cost-effectiveness of ERSs is important. Yet despite the importance placed on determining how cost-effective



ERSs are, the evidence remains uncertain (e.g. Campbell et al., 2015; Edwards et al., 2013; Anokye et al., 2011) and compelling arguments are yet to be determined. Research in this area has subsequently remained one of NICE's (2014) recommended priorities for further investigation.

Whilst the literature presented here is by no means exhaustive, it is argued that all forms of quantitative approaches could be critiqued for both their benefits and limitations; but ultimately all offer something different in demonstrating whether ERSs are effective and in what way. McKenna and Mutrie (2003) suggested that demonstrating intervention effectiveness alone was insufficient. Furthermore, Gidlow and colleagues (2008) suggested that public health promotion and policy should be informed by a rich evidence base, which the authors argued required a greater range of approaches. Indeed, other methods have been sought to generate a deeper understanding of ERSs, which is now discussed.

#### **2.4.2 Qualitative Evidence**

Qualitative research, according to McKenna and Mutrie (2003), was a useful contribution to the existing evidence-base and had the potential to provide information on the effective promotion of physical activity interventions, as well as descriptions of the processes that underpinned these. Within the context of ERSs, the use of qualitative research to gain the perceptions and experiences of all of those involved was important for improved understanding of ERSs (Gidlow et al., 2008).

The BHF (2010) suggested that patient feedback in relation to healthcare was a valued tool, particularly when current health policy had emphasised the need for health services that were focused on patients' needs and on empowering choice. Indeed, many of the ERSs qualitative studies focused on the patient experiences of the exercise programme (Moore et al., 2013) whilst others considered patients' motivation for attendance (Stathi et al., 2004; Hardcastle and Taylor, 2001). Patients' experiences of ERSs appear to be consistently influenced by the EP (Stathi et al., 2004; Wormald and Ingle, 2004; Hardcastle and Taylor, 2005; Moore et al., 2013; Morgan et al., 2016). Wormald and Ingle (2004) identified that attendance had been encouraged by EP support, but that access to the scheme could be restricted by a lack of awareness on the part of primary care staff. Other factors such as the gym environment and the perceived potential benefits also contributed to the overall experience (e.g. health, fitness and quality of life). Moore and colleagues (2013) emphasised the importance of a knowledgeable instructor who provides reassurance, support and supervision. Interestingly what each of the studies highlighted was the influential role of the other actors within ERSs and how this affected the overall patient experience. Therefore, it seems pertinent that the consideration of these actors, their roles and their relationships with others constitutes a central focus of this study.

Reporting of patient experiences had generally been in isolation of the other actors within ERSs, for example HPs and EPs. Within the context of ERSs, the perspective of HPs had largely been neglected (Graham et al., 2005). Smith and colleagues (1996) interviewed both clinical and support staff from practices participating in ERSs, many

of whom considered exercise to be a therapeutic option rather than suitable for the primary prevention of disease. The participants emphasised the psychological benefits of participation in physical activity but were cautious in making recommendations due to the then current authority guidelines. HPs' role in promoting physical activity has been more recently considered by Din et al. (2015) who also identified a reluctance by HPs to recommend. They highlighted a number of barriers to referral that centred around the expertise of the HP, the time constraints placed on them but also the priority of physical activity in relation to other health promotion activities. Graham and colleagues (2005) however explored a different perspective; they attempted to understand the key factors that affected the operation of ERSs from the HP perspective and an understanding of the ERS processes. Four key themes emerged: priority of physical activity promotion by HPs, HPs' barriers to referral, HPs' perceived role in promoting physical activity behaviour change, and methods for identifying patients for referral to an ERS. What perhaps was most pertinent in relation to the current study was the recommendations provided by the authors that identified the need for closer partnership working between HPs and EPs, reinforcing the importance of relationships between these two groups.

Analogous to overlooking HPs' and clinical teams' perspectives, EPs have also been largely overlooked (Moore et al., 2011). Moore and colleagues (2011) examined EPs' experiences of engaging diverse clinical populations in ERSs and the local practices employed to support both uptake and adherence, specifically for the national scheme in Wales. EPs reflected on their own practice and highlighted that this was

dependent on each client, yet the clients' needs varied depending on the reason for attending. Concerns were also expressed over providing support to patients and ensuring dependence was avoided. This study highlighted the influential role of the EP and the importance of the relationships that formed between themselves and the patient.

Whilst the above studies considered the perspectives of defined groups within ERSs, few studies have tried to integrate the perspectives of these groups. Vinson and Parker (2012) captured the experiences of two ERS groups, patients and scheme organisers. Amongst the conclusions made, the roles of staff were found to have considerably contributed to the engagement of patients, with scheme organisers needing to ensure patients had appropriate, sustainable support networks. This continued the theme of the role other actors had played in ERSs but also raised the question, what constituted the processes of an ERS, as from Vinson and Parker's (2012) findings, it was unclear whether the use of support networks for patients was an expected part of the ERS or whether this was something that had naturally emerged for this scheme and as a result become the norm.

Whilst not purely qualitative, Mills and colleagues (2012), through use of a mixed methods approach had explored the perceptions of success by patients, EPs and also the referring HPs. The multidimensional nature of success was highlighted and the authors suggested that success was not a static concept, indeed the perceptions of success altered according to the experiences of the scheme. Mills and colleagues (2012) believed the experience in itself was complex which had resulted in the

potential interaction of the themes they had identified. This integrated interpretation of the data from the three groups demonstrated a more holistic insight into the impact of the scheme itself, which reinforced the benefit of not considering the actors of ERSs in isolation of each other. This therefore supports the main aim of this study, in exploring the groups of actors within ERSs as a collective, rather than isolating certain roles within schemes.

Crone and James (2016) highlighted that the exploration of participants' perceptions provided valuable information on the social, physical and cultural aspects that were associated with the experience of interventions such as ERSs. Indeed, for those qualitative studies highlighted, this appeared the case. Crone and James (2016) also noted that exploration of perceptions offered the opportunity to provide insight into the interactions experienced between other actors. For those studies that had explored more than one defined group, the interactions between other actors appeared to be imperative to the overall functioning of ERSs and yet a deeper exploration of these relationships has not been fully elucidated, or extended to those in managerial roles. Indeed, Thurston and Green (2004) previously suggested that the network of social relations generated by an ERS warranted further consideration. It could therefore be argued that previous calls to understand ERSs (Gidlow et al., 2008; Dugdill et al., 2005) have not only remained but are still very much pertinent. McKenna and Mutrie (2003) suggested that simply demonstrating the effectiveness of interventions is insufficient, indeed, focussing purely on programme outcomes, through the use of quantitative measures, has failed to explore the wider notions of the efficacy of programme development and delivery. Furthermore, scheme

development and delivery are considered dependent upon the agents who design and deliver the schemes, therefore investigating their influence is vital (Gidlow et al., 2008). Researchers have previously identified the complexities of an intervention such as an ERS (Oliver et al, 2016; Crone and James, 2016; Sørensen et al., 2006; Dugdill et al., 2005), through the multiple actors associated and the processes involved. Yet, the current evidence has largely overlooked the exploration of these very complexities and how they may have contoured the delivery of ERSs. Indeed, Pawson (2013) suggested the context of an intervention, particularly in which it plays out is complex and whilst this is worthy of exploration, such complexity of context is rarely acknowledged. Astbury and Leeuw (2010) described the pursuit of such an understanding as unpacking the 'black box'. The authors described this unpacking as a way of explaining why such interventions worked or, perhaps more importantly, failed to work. This did not just apply to different contexts but also for different stakeholders. These ideas had previously been presented and described by Pawson and colleagues (2005), and more recently Pawson (2013), who suggested evidence should consider what works, for whom, and in what circumstances. Yet, having reviewed much of the current ERS evidence base, the 'what' still required further exploration. Moreover, Pawson and colleagues (2005) suggested that such understanding could be found in the knowledge that lies behind the reasoning and actions of the actors within an intervention. Therefore to understand ERSs, the actors, their knowledge and their reasoning has to be explored. Through improved understanding of ERSs, the actors and their perceptions of ERSs, and how these have shaped scheme delivery, there is the potential to inform policy makers,

commissioners and practitioners in relation to their own understanding of ERSs but also to enhance the development and delivery of current and future schemes.

## **2.5 Concluding Thoughts**

The benefits of physical activity underpin the concept of ERSs, and therefore discussion of the benefits formed a relevant starting point for this review of literature. This review considered the relationship between physical activity and health, specifically the benefits of maintaining a physically active lifestyle. Despite such evidence, it was recognised that many of the British population were failing to meet the DoH's recommended guidelines for physical activity, and consequently, primary care moved to the forefront to promote a physically active lifestyle. Whilst the primary care setting offered potential in reaching a large number of the population, questions were raised as to whether professionals working in this environment were the most suitable to provide advice and guidance on physical activity. ERSs emerged as one genre of intervention where HPs could refer their patients to trained EPs to deliver individually tailored exercise programmes. Yet, whilst the number of schemes saw prolific growth, the effectiveness of ERSs remained unclear. This review considered and critiqued examples of different methodological approaches that have been used to explore ERSs. Reviewing the literature highlighted a limited understanding of the complexity of context within which ERSs operate. ERSs involve a number of processes played out by multiple actors and yet, how this could shape the delivery of schemes was largely overlooked in the existing research. This gap in the research presented a clear rationale for the focus of this study, in exploring these actors, their roles, their relationships with

others and how this had influenced the delivery of ERSs. To capture the interdependency between these groups of actors and their influence on ERS processes and delivery, a suitable theoretical framework was required. The next chapter therefore details the chosen theoretical framework for this study.



## CHAPTER 3

### PROCESS SOCIOLOGY

The purpose of this chapter is to outline the theoretical framework that underpins this study. Whilst the use of process sociology is recognised for its application to sport, it has been less widely used in understanding health and physical activity interventions. The broader aim of this research is to provide a processual understanding of an exercise referral scheme (ERS), by exploring the networks of power relations within ERSs and how this has influenced scheme delivery. Taking the work of Norbert Elias (e.g. 1956; 1971a; 1971b; 1978; 1994) and with colleagues (1986; 1991; 1994) as a starting point, the key aspects of process sociology that may be applicable to this understanding of ERSs are explored. The chapter firstly outlines the key concepts of Eliasian process sociology, specifically, the figurational framework, constituted of 'I' identities within networks of 'we' and 'they' relationships. The concept of power within the figuration and its illustration through the use of game models is then explored. Elias's key works, *The Established and Outsiders* and *The Civilising Process* are also considered. Finally, notions of habitus and civilised bodies are also explained. It is acknowledged that consideration of Elias and Dunning's (1986) *Quest for Excitement* is absent from this chapter. This was omitted due to being considered less relevant to the aims and objectives of this specific study.

Finally, it is important to note, that rather than to contribute new theoretical insights into process sociology, the purpose was to use process sociology as a theoretical framework, applying certain aspects to an empirical case, in this instance ERSs. This chapter therefore provides an overview of those aspects of theory pertinent to this study.

### **3.1 The Figural Framework**

Elias (1978) considered sociology to be 'concerned with problems of society, and society is something formed by oneself and other people together' (p.13). This suggests that Elias considered the conceptual division of the individual and society to be a false dichotomy. Instead he considered the two to be interdependent – a society of individuals (Murphy et al., 2000). This, some argued, challenged some of the long-held debates in sociological thought, which had been plagued by dichotomies such as those between individual and society, agency and structure and micro or macro scales of inquiry (Jarvie and Maguire, 1994). Elias and colleagues looked to overcome these dichotomies through the use of the figuration.

In problematising the purported gap between individuals and societies Elias proposed the figuration as a conceptual tool. Dunning (1999) suggested that humans were ineradicably interdependent as a species and without these bonds, humans would not be born or indeed even survive. Elias (1956) captured this in defining the concept of the figuration, he described as a:

‘...generic concept for the pattern which interdependent human beings, as groups or as individuals, form with each other’

(p.85)

This suggested that every individual is connected to others by bonds of interdependence that form webs of relationships. Indeed, Elias advocated a view in which individual ‘I’ identities are situated within networks of ‘we’ and ‘they’ relationships (Elias and Schröter, 1991). Hence, rather than social structures, figurational webs of relationships are constituted by the people situated within them, who are connected via reciprocal relationships or interdependency chains (Elias and Schröter, 1991; Jarvie and Maguire, 1994). Elias believed the figuration could be applied to small groups, such as an exercise class, as well as to larger groups, that ranged from a population of a city to a society made up of thousands and more (Elias, 1978; Quilley and Loyal, 2005).

In drawing these key concepts together, Goudsbloum (1977) outlined four key principles that summarised process sociology, which were later updated and expanded upon by Quilley and Loyal (2005):

1. ‘Human beings are born into relationships of interdependency. The social figurations that they form with each other engender emergent dynamics, which cannot be reduced to individual actions or motivations. Such emergent dynamics fundamentally shape individual processes of growth and development, and the trajectory of individuals’ lives.
2. These figurations are in a state of constant flux and transformation, with interweaving processes of change occurring over different but interlocking time-frames.
3. Long term transformations of human social figurations have been, and continue to be, largely unplanned and unforeseen.

4. The development of human knowledge (including sociological knowledge) takes place within such figurations and forms one aspect of their overall development: hence the inextricable links between Elias's theory of knowledge and the sociology of knowledge processes'.

(p. 813)

These key traits of figurations highlighted that whether applied to small or large groups, figurations could be seen anywhere, such as families, schools or workplaces. As Quilley and Loyal (2005) noted, such relations or interdependency chains between two or more individuals are considered to be in a dynamic tensile state, where the short-term actions of one interweave to create long-term unintended consequences, which are beyond the control of any individual or group (Elias and Schröter, 1991; Jarvie and Maguire, 1994). Indeed, process sociologists considered these ideas to be a unique departure from other sociological theories.

In understanding the figuration and interdependency relationships further, it is worth considering Elias's (1978) concept of the 'triad of controls', which he presented as key criteria for social development. In consideration of the triad, Wouters (2014) suggested that interdependent relationships encapsulate relations of control, power, dependency, information and orientation and the 'triad of controls' served as a means to describe the changes of constituent features of any figuration. This extends to whether bonds are expanding or shrinking, become denser, thicker or diluted and thinner. As an area of Elias's work that received less attention, Goudsblom (1977) described the 'triad of controls' as the extra-human (control of humanity over natural elements), the inter-human (control of people over each other) and the intra-human

(control of each person over herself or himself), the three are interdependent and a change in one leads to a change in the other two. In conceptualising these relations, tensions and conflict, which can be seen between two or more entities within the figuration, Wouters (2014) proposed seven balances:

- *Competition and cooperation* – competitive pressures towards decentralising or centrifugal tendencies against centripetal tendencies or pressures towards cooperation.
- *External social controls and internal self-controls* – the balance between external social control and control over oneself.
- *Power-balance* – the balance of power and dependency within relationships, at all levels.
- *Formalisation and informalisation* – the difference in formal and informal behaviour in different settings and in relation to others.
- *Lust and intimacy* – changes in the balance of lust and intimacy, of sex and love.
- *Involvement and detachment* – increasing levels of detachment from affective involvement of fearful and wishful fantasies goes hand in hand with increasing levels of knowledge and control, not only of (non-human) natural processes but also of social and psychic processes.
- *We-I balance* – the balance between the emotive force of we-identities (of the groups of people under study) and the emotive force of I-identity individuals.

(See Wouters, 2014)

As with the 'triad of controls' such balances are believed to be heavily interconnected, a change in one balance would potentially accompany a change in the others (Wouters, 2014). It could be argued, however, that not all of the seven balances are applicable to any particular study, and specific applicability is dependent on the focus of research. Despite this, Wouters (2014) believed that due to their interconnectedness, the more balances that are drawn in, the more solid the conclusions that can be drawn. Of all seven balances, whilst equally important, power

has been identified as a defining feature of the figuration and therefore it would appear pertinent to explore Elias's meaning of power.

### **3.2 Power**

Elias (1978) believed power to be a 'structural characteristic' (p.74) of all human relationships. He did not view it as simply something that one person possessed and another did not (Elias, 1978), but instead argued for the concept of power being explicitly tied to interdependence (Dunning, 1999). He likened this relationship to that of a parent and baby: whilst the parent attaches any kind of value to the baby, then the baby possesses power over the parent and in the same way the parent over the baby. Although this may not be distributed evenly, a balance of power still exists, as long as a 'functional' interdependence between the individuals remains (Elias, 1978). It therefore becomes apparent that the key to understanding power lies in the interdependency of people, but as Dunning (1999) argued, Elias did not view power-balance as restricted to relationships between just two people, instead power is multi-polar: figurations capture the 'complex configurations of interdependent individuals and groups' (p.192). This interdependence of power is perhaps best conceptualised through Elias's use of 'game models'.

The use of game models allowed Elias to demonstrate how interdependent peoples' actions and responses are viewed as moves in a game (Mennell, 1992). Elias believed that the figurations of interdependent humans could not be explained by studying

humans in isolation (Elias, 1978) and that thought needed to be given to how the web of human relations changes when the distribution of power changes (Elias, 1978). Through the study of games and indeed the figurational framework, Elias (1978) challenged the dichotomies that some of his peers endorsed, as he described in his own words:

‘By using the image of people playing a game as a metaphor for people forming societies together, it is easier to rethink the static ideas which are associated with most of the current concepts used in this context.’

(p.92)

Elias’s ideas regarding the figuration and power are inextricably linked, Elias used the concept of games to represent these ‘hypothetical’ social processes; the games allowed him to demonstrate how social processes generate emergent dynamics (Quilley and Loyal, 2005).

One example proposed is a game between two people, where one player is stronger than the other. In Mennell’s (1992) description he explains how player one, the stronger player, might exert a level of control over the game, which forces player two, a weaker player, to make certain moves. Despite what may have seemed like an uneven balance of power, player 2 possesses some control in the planning of their own moves, which as a result then forces player 1 to take this into account when executing their own moves (Mennell, 1992). Mennell (1992) outlines that both players must possess some ‘strength’ or knowledge about the game otherwise there would be no game at all. If, however player 2 becomes more skilled or

knowledgeable, the dynamics between the players would then change. The stronger player, player 1, becomes less able to control the game and player 2's chances of exhibiting control increases accordingly. This means power passes more freely between each player and predicting future moves becomes more difficult (Mennell, 1992).

Elias provided further examples of game models with an increased number of players, which Mennell (1992) stated produces more complicated figurations. Quilley and Loyal (2005) in their appraisal of the game models approach identified that by increasing the number of players and their arrangements into groups, or 'teams', Elias was able to explore shifting power ratios and the ability of these individuals, within certain situations, to command the course of the game. The authors went on to explain that the model allowed Elias to illustrate that when the number of players increases, the interdependency between the individuals also increases, however, the power ratio between people declines. It was also suggested that, if there is a decline in power to dictate or control the course of the game, then respectively there is a tendency for the resulting dynamics of the game to increasingly dictate and structure the 'moves' of individual players. Jarvie and Maguire (1994) expanded on this concept by explaining that the team has reference only to their past moves and the counter moves produced by their opponents, which could be utilised to draw them together and then to be able to execute further moves. It was clear that no one individual or group could fully determine the outcome of the game itself. Instead, each becomes interlocked in a series of reciprocal moves and as a result the game



dynamic emerges – this was not planned or even intended by either team or any one individual.

These descriptions of game models highlighted that the figuration becomes the ‘unintended outcome of the interweaving of a myriad of intended actions’ (Jarvie and Maguire, 1994, 136), in essence intended actions lead to unintended and unforeseen consequences. Moreover, these intended actions result from the unintended interdependencies within the figuration (Jarvie and Maguire, 1994). Rather than focusing on the rational calculations of any one individual, Elias instead prioritises the fluidity of the game itself, characterised by the interweaving of moves (Giulianotti, 2004). Figurations are described as being in a constant state of flux, for the reasons given above, and as a result undergo transformations that vary in both speed and the level of impact. For those long-term developments that do occur, however, they remain unintended and unforeseen (Jarvie and Maguire, 1994).

Elias’s use of game models also demonstrated how power could be both relational and dynamic, which is perceived both to enable and constrain the interactions of interdependent individuals or ‘players’ (Jarvie and Maguire, 1994), even sometimes at the same time but in different ways. Within the game, relationships are enabling and constraining, necessary for the game to exist but equally limit the choices available. Indeed, within interdependency chains, bonds of association exist that are dynamic, contested, but also subject to complex tension balances which are in flux,

simultaneously constraining and enabling (Elias and Schröter, 1991; Jarvie and Maguire, 1994). Bonds of association can also be more or less dense, expand or constrict, according to their relative intensity and duration (Elias and Scotson, 1994). Interdependency chains therefore have a historical or temporal aspect, the meaning of which is best captured in Elias's *The Civilizing Process*, considered to be his *magnum opus* by some (Loyal, 2011) and yet his most contested work.

### **3.3 The Civilizing Process**

*The Civilizing Process* (Elias, 1994) further served Elias's theory that the individual and society were not two separate entities but instead society was constituted of interdependent individuals. Elias examined the long-term processes of 'social transformation' (Quilley and Loyal, 2005, 818), having traced the development of individuals' behavioural and psychological changes, alongside the social standards that had formed in European societies (Jarvie and Maguire, 1994). Elias suggested this was interwoven with the processes of state formation (Quilley and Loyal, 2005).

From the middle ages to the mid-20<sup>th</sup> century, Elias traced the changes in manners and etiquette, through the use of manner books and other sources and revealed a gradual shift in people's behaviours. He noted that there was a move to becoming what was considered to be more socially acceptable behaviour (Guilianotti, 2004). Individuals presented a more 'even' display of emotions, showing greater self-control and restraint over both their emotions and behaviour. This was accompanied by

increased embarrassment and shame towards the most basic of human functions such as eating habits, bodily functions and sexual behaviour, all of which gradually became viewed through an 'advancing threshold of repugnance' (Dunning, 1999, 44; Jarvie and Maguire, 1994). These changes first emerged through royal court circles, emanating from those in more powerful positions. Then, through lengthening chains of interdependency, these behaviours filtered down through the hierarchical structure of society (Jarvie and Maguire, 1994). Such ideas were contentious to some, and Mennell (1992) suggested that this was because Elias proposed a long-term trend in changes to peoples' behaviour and psychological make-up, rather than such changes occurring merely by chance.

Evidently, there was more to Elias's observations than just a 'history of manners', as Mennell (1992) suggested some had perceived *The Civilizing Process*; it was instead, an exploration of how the internalisation of emotion and restrained behaviour was inextricably linked to state formation (Quilley and Loyal, 2005: 818). Dunning (1999) explained that Elias believed that through the monopolisation of taxation and violence (amongst other things), decentralised feudal societies had made the transition to centralised dynastic states and that in time these became nation-states. Such long-term processes had led to the lengthening of interdependency chains (Elias, 1994; Maguire, 2005). Dunning (1999) also commented that Elias observed that these unplanned developments aligned to states becoming 'increasingly pacified internally' alongside a further lengthening of interdependency chains, shifting from bonds of a local nature to those of national and international (p.44). Such processes,

and the character of the interdependency chains within figurations, influenced the development of 'established' and 'outsider' groups; the discussion of these groups is where this chapter now turns.

### **3.4 The Established and Outsiders**

*The Established and Outsiders* (Elias and Scotson, 1994) was an empirical study exploring power relations from a figurational perspective. The study considered a small suburban community in the UK and examined the dynamics between three neighbourhoods or 'zones'. Zone one was characterised by a middle-class population, zone two an older more established working class population (the village) and zone three a newly arrived working class population (the estate) (Elias and Scotson, 1994). Each of these zones was on the surface identical, as Dunning (1999) described them, in terms of 'all conventional indices of social stratification' (p.186), however the one difference between these groups was their length of residency.

The 'established' were observed as those who had lived in the community for several generations and where possible avoided dealings with 'outsiders', those who were characterised as newcomers to the community (Dunning, 1999). The old-established group showed contempt for the new-outsiders and considered them to be unruly, however as Elias and Scotson (1994) argued, this was not due to ethnic or class-related reasons, this was simply due to the duration of residence. Elias and Scotson (1994) believed that over a longer period of time, 'we-group' bonds of association

were maintained and became stronger. This provided a sense of belonging and identity, forming stronger bonds of association, which the 'established' group believed afforded its members the right to show contempt for others (Elias and Scotson, 1994). Those families that had resided in the community for generations and which had known other families for generations presented a 'powerful superiority' in comparison to newcomers who were strangers to both them and to each other (Elias and Scotson, 1994). Indeed, established groups had greater influence in defining the accepted socio-cultural norms of the figuration. Elias believed that such an unequal power ratio could be produced as a result of the groups' cohesiveness and their interdependency bonds (see also, Loyal, 2011). When established groups feel exposed, Elias believed that they would use negative labelling, stigmatisation and exclusion processes as a means to maintain their position:

'...attaching the label of lower human value to another group is one of the weapons used in power struggles by superior groups as a means of maintaining their social superiority'

(Elias and Scotson, 1994, xxi)

Established groups reinforced minority examples as though typical of all, characterising members of outsider groups as the 'minority of the worst'. In relation to this study, the established sought to maintain a positive 'we-image' whilst creating a negative 'they-image' for the outsiders (Loyal, 2011). More recently, Lake (2013) presented a summary of the dominant themes that typically characterise an established-outsider figuration, which he applied to examine member relations in a tennis club. He identified:

- 'i) The legitimization and internalization of a positive identity for the established group and a negative identity among outsiders, where by all groups measured themselves against established group standards;
- ii) The lack of means for outsiders to successfully challenge their subordination;
- iii) The tendency for the established group to reinforce exceptional 'minority' examples as though typical of each group.'

(Lake, 2013, 117)

It would be difficult to comment on whether these characteristics were all always applicable, and it would fall to the discretion of the researcher to determine whether and to what extent these themes characterised a figuration. What these distinctions between established and outsider groups have highlighted however is the presence of power within a figuration, alongside exclusion and inequality. Elias and Scotson (1994) believed this provided a framework that enabled researchers to better grasp the similarities and differences of other cases, which allows application to other figurations. Indeed, such inter and intra-group relations have been central to a number of studies within sport and more recently exercise and health, where gendered (Mansfield, 2007), ageist (Evans and Crust, 2015; Evans and Sleep, 2012) and embodied (Evans et al., 2016; Powell et al., 2014) behaviours have been explored, in addition to class (Lake, 2013), as previously mentioned. Such behaviours and the ability of the 'established' group to define accepted socio-cultural norms for the figuration creates a habitus; a concept that is now explored.

### 3.5 Habitus

Mennell (1992) described Elias's take on habitus as 'second nature', those personal characteristics that are shared with others from their social groups. For Elias, habitus is the point where structure and agency intersect. This is characterised by social norms where the expectations of society act on the individual. Over time these become internalised and as a result contour behaviour to become the norm (Jarvie and Maguire, 1994, Evans and Sleaf, 2012). For example, if a doctor were to treat a terminally ill patient, the individual might acknowledge that it would not be socially acceptable to express an emotional response in front of the patient. Yet at the same time, the emotion might be so overwhelming that the doctor cries anyway. Therefore, habitus is the juncture between conscious, socially regulated actions and unconscious decision making, in a way that influences behaviour, but at the same time does not determine it. The embodied intersection of sociogenetic and psychogenetic processes include such components as physiological, psychological, social and historical-biographical, all of which intersect at 'the hinge', which in turn drives the habitus (Elias, 1994; Elias and Dunning, 1986). Indeed, the hinge can 'flip' between any of these components, depending on which takes precedence in a given situation.

As previously explained, individuals internalise those norms and behaviours that are considered socially acceptable or remain above the 'threshold of repugnance' (Elias and Dunning, 1986). The development of such a threshold emanates from the powerful who develop a level for what is determined acceptable behaviour, as noted

earlier in the chapter (see 3.3 *The Civilizing Process*). This provides some understanding within the context of health and fitness, for example, the maintenance of healthy, active lifestyles (Elias and Dunning, 1986; Shilling, 1999) where a decision to be physically inactive is considered irresponsible (Malcolm, 2016) or the marginalisation of chronically diseased bodies (Evans and Crust, 2015). In order to elaborate on this further, Elias's work on civilised bodies is now considered.

### **3.6 The 'Civilised' Body**

*The Civilizing Process* and Elias's concept of habitus have been employed analytically within a variety of contexts. It was considered no accident that Elias had focused on the etiquette of bodily functions, such as maintaining personal hygiene; Maguire and Mansfield (1998) claimed bodies were indeed one of the main 'loci' of *The Civilizing Process* itself. Jarvie and Maguire (1994) suggested it was viewed as a deliberate decision by Elias, to further highlight the relationship between the body, personality and the structure of society. This was well-illustrated by Shilling (1999) who used *The Civilizing Process* in a historical understanding of people and their bodies.

Shilling (1999) depicted the development of the civilised body and the long-term processes involved, which he characterises as socialisation, rationalisation and internalisation. Shilling (1999) highlighted socialisation as the process of a gradual shift for natural functions to be hidden away, for example maintaining personal hygiene, a previously acceptable act that moved away from the public domain and



into private. This could also be applied to death and the act of dying itself being hidden away from public view (Jarvie and Maguire, 1994). Rationalisation referred to the self-control exhibited by the body, the ability to control emotion and maintain 'good' moral behaviour whilst restraining one's instinctive behaviour. Finally, individualisation is characterised by how people view their own bodies. How people perceive their bodies have changed, according to Shilling (1999), as people learn to 'separate' self from the physical body, to some extent. Elias (1978) believed the nightshirt and handkerchief to be symbolic of this 'separation' as people create an emotional barrier between themselves and their body. These observations highlighted how bodies are controlled and moulded by social processes, whilst in parallel it is these embodied individuals that constitute society; therefore, the body and society are interdependent (Evans and Crust, 2015).

Shilling (1999) identified that the body is socially regulated and through a culmination of long-term 'civilizing' processes, bodies have become 'civilised'. Maguire and Mansfield (1998) drew on Elias's work further in their consideration of 'civilised' female bodies. In parallel with Shilling (1999) they identified that bodies become conditioned to a rationalised command of the techniques, practices and rituals of exercise and bodily control (Maguire and Mansfield, 1998). Symptomatic of this is the desire to achieve a healthy, fit body, which has become a central component in the creation of the contemporary self (Evans and Crust, 2015), labelled by Maguire and Mansfield (1998) as the 'exercise body-beautiful complex'. This complex presents a web of relationships that influence the lived embodied experiences of

women and the exercise regime. Amongst those elements within the web, emphasis is placed on the role of scientific knowledge that reinforces the importance of healthy functioning bodies and consequently marginalises the ageing or chronically ill body (Evans and Sleaf, 2012). The changes that ageing and chronic disease could bring to the body, challenge the limits of bodily regulation whilst placing the issue of mortality into the spotlight. Both ageing and chronic disease are unwelcome and, as Elias observed, care for the ageing or chronically ill had largely been removed from the public eye and confined to more private domains (Elias, 1985; Evans and Crust, 2015). Hence, for the individuals whose bodies have not conformed with the socially acceptable 'civilised' body, which Maguire and Mansfield (1998) suggested to be young, slim and toned, they are considered less socially valued, less powerful and became more widely recognised as 'outsiders' (Elias and Scotson, 1994; Evans and Sleaf, 2012).

### **3.7 Critique of Process Sociology**

The use of process sociology is recognised as a well-established theoretical framework in the sociology of sport and leisure (Liston, 2011), indeed Elias is regarded by some as one of the most important sociologists of the twentieth century (Bloyce and Murphy, 2007) and yet his work is not without criticism. This discussion addresses some key criticisms, specifically in relation to those aspects of Elias's work most relevant to this thesis.

*The Civilizing Process*, that has become a central pillar of Elias's process sociology is regarded as one of his most contentious pieces of work. Elias's exploration of the long-term structured processes of development at both the social and individual level has incited much debate, with some dismissing his *magnum opus* as nothing more than a history of manners (Mennell, 1992). Indeed, Mennell (1992) suggested that such ideas were possibly contentious due to Elias proposing that people's changes in behaviour and psychological make-up were a long-term trend, rather than occurring merely by chance. Liston (2011) proposed that some of these early and continued criticisms have arisen from a misunderstanding of *The Civilizing Process*, where the work is considered to amount to nothing more than an analysis of violence and aggression with the exclusion of other relevant research. Furthermore, the immense scope of the theory of civilizing processes poses issue for some; as Liston (2011) identified, process sociologists have sought to apply the concept of civilization to a wide range of seemingly unrelated phenomena, such as:

'...patterns of hygiene, gender relations, work, leisure, play, sport celebrities, state formation, food and eating, globalization, national identities, nuclear war, drug use including tobacco, informalization processes, sex, race relations, criminology and manners'.

(p.162)

Despite this suggested wide-ranging coverage, figurational research remains commonly associated with the notion of the long-term moderating of violence and aggression within societies (Liston, 2011).

Difficulties with *The Established and the Outsiders* (Elias and Scotson, 1994) have also been identified, yet possibly not openly recognised by all figurational sociologists or

all their critics (Bloyce and Murphy, 2007). As previously explained in 3.4, *The Established and the Outsiders* is an empirical study that explores power relations from a figurational perspective, by considering a small suburban community in the UK and the dynamics between three neighbourhoods. In a similar way to *The Civilizing Process*, the application of the conceptualisation of established and outsiders was far reaching, with claims by Elias and Scotson (1994) that this model could be applied to a range of social inequalities, such as those between ethnic groups, colonized and colonizing, children and adults, gay and straight, men and women (Mennell, 1989); a suggestion that appeared readily accepted by some figurational sociologists. Despite these far-reaching claims, it was the origins of the book that generated some doubts. Mennell (1989) suggested that the origins of the book had been from data collected for Scotson's Master's thesis. Indeed, it was proposed that Elias had used Scotson's data as a vehicle to drive forward ideas that had occupied his mind as far back as 1935. These comments have been viewed by some as suggesting Elias's intent to prove the sociological value of the theory, despite how it may have detracted from the object-adequacy of the work with such unwarranted assumptions (Bloyce and Murphy, 2007). Bloyce and Murphy's (2007) comments pose an interesting point as, if true, this would suggest Elias defined a problem to suit theory, which would not be in keeping with Elias's own thoughts on what figurational sociology should be. Despite such interpretations, there is nothing to suggest, however, that the theory of *The Established and the Outsiders* lacks application.

In Bloyce and Murphy's (2007) critique of *The Established and the Outsiders*, the authors suggested that Elias pursued his intellectual objectives, to a point where this clouded his judgement, specifically with regard to Scotson's data. Bloyce and Murphy (2007) go on to provide a number of detailed examples where data were gathered but not presented, where speculative leaps were made and where research avenues were left unexplored. Although it is beyond the scope of this thesis to consider all these instances, one salient example is regarding a key characteristic of established-outsider relations, where outsiders accept their inferior position and lack the means to challenge this (Elias and Scotson, 1994). A position of accepted inferiority is a characteristic that is also supported by more recent explorations of established and outsider relations, such as the work of Lake (2013). Yet despite these claims, Bloyce and Murphy (2007) argue that evidence was found within Elias and Scotson's data to the contrary, that outsiders did not accept their inferiority and instead challenged their position. Examples manifested by way of retaliation by juveniles, political opposition, the taking over of the village pub and a dominance of the working men's club. The combined relevance of such data failed to be acknowledged. Fletcher (1997) noted that when power differentials are relatively even, then outsiders will begin to retaliate and counter-stigmatise, which appeared to be the case in Bloyce and Murphy's (2007) example and as others have shown (for example Evans and Crust, 2015). Indeed, it could be argued that Elias and Scotson's (1994) original work has come some way since its initial conception.

Furthermore, it could be argued that because of the narrowness of focus presented by Elias and Scotson (1994), their analysis simplified and even distorted the power

dynamics that characterised the village in the study. Indeed, their desire to demonstrate the efficacy of established and outsider concepts resulted in focusing on only one dimension of the network of relations to the neglect of others that were potentially of greater significance in the understanding of power dynamics (Bloyce and Murphy, 2007). These arguments could seem somewhat ironic, for a theorist who argued for the need for researchers to achieve a blend between involvement and detachment (Elias, 1956) in their approach to research.

Mennell (1989) suggested that perhaps 'established' and 'outsiders' were not the most 'inherently dynamic' terms that Elias could have introduced (p.125) and there are evident limitations highlighted here. Bloyce and Murphy (2007), however, argue that the theory can still be used effectively. This is however, dependent on an awareness of the theory's limitations and the need to locate those particular relations under investigation, within a broader figuration.

Other criticisms of Elias's work have extended to its low predictive value, in that the use of process sociology is perceived to be politically 'quiet' and have little practical relevance (Liston, 2011). Indeed, Liston (2011) suggested that few process sociologists are explicit about the way in which reality-congruent knowledge can be used to formulate effective and realistic ways to deal with a problem. These ideas are of course at odds with Marxists and feminist theorists who believe theory is only of use if it informs political action and practice in some way (Liston, 2011).

Dunne (2009) outlined how Elias believed sociologists should strive to show *how* society works, without expressing how it *should* work, presenting a more reality congruent understanding of the world. That is not to say such recommendations may never come, but Dunne (2009) suggested that it was instead a matter of patience, that once a more complete understanding has been achieved only then would figurational sociologists engage politically. Mennell (1992) however, presented somewhat of a different perspective on this issue and suggested that if an individual can maintain a level of detachment, form a symbolic representation of the situation and on that basis, change the situation, then this would be acceptable. Mansfield (2008) suggested that such political action and possible social change would need to be founded on a high degree of adequate knowledge, produced with a suitable measure of involvement and detachment. Interestingly, the emphasis on the use of process sociology to create change rests on the blend of involvement and detachment achieved by the researcher. Some researchers who have employed process sociology, have been more outspoken, and Liston (2011) identifies researchers such as Green (2008) who predicted a potential 'academic' basis for the future of physical education and Waddington and Smith's (2009) consideration for the possibility for differentiating anti-doping policy on sport. Such commentaries do exist and challenge ideas of political quietness.

In further critique, Guilianotti (2004) perceived figurational sociologists to be something of a cult, in their 'worship' of the work of Elias. Indeed, this is believed to stem from some figurational sociologists' inability to accept alternative interpretations of Elias's work, based on either limited reading of his work or the

separation of aspects of Elias's work from the totality of his arguments (Liston, 2011). Indeed, there is an air of theoretical isolationism when engaging with process sociology and this may be accounted for by Elias's precise application of theoretical concepts (Liston, 2011). Yet despite this, as a researcher it is important to acknowledge the limitations of any such theory, particularly in the application to one's own work.

It is now possible to summarise this chapter.

### **3.8 Summary**

This chapter provided an overview of several key components of process sociology and demonstrated the application of the figural framework to a broad range of contexts. Figurations are suggested to be everywhere, comprised of small and large groups, from exercise classes to nation states, but what is emphasised within the use of this theory is the interdependency of those within the figuration. Indeed, Baur and Ernst (2011) believed that by understanding individuals' positions within the figuration, together with their perceptions of their ability to influence their social position, this enables analysis of how individual actions impact on the rest of the figuration. Therefore, it seems highly appropriate for process sociology to be employed, and applied to, the current exploration of ERSs.

The figural concepts that are central to understanding process sociology have also been explained, with reference to the conceptualisation of power and how this



is illustrated through Elias's use of game models, in addition to the exploration of the 'triad of controls' and Wouters's (2014) seven balances. The theorised distinction between 'established' and 'outsider' groups was considered, how 'we' group bonds of association develop over a period of time in relation to the weaker, more recently shared identities of an 'outsider' group. This provided insight into Elias's views on the complexity of power relations and how tensile power balances mark all interdependency chains.

Bonds of interdependency, held together by the balance of power provide a cornerstone for Elias's (1994) *The Civilizing Process*. Figurations are historically and culturally produced, and *The Civilizing Process* provides an explanation as to how this may have happened whilst also explaining how habitus changes and develops over time. Indeed, this is where these two areas are so closely intertwined. This chapter explained how Elias's interpretation of the long-term 'civilizing' processes have also led to the development of 'civilised' bodies over a period of transformation from the Middle Ages to the present. Elias believed that bodies are socially regulated, contoured by both sociogenetic and psychogenetic processes. A figurational approach therefore emphasises the interdependence of external sociogenetic and internal psychogenetic processes in how bodies are understood, rationalised and experienced (Jarvie and Maguire, 1994; Evans and Crust, 2015), particularly in relation to those considered 'outsiders' such as the ageing and chronically ill - those individuals most likely to be referred to an ERS.

Having portrayed the theoretical framework in this chapter, the following chapter provides a contextual explanation of the chosen case-study ERS as the specific focus of this study.

## CHAPTER 4

### CONTEXTUAL OVERVIEW OF LOCAL EXERCISE REFERRAL SCHEME PROVISION

Having set the scene for the aims and objectives and explored the theoretical framework that underpins this study, it is necessary to provide some contextual background to the chosen exercise referral scheme (ERS). Although ERSs and their broader origins have been discussed within Chapter 2, it is important to provide some context regarding the structure of the case-study ERS within the chosen county.

The county in question is one of the largest geographically in the UK and is divided into seven districts housing a population of just under 750,000 residents. The county is recognised for being rural in nature and poses geographical barriers in relation to transport and connections. These issues present challenges for those individuals delivering health improvement interventions to ensure that there is sufficient coverage across the county. The county is also characterised by a large ageing population, specifically sixty-five and over, which has continued to increase as a proportion of the population in recent years, in contrast to a declining population of younger people. This poses further issues for health services in regards to the increased risk of disease and dependency that accompanies older adults. Finally, high levels of deprivation can be found within some districts, with twenty-nine areas in the county falling within the most deprived 10% of lowest super output areas in the UK. Although this may be considered basic factual evidence regarding the county, it

is useful to appreciate the challenges faced by health service providers and why there is a need for a service such as ERSs to target health and inequality.

ERSs have existed in the county since 2000 in various forms, with some districts offering their own version of a referral for exercise to residents. The first scheme emerged in 2000 from one district, as a result of local support from the medical profession, whereas the last newly formed scheme was in 2011. In its infancy, ERSs were funded by small pockets of localised investment, however, from 2006, the county National Health Service (NHS) commissioned ERSs in a number of areas. Since this point, investment has steadily increased and in 2009 a one third uplift was provided by the Health and Wellbeing Fund to add value to all ERS services across the county. This application for funding was a combined effort from the county sports partnership (CSP) and local NHS. The funding received was considered to have a notable effect on capacity, extending schemes to other areas and improving the level of service already provided. From 2011, following the end of the Health and Well Being Fund investment, ERSs continued to be commissioned by the local NHS, which later became Public Health, situated in local authority, following the decommissioning of the Primary Care Trusts.

Through the funding and overseeing of ERSs by local Public Health and the CSP, it is necessary to explore the tiers of organisation that exist below this level. Below the level of local Public Health management, responsibility is transferred to the designated district manager, who is responsible for ERS provision within their own

district, amongst other services (dependent on an individual’s job description). This individual then coordinates with the designated ERS coordinator, who is responsible for the day-to-day management of the ERS service and the exercise practitioners (EP) working on the scheme. This may include multiple sites across one district. The ERS coordinator also typically works as an EP on the ERS. EPs work with those patients referred by their health professional (HP), and deliver a twelve-week supervised exercise programme. The method of delivery can vary from scheme to scheme, for example one-to-one or small group training. The hierarchical structure described here is typical of each of the seven districts, with the exception of only one district. One of the seven districts has a separate scheme that is delivered by an independently managed facility, which is not overseen by a district manager but instead a business manager and has its own ERS coordinator in post. The hierarchical structure of ERS provision within the county is presented in Figure 4.1.

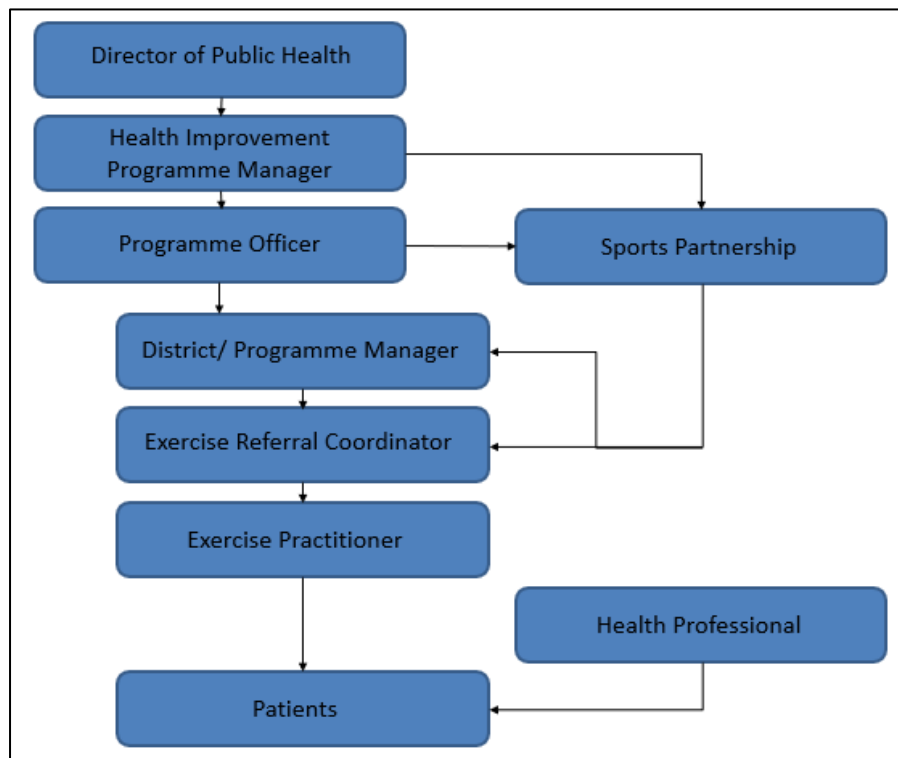


Figure 4.1 Hierarchical structure of county exercise referral scheme provision

During the period of investment from the Health and Well Being Fund, those districts that had created different ERSs were brought together to develop a countywide approach through local Public Health and the CSP. This combined approach allowed districts to identify and develop capacity, as well as the creation of new schemes in areas where there were previously gaps, aiming to provide a more comprehensive service. The CSP and Public Health also hosted quarterly fora for discussions and the sharing of good practice, bringing together ERS coordinators and district/ business managers. It was these quarterly meetings that the researcher was invited to attend in her role as an academic member of staff at a University. This unified approach meant the introduction of more robust mechanisms of auditing, which became an important tool in assessing the effects and impact of the ERS, from the point of referral through to follow up. From this coordinated approach, a structure to the ERS process could be identified.

As previously stated, within the county, referral of a patient to exercise had traditionally been made by general practitioners (GPs) and practice nurses; however, increasing partnerships with a range of health professionals has seen the inclusion of other professionals such as, health visitors, physiotherapists and weight loss advisors. Referrals can be made for a number of reasons and although each case is generally considered individually, the county provides a broad intervention offering the inclusion of a range of physical and mental conditions, which are:

- CHD risk factors e.g. hypertension and elevated blood cholesterol.
- Musculoskeletal disorders and conditions that affect mobility e.g. osteoarthritis and back pain.

- Psychological problems e.g. anxiety, stress and depression.
- Metabolic/endocrine problems e.g. type 2 diabetes.
- Respiratory conditions e.g. asthma and chronic obstructive pulmonary disorder (COPD).
- Neurological conditions e.g. epilepsy and Parkinson's disease.
- Long term conditions e.g. chronic fatigue syndrome, multiple sclerosis.
- Obesity.

The actual delivery of the twelve-week ERS is conducted in a variety of settings, with the gym environment being the most common. There are also opportunities for swimming, walking, gentle group exercise classes and some sports such as badminton. Although delivery of the ERS primarily relies on the use of local authority leisure premises, other facilities such as community venues, private gyms and schools have been used. Uniquely, one gym is located within a local medical practice. Charging for this service has varied across districts, with three districts that have charged a nominal fee since their inception, on the premise that those districts wished the service to be one that is construed as 'valued' by participants (Allen-Collinson et al., 2011). It was also believed that if participants could not afford the service at this point they would be unlikely to be able to continue with subsidised gym membership on completion of the programme. In the last three years, however, these charges have been removed to offer a free service to all those accessing ERSs.

At the time of writing, local Public Health announced the decommissioning of non-essential services due to budget cuts, and ERSs was one of those. Districts were offered the opportunity to continue to deliver ERSs under their own commercial model. Some districts took the decision to continue, with larger schemes remaining available to patients but at a cost. Others, mainly smaller schemes, within the district

were forced to cease provision. Funding was a central issue to maintain the momentum of ERSs and it was believed by staff that schemes could not be delivered without allocated funding for trained and professional ERS staff, co-ordination and administration, and the use of premises. At the time of writing, the county's future of ERS delivery remains unclear.



## CHAPTER 5

### GENERAL METHODS

This study is concerned with developing an understanding of exercise referral schemes (ERSs), which are examined through the use of process sociology, as detailed in Chapter 3. Having contextualised the ERS under focus in the previous chapter, this General Methods chapter outlines the processes undertaken for both data collection and analysis. In line with a process sociological framework, the philosophical assumptions that underpin the methods employed are first outlined, followed by an acknowledgement of the researcher's own position in relation to the research and how this specifically aligns to process sociology. A rationale for the chosen research design is provided together with a justification for the methods selected. Subsequently, data collection and analysis processes are described.

Before detailing the content of this chapter, it is necessary to provide some background as to how the research evolved to the point of the General Methods chapter which is presented here.

#### **5.1 Background to Methodological Approach**

Initially when embarking on this research, the intended aim was to explore one ERS, to consider the delivery processes used from multiple perspectives and the scheme's impact. Therefore, although exploratory, the study was initially formulated from a post-positivist position, in that it was intended to follow an approach informed by

relativist ontology, objectivist epistemology and experimentally and/ or manipulative methodologies (Gibson, 2016). Yet, following reflections on initial interview data collected, interestingly, these data suggested that participants (exercise practitioners [EPs], health professionals [HPs] and patients) had conflicting conceptualisations of ERSs; for example, what the goals of ERSs were, or the nature of the delivery processes involved and how these should be managed. Furthermore, some individuals appeared to define their role in relation to others, which implied that experiences of ERSs were co-constructed in an interdependent way. Therefore, it became apparent that the ERS was not a static single programme but instead constituted a service delivered in multiple ways, by multiple groups of service providers who all had different ideas regarding what ERSs were and what they should achieve, which went beyond the complexities that had already been assumed for ERSs from the existing literature.

This presented a number of challenges, particularly with the initial study aims, which subsequently seemed to lack congruence with what the researcher had identified in the preliminary data. This also posed the problem; how could an ERS be assessed for how well the scheme was working, if the scheme was not first explored and understood? Following discussions with the supervisory team, a decision to move away from the researcher's initial standpoint was made. Instead, the focus shifted to examination of how ERSs were conceptualised as a socio-cultural phenomenon and the adoption of a figurational framework, or process sociology, was more philosophically compatible. Therefore, this methods section is written from a process

sociological stand point, and now turns to portray the underpinning philosophical position.

## **5.2 Philosophical Assumptions**

It has been suggested that the essence of research centres upon the production of knowledge and the subsequent ability to claim the 'validity' of this knowledge (Green and Thorogood, 2014). This could be considered an idealised and somewhat simplified definition in that research can be a complex process, even messy at times. In the quest to produce knowledge and engage in the research process, Sparkes (1992) suggested a researcher must establish a viewpoint, a way in which to see the world and somehow make sense of it. This viewpoint, within research, is more widely recognised as a research paradigm, as Sparkes and Smith (2014) outline:

'...we conduct inquiry via a particular paradigm because it embodies assumptions about the world that we believe in and supports values that we hold dear. And, because we hold these assumptions and values we conduct inquiry according to the precepts of that paradigm.'

(p.9)

Therefore, when researchers adopt a paradigm, it relates not just to a set of shared beliefs and scientific conventions and practices, but it is an adoption of a process, whereby a question is conceptualised, investigated and ultimately explained commensurate with the particular paradigm (Sparkes, 1992). Acknowledging the range of scholarly traditions that are embedded in such diverse cultural contexts (Grix, 2002), it is perhaps unsurprising that approaches to social enquiry and ultimately the way knowledge is produced can vary considerably between

researchers, perhaps more commonly recognised as the paradigm debate. Indeed, it was the work of Kuhn (1963) in *The Structure of Scientific Revolutions*, that popularised terms such as ‘paradigm’, and gave rise to intense debates regarding the nature of research itself, more specifically, how the research process, the researcher herself/himself and their understanding of the world, is conceptualised (Sparkes, 1992).

Orientating Elias’s work within this debate would be challenging, however, as Baur and Ernst (2011) outline, Elias did not write about his methodological position in a way that would be recognised by those engaged in the modern-day paradigm debate. Not only did much of Elias’ work pre-date *The Structure of Scientific Revolutions* (Kuhn, 1963), he was also critical of overly abstract philosophical approaches to knowledge generation and scientific inquiry, arguing that philosophy provided a poor guide to the theoretical-empirical examination of societies (Dolan, 2009). Instead Elias advocated a theory of knowledge that is grounded in sociological methodology, promoting the investigation of how humans understand the world in which they live and the relationships they have with one another (Baur and Ernst, 2011). Elias therefore argued that a ‘sociology of knowledge’ perspective should be taken rather than following particular abstract philosophical positions. Dolan (2009) expands on the Eliasian approach thus:

‘While contemporary philosophy of knowledge, or philosophical epistemology, might have developed interesting and relevant insights regarding the discovery of social scientific knowledge, it is not necessary to follow or adapt the methodological guidelines of such philosophies in order to produce such knowledge’.

(p.189)

Dolan and Connelly (2014) surmised, process sociologists, no matter their area of investigation, attempt to bypass the dualistic tendencies of philosophical theories of knowledge, specifically in maintaining separate notions of ontology and epistemology. Indeed, process sociologists tend not to limit their work to a specific ontological and epistemological position. Whilst it has become common practice in social-science methodologies to detail the ontological and epistemological considerations that guide a study (Bryman, 2008), Bloyce (2004) suggested that there are more 'object-adequate' ways of understanding the focus of social research (p.146), not in the sense of 'objective' but in answering the specific aims of a study. Indeed, separate notions of ontology and epistemology are considered a false dichotomy by process sociologists (amongst others), as they believe the two concepts are interdependent, and not to be treated separately as Grix (2002) had suggested. Bloyce (2004) explained that the production of knowledge and conceptions of 'reality' (in the figurational sense) are part of the same process, fundamentally linked to both knowledge production and development. Therefore, it is important to discuss the figurational stance on both knowledge production and 'reality'.

Separate notions of ontology and epistemology are not the only 'false' dichotomy that Elias challenged in relation to knowledge production. Indeed, Elias questioned the opposition of subjectivity versus objectivity, whether objective facts speak for themselves or whether subjectivity distorts the interpretation of such facts. This is a key distinction between the opposing positivist and constructivist paradigms (Baur and Ernst, 2011). Dolan (2009) described Elias's emphasis on the 'object' of enquiry

as misleading, potentially advocating an inductive, empiricist position; however, this was not the case. Instead, Elias proposed no separation of the subject and object of inquiry. As Elias suggested, the researcher:

‘...does not first deduce hypotheses or conclusions from laws in his or her imagination or mind and then seek support in the objective, external world. Nor does the researcher simply observe facts devoid of prior synthetic reflection, and then attempt to link observations together to formulate theory. There is a constant two-way traffic between two layers of knowledge: that of general ideas, theories or models and that of observations and perceptions of specific events’.

(Elias 2007, 89)

Any static relationship between subject and object was, according to Elias, completely unworkable, based on his conceptualisation of knowledge development (Baur and Ernst, 2011). Elias (1971b) suggested that during the process of gaining knowledge, knowledge changes, as do the researcher and the researched. This dynamism of knowledge production and development was important to Elias, as he suggested (somewhat contentiously) such dynamism was something contemporary sociological theories of knowledge lacked (Elias 1971b). Elias’s primary theories were concerned with the development of knowledge (Baur and Ernst, 2011). From his perspective knowledge changes and he proposed that researchers can only ever aspire to develop explanations that are more ‘object’ adequate than were previous explanations. In this sense, for Elias, ideas of ‘ultimate truths’ have no place but are instead replaced by ideas that more adequately reflect ‘reality,’ or as Elias termed it, reality congruence (Murphy et al., 2000). This also implies that reality congruence builds over time as knowledge becomes refined by successive generations. Elias (1971a) explained:

‘The knowledge of what people have at any given time is derived from, and is a continuation of, a long process of knowledge acquisition of the past. It can be neither understood nor explained without reference to the structured sequence to which we refer when we speak of the ‘growth of knowledge’ of the ‘development of knowledge’ which, in turn, is part of the wider development of the societies where knowledge develops and, ultimately, of that of mankind.’

(Elias, 1971a, 158-159)

Not only did this reinforce the processual nature of knowledge development but also reinforced the notion that knowledge is socially produced. Quilley and Loyal (2005) suggested that the development of human knowledge (including sociological knowledge) takes place within the figurations that individuals form and so highlighted the inextricable link between Elias’s theory of knowledge and the processes associated with the production of sociological knowledge. If, as suggested, knowledge is socially produced then it is also subjective. As all human beings exist in a society of humans, maintaining a level of objectivity becomes impossible. Baur and Ernst (2011) suggested that subjectivity exists in a number of forms, all of which hold implications for the researcher in relation to their own reflexivity. It is therefore important to consider these forms of subjectivity and the balance between involvement and detachment.

### **5.3 Reflexivity**

As discussed earlier in the chapter, Elias considered notions of a static subject-object relationship unusable due to the dynamism of knowledge production (Baur and Ernst, 2011). Instead, Elias took what Baur (2008) considered a more interpretative stance; he did not question whether subjectivity influenced perception, rather, he reframed this problem by asking *how* it framed perception (Baur, 2008). The ‘how’

was explained by Baur and Ernst (2011), who suggested that subjectivity could take three forms, *verstehen*, *partiality* and *perspectivity*. In Baur and Ernst's (2011) explanations of these three forms, *verstehen* is the recognition of the positionality of the subject of research, in that it is necessary to understand meanings in actions, words and contexts (Evans et al., in press) or the insider perspective. Baur and Ernst (2011) suggested as humans, every individual forms part of the figuration, and therefore part of the social phenomenon that is being investigated, so this needs to be made explicit. The second subjectivity is partiality (sometimes referred to as *parteilichkeit*) which suggests that subjectivity can 'distort' the research and analysis due to being very closely linked to a researcher's own values or political stance. Therefore, a researcher's own ideas and pre-judgements could influence the way in which data are interpreted, which could be misleading. Baur and Ernst (2012) note that such subjectivity should be avoided, which conflicts with more 'standpoint' or politically motivated approaches, such as Marxist or Critical Feminist work (Evans et al., in press). Finally, *perspectivity* (sometimes referred to as *perspektivität*) acknowledges that subjectivity is a pre-requisite for grasping reality and meaning (Baur and Ernst, 2011). This referred to a researcher's subjectivity as both a scientist and a person, for example their knowledge of social theory, their ability to set research questions, and to collect data (Evans et al., in press).

Baur and Ernst (2011) suggested that Elias argued that subjectivity was necessary and unavoidable, which means researchers should try to minimise their level of partiality within research in order to seek to avoid what Elias believed to be the potential danger of pre-judging or perhaps politicising knowledge. Indeed, politicising



knowledge was considered beyond the role of the researcher, whose role was instead to provide knowledge for others, particularly political actors to base decisions upon. A researcher's *verstehen* is also a factor; researchers are human beings and part of the figuration, and therefore part of the social phenomena under scrutiny. So therein lies two types of subjectivity: the type humans need to understand other humans but also the type that could 'distort' research and findings by promoting a particular agenda. The latter could be considered more problematic, and in an attempt to reduce partiality, Baur and Ernst (2011) suggested that the researcher adopt a clear theoretical stance and discloses their perspectivity. At the same time, however, the need for insider perspective is recognised, and Baur and Ernst (2011) suggested that researchers immerse themselves in the research process. For these reasons, partiality and perspectivity are closely entwined within the processes of research and it is the researcher's responsibility to make their partiality and perspectivity as clear as possible. The tensions that exist between these forms of subjectivity are best elucidated in Elias's (1956) discussions of involvement and detachment.

Elias (1956) suggested that involvement and detachment lay at opposing ends of a continuum, where typical adult behaviour sits somewhere in the middle of this continuum. He believed that ordered group life is dependent on the interplay of individuals' thoughts and actions of impulses in either direction – those that involve and those that detach, keeping each in check. Elias (1956) described this as 'changing equilibria between sets of mental activities' (p.227) which as humans, relationships with others, with objects or even ourselves, can be involved and detached.

Therefore, for Elias (1956), a balance between involvement and detachment is a way of thinking, and he believed it is ineffective to consider the two as separate concepts. Evidently both have an important role to play.

Elias (1956) considered how involvement could be beneficial to sociologists, and suggested that sociologists as humans, are part of the same interdependent patterns and processes that people form together. By this notion, it is suggested that the researcher possesses a degree of insider knowledge and, ultimately, involvement is unavoidable. In some ways, this may be advantageous, however, Elias (1956) was also concerned that too great a level of involvement may hinder the research process itself, causing the researcher's own partiality to limit their own viewpoint. For this reason, a 'detour via detachment' is recommended, which implies that the researcher should be able to put aside personal emotions to maximise the chances of developing a reality congruent picture of the area of study to be researched (Dunning, 1999).

These ideas were well illustrated through Elias's (1956) explanation of Poe's *A Descent into the Maelstrom*. Elias (1956) described two brothers' reactions when faced with their boat being drawn into a whirlpool. Whilst both initially overwhelmed by fear, one brother was able to overcome this. By stepping back from the situation, he observed what was happening and began to develop awareness for certain regularities in the movements of the boat and other objects. In doing so, he connected a picture of the process in which he was involved and a theory as to how he might have escaped. The brother concluded that small cylindrical objects sank

more slowly than other shapes and sizes, so he tied himself to a cask and threw himself overboard. The boat, with the other brother, was taken by the sea; however, the cask sank more slowly, which allowed the fisherman to return to the water's surface and he survived. For Elias (1956), this suggested that as the brother developed a picture of the regularities in the process with which he was involved and recognised the relevance of this to his own situation, he was able to escape. This included adopting a less emotive response and thus a greater control of the situation, which demonstrated the benefits of a balance between these polarities.

Perry and colleagues (2004) argued for the significant role both involvement and detachment can play in developing a more reality congruent picture of complex aspects of the social world. Moreover, Perry et al. (2004) suggested this was why process sociologists prefer the concept of involvement and detachment, as it offers a more accurate reflection of a process sociologist's personal situation in comparison to more traditional notions of objectivity and subjectivity. Indeed, the recognition that a researcher is *part* of the research process, rather than a detached observer, challenges the notion that research should be presented as a 'view from nowhere' (Hesse-Biber, 2016) and the assertion that complete objectivity is achievable. Perhaps the greater challenge for researchers is how this balance can be achieved.

Dunning (1999) suggested that some believed Elias to have advocated a methodology of detachment, however Dunning (1999) argued that neither involvement or detachment should be prioritised at the expense of the other. Indeed, Bloyce (2004) commented that process sociology encourages sociologists to strive for an

appropriate blend between both involvement and detachment. This did not mean changing the *balance* between involvement and detachment, such as being one more so than the other as Perry et al. (2004) highlighted, but instead a *blend* between the two. For Bloyce (2004) this meant the recognition of one's own involvement as far as was possible and by doing so strive to distance oneself as far as was possible from one's political values. Rojek (1986), although recognising the usefulness of the involvement-detachment concept, also argued there were no clear rules as to how this balance can be achieved or how appropriate levels can be maintained. Bloyce (2004) suggested that the issue should be about the researcher's awareness of the concept initially rather than what 'tools' were needed to achieve this. Both Maguire (1988) and Dunning (1999), however, made some suggestions as to how to approach this. Maguire's (1988) suggestions for 'self-distancing' included, variously: the adoption of a long-term developmental perspective which resists today-centred thinking, taking a stance of 'not knowing', and the use of personal pronouns such as I, we, they, to allow understanding of relationships.

In striving for a blend between involvement-detachment and based on Maguire's (1988) recommendations it was important to consider the role of reflexivity in the current study. Perry et al. (2004) suggested that some researchers may view the concept of involvement-detachment and reflexivity as synonymous, but these writers themselves consider this to be misguided, and instead they viewed reflexivity as one aspect of the issue of involvement-detachment. In understanding what it means to be reflexive, Markula and Silk (2011) described how the researcher is unavoidably central to the research process itself. Researchers are individuals, and

inevitably have characteristics such as gender, ethnicity, class and nationality, amongst many others, which influence and emplace them. As researchers, decisions regarding the research process have to be made: where the focus lies, to whom they should speak to garner information, and how best to analyse data. For these reasons, there must be an awareness and acknowledgement of the self within the research process.

Reflexivity is well illustrated through Richardson's (2000) metaphor of a crystal. When looking through a crystal, no matter what angle, something different can be seen. Even if two people looked through the same angle, they would each see something different; as Richardson (2000) described, 'what we see depends on our angle of repose' (p.934). Markula and Silk (2011) therefore suggested that the researcher is only ever able to gain a partial understanding of the phenomenon being studied. Indeed, by being self-reflexive, it allows an understanding of how the subject matter has been approached previously and yet questions what is known and acknowledges that there is always more to know. Applying this understanding of reflexivity to the concept of involvement-detachment, Perry et al. (2004) suggested that being reflexive allows researchers to explore their own levels of involvement and detachment in a more open manner. For this reason, and congruent with the methodological and theoretical approaches adopted, it is necessary to recognise the researcher's own position within the research. For the purpose of the following discussion, and to render this easier to read, the narrative is changed to the first person.

#### **5.4 The Researcher's Position**

I was very aware that my interest and involvement with ERSs had not been initiated with the start of this study. My involvement in ERSs in fact dated back nearly sixteen years. My first job on leaving university was as a gym instructor or EP, as they are referred to in this study. As part of this role I was required to support the gym's ERS. Although not specifically qualified in referral at the time, I was involved in taking health-related measures for newly referred patients before they were passed to qualified EPs, who were then responsible for the exercise programme design. I had first-hand experience of seeing nervous patients come through the door, with a range of conditions, wondering what exactly a referral for exercise would involve for them. I also witnessed the time and the effort EPs took in working with these patients, building their confidence as well as improving their fitness. I observed the transition that many of these patients went through, which culminated in the repeating of their health assessment at the end of the referral period. Many patients were driven by these outcomes, with so much centred on an improvement in numbers, whether this was weight, blood pressure or cardio-respiratory fitness. I observed the challenges and frustrations of the EPs, when insufficient information had been received about a patient or a patient had to be referred back to their GP, for example, due to blood pressure being too high. Although some months later my employment changed, such experiences inspired me to pursue the ERS qualification myself, so that I could support individuals in the same way that I had observed. I was very aware that such insight could have impacted on my own partiality in relation to the focus of this current study, which could have led to certain sympathies with the EP role or even with patients. It was important in my role as researcher, therefore, that I achieved a

blend of both involvement and detachment, placing such experiences and insight to one side as much as possible, via a form of partial 'bracketing' (Allen-Collinson, 2011) but at the same time not overlooking the importance of having such knowledge of ERSs.

Although my career path subsequently changed, my involvement with ERSs continued. Indeed, within my lecturing role, I developed modules that examined the use of ERSs, and I arranged placements for students at local ERSs to gain experience supporting patients. This then led to the arrangement of course endorsement, which involved the national occupational standards for ERS practitioners being embedded into a third-year elective module. This meant that alongside academic delivery I was also training potentially future EPs who would work on ERSs. Again, such experiences had shaped my *verstehen*, with obvious potential to have influenced my own partiality. Once again, a balance of involvement and detachment was required.

Involvement with local ERSs had led to my participation in the county's ERS structure that was central to the focus of this study. Having originally volunteered to attend the county's ERS quarterly network meetings (as explained in Chapter 4) to provide an academic perspective, I became privy to the open discussions regarding the running and development of the county's ERS, which covered the county's seven districts. These were meetings organised by local Public Health and the County Sports Partnership (CSP), for district managers, ERS coordinators and in some cases EPs. This placed me in a privileged position to the discussions that took place. I witnessed the interactions that occurred between individuals, mostly at a strategic management

level, and the dynamics of such meetings. Whilst generally supportive in nature, these meetings also left some people visibly frustrated when certain topics were discussed; for example, debating whether to charge patients for ERSs or the decommissioning process.

Throughout data analysis I found myself reflecting on whether my data appeared to confirm or contradict what I had heard and seen in the meetings. This presented a dilemma in that I had not formally collected data from these meetings nor had I obtained consent to quote participants. Yet through discussions with my supervisory team, all agreed that my observations had given me significant insights and positioned me as a relatively impartial insider to the ERS figuration. It was therefore considered necessary that I try to document this in making explicit my own positionality, and also how my attendance at these meetings could contribute to the data.

An auto-methodological element (Allen-Collinson, 2011) was therefore introduced via self-elicited reflections. I completed a number of self-elicited reflections on what I heard and saw in meetings, particularly those that I could recall most clearly and perhaps went beyond the 'mundane' operation of the meetings. In being as systematic as possible, these reflections were stimulated by reading the minutes of those meetings that I had attended, then verbally describing and recording specific incidents or recollections I had. I particularly focused upon discussions or situations which were more emotive than usual or other 'magnified moments' (Hochschild, 1998) which stood out. For example, a debate regarding whether to charge for ERSs



took place in one scheme meeting and this sparked some debate between district managers and public health representatives. These reflections were recorded via digital Dictaphone and then transcribed verbatim (an example can be found in Appendix A). The reflexive transcripts were then read and edited with handwritten notes, which highlighted key points as a reminder to myself. These transcripts were then reviewed alongside the reading of participant interview transcripts. During data analysis, in addition to my procedures of thematic analysis, I was then able to re-examine and cross-reference the themes I produced, and the quotes within them, with my recollections of the meetings. This provided the analysis with an additional layer of 'reality congruence'.

In the meetings attended, listening to the discussions, I would think about the interview data; the experience felt like seeing my findings or my themes 'played out' in front of me. I was also very aware that this placed me in an advantageous position, and therefore it was important that such reflections were discussed with the supervisory team in an attempt to delineate those elements that related to my *verstehen* and perspectivity. The process also highlighted and facilitated critical discussions of elements of my own partiality, for example, political sympathies with a particular group or process. The pursuit of strong ethical practices was also vital during the presentation of results, to ensure all efforts were made regarding participant anonymity.

Having considered this auto-methodological element, I now return to a third-person narrative to address the research design employed for this study.

## 5.5 Research Design

Baur and Ernst (2011) suggested that process sociological studies are typically situated within several levels of theoretical abstraction. The authors distinguished three broad levels of theoretical abstraction: *Sozialtheorien* (or social theories), which referred to the social dynamics at the group and individual level, Middle-range theories, which concentrated on social processes with a given socio-historical context, and *Gesellschaftstheorien* (or theories of society), which referred to those theories of a more macro-scale, both in size and time. This study operated at the Middle-range level. This meant that the level of abstraction focused upon on a specific thematic field that was contextualised by a particular historical period and a given geographical region (Baur and Ernst, 2011). In the case of the current study, it meant the selection of ERSs, conducted within a chosen county, during the 21<sup>st</sup> century. This involved recruitment of participants who were central to ERSs and allowed their interdependencies to be explored. It also enabled participant perceptions of their own position within the ERS figuration to be considered in addition to their perceptions of their ability to influence the figuration itself.

Having already identified why process sociology was selected more generally as a theoretical framework for this study (see 5.1), it was apparent that to have explored each of these three levels of theoretical abstraction would have exceeded the aim and objectives of this study. Therefore, the selection of the Middle-range level was deemed most appropriate to enable the aim and research objectives of this study to be answered.

Baur and Ernst (2011) suggested that Elias believed social theory was necessary in selecting a suitable research design, and also to guide social research. As a consequence, these authors (2011) suggested that during the initial stages of choosing the research design, the researcher should reconstruct their own perspective, considering questions such as, why a specific kind of question was being asked and which general social theory was being used. For this study, both these questions were considered and discussed within the current and previous chapters where the theory being used (Chapter 3) and the researcher's position (Chapter 5) were detailed. Baur and Ernst (2011) explained that Elias's own theoretical perspective, identified as process sociology (as discussed in Chapter 3) informs a process-oriented framework for understanding social contexts (as shown in Figure 5.1), that consists of three key possible steps: reconstructing the rules and social structure of the figuration (macro-level), reconstructing the individual's placement within the figuration, including their perception and ability to change the figuration (micro-level), and finally reconstructing the sociogenesis, or the unfolding of the figuration's becoming, changing and if relevant, ending (Baur and Ernst, 2011).

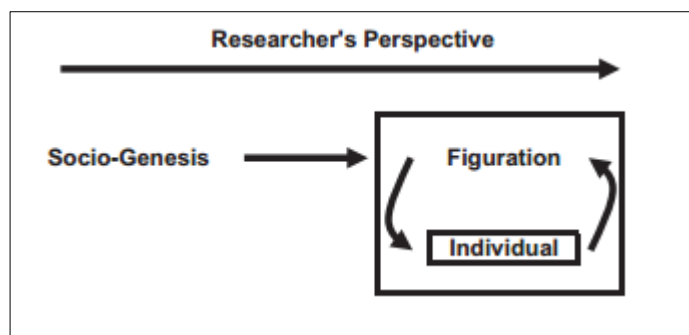


Figure 5.1 Concepts of a process-oriented framework (taken from Baur and Ernst, 2011)

Baur and Ernst (2011) concluded that these steps were embedded within Elias's broader conceptualisation of process sociology, which demonstrates that the individual is able to influence the figuration, change their position within it but also change the figuration itself (the rules and social structure). It was for these reasons that Baur and Ernst (2011) emphasised the importance for process sociologists to analyse how individuals perceive their figuration and their own position within it, implying the relationship between the micro and macro level as well as the long-term development.

In identifying and selecting methods to capture such concepts, process sociologists suggest the object of inquiry should be prioritised rather than elevate any particular method as superior (Dolan, 2009). Dolan (2009) explained that:

'...any research method should be appropriate to the nature of the object of inquiry and cannot be posited prior to an understanding, theoretically informed, of the structure and dynamic processes immanent within such an object'

(p.188)

Indeed, Bloyce (2004) suggested that the process sociological researcher should utilise the most appropriate research tool to address their particular research question, doing justice to the complexity of the research process rather than over simplifying. For Bloyce (2004), this meant allowing the methodological framework to 'flow' from the nature of the problem rather than be limited to one particular individual research strategy.

In consideration of this guidance, the structure proposed by Baur and Ernst (2011) (Figure 5.1) was employed for this study to a greater extent, yet it is important to recognise that to do all three would go beyond the boundaries of this thesis. Prior to the study design, the review of literature and contextual chapter (2 and 4 respectively) provided an overview of the historical development of ERSs within the UK and the specific county in question, which enabled a general theory of development to be constructed and provided some insight into the sociogenesis of the figuration itself. In response to the conclusions drawn from this literature review, two phases of study were conducted to explore the perceptions and experiences of ERSs, for those individuals central to one county's ERS. Combined, these two phases of research presented an understanding of how the ERS process functioned and was produced by the interactions of those who contributed to it (shown in Figure 5.2), which was intended to answer the aim of this study and address the three specific research objectives. These phases of data collection provided a micro-scale perspective that enabled the impact each individual had on the figuration, and vice versa, to be explored. Phase one initially explored the perceptions, beliefs and experiences of patients, EPs and HPs, who participated or contributed to the identified county's ERS. As previously stated (see 5.1), this first phase was exploratory by design but enabled the participants' individual perceptions of the ERS process to be identified, the interdependent relationships between the three groups and how they had contributed to the socio-cultural norms of this particular scheme. This study also provided an understanding of the current ERS delivery processes and how they had been received. Following the outcomes of phase one of the research, phase two followed a similar approach and examined the perceptions and beliefs regarding ERS

provision but from the perspective of those personnel at a ‘strategic management’ level, at both district and county level. This enabled understanding of ERSs to be examined in greater depth from the perspective of those not directly involved in the day-to-day delivery processes.

In conjunction with these two phases of the research, as described previously, self-elicited reflections were also made to ensure the researcher’s own positionality was made explicit. These sensitising procedures were taken forward into data collection and analysis, and continued to be reflected upon through ongoing discussions with the supervisory team.

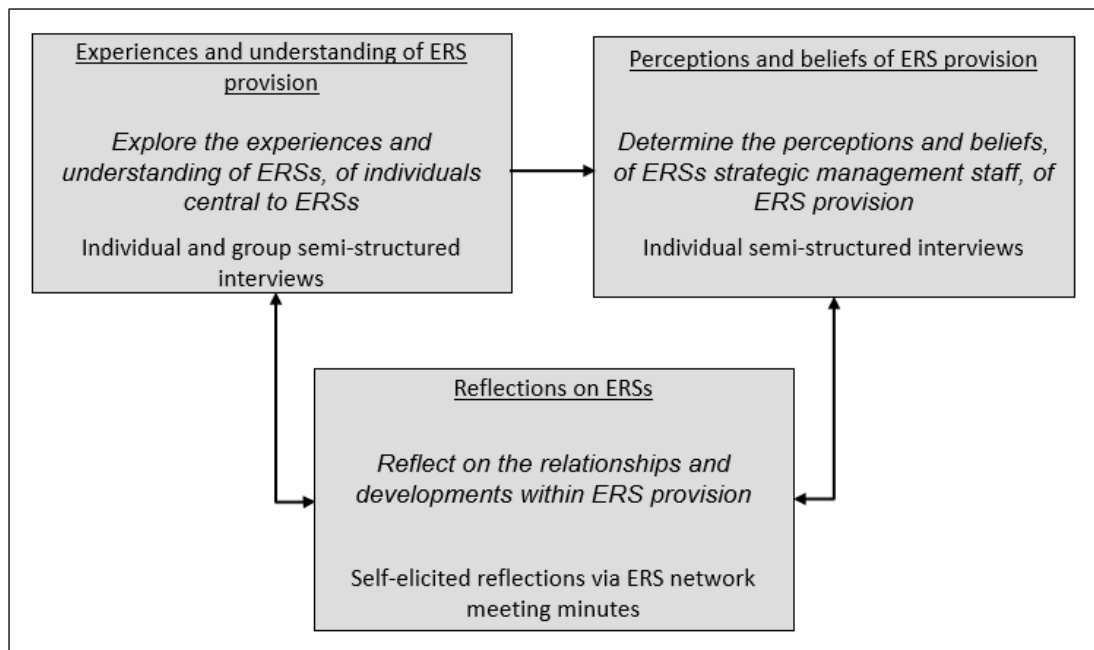


Figure 5.2 Research design

As previously identified, the two phases of study, alongside the self-elicited reflections, were applied to one East Midlands County’s ERS (as outlined in Chapter 4). In deciding which county was selected, sampling criteria were used. Firstly, a

county had to offer a well-established ERS, so as to avoid researching a scheme that was newly developed or still experiencing 'teething' issues; secondly, it was necessary to select a county that was easily accessible to the researcher, for practical reasons of time and resources. Based on this aforementioned inclusion criteria, four counties were eligible, and one was subsequently selected due to enhanced accessibility and also geographical familiarity to the researcher. The focus on a single county's ERS was commensurate with a case study approach.

Bryman (2008) described a case study as a 'detailed and intensive analysis of a single case' (p.52). Hodge and Sharp (2016) however, suggested that a case study was actually about the boundedness of the case and not just an in-depth study, in that, the phenomenon of interest could have been a person, group, process but also extended to a community or organisation. Furthermore, the authors proposed that a case study was expected to capture the complexity of the single bounded case. Denscombe (1998) suggested that this approach lent itself to emphasising the detailed workings of the relationships and social processes, rather than restricting attention to the outcomes of these, which was pertinent to this study. Simons (2009) defined the case study as:

'...an in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a "real life" context'.

(Simons, 2009, 21)

On reflection of the research aim and objectives of this study, the statement above highlighted the worth of the case study design. This study looked to explore the complexity with which ERSs operated, from individuals' perspectives and their

understanding of schemes, according to the role held within the figuration. Therefore, a case study design was deemed appropriate. Importantly too, Bloyce (2004) also supported the notion that a case study design was consistent with a process sociological approach.

Bryman (2008), however, highlighted the limitations of a case study design and identified issues such as limited generalisability. Indeed, Hodge and Sharp (2016) suggested that the perceived limitations of case study findings may lead to a number of 'misunderstandings' about the worth of a case study approach. It was therefore important to acknowledge that the findings that pertained to one UK County's ERS could not necessarily be generalised to all other ERSs in the UK and the current research was clear in making no claims to wider generalisability. Hodge and Sharp (2016) did note, however, the potential 'transferability' that a case study design offers. Transferability, as described by Tracy (2000), is achieved when readers perceive a degree of overlap with their own situation and intuitively transfer the findings to their own contextual actions. Therefore, the current research presented an opportunity for other individuals associated with ERSs, to transfer the findings from this case study and draw parallels with their own situation; for example, the possible empowerment of a commissioner to make informed decisions based on reality congruent data.

In the application of the described research design, the methods for this study are now considered.



## 5.6 Methods

Prior to the collection of any data, ethical approval was sought from the researcher's own awarding institution, in addition to the National Health Service (NHS). NHS ethics were deemed necessary at the time due to the inclusion of clinical HPs as participants. Copies of the relevant documentation can be found in Appendix B and C.

Table 5.1 Overview of the research journey

Year	Research Activity
2007	<ul style="list-style-type: none"> <li>• October – Commence studies.</li> <li>• Planning of phases of study.</li> <li>• Completion and submission of ethics paperwork – University and NHS.</li> </ul>
2008	<ul style="list-style-type: none"> <li>• January – received NHS and University ethical approval.</li> <li>• Writing of review of literature.</li> <li>• Refining of methods for Phase 1.</li> </ul>
2009	<ul style="list-style-type: none"> <li>• Recruitment of participants for Phase 1.</li> <li>• June – commence semi-structured interviews and focus groups with patients, EPs and HPs.</li> <li>• Transcription of interview data.</li> </ul>
2010	<ul style="list-style-type: none"> <li>• March – complete EP interviews (3x ERS coordinators and 4x EPs).</li> <li>• April – complete patient focus groups (15x patients).</li> <li>• October – complete HP interviews (5x HPs).</li> <li>• Transcription of interview data</li> </ul>
2011	<ul style="list-style-type: none"> <li>• Complete transcription of interview data.</li> <li>• Coding of transcripts and generation of themes.</li> <li>• December – Discussions with colleagues regarding suitable theoretical lens.</li> </ul>
2012	<ul style="list-style-type: none"> <li>• January – finalise theoretical lens for thematic analysis of Phase 1 data and refine research aims and objectives.</li> <li>• April – Submit MPhil to PhD transfer report.</li> <li>• June – complete MPhil to PhD transfer viva.</li> <li>• Write up results from Phase 1.</li> <li>• Planning of Phase 2.</li> <li>• Started attending County ERS network fora.</li> </ul>
2013	<ul style="list-style-type: none"> <li>• Interruption of studies.</li> </ul>
2014	<ul style="list-style-type: none"> <li>• Interruption of studies.</li> <li>• September – recommence studies.</li> <li>• Refine writing of review of literature, methods and results for Phase 1.</li> </ul>
2015	<ul style="list-style-type: none"> <li>• Planning and refining of Phase 2.</li> <li>• Recruitment for Phase 2.</li> <li>• November to December – Semi-structured interviews with strategic managers (2x Public Health staff, 2x CSP staff, 1x District manager).</li> </ul>
2016	<ul style="list-style-type: none"> <li>• Transcription and thematic analysis of Phase 2 interviews.</li> <li>• Write up methods and results for Phase 2.</li> <li>• Formulate structure for discussion chapter.</li> </ul>
2017	<ul style="list-style-type: none"> <li>• Finalise discussion and conclusion chapters.</li> <li>• May - Finalise thesis and submit.</li> </ul>

Table 5.1 identifies the key milestones and timeline of the research journey undertaken. As has already been noted (see 5.1), when embarking on this research, the intended aim was to explore one ERS, considering the delivery processes used from multiple perspectives and the scheme's impact. This led to the development of the first phase of study. Phase one was exploratory and designed to explore the multiple perceptions of those individuals central to the delivery processes of ERSs (EPs, HPs and patients). At this point phase two was still undecided, however the researcher had considered a mixed methods approach, collecting quantitative data relating to physiological health measures and patient attendance, to detail the scheme's impact. As described in 5.1, reflecting on initial interview data, findings suggested that participants' (EPs, HPs and patients) conceptualisations of ERSs were conflicting and some individuals appeared to define their own role in relation to others, which implied that experiences of ERSs were co-constructed in an interdependent way. These insights were unfamiliar to the researcher and went beyond the complexities that had previously been assumed for ERSs from the existing literature. This posed the problem: how could an ERS be assessed for how well the scheme was working, if the scheme was not first explored and understood. The focus of this first phase therefore shifted to the examination of how ERSs were conceptualised as a socio-cultural phenomenon, and the adoption of a figurational framework was considered more philosophically compatible. Adoption of this theoretical lens in the analysis of phase one data then informed the design of phase two of the research. Having highlighted the power balances at play between the participant groups (EPs, HPs and patients) and how these had influenced the delivery of the ERS, it appeared appropriate to consider whether these same issues were

apparent amongst other individuals within the county's ERS hierarchical structure, specifically those at strategic management level. This meant exploring the perceptions of individuals in Public Health, the County Sports Partnership (CSP) and District Managers. By examining the perceptions of strategic managers, alongside those individuals central to the delivery of ERSs, it became possible to provide a more comprehensive understanding of ERSs, through a process sociological lens.

### **5.6.1 Interviews**

Interviews formed the primary method of data collection utilised in the study. They were employed in both phases one and two of the research design to address the identified aims, as depicted in Figure 5.2. In phase one, group interviews were employed with patients and the ERS coordinators, whilst one-to-one interviews were used with the EPs and HPs. In phase two only one-to-one interviews were employed with all participants at a strategic management level. The rationale for dividing the interviews in this way is provided later in the chapter. This section begins by first exploring the use of interviews.

Kvale (1996) described the research interview as a conversation that attempts to understand the world from the participant's perspective and to unfold the meaning of people's experiences. Indeed, Smith and Sparkes (2016) suggested that interviews are an effective way for participants to describe their experiences in both a rich and detailed way, whilst also communicating their perspectives and interpretations of these particular experiences. The purpose of the current research was to build an understanding of ERSs from the perspective of those individuals involved with

schemes, which varied according to their particular role. Interviews were not considered the only qualitative technique to have offered insight into individuals' experiences and understanding, and other methods could have been used, for example, participant observation, or observations (see Smith and Sparkes, 2016). Yet, interviews offered the opportunity to go beyond the 'experience', and provided insight into participants' decisions, their reasoning for these decisions and how this had perhaps been shaped by others. Therefore, interviews were deemed an appropriate technique to use.

Interviews can be designed in various formats, such as unstructured, semi-structured or structured. The semi-structured interview method was employed for this study due to the degree of freedom it offered for interviewee responses (Bryman, 2008). Use of a semi-structured approach allowed participants to outline their own perspective more so than would be possible in a structured interview (Sparkes and Smith, 2014). Whilst the use of unstructured interviews also offered freedom, it was felt that due to the specific topics the researcher wished to discuss with participants, some form of pre-set structure was required (see Smith and Sparkes, 2016), and therefore semi-structured interviews were chosen.

The researcher developed a pre-planned interview structure that directed the interaction whilst utilising open-ended questions (see also Sparkes and Smith, 2014). There were strengths in adopting such an approach as although the researcher did not ask the questions in the same, standardised way to each participant, the structure ensured that as far as possible the relevant information was collected from

all those interviewed (Sparkes and Smith, 2014). It also meant that participants were able to answer relatively freely, develop their own explanations and explore the area in depth (Kreuger and Casey, 2000) addressing the areas of interest to the study but without the content being overly dictated by the researcher. The content of the questions was designed to explore participants' opinions and experiences of ERSs from their perspective, capturing their particular role and the contribution they made to the ERS process. The questions used for the first phase of the research were open and exploratory in nature, designed to elicit participants' experiences of each stage of the ERS, from initial referral, through to the delivery of the supervised exercise, and culminating with their recollections of scheme completion. They were structured in this way due to the participant groups: patients, EPs and HPs, where a broader understanding of what happened at each level of ERS delivery was required. The questions used for the second phase of the research were more specifically role related, but still exploratory in nature. Having reflected on the theoretical framework, this was an attempt to avoid undue researcher partiality, whilst managing her own *verstehen* and perspectivity. Indeed, as the questions were more exploratory then this allowed partiality to be minimised. Questions were also built on the findings of the initial phase of research, which was deemed necessary to 'unpick' the wider understanding of ERSs at a strategic level. The questions asked in phases one and two can be found in Appendix D and E.

Questions were arranged to ensure respondents were taken through the same sequence of questions (Patton, 1990), and this allowed the researcher to maintain some degree of control, which was important for analysis when comparing individual

responses. Participants were allowed to depart from the general structure, however, probes or curiosity-driven questions (see Smith and Sparkes, 2016) were used to encourage greater depth of responses. This not only increased the richness of the data (Patton, 1990) but also demonstrated the researcher's active listening (see Smith and Sparkes, 2016). Curiosity-driven questions were designed to encourage respondents to elaborate on their thoughts, feelings, opinions and accounts of their experiences, for example "and what did you think about that?". Questioning beyond the central schedule therefore encouraged participants to offer full and honest explanations, as well as foster discussion (Kreuger and Casey, 2000).

Having determined the general structure of the interview it was then necessary to decide *how* to conduct the interviews. The use of focus groups were initially selected. Focus groups are considered to be an effective technique to identify the range of thoughts that individuals may have had about a specific topic (Kreuger and Casey, 2000) much like any form of interview. The difference, however, is that individuals are able to consider their views in the context of others (Patton, 1990). By having more than one interviewee, group interactions provide multiple versions of events that potentially complement each other (Arksey and Knight, 1999), whilst also stimulating discussions in directions that the researcher may not have originally envisaged. Moreover, a focus group provided potential insight into the similarities and differences between opinions and experiences (Morgan, 1997). Being able to compare and contrast these experiences was particularly relevant for this research as all participants had experience of the ERS, but from different perspectives.

Limitations have been identified when using focus group interviews, however. Whilst Kreuger (1988), for example, considered the group interview environment to be permissive and non-threatening, Arksey and Knight (1999) identified that some individuals may feel reticent in front of others, whilst some may try to dominate the interview. For these reasons, prompts such as “would you agree?” were directed to individuals in an effort to ensure all participants had equal opportunity to respond. Therefore, the researcher’s role was to facilitate these interactions and to refocus these where required (Bender & Ewbank, 1994). It was also acknowledged, however, that a lack of interaction from some was not always a drawback, as focus groups could also highlight the interactional dynamics that occurred between individuals (Sparkes and Smith, 2014), which could be equally as pertinent. Indeed, being able to witness how individuals reacted and responded to each other would have provided further insight into the relationships between these people, particularly when compared to what was actually said. This, on reflection, was perhaps a limitation, in that the researcher had not collected this additional data; however, it could be argued that for those groups where data would have been most pertinent (ERS coordinators, district managers, Public Health and CSP representatives) anything particularly notable was documented through the self-elicited reflections.

When considering the use of focus groups for all potential participants, it was decided that this may not have been appropriate. Arksey and Knight (1999) identified that if a group is already established as a social group, this could lead to the discovery of thoughts or feelings that would have otherwise not been gained from one-to-one interviewing. This applied to the patients who were an established social group, they had attended the ERS at the same time, at the same facility over a number of weeks.

Therefore, the use of focus groups was considered to be appropriate for patients. For all other participants: EPs, HPs and strategic management, it was considered more appropriate to hold individual interviews. These individuals' relationships were less intercorporeal as they often worked independently and in isolation from each other. Therefore, it was considered more appropriate to speak to these individuals in these settings. Those in a position of strategic management were also relationally more powerful than the other groups, which in the scenario of a focus group may have hindered the latter's ability to speak freely. Furthermore, focus groups presented issues such as logistics and time constraints (see Patton, 1990; Morgan, 1997) which made group interviews impractical for some participants. For example, HPs found it difficult to identify their availability for sufficient time for a focus group to be conducted. For these reasons, it was decided that focus groups would be conducted with patients and individual interviews were used for all other participants.

Although the benefits of focus groups have been identified, there were also positive benefits in conducting one-to-one interviews. Unlike focus groups where response time to questions can be increased due to the number of people participating (Patton, 1990), interviewers are provided an opportunity to potentially elicit greater information in the time available (Morgan, 1997). This technique was therefore considered to be more practical for the remaining participants (excluding patients), for reasons stated previously.

Despite the benefits of individual interviews, this approach still proved extremely challenging with the HPs, who found it difficult to commit to the time required for



face-to-face interviews. To combat issues of HP workload and difficulty in recruitment, the alternative of telephone interviews was offered. Telephone interviews can be quicker (Arksey and Knight, 1999) and enable engagement with participants who are otherwise unavailable (see Smith and Sparkes, 2016). In this instance this proved correct, as more HPs were willing to commit to this invitation. It is, however, acknowledged there were limitations of using this technique, and the lack of co-presence and co-visibility of the interviewee were potential issues, alongside the missing of visual cues such as embodied responses (Arksey and Knight, 1999), which may have prevented the researcher tailoring questions accordingly. In an attempt to overcome this, contact with the HPs was established early in the recruitment process, where exchanges occurred via email prior to the actual interview, in order to establish some form of rapport.

Having provided the rationale for the methods employed within both phases of the study, the process of data collection is now portrayed.

### **5.6.2 Procedure for Phase One**

From the outset, the initial aim of this study was to explore perceptions and understanding of ERSs, and therefore those individuals best positioned to provide this information were identified as those people involved in the ERS on a daily basis, at a delivery level. Identifying participants in this way is referred to as purposive sampling, a technique whereby the researcher selects individuals likely to be able to offer the greatest insight in to those issues central to the research (Patton, 1990). For these reasons, participants in the present study were recruited from the

following groups: patients, EPs, and HPs. Whilst participants could have been recruited from any of the seven districts within the chosen county, only one was initially identified. As the first phase of the research was intended to be exploratory (as explained in 5.1) the intention had been potentially to explore other districts at a later stage in the research, based on the outcomes of the first phase; as it transpired, this never occurred. The district that was chosen was done so for two reasons. Firstly, the selection was made as this particular district had been one of the first ERSs delivered in the county and therefore one of the most established in relation to staff and procedures. Secondly, this district was geographically familiar to the researcher which enabled easier access. Once the district had been chosen, the appropriate individuals were identified for recruitment.

EPs were deemed an appropriate group to recruit due to their role in providing supervised exercise to the patients and for some, who held a dual role, in co-ordinating the ERS. Therefore, the sampling criteria for this group applied to any EP who was qualified in the delivery of exercise for referred patients and was actively delivering. This inclusion criteria applied to seven EPs who worked within the chosen district. All seven were approached by letter of invitation (see Appendix F), which included a participant information sheet (see Appendix G) that detailed the purpose of the study and their involvement. All seven EPs (five male, two female) consented to participate and completed an informed consent form (see Appendix H) prior to the start of their interview. The researcher was already known on a professional level to three of the seven EPs, primarily due to overlapping of professional networks. This obviously aided the recruitment process for these three but also supported the

recruitment of the remaining four. It was also the EPs who later played an important role in facilitating the recruitment of participants from the other groups of patients and HPs.

When sampling the patient group, patients were included if they were at six weeks or beyond through their twelve-week referral, and this also included anyone who had possibly completed the full twelve weeks. In order to recruit these participants, EPs who worked at the three main ERS sites were asked to provide patients with a letter of invitation (see Appendix F) which included an information sheet (see Appendix G) detailing the purpose of the study and their involvement, as well as an informed consent. Although the researcher could have done this herself, it was decided that it would be better received from someone who had a well-established relationship with the patients. The EPs also confirmed that they felt this would be more appropriate and would not contravene any data protection issues. Although EPs kept no record as to how many forms were distributed, fifteen patients were recruited in total (eight male and seven female), which amounted to three focus groups. Prior to the start of the focus groups, all patients gave written informed consent (see Appendix H).

HPs were sampled according to their involvement with the ERS, those who had made a referral to the district's scheme were eligible for inclusion. This was regardless of their particular discipline, for example general practitioner (GP), practice nurse or physiotherapist. The EPs identified those medical practices, and the HPs who sat outside of the medical practice environment, who referred patients to their ERS, and

this was regardless of the number of referrals they had made. Nineteen medical practices were initially contacted for an expression of interest and admittedly it proved difficult to gain a response. Due to a lack of response the researcher contacted the ERS coordinators to determine if there were any practices that they believed would be willing to be interviewed. The researcher fully acknowledged that this could be considered a limitation as the ERS coordinators were more likely to have suggested those medical practices that were more engaged with the ERS service; however, this was accepted for pragmatic purposes, in an effort to recruit from this group. On the ERS coordinators' advice, two medical practices were contacted again, in addition to four HPs who worked outside of the practice environment. Of those approached, five HPs (one male, four female) agreed to participate. The five HPs included: one general practitioner (GP), two practice nurses, one physiotherapist and one weight loss advisor. The HPs were provided with a letter of invitation (see Appendix F), in addition to an information sheet (see Appendix G) and informed consent, all via email. On agreeing to participate each individual was contacted to arrange a convenient time to conduct the telephone interview, at which informed consent was obtained. As already noted, where possible a number of emails were exchanged with the HPs prior to the interview to develop some degree of rapport with the participants in an attempt to address the potential limitations of telephone interviews. A brief profile for all participants from the first phase of research can be found in Appendix I.

Prior to the start of all interviews, initial introductions and familiarisation between the participants and the interviewer were undertaken. This was in line with

recommendations made by Krueger and Casey (2000) who suggested that this helps to foster a comfortable environment with the greatest potential for data gathering. An explanation of the aims of the interview and how the interview would be conducted was also provided, which was taken from the participant information sheet. All interviews were recorded via the use of a digital Dictaphone and this was explained to the participants from the outset. All participants were provided with the opportunity to express any concerns about being recorded, but none expressed any concern. At the end of each interview the key points were summarised and additional comments were invited (see also Redmond & Curtis, 2009). In concluding, the participants were thanked for their involvement and invited to contact the researcher should they have anything they wished to add at later point, which none did.

As each of the three participant groups (patients, EPs and HPs) were based in different locations, interviews were held in locations convenient to the participants. This minimised problems such as transport and travel time. This also meant that locations were familiar to the participants, which it was hoped would help to reduce potential anxieties. The EP interviews were held in private meeting rooms that were located on the site of the ERS where the instructor worked. Initially this had been planned as seven separate interviews, however, three of the EPs (who were also ERS coordinators) requested to be interviewed as a group. They identified that this would be beneficial due to the overlap in their work for the coordination and management of ERS in the district. Indeed, three EPs, who also held the role of ERS coordinator, regularly met to discuss the district's scheme and they viewed the interview as an

extension of this. For this reason, one group interview was held with the three ERS coordinators (two male and one female) and four further individual interviews were conducted with the remaining EPs (three male and one female) from each of the three sites where the district's ERS was delivered, within the district. As previously noted, the researcher was already known to some of the EPs and this familiarity seemingly eased the discussions with these participants. This was particularly noticeable with the ERS coordinators, who spoke freely about the ERS service and its challenges.

For the three patient focus groups, each was held in a private meeting room located at the site of the ERS that the patients attended. This meant that the focus group could be held immediately following the patients' attendance at their exercise session. All patients appeared enthusiastic at the opportunity to discuss their experiences of the ERS and openly shared their thoughts. This did raise some concerns at the time and the researcher reflected on how a patient who was less positive about the service may have responded. This could be considered a limitation in speaking only to those participants who had had a positive ERS experience, however, at the point of recruitment there would have been no way of knowing this for certain.

Finally, as the HPs participated in telephone interviews, these were conducted in a private office convenient to the researcher where the phone call was placed on speakerphone to allow recording to take place. These interviews were perhaps the most challenging, particularly in comparison to the other groups. Some of the HP

interviews felt less relaxed although the researcher considered the telephone probably not to be the barrier but instead the pressure of time. Some HP responses were brief and abrupt, which made it difficult to probe further.

In summary, the EPs' group interview lasted thirty-five minutes and each individual EP interview lasted between ten to fifteen minutes. The patients' focus groups lasted between twenty-five to sixty-six minutes and each HP interview lasted between eight to fifteen minutes. The EP and HP interviews could be considered relatively short in length. For the HPs this was attributed to the limited time they had allocated for the interview itself and the pressure the researcher was placed under to complete the interview in the given time. The EPs presented with similar time issues as interviews were generally conducted between patient appointments, however this affected some EPs more than others. Additionally, for some members of the group there was a reluctance to elaborate further on points made and when probed no further information was offered.

### **5.6.3 Procedure for Phase Two**

The primary aim of the second phase of research was to investigate the perceptions and beliefs of those individuals in a strategic management position for ERS provision. This was less exploratory than the first phase and more focused in examining how those outside of the day-to-day activities of the ERS viewed what ERSs were and what it meant. Despite this, the use of purposive sampling remained relevant, due to the need to collect data from a small number of key individuals at strategic management level (Bryman and Teevan, 2004). The individuals who were considered pertinent

were those in a position of authority or decision-makers within the county's ERS framework. Having already considered the ERS hierarchy for the county (as depicted in Figure 4.1 in Chapter 4) there were a limited number of people to whom this applied: Public Health representatives, CSP staff and district managers. Of the roles highlighted, two individuals represented Public Health, two individuals represented the CSP and there were seven district managers, in addition to one business manager (equivalent to district manager role).

As only one district was sampled during the first phase of the research it was decided that the district manager from the same district would be included. This resulted in a total of five individuals being invited to participate. All had been approached informally when seen at meetings and this was subsequently followed up with an email including an information sheet (see Appendix J) that detailed the purpose of the study and their involvement. All five individuals (one male, four female) agreed to participate and completed an informed consent form (see Appendix K) prior to the start of their interview. A profile for these participants can be found in Appendix L. The researcher was known professionally to all five of the phase two participants, primarily through attendance at the county ERS network fora. This facilitated the recruitment process greatly, however it was also noted that this could potentially present challenges. Due to this familiarity, some participants may have been less inclined to openly discuss aspects of the ERS service, particularly if this related to other colleagues who were known to the researcher. Therefore, it was important to reinforce the confidentiality of the interviews from the outset.



As detailed in 5.6.2, the same approach was taken to these interviews as employed for the first phase of research. A brief introduction regarding the purpose of the interview and how it would be conducted was provided. Establishing rapport with these participants was easier than in the first phase of the research, as the researcher had previously had professional interactions with each individual and this appeared to create a more relaxed environment. Each interview was recorded using a digital Dictaphone and this was explained to the participants prior to recording. All participants were given the opportunity to highlight if they had any concerns about being recorded; however, none did so. Each of the five participants was based in different locations, they were invited to be interviewed within their own surroundings or attend the researcher's campus location, depending on what was deemed more convenient for the participant. Three chose to remain in their own office for their convenience and two opted to attend the campus. Regardless of venue, the interview was conducted in a private meeting room. In closing each interview, the main points were summarised and participants were invited to make any additional comments. Participants were thanked for their involvement and offered the opportunity to contact the researcher should they have wished to discuss anything further, which none did.

In summary, the interviews lasted between approximately twenty minutes and forty-seven minutes. It was interesting to note that the interview that had taken twenty minutes was the one with which the researcher struggled most. With the other four interviews, participants were happy to speak freely and were candid about their thoughts on the county's ERS. Despite this, the interview held with one

representative from Public Health proved more challenging. The responses given were far more formal in comparison to others, almost as if rehearsed and any 'curiosity-driven' questions from the researcher generated very little additional information. On reflection this was disappointing, this was one interview from which the researcher had hoped to glean real insight into the strategic viewpoint on ERSs and instead the responses had felt restrained in some way. It was unclear at the time the reason for this however in hindsight it may have been that Public Health had already made the decision to decommission ERSs and therefore the participant may have felt uncomfortable discussing the scheme.

#### **5.6.4 Data Analysis**

All interviews were recorded and transcribed verbatim, then thematically analysed. Use of thematic content analysis enabled patterns within the data to be identified, analysed and reported (Braun and Clark, 2006). These patterns or themes were general propositions that emerged from the individual's experience (Bradley et al., 2007) and provided recurrent unifying concepts or statements that were specifically about the subject being examined (Boyatzis, 1998). Whilst different versions of thematic analysis have been proposed in line with specific methodologies, for the purpose of this research it was simply employed as an analytic technique (Clark and Braun, 2013). By utilising this approach a rich thematic description of the data was generated, which was considered to be particularly useful when exploring an under-researched area (Braun and Clark, 2006). The six phases of thematic analysis detailed by Braun and Clark (2006) were employed, and comprised: familiarisation with the data, coding, searching for themes, reviewing themes, defining and naming themes

and writing up. Therefore, data analysis encompassed a 'two-way' traffic between the adopted theoretical concepts and ideas, and the observations and perceptions at the semantic level (Clarke and Braun, 2014; Elias, 1956). The intention was to seek 'reality congruence', which meant ensuring data reflected participants' 'reality', rather than objective truths (Dunning, 1999), as proposed by a process sociological approach.

This process involved repeated close reading of the transcripts, which allowed general understanding of both the scope and context of the experiences to be gained (Bradley et al., 2007). This also enabled the researcher to become immersed in, and as a result familiar with, the data (Clarke and Braun, 2013). A process of open coding was employed, allowing codes to emerge from the participants' language and emotions. Baur and Ernst (2011) suggested that the use of a purely inductive approach was questioned by Elias (2007), who instead proposed that inductive/deductive differentiation was another false dichotomy, implying that it would be difficult to be completely 'data-driven' with no regard for theory or equally for the researcher's own subjectivity. Similarly, Boyatzis (1998) suggested that a complete absence of theoretical underpinning in the analysis process was not possible, as the two co-existed. Equally, it was also acknowledged data may not always follow exact patterns, driven purely by theoretical concepts, commensurate with a more deductive approach (see Braun et al., 2016). Therefore, the use of open coding, with a dialectical approach between theory and data was employed, which allowed for a full range of themes to be uncovered.

Segments of text were identified as containing meaningful units, and a code was created and assigned to that particular segment (see Thomas, 2006), as shown in Table 5.2. This also meant reviewing text before and after the particular extract, to ensure data were not taken out of context.

Table 5.2 Example of transcript coding

Raw Data	Codes
<i>Losing weight, again that's a bit of a one in 3 months, it is possible to do it and I have had clients who've lost loads of weight</i>	Weight loss
<i>To get them exercising and to get them lowering medication bringing down their BMIs</i>	Reduce medication
<i>To be honest most of them don't really know what the scheme is and the person gets here and they've kind of been misinformed, or you know they've had a vague idea</i>	ERS not explained
<i>you know they haven't been told, they get a phone call from one of us and they'll go ' why you calling me, oh you've been referred by the GP and</i>	ERS not explained
<i>You do see people reducing medication and they are losing the weight, they are building their confidence in group situations which is everything we believe in so strongly</i>	Weight loss

The codes allowed key text to be catalogued, whilst also maintaining the context in which they occurred (see Bradley et al., 2007), and through iterative reviewing of the data, these codes were continually revised and refined (Thomas, 2006). An example of a coded transcript can be found in Appendix M. The codes generated and the relevant coded data extracts were grouped and organised into logical, meaningful patterns that allowed the construction of themes (Clark and Braun, 2013). These themes were reviewed and where appropriate revised to ensure reality congruence

of the participants' version of reality, this meant some themes were brought together and others were disaggregated. This systematic approach also allowed the checking and rechecking of data to ensure it was comprehensively coded (Pope et al., 2000). This was illustrated in the example table below (see Table 5.3). Finally, this process was repeated to generate higher order themes to bring data together and support the writing up process.

Table 5.3 Example of allocated themes to coded data

Raw Data	Codes	Themes
<i>Losing weight, again that's a bit of a one in 3 months, it is possible to do it and I have had clients who've lost loads of weight</i>	Weight loss	Benefits of ER
<i>You do see people reducing medication and they are losing the weight, they are building their confidence in group situations which is everything we believe in so strongly</i>	Weight loss	
<i>To get them exercising and to get them lowering medication bringing down their BMIs</i>	Reduce medication	
<i>To be honest most of them don't really know what the scheme is and the person gets here and they've kind of been misinformed, or you know they've had a vague idea</i>	ERS not explained	Knowledge of ERS
<i>you know they haven't been told, they get a phone call from one of us and they'll go 'why you calling me, oh you've been referred by the GP and</i>	ERS not explained	

The use of a figurational framework as a lens enabled the data to be examined and through this gain insight into ERSs, through the participants' experiences, roles and relationships with each other. The process of writing up brought these insights together, which allowed the analytic narrative and extracts to be woven together (see Clark and Braun, 2013). Summarised tables of the thematic frameworks generated for each phase of the study can be found in Appendix N and O.

In generating a reality congruent understanding of ERSs, careful consideration was given when conducting the analysis process. This included the coding of data, generating themes and also determining which extracts from data to utilise to suitably capture these themes. There are different schools of thought as to how quality of qualitative research is achieved. For example, Tracy (2010) advocates an eight-point set of criteria that is intended to enable the researcher to judge the qualitative quality of the research, whereas Sparkes and Smith (2009) propose a more fluid approach guided by the nature of the research itself and the researcher. Elias (1956) advocated a blend between involvement and detachment throughout the research process, and the researcher strove to achieve this. Therefore, in the analysis process it was the researcher's interpretation of data; she coded data and generated themes, all whilst reflecting on the interviews and recalling her own experiences of ERSs and particularly the ERS network meetings. This was the researcher's involvement in the study.

At the same time, Tracy's (2010) eight criteria: worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical, meaningful coherence, were

reflected upon during the analysis process. This ensured a more systematic approach in evaluating the analysis process and the overall quality of the extracts selected to represent themes. The researcher, therefore, was able to 'detach' to some extent from what she knew and reflected on the data more objectively. Whilst the first four of Tracy's criteria, listed above, perhaps related more directly to the nature of the overall study, the remaining four could be applied to data. For example, in consideration of 'credibility', Tracy (2010) recommended triangulation as a means of achieving this. The researcher had some previous, but limited experience in thematically coding data, and therefore 'researcher triangulation' with supervisors was conducted to ensure the codes and themes selected by the researcher reflected the chosen extracts and were appropriate. This was not about the supervisors simply providing confirmation of the researcher's code and theme selection but instead acting as facilitators and challenged the researcher to consider 'why?' or 'what were you thinking to select this?' Other examples included the criteria of 'meaningful coherence' and 'resonance'. Indeed, the researcher went to great lengths to try and piece data together like a jigsaw (literally at times by using mind maps and notes), grouping codes to develop suitable themes, ensuring that these remained in context to the original text, yet provided meaningful insight into the data. This was by no means an easy process and one that the researcher found challenging, having to draw together participant perceptions at the semantic level whilst also seeking to identify the latent meaning. For example, when Public Health discussed the impact of ERSs and participant numbers, whilst this was the manifest meaning, the researcher also noted that this comment provided no explanation on how 'impact' was defined or *what* these numbers were and questioned whether the participant

knew either of these. This was the underlying, latent or hidden meaning of the comment. This also made the process of writing up equally as challenging to accurately convey data and findings as accurately as possible.

When reporting data, whilst all participants' comments were valued, the patient voice was less represented than perhaps might have been expected in a study that explored the receipt of a service designed to benefit and improve patients' health. The priority was to ensure the aims and objectives of the study were appropriately addressed, and this meant reporting data that exemplified the relationships between all participants engaged in ERSs and not just the experiences of service delivery, as presented by the patient group. Indeed, whilst the patient experience of ERSs was recognised, these data served more as an insight into the resultant outcomes of the professional relationships between other participants. It was also noted that the patient experience had already been well documented within the literature, for example Moore et al. (2013) and it was not therefore deemed productive to repeat these findings in the context of this study.

The following chapter discusses these findings, from both phases of the study in turn, and contextualises these in relation to the theoretical framework of process sociology and the relevant literature.



## **CHAPTER 6**

### **KEY FINDINGS**

This chapter considers the findings from phases one and two of the research. Data collected were thematically analysed, which identified a number of general dimensions and themes. Themes derived from the data are explained and considered through the use of a process sociological lens. Where appropriate, this theory is drawn on alongside relevant existing literature regarding exercise referral schemes (ERSs). Reflections are also made on what the researcher considered she knew about the structure of the ERS figuration and its operations, based on her attendance at the county ERS quarterly network meetings. Phases one and two of the research are initially explored separately in 6.1 and 6.2 respectively, so as to first consider each of the participant groups in isolation. These two phases are then combined in Chapter 7 to enable a processual understanding of the case study focus to be presented, to answer the overarching aim of the study and research objectives.

This chapter begins with an exploration of the findings from the first phase of study.

#### **6.1 Findings from Phase One**

##### **6.1.1 Introduction**

This section explores data that were derived from the one-to-one and group interviews conducted with individuals central to the delivery and receipt of the exercise referral scheme (ERS). This involved: fifteen patients in receipt of the ERS; seven exercise practitioners (EPs) (three of whom were also ERS coordinators), who

were responsible for the delivery of the ERS; and finally, five health professionals (HPs) who referred patients to the ERS. The purpose of this study was to explore people's beliefs and perceptions regarding ERSs. The questions asked during the interviews reflected aspects of the ERS, from the point when the referral was made through to how the overall experience of the ERS had been received. The responses provided were varied and reflected the diverse opinions and understanding of ERSs, which were not just specific to the role (patient, EP and HP) but also to the individuals within these groups.

Having embarked the process of analysis, the findings were in many ways unexpected. The researcher had, inevitably, some expectations, which were grounded in the previous ERS literature and her own experiences of ERSs, however, when data were combined something unexpected emerged (as explained in 5.1). Through use of process sociology as a theoretical lens, the complexity of the relationships between these three groups of people emerged strongly, together with the power balances that existed between them. Having explored the bonds of association between these individuals, there was evidence of conflicting and inconsistent perceptions that suggested a resistance and sometimes reinvention of what others believed ERSs and its processes to be. These perceptions then shaped the way the ERS was delivered. By understanding the power relationships within the ERS figuration it became possible to see how the intended actions of all had interacted within the delivery of the ERS and created some interesting yet unintended consequences.

This section will firstly consider participants' expectations of the ERS process, as regardless of role, each individual held expectations, often quite different, of what the ERS should offer as a service. The relationship between individuals is then explored and how the bonds of association impacted on the delivery of ERS provision. The perceptions of how the scheme was delivered are subsequently considered, identifying the mechanisms used and the inconsistencies of delivery in relation to the county's service. Finally, the way in which all those involved in the ERS experienced the scheme is examined, highlighting those aspects that supported successful delivery in addition to the barriers that prevented success. Additional themes regarding the future development of ERS were also identified, however, as the aim of this study focused on understanding current experiences of ERS and not the future development of schemes, these data are omitted from the current discussion. It is also acknowledged that the patient voice was less represented than perhaps might have been expected when exploring the receipt of a service designed for patient health benefit. As identified in 5.6.4, this was due to patient experience already being well documented in the literature and not the primary focus of the research objectives. Where appropriate, reference has been made to the county's ERS network meetings that the researcher attended, in order to reflect on her 'insider' knowledge regarding the operations of the ERS. This next section considers the expectations of ERS provision that participants held.

### **6.1.2 Expectations of Exercise Referral Schemes**

The expectations of ERSs encapsulated those themes that explained individuals' perceptions of ERS, what schemes offered as a service and what could be gained from

participating. Having engaged with one district's ERS, participants all had varying ideas on what they expected from the service, which ranged from the environment that the scheme provided, to the perceived benefits that would be potentially gained from taking part in an ERS. The knowledge held by participants regarding what ERSs were, was also highlighted. The hierarchy of importance of these issues, in the main, differed according to the participant's role within the scheme and demonstrated the interdependency of these individuals within the figuration of ERSs. This section begins by initially examining what ERSs as a service was perceived to offer, according to each of the participant groups.

#### **6.1.2.1 Perceived Benefits of Exercise Referral Schemes**

When considering what ERSs had to offer, it was evident that those who delivered the scheme held an overall belief that ERSs addressed a need for, and was a means of tackling poor health, as one EP, David commented:

*...well I do think it is an essential part of the modern day, we've got to this point you know, the way the country has gone with diet, with inactivity, with stigmas about places like gyms and things...*

David (EP) believed that ERSs were now an essential part of modern life and a service that was needed, primarily due to the poor health of the population. David's comments could be considered as somewhat vague, he generally referred to 'health' at a population level and specifics such as target groups, goals or examples of activity were absent. This was reflected in comments made by other EPs, who believed that ERSs were ultimately a good idea and worthwhile but did little to provide a specific rationale for their beliefs. Being able to offer ERSs to the public was perceived as a

positive action and perhaps reflected the number of years some individuals had worked on the ERS, having witnessed the positive impact the service could have. One HP, Hilary, reflected the opinions held by many EPs in her positive perception of schemes to enable her patients to undertake exercise:

*...as far as a tool for referring in I think it's a great idea and I'm talking about a service I can actually offer for someone.*

Despite Hilary's advocacy of the scheme, the endorsement of ERSs was primarily driven by the EPs. This was most notable in the comments that recognised the specialist environment that ERSs offered patients, as Natasha (ERS coordinator) identified:

*...it provides... a safer environment for them to be able to start exercising with the reassurance that there is an instructor there who might have or should have some knowledge of that particular condition and be able to give them a programme accordingly... so I think that it can be very beneficial.*

Natasha believed that an ERS offered a 'safe environment' for patients to exercise, particularly for those with specific medical conditions that met the inclusion criteria for the scheme (see Chapter 4), for example obesity, type 2 diabetes or osteoarthritis, conditions typical of the patients who accessed the ERS. Daniel (HP) however believed the service went beyond just providing a safe environment but extended this to a supportive context that would aid patients who were trying to improve their health, as he explained:

*...the support given by a referral scheme like this to help someone and be there to help them on their way and support them while they do it and help them is an opportunity not just in our little room, is beneficial...*

Daniel (HP) along with other EPs expressed what they perceived ERSs to offer, a valuable worthwhile service with a safe and supported environment that would help the patient in their experiences of exercise. The need for a safe and supportive environment was an interesting notion. Shilling (1999) in his description of the civilised body argued that ageing or chronically ill bodies have become marginalised and viewed as having a certain frailty. Evans and Crust (2015) suggested that as a result of this, the development of separate exercise away from 'mainstream' exercise sessions has become common practice, and as such normalised. Indeed, the EPs had internalised these notions of frailty as being 'natural' and believed that what defined ERSs was the 'safe' environment that could be provided to patients with an existing medical condition. It was implied that the re-labelling of exercise spaces as ERSs, coupled with supervision by EPs, was necessary in order to help patients become active. In such a way, care within ERSs could be perceived to be somewhat paternalistic in conception.

#### **6.1.2.2 Knowledge of Exercise Referral Schemes**

Patients provided little insight as to what they expected from embarking on ERSs, being much less concerned with the process itself but rather (and understandably) with their own anxieties about being referred. This highlighted the lack of understanding that many patients had about the ERS process and suggested they had not had the scheme explained to them at the point when they were referred, as Eddie (patient) recalled:

*I had no idea [what an ERS was]. I didn't know what to expect at all. I sort of assumed that it was going to be... you'd be lying down and somebody was going to be either pulling you around or massaging your muscles or something*

*like that, I didn't know it would... I'd be... going to the gym. I never, never envisaged that at all...*

Eddie was not the only patient to have been unclear in terms of what ERSs actually involved. Many of the patients interviewed had no idea what to expect, as James (patient) reflected on how he had approached the programme with some anxiety:

*Yes, I just didn't know what to expect, it's a normal nervous thing isn't it really, stepping into the unknown, I was totally anxious about it.*

As James and Eddie both identified, they were not embarking on the scheme with aims of what they might have achieved but were instead preoccupied by attending a service they knew very little about and what was assumed, in the case of Eddie, was somewhat of a misconception. For individuals within the figuration of ERSs, situations such as these highlighted their interdependency. Elias (1978) conceived that individuals are connected via 'chains of interdependence' or a network of relations, which exert influence on each other in different ways (see also Lake, 2013). As part of this web of relations, Dolan (2009) suggested that these interdependencies are typically characterised according to their role, function, or the kind of services they provided for each other. In this instance, patients were dependent on HPs to explain what ERSs were when the referral was actually made; however, patient comments implied that this had not been the case. This lack of information was supported by a number of the EPs, who believed that the blame for a lack of information lay with the HPs. In turn, EPs believed that the HPs lacked knowledge about ERSs, which resulted in the lack of information they provided to patients. Aidan (EP) identified:

*To be honest most of them [patients] don't really know what the scheme is and the person gets here and they've kind of been misinformed, or you know they've had a vague idea...*

Aidan (EP) was not the only one to have drawn these conclusions. Matt (ERS coordinator) had made similar observations but also believed that the lack of explanation provided by HPs actually led to some patients choosing to leave the scheme before the end of the twelve weeks or 'drop out' as it was referred to; he explained:

*The one, the ones that drop out quite early on are the ones that are the opposite [to those that complete the scheme] that haven't had it explained...*

If, as Matt (ERS coordinator) implied, this was the case, there was the potential for patients to be discouraged to attend by their own fears, whilst EPs only had the opportunity to dispel those anxieties if patients attended their initial appointment; which was not always the case. This reinforced the notion of interdependency between those groups associated with ERSs. Dunning (1999) proposed that interdependency is ingrained in the human condition, and Dolan (2009) suggested that these bonds of association are marked by unstable power balances, which are typically organised according to group interests or identities, for example, by different professions. The EPs' and ERS coordinators' comments implied that the position they found themselves in was constrained by the HPs, therefore relatively less powerful. If the HPs failed to explain the scheme fully to the patients, or patients did not engage in the service on a face-to-face basis from the outset, then EPs outlined how such individuals were more likely to 'drop out', despite the efforts of EPs. The lack of patient understanding with regard to ERSs was further highlighted by patients' failure to recognise the potential benefits of schemes: EPs and HPs felt that only they observed the benefits that attendance brought. The EPs, who had delivered ERSs and observed first-hand the changes to their previous patients, clearly



recognised that embarking on a programme of physical activity was beneficial. EPs recognised the benefits of ERSs for patients with existing medical conditions as well as understanding the potential improvements physical activity made to patients' medical conditions and the dosage of medication they took. David (EP), for example, suggested that the expected benefits of ERSs were more than just physical, as he had observed:

*...to get them exercising and to get them lowering medication bringing down their BMIs, you know giving themselves a better standard of life is massive you know, and without the scheme they wouldn't have gone to the gym, they wouldn't and their condition would have got worse so that I think is the biggest positive is it does have a real effect on people's lives.*

David (EP) believed ERSs affected patients' lives for the better, an opportunity that they would have otherwise missed had they not attended the gym. HPs were also able to recognise the potential benefits for a patient when they attended an ERS, as Hilary (HP) explained:

*...my expectations were that I'd get better results with my clients, that they'd lose more weight through it erm because obviously they would know that diet is one aspect of it but the exercise is a massive part of it and I thought that would really help people.*

Hilary's (HP) observations were limited to the physical changes in medical conditions that she hoped to see for her patients, which perhaps highlighted their motivations for engaging with the service and what HPs considered to be a priority.

Evidently, the EPs had clear expectations of ERSs in terms of what the service provided and the benefits that would be gained by engaging with the service. EPs also expected patients to have a sound knowledge of the ERS prior to their arrival, as

this could have impacted on whether a patient completed the full twelve-week programme. This was possibly expected, as HPs were required to obtain a patient signature to endorse the referral. The signature was also to confirm that the patient understood the reason for referral and what the process involved. HPs, however, provided a limited insight as to their expectations, with only scant acknowledgement of the potential benefits to patients. EPs believed this was a reflection of the HPs' knowledge of the programme and engagement with the delivery process. Patients however had very few expectations on entering the scheme. A limited knowledge of the programme (such as the environment in which services were delivered, and the potential benefits of participation) meant that some patients approached the scheme with some apprehension, which might have been enough to discourage some from attending. This went some way to highlight the interdependency of these groups. Even before the patients had commenced their ERS, they were dependent on the HPs providing them with sufficient information, which would have allowed them some understanding of what they were committing to. Moreover, EPs were also reliant on this initial conversation, otherwise, they had to calm any fears the patient had but they also stood the chance of never getting the opportunity to do so. These tensile bonds of association highlighted the need for positive relationships for the successful delivery of the scheme.

### **6.1.3 Relationships**

The term 'relationships' captured the connection between those individuals who interacted within ERSs and the need for them to work together to support the effective delivery of schemes. Within the current data, partnership working was

identified as being key to a successful relationship and ultimately the successful delivery of ERS. Unfortunately, ERS services were beset by power imbalances that created tension in service delivery pathways. This was an area that was mostly discussed by the EPs, whilst in contrast, the patients and HPs offered no opinion on the need for partnership working. Factors that contributed to successful partnership working were also discussed by EPs, with areas such as effective communication and the attitudes of others raised. These opinions highlighted established and outsider relations, where comments were made by the EPs and how they perceived the delivery of ERSs to impact on issues such as working in partnership. Finally, there appeared to be a growing frustration amongst some of the EPs, which had negatively influenced working relationships and was exhibited through inconsistent perceptions of ERSs. These perceptions suggested that different viewpoints had, for some, created frustration and even tension within and between 'I', 'we' and 'they' groups, with further evidence of emergent established and outsider groups. The section begins by exploring the theme of partnership.

#### **6.1.3.1 Partnership Working**

In the delivery of ERSs, EPs highlighted the importance of face-to-face, long-term intercorporeal partnership work, as Fran (EP) expressed:

*I suppose if you're working with other organisations... I think you all need to be singing off the same page, you all need to be, want to do it and you just need to gel together as a team which is hard when you're all working from different offices.*

Fran (EP) believed that all EPs needed to work together despite working from different locations; she believed that it was important that the EPs were consistent

in the service they offered. This was important as Fran's comments suggested that this particular 'we' group extended beyond corporeal contact alone, with a number of the EPs working from different locations. Within the district, the three ERS sites had tried to unify their approach, to offer a scheme that enabled any patient in the district to access any of the sites. Malcolm (ERS coordinator) suggested that this was as a result of successful partnership working, as he explained:

*3 years of intense partnership working and building up err for quite a good partnership... the partnership is fantastic and its considerably better run and marketed than it was ever, it's probably the best one that I've known of.*

Malcolm (ERS coordinator) implied that the team of EPs that worked across the three different sites delivering the ERS had developed a successful partnership. Indeed, such comments implied a strong sense of professional affiliation and 'we' group identity. Malcolm also suggested that these partnerships had been for the benefit of the scheme, which he felt was now managed and delivered far better than the service had previously been. The need for effective relationships went beyond the team of EPs however and Malcolm (ERS coordinator) believed that a successful partnership needed to include the HPs who referred patients to the scheme:

*I think that it can be very beneficial but as long as, as the partnership with the referring agents are working well... partnership working can be a major problem especially in relation to health professionals.*

Malcolm (ERS coordinator) suggested that partnership working extended further than EPs alone and the relationships with the HPs, who referred patients, was integral to the success of the scheme. This pointed to the interdependencies of the ERS figuration going beyond the 'we' group of EPs. Other EPs shared the belief that successful relationships with the HPs were important, and Aidan (EP) developed this

further, as he had initially mistakenly thought that HPs, specifically general practitioners (GPs), had greater involvement:

*I mean I was under the impression that GP referral schemes was in conferences with GPs, this idea that, probably a stupid idea but I always assumed that there was that, GPs got together maybe with the council and discussed it but it doesn't seem to, you know I realise that was a naïve idea...*

Aidan (EP) acknowledged how he had perhaps been naïve about the involvement GPs had in ERSs, where contact between the two groups rarely extended beyond the referral of the patient. He believed that GPs would be heavily involved with the planning and organisation of the scheme and he had come to realise this was not the case. Whilst partnerships between EPs were judged to be successful, relationships with HPs were adjudged to be less so, which led EPs to suggest that a professional divide existed between the two groups. EPs demonstrated a strong sense of professional affiliation and presented a relatively cohesive and established 'we' group identity. Their bonds of association were seemingly rooted in their history, in that they were older and therefore more established (see Elias and Scotson, 1994). The work of Elias and Scotson (1994) in *Established and Outsiders* identified that for groups within a figuration, an unequal balance of power leads to the creation of 'we' and 'they' groups. Indeed, the 'we' group maintains a 'superior' established position and perceive the 'they' group to be inferior outsiders. Moreover, Lake (2013) suggested that this is characterised by established groups reinforcing exceptional 'minority' examples as though typical of all of the outsider group. EPs appeared mostly critical about the HPs' limited involvement within the ERSs but it was not made clear whether this applied to all HPs that had made referrals. Furthermore, HPs would have undoubtedly had other priorities and responsibilities that extended

beyond ERSs, as previously suggested (see Lawlor et al., 1999). It was only the EPs that reported feeling this way and HPs made no reference to the role of the EPs, therefore there was a lack of clarity as to how these opinions were formed.

### **6.1.3.2 Communication**

Having explored issues that had arisen from partnership working, further comments from the EPs highlighted communication as a barrier that prevented effective working relations between themselves and the HPs. Aidan (EP) suggested that communication amongst the EPs, HPs and the county council had become a contentious issue. He explained:

*There is a definite miscommunication...the negatives are definitely that there's no real communication between the council, the GPs and us as a three-way network and by us, I mean the people that are actually administering it...*

Aidan (EP) believed that there was little communication between EPs, HPs, specifically GPs and the county council. The lack of communication from upper management was portrayed negatively, as Aidan emphasised, because these were the individuals whom he perceived to be responsible for ERSs in the county. Fran (EP) also expressed the limited communication that took place and identified the level of detachment demonstrated by the HPs that she had experienced:

*...no there's not much communication, they [HPs] sign them [patients] over to us, they're ours...*

Fran (EP) acknowledged the lack of communication between herself as an EP and the HPs. This was reinforced in her description of one ERS process, which Fran (EP) simplified to a matter of signing the patients over; the contact between the two

groups extended no further. On reflection, all the EPs believed the communication between themselves and the HPs was limited and only occurred when a situation arose that required contact, for example if a patient needed to be sent back to the HP for further investigation. On the basis of the comments made by the HPs, such communication was not often. Dunning (1999) suggested established 'we' groups avoid outsider 'they' groups and also avoid dealings with them where possible, however, the question remained as to who avoided whom. The limited communication between the EPs and HPs reinforced the notion of a perceptual we-they divide, specifically from the perspective of the EPs.

#### **6.1.3.3 Professional Differences**

Communication was not the only source of contention however with regards to working relationships; other factors appeared to contribute to the tensile power relations between the EPs and HPs. For example, general attitudes of members within the HP 'they' group were questioned by some in the ERS figuration, which appeared to have a negative impact on relationships. David (EP) explained that ERSs were not taken seriously by those HPs who referred patients:

*I think that's one of your biggest problems how seriously people outside of gyms take it...and if they're going to send people in...*

David (EP) implied that HPs had not taken ERSs seriously and believed this to be challenging for working relations. This was especially an issue as the HPs were responsible for referring patients to the scheme. David (EP) implied that if the HPs did not take it seriously then they would be unlikely to refer patients. This was an

opinion held by the majority of EPs, a number of whom suggested potential reasons for why this was the case. Malcolm (ERS coordinator), for example, speculated that it was down to trust:

*I think what a lot of it has to do with the trust... maybe they [HPs] don't trust who they're referring into... I think a lot of that comes because of the divide between us as in health professionals and them as medical professionals and there being a lack of understanding of each other's speciality and there's a, a massive divide between the two.*

Malcolm perceived there to be issues of trust and professional boundaries, and identified there to be a 'massive' divide between his own role and that of the HPs. It was interesting to note how Malcolm (ERS coordinator) referred to himself as a 'health professional'. Malcolm (2016) suggested exercise trainers feel empowered to encroach into the domains of healthcare professions, as a result of the convergence between the fitness industry and the medical field. Whilst Malcolm (ERS coordinator) still separated himself from the 'medical professionals' and did not perceive himself to be one of this group, he still appeared to upgrade his own role.

Trust was also noted to be an issue in that the EPs perceived that HPs possibly did not trust the work the former did. This demonstrated further the strong sense of professional affiliation of the 'we' group versus the 'they' group. Mennell (1992) suggested that the uneven, tensile balances of power that marked individual's interdependencies with each other, could lead to the development of established and outsider groups. Indeed, Powell et al. (2014) in their exploration of health improvement partnerships identified how an association with a particular area of expertise could shape how a person defined their own professional identity and who



they identified with, arguably in this case those who understood and prioritised physical activity, and those who were perceived not to. EPs appeared to have adopted the role of the established group through their knowledge and experience but also their older bonds of association, whereas the HPs were on the fringe of the figuration. An alternative argument was that EPs adopted the role of outsider in a medical figuration, they appeared to have created a negative perception of themselves through the eyes of the HPs, which in turn had been internalised. They perceived that HPs had not taken them seriously, that they were not trusted and they were simply misunderstood; yet there was no evidence from HPs that confirmed this. Therefore, this may have been one way for the EPs to stigmatise the HPs with such negative labelling, which enabled them to retain their own established position in the ERS figuration.

As previously noted, HPs made no comment with regards to how they perceived the EPs and their work. This could imply that HPs had no issues of trust or competency in relation to EPs and from their perspective working relations were positive. This has possibly not always been the case, as whilst all HPs appeared positive about their involvement with ERSs, one HP, Pam, reflected on her original reaction to the prospect of referring her patients to an ERS:

*Cautious, very cautious when I was introduced to the scheme. I didn't know how it would work. I mean I've got some unusual patients, let say. I don't think they believed it was possible...*

Pam's (HP) caution when first confronted with the idea of referring her patients to an ERS seemed to imply that she had not trusted others with 'her' patients. It was

plausible that other HPs may have felt the same but not expressed this. If HPs had remained cautious about ERSs and referring patients to the service, this could have explained their lack of overall engagement and limited communication with the EPs. Regardless of the potential reasons, EPs negatively viewed the role of the HP and this appeared to be due to an imagined lack of respect shown by the HPs. Huxham and Vangen (2000) suggested that trust was imperative for successful partnership working but also suggested that power was an obstacle in achieving this. It is unclear what Huxham and Vangen's (2000) interpretation of power was compared to that proposed by Elias and yet they identified power to form a key component of trust. The interdependency between these two groups was marked by an unequal power ratio and it was implied that trust between the two groups had contributed to this in some way.

#### **6.1.3.4 Inconsistency in Delivery Processes**

EPs' perception of a professional divide further played out through a number of inconsistent viewpoints between themselves and the other participant groups, that were presented in discussions regarding ERS provision. Aidan (EP) believed that patients were not provided with a clear explanation as to what schemes were and what would be involved. Conversely, several patients provided comments which contradicted this perception. One patient, Valerie, recalled her experience:

*She [referring HP] told me about coming here. She explained about the gym, she explained about the back class, she said I don't know if you'll be able to do the other things but like you know you'll see Natasha and she said well give it a try.*

Valerie (patient) had had the scheme explained to her by her physiotherapist, she knew what an ERS was, what was involved and what she could expect. Valerie's experience challenged EPs' perceptions and demonstrated that not all HPs had failed to explain the process of the scheme. Having discussed the mechanism of referral with participants, the patients' responses were mixed, some were provided with a clear overview, like Valerie, whilst other patients had no idea what an ERS was and what would be involved for them. Further examples of inconsistencies were evidenced in other areas of the scheme's provision, particularly regarding the use of feedback.

A number of EPs confirmed that they had chosen not to offer HPs feedback on patient completion of the ERS. EPs had based this decision on the, sometimes mistaken, premise that HPs were not interested in feedback, as Aidan (EP) identified:

*...in the year that I've been doing this they've never wanted feedback from, they've never requested it from me, as I said they kind of refer it and that's my contact with that GP gone.*

Aidan (EP) had chosen not to send feedback to HPs as he believed they had never wanted this information. He believed that when HPs referred the patient, this completed any interaction that they might have had. This was an opinion held by a number of other EPs also. Two of the five HPs interviewed offered differing opinions to those expressed by Aidan. Hilary (HP) had requested feedback and was yet to receive any:

*Right, there's a box on the sheet saying would you like to keep informed on the success or how the person is getting on and I always tick that but as yet I've not heard anything and I've probably been referring in a good few months now, must have been, since before Christmas.*

Hilary (HP) had opted to receive feedback regarding the progress of her patients but she was yet to receive anything from the EPs. Tara (HP) had also expressed how she valued feedback about her patients as she felt it provided an insight into how motivated the individual was and whether they were committed to change. The provision of feedback was not monitored or controlled by anyone in a managerial position. EPs had largely dictated how much was offered, to whom and how often. Quilley and Loyal (2005) described figurations as constantly in flux: what emerged was largely unplanned and indeed unforeseen. The lack of feedback provided to HPs illustrated this well. In some ways, this raised the question of what overarching management processes were in place. Through what appeared to be a lack of clear direction or governance at the strategic level, some EPs had taken the decision not to provide feedback, which was opposite to what the HPs reported actually wanting. It was possible that a seemingly decentralised approach to management had led to the unintended outcome of EPs, who appeared to be the established group, becoming arbiters of service delivery and feedback mechanisms at a local level.

No one participant directly referred to their relationship with another individual, but participants' comments provided a valuable insight into how perceptions of ERSs differed for EPs and HPs. EPs were clear on their opinions of HPs' attitude and commitment to schemes. Despite this, HPs demonstrated no acknowledgement or awareness of a possible professional divide and overall presented a positive attitude towards the scheme. This further indicated a division between these two groups. EPs comments and actions seemingly indicated a superior established group and the HPs

as inferior outsiders. Patient comments highlighted a lack of awareness of these tensions and yet their own experiences provided further evidence of the inconsistencies and tension within the ERS figuration, as discussed in 6.1.4.

#### **6.1.4 Perceptions of Exercise Referral Scheme Delivery**

The delivery and management of ERSs were reflected throughout the data. Comments highlighted the varied perceptions of the day-to-day activities and how effective these were perceived to be by participants. Perhaps unsurprisingly, these were areas dominated by the EPs, who were responsible for both the delivery and coordination of the scheme. EPs considered which factors contributed to the effective delivery of ERSs based on their own experiences, such as HPs who were advocates of the service and those that had an awareness and understanding of the processes involved. Themes relating to organisation and efficiency of the service were also apparent, and recognised by those in receipt of the scheme, the patients. The suitability of the patients referred to the service was also deemed imperative, an important decision that the EPs were dependent on the HPs for making, and thus a source of tension. Finally, feedback highlighted further inconsistency in the way ERSs were delivered and reinforced the established-outsider perceptions of EPs and HPs. This next section first explores how the advocacy shown by a HP was reported to influence ERS delivery.

##### **6.1.4.1 Scheme Advocates**

The effectiveness of ERS delivery was perceived to be dependent on whether the referring HP was an advocate of the scheme. EPs implied that HPs' advocacy for the

scheme was reflected by the HPs' engagement with the service, as Malcolm (ERS coordinator) highlighted:

*You usually just get an advocate, cos I've had that before where you've had a practice nurse who really likes the idea and they've seen it in another place and they've done it before and they know that you know, it can really help people or you'll get the opposite...*

Malcolm (ERS coordinator) believed that for one HP to really support an ERS and make a high number of referrals to that scheme was quite typical. He also suggested that this often resulted from the HP already having some previous experience of an ERS. This belief was echoed by other EPs who had had similar experiences. David (EP) suggested that eighty percent of his patients had come from the same HP. In contrast to these experiences, however, there were also HPs who were less proactive and supportive, as Fran (EP) had observed:

*GPs, some of them are brilliant and you get loads from the same medical practice but others don't want anything to do with it and I don't know whether they don't believe in physical activity is of benefit or they just don't recognise the scheme...*

Fran (EP) suggested that whilst some HPs supported ERSs and had made a number of referrals to the scheme, in contrast there were those who did not want to be involved. Fran (EP) had identified this to be specifically GPs and through the course of the interviews it was apparent that not all HPs were viewed equally, some HPs appeared to be greater advocates than others as Fran (EP) explained:

*We get a lot of physios – are very good obviously because they come from a physical activity background and so they're great for referring people in.*

Fran (EP) had, in figurational terms, 'upgraded' physiotherapists (Wouters, 2014). She believed that as physiotherapists' backgrounds were related to physical activity,

they were more likely to understand the benefits of ERSs and therefore more likely to have referred to the service. Indeed, Powell et al. (2014) suggested that an individual's area of expertise could influence who they identified with. EPs had generally responded negatively about HPs but singled out physiotherapists as being different to other HPs due to their perceived understanding of physical activity. EPs appeared to demonstrate increased identification with the physiotherapists and seemingly viewed them as part of their established group. EPs believed that the number of referred patients varied according to the HP who made the referral and perceived this to be an indication of a particular HP's interest in ERSs.

#### **6.1.4.2 Suitability**

Unfortunately, those patients who were referred were not always considered suitable for ERSs, and Aidan (EP) commented on some of the problems he had experienced:

*There are some people that are coming through who aren't on the referral form and we've actually had to double check, can I work with this person. We have taken on probably one of two we shouldn't have but we went through the right forms of getting a doctor's note, got their consent from a doctor...*

Aidan (EP) suggested that not all referrals made were suitable for ERS and it was questionable as to whether they met the inclusion criteria for acceptance on to the scheme. He also admitted to accepting referrals when perhaps he should not have done so. Aidan (EP) was not the only EP to have experienced inappropriately made referrals. Fran (EP) echoed his comments, and identified that some individuals referred presented multiple conditions that were unsuitable for 'treatment' via the scheme:

*Yes the GPs we do often have... oh my god a list of about ten things wrong with you, you just think I can't do anything with that person, so I don't know why they refer them so sometimes we have to reiterate, we have to send a letter back to them saying you can't refer them if they've got these problems please refer back to the referral form, it does clearly say on there what it is, but yeah, you know what they're like, in a rush and they just scribble it down...*

Fran (EP) and Aidan (EP) had both experienced unsuitable referrals, in that exercise could have exacerbated the patients' health rather than be of benefit. Fran (EP) expressed her frustration with this as she believed the referral form clearly stated the type of patients she was able to accept through the ERS, and she appeared to blame the referring HP for this mistake. The nature of inappropriate referrals is not unusual amongst ERSs (Halley Johnston et al., 2005) however such mistakes appeared to exceed a professional threshold of acceptability from the perspective of the EPs.

In Elias's (1978) discussion of the 'triad of controls', he identified three balances, one of which was that between a person and others. In characterising such a balance, Wouters (2014) suggested there could be a blend of both competition and cooperation. EPs' general attitude towards the HPs was critical as they described how the HPs were unable to complete some of the basic scheme processes, for example completing paperwork. It could be considered that HPs were not included within the EPs' established 'we' group, and there was a sense that HPs were perceived less as allies and more as competitors for status. Loyal (2011) suggested that established groups seek to maintain a positive 'we-image' and create a negative 'they-image' which could be achieved through stigmatisation and negative labelling of the 'othered' group, which extends to the use of 'blame gossip'. EPs quickly recalled the



mistakes made by the HP ‘they’ group when patients had been referred; an example of how an established group is able to reinforce ‘minority’ examples as though typical (Lake, 2013). On occasion, this was to the point of perceived ineptitude and group-level failings. The suitability of the referrals formed a key component of ERS provision. From a health and safety perspective it was important that those individuals who met the scheme criteria were referred and fully understood what the ERS involved. Despite this, it was apparent that some referrals were not always appropriate and in some cases patients also had no interest in attending. These were problems only recognised by the EPs; HPs made no acknowledgement to the researcher of having made any ‘unsuitable’ referrals. Although no explanations were provided as to why inappropriate referrals were made, comments were made by EPs regarding the general lack of awareness of ERSs shown by HPs, which could have influenced the number of inappropriate referrals (from the perspective of the EPs) made.

#### **6.1.4.3 Awareness**

A number of individuals believed HPs lacked awareness regarding ERSs, which was recognised by both EPs and patients. Patients perceived that many of the HPs they had been in contact with were unaware of the scheme, as Beth (patient) noted:

*You’re not being told by your doctors, or the hospital, or anyone else that this is [ERSs] available, people just don’t do anything and they’re not going to do anything.*

Beth (patient) appeared frustrated by HPs’ lack of awareness about the scheme; she suggested that no one knew about ERSs and no one would do, if the current situation

remained. Whilst Beth was frustrated, for others a lack of awareness had become a source of amusement. Paul (patient) recalled his first meeting with his GP since he started attending the scheme:

*I mean I thanked my doctor for sending me up here and he said 'what? What have you been doing?'*

Paul's GP had no idea that he had attended an ERS and through discussions it was later revealed that Paul's physiotherapist had made the referral. Paul's GP seemed unaware of what an ERS was but Paul was not the only patient who had experienced this; Eddie (patient) joked:

*As I say you got three people here who believe our doctors don't know we're doing what we're doing. There could be three doctors who don't know that there's three wrinklies here running up and down hills...*

Eddie (patient) along with Paul and one other in the group acknowledged that their GPs had no idea that they attended the scheme or what they were doing. If the HPs had not made the referral then it would be understandable why they were unaware of their patients' attendance; however, this appeared to go further, in that HPs or the GPs in this instance, appeared not to know what the scheme was and what was involved. In contrast, those HPs interviewed reported that they regularly made referrals and were aware of the ERS process. None made any comment that demonstrated a lack of awareness regarding the scheme and yet patients still questioned HPs' understanding of the service. Lake (2013) implied that an established group's power is determined by the extent to which it is able to withhold something that another group need or desire. Here a number of patients recognised that they knew more about their ERS participation than their own GP did. The

patients, on this dimension, were relatively more powerful than some HPs in their knowledge of the scheme. The patients, in their knowledge and understanding were not alone however as EPs also maintained a level of superiority with regards to HPs' knowledge of ERSs.

#### **6.1.4.3 Knowledge and Understanding**

EPs believed that HPs had a limited understanding of the ERS and the associated protocols, and identified a number of issues that highlighted this perceived lack of understanding. This appeared predominantly in relation to GPs. Aidan (EP), for example, explained:

*... I think the GPs themselves generally don't know what the system [ERS] is.*

Aidan (EP) believed that GPs did not understand what ERSs involved and went on to suggest that as a result they were unable to fully explain what an ERS was to patients. Once again, an EP was critical of a HP, which reinforced the idea of an unequal balance between competition and cooperation, between that of the self (the EP) and others (the HPs) (see Wouters, 2014). Aidan (EP) made no comment as to discussing this with the GP or whether he had tried to help the GP understand the system better. This would have then been indicative of a more cooperative blend between the EPs and HPs. Other EPs presented similar opinions which focused on GPs as the source of the problem. Physiotherapists however were again viewed differently by EPs and, as noted above, were 'upgraded'. EPs considered physiotherapists to have a better understanding of ERSs, as Natasha (ERS coordinator) explained:

*Their whole treatment process involves exercise to a certain extent anyway so it's kind of just a continuation of that.*

Natasha (ERS coordinator) believed that, as physiotherapists used exercise as part of their everyday occupational work, this distinguished them from other referring HPs, as they understood the benefits of exercise; this, the EPs considered, set them apart from HPs more generally. These comments further implied that HPs were the outsiders to ERSs whereas physiotherapists were not included as part of this 'they' group. EPs thus identified with the physiotherapists (see Powell et al., 2014) and considered them to be part of their established we-group. Established we-groups are suggested to share strong bonds of association according to Elias and Scotson (1994) and this appeared to be reinforced by the EPs' perception of a shared understanding of exercise between themselves and physiotherapists. It could be argued, this was also used as a means to further stigmatise the other HPs, in a bid to maintain the HPs' inferior outsider position (see Elias and Scotson, 1994). EPs separated the HPs in relation to the latter's understanding of the process and their knowledge of the benefits of ERSs. EPs believed GPs lacked understanding about the ERS processes and the benefits of exercise in contrast to the physiotherapists, where exercise was embedded within their work. EPs believed that this brought a better understanding of ERS and therefore an increased number of referrals from the physiotherapists.

Understanding was not just concerned with the ERS process but also the scheme's related protocols. EPs were frustrated with the GPs in their lack of understanding of the paperwork associated with the scheme, as they felt that the importance of completing paperwork correctly was overlooked. Natasha (ERS coordinator) expressed such concerns:

*I don't think sometimes they [GPs] realise how important it is to include you know as much as they can in terms of information so err history of medical conditions, medications... some forms that I've had though are literally you had nothing in apart from they've ticked the box to say the client's overweight but actually they've got heart conditions, high blood pressure, they've got all sorts going on so it's about how thorough they are in completing the form.*

Natasha (ERS coordinator) recognised the importance of paperwork in ERSs, these were documents that identified the patient's condition and severity, and contained vital information for EPs for safe exercise programming. A number of EPs blamed HPs, and more specifically the GPs, for poor completion of paperwork. These types of comments resonated with Elias and Scotson's (1994) description of negative labelling, and implied an uneven balance of cooperation and competition, as had previously been seen. There was no suggestion by Natasha that she had tried to help the HPs and explain to them the importance of paperwork, which would have implied a more cooperative relationship. Instead it was suggestive of promoting what the established 'we' did well against what the outsider 'they' group 'got wrong', overall more competitive in nature. Indeed, Natasha's comments appeared a further means with which to negatively label the HPs and by doing so maintain the superiority of the EP role (see Elias and Scotson, 1994).

Relationships have already been discussed within this chapter (6.1.3) and Natasha's (ERS coordinator) comments highlighted the way in which some relationships within ERSs were not intercorporeal but occurred within a paperwork trail, which perhaps made it easier for EPs to criticise unfamiliar 'others', leaving the HPs unable to respond. Relatedly, Lake (2013) suggested that a common characteristic of an established-outsider figuration is that the outsider group lacks the means of

challenging their position. Through the absence of intercorporeal relations this meant there were minimal opportunities for HPs to raise any issues they had experienced. If this was the case, HPs made no acknowledgement regarding the scheme's paperwork. Indeed, HPs even commented on the simplicity of the form's design, which had made it easier to complete. The inconsistent perceptions of the ERS between the HPs and EPs appeared to further divide the two roles, something about which the HPs appeared to have little awareness.

#### **6.1.4.4 Inconsistent Organisation**

Perceptions of the service were not the only inconsistencies to be observed (as discussed in 6.1.3), as inconsistent organisation of the way in which ERSs were delivered appeared inherent. EPs recognised that not all ERSs across the districts were delivered in the same way, Fran (EP) explained:

*...you see it's different in all places so that's why it's hard to track it down you know... they [other districts] do it different to us they do all their clients and we don't hear much about theirs.*

Fran (EP) was aware that different districts delivered their ERSs in different ways and there was little interaction between the districts. David (EP) however suggested this went further and perhaps the delivery of schemes also varied within districts:

*Depends on how you look at the process, obviously that's going to be different from gym to gym.*

David (EP) recognised that even between gyms ERSs could be different, and this included both the staff and the facilities as well as how the EPs worked with their patients and their approach to training, for example one-to-one or as a group. The

acknowledgment of differences in practice demonstrated that EPs perhaps knew that they all delivered something different and implied that depending on where a patient was referred, this influenced the experience the patient had. Interestingly, Fran was the only EP who believed this was an issue, as she commented:

*I suppose if you're working with other organisations who are not as enthusiastic as you about it, I think you all need to be singing off the same page, you all need to be.*

Fran (EP) believed there was a need for consistency in the delivery of ERS but also recognised this was challenging when working with others who perhaps were not as enthusiastic about the use of ERSs. The apparent inconsistency could be attributed to a lack of governance, which through the chains of interdependency had enabled EPs to interpret and deliver the scheme in a way that they saw fit and not necessarily how the service was intended to be delivered by those in a strategic management position. Although there appeared no clear guidelines as to how the scheme should be run, other than those guidelines nationally available (e.g. NQAF and BHF toolkit), the purpose of forming a county-wide scheme had been to provide a consistent service to anyone referred, which perhaps had not been the case. These were outcomes that were both unintended and unforeseen, a key characteristic of the long-term transformation of a figuration (Quilley and Loyal, 2005). Inconsistency in the way the ERS was organised was apparent from the perspective of the EPs, but patients were also aware that they had not all had similar experiences of the scheme.

#### **6.1.4.5 Efficiency of Process Delivery**

This was perhaps best exemplified in the time it took for patients to start their referral. Some patients had felt that it had taken too long between being referred and actually starting the exercise programme. Paul (patient) explained:

*I think your hopes is building up, oh great I've got on the scheme and then you sit there waiting.*

Paul (patient) had felt disappointed due to the delay in starting his referral and he appeared to have received no communication to inform him of the delay. Many of the patients were already anxious at the prospect of being referred and lacked a clear understanding of the ERS process, so to be delayed had only cemented this anxiety.

This was noted by Lisa (patient), who reflected:

*I would have liked it faster, you know in your head and you want to get on with it before you lose that momentum, that's my only negative.*

For Lisa (patient) the delay was a negative experience, and she admitted how the delay resulted in a loss of momentum in attending the scheme. Ultimately, she was glad she had not given up and attended, but for others this might not have been the case. EPs were also aware of the delay that some patients experienced and recognised that the longer a patient had to wait the less likely they were to attend. Not all patients had experienced this however; there were some who, on referral had quickly received a starting date and had felt that the whole experience had been managed smoothly. These opinions were shared by some EPs who believed the process of being referred and starting was very simple and efficient. This reinforced the contrasting experiences and varying interpretations of ERSs dependent on who was asked and the further inconsistencies in scheme delivery, but from the



perspective of the patient. Moreover, these instances exemplified the unintended outcomes for those in receipt of ERSs. Via the chains of interdependency, patients were unintentionally affected by the intended actions of those acting at a higher level. Jarvie and Maguire (1994) referred to this as the 'unintended outcome of the interweaving of a myriad of intended actions' (p.136). Inconsistencies in the organisation of ERSs were apparent, EPs were aware that colleagues delivered ERSs differently and the patient experience had gone some way to exemplify this. It is possible that the constraints some EPs found themselves bound by was one explanation as to why the delivery of schemes varied between providers.

#### **6.1.4.6 Capacity**

The challenge of capacity was an issue of which EPs were very much aware, in relation to the number of staff who delivered the scheme and the number of patients that could be accepted onto the ERS. A number of the EPs were concerned as to how they felt limited in the service they were able to offer. Aidan (EP) explained his frustrations:

*...we have 3 members of staff we run on volunteers, we have about six volunteers up at one time who can't work with the population we're working with, they can't help, we've got an extremely busy manager who can't put in as much as he could and the other member of staff is level 2 qualified, so its solely down to me so yeah maybe understaffed is a negative...we don't have the available resources to see everyone who wants to come in...*

Aidan (EP) recognised the challenge of staffing issues he had experienced. To deliver exercise on an ERS, EPs were required to hold a specialist qualification that restricted which EPs could work with patients. Aidan was not alone, other EPs expressed the difficulties in offering a scheme with limited staffing, which impacted on the number

of patients that were seen and the speed at which they were seen. An increased number of referred patients had compounded the situation. Natasha (ERS coordinator) noted:

*...the numbers [of patients] have increased quite significantly over the last year so it's trying to make sure that we've got enough staff to kind of to cater for the number of clients we've got.*

The increased number of patients who had been referred had further burdened the already limited staff numbers. One EP, Aidan, reported that his numbers had increased from four a week to over thirty and he did not have the capacity to manage those numbers. Dolan (2009) suggested that each person within the figuration is both enabled and constrained by their relationships with others, although may not be fully aware of this. Aidan displayed signs of feeling constrained by the limitations of the service he provided. This could be attributed to the decentralised style of management that was employed by Public Health. Having attended a network meeting (4<sup>th</sup> March 2014) and observed ERS coordinators and district managers negotiate their own numbers, Public Health had encouraged EPs to aim high and not perhaps consider what would be realistic for the staff to manage. Public Health simply wanted district teams to build on numbers from the previous year.

#### **6.1.4.7 Feedback**

On completion of the twelve-week ERS, feedback was typically provided from the EP to the HP, who reported on the progress made by the individual during the course of the scheme. Discussions around this topic generated some interesting admissions from the EPs and highlighted how some had resisted the process of providing

feedback. Malcolm (ERS coordinator) admitted he had not complied with providing feedback to HPs:

*See if I'm honest I don't send those out...I honestly don't see the point in sending them anything out because I doubt they even read it let alone take any of the information in.*

Malcolm (ERS coordinator) had actively chosen not to provide HPs with feedback regarding his patients. He felt that this was a pointless task, as he believed the HPs were not interested. Other EPs had also chosen not to feed patient information back to the HPs. David (EP) believed that HPs did not want feedback, as he explained:

*We just found that people weren't taking an interest and again it was taking up... adding to hours writing up what people were doing, what results they had for things that just weren't being well received.*

David (EP) felt that HPs had not shown an interest in the feedback when it had been sent to them, although no specific examples of this were provided as evidence. He viewed the process as a 'waste of time' and as a result stopped providing the feedback. Five of the seven EPs interviewed no longer provided feedback to their referring HPs. Unsurprisingly HPs confirmed that they did not receive feedback from the EPs regarding the progress of their patients. Contrary to EPs' assumptions, however, it emerged that HPs did indeed want feedback, as Pam (HP) noted:

*Yes I would, that would help, I think even if it's just to say 'the patient you have referred came for two weeks and we haven't seen them blah' that sort of thing you'd at least know where you were up to.*

Pam was not the only HP who would have appreciated feedback. Each of the HPs expressed an interest in feedback and what the information would tell them, such as the pattern of attendance, the patient's motivation to change or whether they experienced any secondary complications. Each HP had their own reason why

feedback would have been useful and yet both Pam and Hilary commented that they had received nothing. Above, it was noted that unintended outcomes resulted from a myriad of intended actions (Jarvie and Maguire, 1994). Indeed, EPs appeared to resist and in some cases, alter and reinvent some of the key processes of ERS delivery, in this instance the provision of feedback. This further demonstrated the EPs role as arbiters of the scheme at a local level.

As previously suggested, this could have been attributed to a lack of governance at a higher level, and therefore EPs and ERS coordinators were left to interpret scheme delivery as they saw appropriate and, as a result, made their own decisions. This was an interesting situation: EPs felt strongly about not providing feedback, they acknowledged feedback was part of the delivery of an ERS and yet had failed to provide this to HPs, acting on the presumption that HPs were not interested in the information. HPs, however, had requested feedback, and, importantly, they appeared to value feedback, particularly in regard to their use of the ERS service. In Allen and colleagues' (2004) use of game models to explore the care provision for stroke patients, they suggested how one individual, who perceived themselves to be committed to the 'best' outcome, discredited other 'players' within the game and consequently disregarded these players' input. Indeed, parallels could be drawn with the behaviour of the EPs and how they had disregarded the HPs.

The delivery and management of ERSs highlighted inconsistencies in the perceptions of the effectiveness of the service and the roles other individuals had played. This demonstrated the stark differences between those groups within the ERS figuration

and their specific established-outsider positions. These relationships conveyed the tensile state and imbalance of power that had given rise to a number of unintended outcomes that altered not only the way in which the scheme was delivered but also how the scheme was received by patients.

#### **6.1.5 Receipt of Exercise Referral Scheme Delivery**

The receipt of scheme delivery referred to the range of lived experiences of those involved in the ERS. This was perhaps best summarised as what was needed for a positive experience, the outcome of a positive experience and what barriers might have prevented this. Data were primarily driven by the patients' lived experiences, however, both EPs and HPs had considered some of the outcomes of a positive experience and also had a greater awareness of what prevented this from happening. Patient comments highlighted the importance of the exercise environment, the staff, and the support they had received during their referral experience. Additionally, EPs and patients were aware of the range of benefits that could be attributed to the scheme and how a positive experience could lead to adherence to exercise and ultimately a change in habits. These outcomes were considered to be influenced by the commitment and motivation of the patient but also whether they valued the service. Monetary costs were also considered to have an influence, as has been found in other research on ERSs (e.g. Allen-Collinson et al., 2011). This section first considers those factors that had influenced the patient experience, specifically the exercise environment and ERS staff.

### 6.1.5.1 Exercise Environment

The exercise environment where the scheme took place was considered to be important for the patients who had been referred. A number of patients highlighted the importance of feeling comfortable in the gym they were attending and how the locations they attended were perceived to be different than a typical fitness club environment. Simon (patient) commented:

*I'd rather come here and do what I'm doing than go to a big high name fitness club, feel vulnerable with all these big muscle guys putting you to shame.*

Simon (patient) expressed the potential feelings of intimidation he might have felt had he attended a fitness club. Simon's feeling of 'shame' drew parallels with the ideas presented by Elias on 'civilised bodies' (Shilling, 1999) and a threshold of repugnance to what is considered the embodied ideal within the gym environment. Shilling (1999) identified how, from Elias's perspective, the gradual civilising of the body has led to 'fears' of shame and embarrassment in modern society of previously acceptable public acts, which includes the chronically ill and aging populations. Use of this theory has been extended to the desire to achieve a healthy, fit body (Evans and Crust, 2015), labelled by Maguire and Mansfield (1998) as the 'exercise body-beautiful complex'. Simon believed as he lacked fitness, a typical fitness club would not have been a comfortable environment for him. Although the gym Simon (patient) attended could have been accessed by any member of the public, it was community-based and located within a local community centre, which is perhaps why he did not view the gym as a fitness club. Simon (patient) was not alone in these sentiments, as other patients acknowledged their own feelings of intimidation, as they compared

their own perceived physical fitness with others, the established groups of the fitness figuration and body beautiful complex (Evans and Sleep, 2012). Lisa (patient) explained:

*At a gym, you're just a fee, the girls are all there in their little crop tops looking like a night out and exercising, totally different environment, that's a business, that's what makes you feel intimidated. You know what it's like but you are really conscious of your weight, somebody watching you and they're all in their little crop tops, me sweating profusely!*

Patients presented a preconceived idea of what gyms were like and viewed the facilities they attended as a different environment, almost a specialist facility for referred individuals, which they welcomed. Evans and Sleep (2012) presented a similar suggestion in their exploration of older adults and aquatic activity. The participants had appreciated that age-specific swimming sessions meant other participants were generally homogenous and lead to the development of an outsider 'us' group. Indeed, the separation of exercise provision for ERS patients from mainstream services, had further marginalised the patients and reinforced the notion of a group of people who should be hidden away (Evans and Crust, 2015). As a result of this, it was perhaps unsurprising that the ERS patients had demonstrated strong bonds of association, with one patient (Julian) referring to his group as 'like a family'. Through feelings of marginalisation, patients were aware of their 'outsider' status in a health and fitness figuration. The environment appeared instrumental in ensuring patients felt relaxed and at ease when they embarked on the scheme, which in turn supported their adherence to the exercise programme, a factor that has been found with other ERSs (e.g. Moore et al., 2011). The gym environment was not the only

factor to have influenced patients, as staff and the support they provided was also considered pivotal.

#### **6.1.5.2 Role of Staff**

From patient comments, the role of the ERS staff, specifically EPs, and the support they provided had influenced patients' experiences of the scheme and aided adherence to the twelve-week programme. Patients appreciated the time EPs invested in them and the effect this had had. Paul (patient), for example, reported feeling 'motivated' simply because someone had taken an interest in him personally, and Eddie (patient) described the important role EPs played:

*Yes I think you need, you need the contact with something sorry someone to continue, I think if you said that's it, fifteen or ten pound or it's free whatever, you're on your own now I wouldn't come.*

Eddie (patient) appreciated the contact and support he received from the EPs and other patients echoed these comments admitting they felt cared for and watched over. EPs were also aware of this and recognised that if a patient had met a 'good' EP who was caring and friendly, the patient would keep coming back (Malcolm). This provided a nurturing environment that allowed patients to thrive although, as implied in Eddie's previous comment, there could be a reliance on the support provided.



### 6.1.5.3 Support

If the staff 'contact' had not been there, even if the service was free, Eddie would not have attended. Although the exact origins of Eddie's and other patients' dependency was unclear, the civilising processes and the civilised body could be considered relevant here. The ageing or chronically ill body has become marginalised (Evans and Sleaf, 2012) and ideas surrounding corporeal frailty have been internalised by many older adults and perceived as 'natural', thereby reproducing their own marginalisation (Tulle, 2008; Evans and Crust, 2015). If, as suggested, these patients had indeed internalised suggestions regarding their own state of health, the perception might well be that they needed support and were unable to exercise without such support. By the end of the twelve-week programme, EPs suggested that some patients were not keen to let go of the support they had received, as Fran (EP) noted:

*There's some people who still want to see us after the twelve weeks, they don't feel confident enough... Some do hold onto us a little bit longer if they can...*

Fran and other EPs were aware that even after twelve weeks, patients wanted to hold on to the support they had received and were reluctant to start exercising independently. If the original goal had been to develop confident independent exercisers, this was not always the result, as some simply seemed to become more dependent. Perhaps it could be argued that this was simply due to patients internalising the idea that to exercise independently in their condition would be

'unnatural' as it would have been unsafe to do so. Aidan (EP) admitted that in these situations he had opted to bend the rules, as he explained:

*If they [patients] are very keen and the people who have seen results, I mean there is two or three people that I have this is the fourth time through the system, they are not in a financial state to join a regular gym and I don't want to lose them so I'd rather keep them on the scheme.*

Here Aidan (EP) had opted to allow patients back into the referral programme. He had allowed patients to be re-referred by their HP so that they continued to benefit from the exercise but also the reduced rate charged for the scheme. Aidan was not the only EP to have done this, others admitted they had offered a repeat referral where they considered it appropriate, for example if the patient had lacked confidence (Natasha, ERS coordinator). Therefore, EPs appeared to resist one of the key processes of ERS delivery, the delivery of what should have been a twelve-week exercise programme, became twenty four weeks and in some instances longer. EPs, once again, demonstrated themselves to be arbiters of ERS service delivery. Such decisions had impact, indeed, due to the interdependency of those individuals within the figuration, for every intended action there are unintended outcomes (Jarvie and Maguire, 1994). For EPs who resisted, and in some ways redefined what the ERS process was, the unintended outcome was dependent patients. Only Pam, as a HP, acknowledged that this was an accepted practice when she suggested re-referring 'if things are going good'. Evidently, this was a practice that had become accepted and unquestioned even by those individuals who made the referrals, it had become part of the ERS habitus.

There appeared to be a number of factors that contributed to the overall experience of ERSs: the exercise environment, the quality of the EPs and the support patients received. Patients highlighted that a small, non-commercial environment, staffed by EPs with good people skills and the ability to provide a high level of support, ultimately contributed to low patient attrition, all potential factors that had been previously highlighted within the ERS literature (e.g. Moore et al., 2013; Morgan et al., 2016; Wormald and Ingle, 2004). EPs also recognised the importance of their role and knew that a high level of care was required to support patient adherence, even if this meant 'bending the rules'. Ultimately if these elements met patient needs, then patients benefitted in a variety of ways.

#### **6.1.5.4 Benefits**

The benefits patients identified ranged from improvements in a patient's physical health to their state of mind, as well as the opportunity for increased social interaction. Some patients, who had attended their ERS consistently, reported that they engaged in physical activity outside of the programmed sessions. Not only had physical activity levels generally increased as part of the ERS but also during the patients' recreational time as they made the conscious decision to do more activity. These increases had also been observed by the EPs. Increased activity levels brought further benefits for the patients, specifically improvements in their overall health. Although patients reported a range of improved changes to their health, many focused on the resultant weight loss that they had experienced. Paul (patient) noted:

*I've gone down from a large to a medium, I've gone down four inches on my waist, I've had to buy myself a complete new set of clothes (laughing) because the rest were hanging off me like sacks*

Paul (patient) had also managed to stabilise his diabetes, which he acknowledged in passing, and instead focused on the weight he had lost since he had started the scheme. Paul appeared to define himself by his change in size, which demonstrated some relevance to Shilling's (1999) description of individualisation of the body, which suggested this is characterised by greater reflexivity shown by people regarding their own bodies and how they perceive their bodies to have changed. For Shilling (1999), there is a learned separation of the self from the physical body itself, the actions of which were suggested to have stemmed from the civilising process. Participation in the ERS had positively contributed to patients' health in a variety of ways, broadly and more specifically. This was evidenced when the issue of pain was discussed and how this had been eased through programmed exercise. James (patient), for example, commented:

*It's really worked and my knee is... well I can't feel any pain now!*

James (patient) acknowledged the difference he had felt exercise had made to the knee pain he suffered. This idea of problem areas being addressed through exercise was raised by other patients, for example, Bruce had gained the fitness needed to 'sort' his back and Valerie's mobility had improved so she was able to walk without her stick. Although this was not perhaps a direct example of patients objectifying their bodies, there was some element of the scientific rationalisation of the body (Evans and Crust, 2015), where the focus becomes the measurement or treatment of

'parts' of the body. Hence 'my knee' became 'my pain free knee'. Evidently patients perceived exercise to have targeted their problem areas but the benefits also extended to improvements in overall physical fitness, perceived mental state and the patient's ability to execute functional activities.

#### **6.1.5.5 Adherence and Habit Forming**

To gain some of the benefits detailed above, patients had adhered to the ERS, and this exercise needed to be maintained after the twelve-week programme had ended; exercise needed to become habituated activity. All patients interviewed implied they were committed to maintaining an active lifestyle following their experience of the scheme. These comments were echoed by the EPs who acknowledged there were very few patients who achieved twelve weeks of exercise and then wanted to stop exercising. What appeared to be more of a point for discussion was whether twelve weeks was sufficient, and as previously noted, some EPs had already admitted to orchestrating repeat referrals when necessary. Daniel (EP) believed twelve weeks were enough and he elaborated on this:

*Looking at longer term at some point they've got to take some responsibility for their own health and exercise so I think three months is a reasonable time to make that decision.*

Daniel (EP) suggested that ultimately patients had to take responsibility for their own health, they could not be supported indefinitely through ERSs and he believed twelve weeks was enough to do this, to ensure that the patients were able to exercise independently. Darren's (EP) opinion differed however, as he suggested:

*If they're not coming regularly then it's a bit pointless really, twelve weeks is a short period of time.*

Darren (EP) believed twelve weeks was not long enough for patients to become confident to exercise independently, especially if they had not attended regularly. Given this explanation it was perhaps unsurprising that most patients wanted to be referred again and many of the EPs believed patients should be, if they had shown improvement over the twelve-week period. Although some patients were regarded as having changed their behaviour over the twelve weeks, some EPs believed embodied habitual activity could not be developed in that time. For those who had managed to change their behaviour within the twelve weeks, patients, EPs and HPs all recognised that motivation and commitment by the patient, were required.

#### **6.1.5.6 Motivation**

In identifying factors that contributed to patient adherence in ERSs, all participants interviewed recognised that patients needed to be both committed and motivated. Aidan (EP) believed that ultimately this concerned the characteristics of the individual and how the EP worked with that individual:

*It is dependent on the individual you are working with, and the way you work with that person because I've had people that have done one or two weeks and then I haven't seen them again, and there's people that I've been working with for a year now. So it is and it isn't depending on the person.*

Aidan (EP) implied that the level of commitment was related to individual motivations and characteristics, and some patients were more motivated than

others. Two HPs (Hilary and Tara) echoed these thoughts, and both understood that the gym was not for everyone but those who were motivated generally did very well and those who were not soon withdrew from the scheme. Morgan (2005) had suggested that ERSs worked for those who were already active or used to be active, as this influenced motivation, and this was reflected in the current study, as highlighted by James (patient):

*I've always been fairly active all my life, I've done all sorts of things all the way through. When I was working I used to go to the gym at lunchtimes, I was in the air force – it's a way of life in the military you keep fit. I left the military in 1992, long time ago now but I like to try and stay fit, this is keeping me going.*

James's comments reinforced ideas that perhaps those who adhered to ERSs were already motivated but also implied that this originated from the patient's exercise history and whether the individual already understood the benefits of maintaining an active lifestyle. This idea was further confirmed by a number of patients who admitted that they had deliberately sought out an ERS and requested that their HP referred them. Participant comments confirmed that a lack of motivation and commitment were potential barriers to completing the twelve week programme. Other barriers were also noted to have impacted on adherence.

#### **6.1.5.7 Value and Cost**

As identified in analogous research on other physical activity programmes (e.g. Allen-Collinson et al., 2011) cost was perceived to be a potential barrier to patients who were offered an ERS, as some EPs believed that there were patients who could not

afford to pay (Malcolm, Aidan). Alternatively, David (EP) believed that the reduced cost of schemes had led to some patients abusing ERSs in order to secure cheap gym membership. Being referred to a gym presented an affordable option for many who were unlikely to have accessed this type of service, in addition to other fitness clubs being classed as too expensive, something recognised by all three groups interviewed. What appeared a bigger issue however was that the charges applied to the ERS were not consistent and patients believed they were subjected to a 'postcode lottery', as Paul (patient) explained:

*I'm outside, a mile outside the [town] boundary, at village X and really that's not fair and really... we're all in the same boat aren't... I'm a pensioner as well but why should I have to pay double?*

Paul (patient) was frustrated by the differences in costs charged dependent on whether patients were within or outside of the town's boundary. This annoyed a number of the patients who had experienced different charges based on where they lived. There was a rationale behind this - the funding for that district served the people within the town's boundary and therefore any resident outside of that area was required to pay a higher fee; whether this was fair or not was debated. A defined approach to governance of the ERS appeared to be lacking and indeed more a case of governance by network. The ERS coordinators, along with the district manager, had decided how much to charge for the ERS and Public Health had apparently not stopped them. Perhaps this was another unintended outcome proceeding from a decentralised approach to governance, however, the result was an inconsistent experience for those in receipt of the scheme. This was not something that either the EPs or the HPs expressed an opinion on, other than indicating they believed that the



idea of charging was appropriate. Indeed, both the EPs and HPs believed that charging added value to the scheme, as has been echoed within the ERS literature (Allen-Collinson et al., 2011). Some EPs even felt that those who withdrew from the ERS had never really valued the service from the start. Malcolm (ERS coordinator) explained:

*We [ERS coordinators] all agreed that it shouldn't be free, we don't think it should be free as... it's about value, it's about adding value to something.*

Ensuring patients valued the ERS was believed to be important and charges had been implemented to support this. Patients, however, had already identified that cost was a barrier, particularly when there was inconsistency in the charges applied. This opinion was in contrast to one held by the Public Health who oversaw ERSs for the county, as a decision was later made to remove all charges for ERSs. The researcher recalled attending a county ERS network meeting (11<sup>th</sup> December 2012) that debated this issue. The particular district interviewed was eager to maintain charges for the very reason Malcolm identified and a case was made for this by the district manager. Moreover, evidence had been provided to Public Health that demonstrated improved 'completion' (those who attended at week twelve of the programme) of the scheme with payment. At a later meeting, where the researcher was not present, the decision was made that ERSs were to become a free service across the county. The overall situation reinforced the relatively less powerful position EPs, ERS coordinators, and even district managers were in, therefore and perhaps unsurprisingly EPs appeared to resist this, and the outcome was EPs interpreted ERSs as they saw fit, offering repeat referrals to those whom they believed would benefit.

In summary, this section considered the lived experiences of ERSs. Patients identified the importance of their exercise environment and whilst they were happy with the extensive support they had received, many appeared almost conditioned to the notion that they could not exercise without the support of the EP. Data also demonstrated the lengths some EPs went to fulfil this need, even if this meant resisting ERS protocols. Emergent from adherence to the ERS, a range of benefits, both physical and mental, were reported but could be interpreted as patients' scientific rationalisation of their bodies in the way they had recalled the changes they had observed. Finally, patients acknowledged the barriers that had prevented completion of the ERS, which were underpinned by motivation and completion. Moreover, basic issues such as cost were also highlighted as a barrier but also an area of inconsistency in the delivery of ERSs.

#### **6.1.6 Concluding Thoughts**

The purpose of this section was to consider themes identified following interviews with those individuals central to the delivery and receipt of ERSs. The primary aim of this study was to explore participants' beliefs and perceptions of ERS delivery, from those who were engaged with the scheme: patients, EPs (inclusive of ERS coordinators) and HPs. In order to try and understand ERSs from these perspectives, concepts drawn from Elias's process sociology were used to provide a theoretical lens. These concepts included Elias's use of the figuration and bonds of association, established-outsider relations, and the civilised body. The application of these concepts to the data highlighted the complex relationships between all participants

but specifically between the EP and HP groups. Evidence of fluctuating tensile power relations underpinned a number of the interactions that occurred between these two groups.

The way in which participants perceived the ERS was often conflicting and inconsistent. This was exemplified by some patients experiencing the ERS differently to others, which appeared to originate, amongst other things, from some EPs resisting and reinventing what the scheme was originally perceived to be. Indeed, EPs appeared the arbiters, at a local level, for scheme delivery, with actions such as making repeat referrals or failing to feedback to HPs, which shaped the way the scheme was delivered. Yet EPs made no comment as to whether management had challenged this. Furthermore, this resisting and reinventing of processes was accepted, as if the 'norm', which only further contributed to the complexities of the ERS figuration. EPs evidently considered themselves the 'real' insiders to ERSs.

Having considered the key findings from this initial exploratory phase, it is now possible to examine data from the second phase. The second phase explored further some of the ideas that have been considered here, but in addition seeks to understand if and how the power balances between those individuals in a managerial position had influenced ERS provision and therefore the ERS figuration.

## **6.2 Findings from Phase Two**

### **6.2.1 Introduction**

This chapter examines the themes that emerged from the interviews with individuals involved in the management and organisation of exercise referral scheme (ERS) provision. This included two participants from Public Health, two from the county sports partnership (CSP) organisation, and one district manager. The purpose of this second phase was to further explore strategic manager's perceptions of ERSs and more importantly, to try to understand the power balances at play that had impacted on or influenced the way in which the ERS was managed and had evolved. From the first phase, the responses of those engaged in the delivery of the scheme: patients, EPs and HPs, demonstrated the conflicting and inconsistent nature of their perceptions, both within and between groups, which had ultimately shaped ERS provision. Therefore, the purpose of this study was to explore these ideas further but at a strategic management level, trying to understand the power balances at play and the impact that these had had on ERS provision.

Analysis of the interviews proved to be a complex process, more so than had originally been anticipated. This was primarily due to the plethora of information provided. The researcher attempted to capture the diverse themes that ranged from the pragmatics and challenges of managing the scheme to the uncertainty and debate over the future of ERSs within the county. Data also reflected the relationships between individuals and groups of individuals within the ERS figuration. Commensurate with the main aim and research objectives of the study, and within the constraints of this thesis, it was not possible to detail every theme generated

through the analysis process, as the scope of the study had to be delimited. Data were further supported, where appropriate by the inclusion of researcher's reflections from those county ERS network meetings that had been attended by the researcher.

This section of the chapter will firstly consider the power dynamics between those at a strategic management level and how these impacted on the ERS figuration. Resultant from these dynamics, fragmented leadership of the ERS is then discussed, highlighting examples of where clear management for ERSs appeared largely absent. The question over sustainability of ERS provision is finally explored and the uncertainty that existed over the future of scheme is captured. These themes are examined via key concepts of process sociology as a framework to explore the interdependent nature of relationships and how the balance of power influenced the figuration of the ERS. Finally, notions of moving to a commercial model for the delivery of schemes, the characteristics of ERS delivery processes and the positive qualities of schemes emerged through analysis; yet as previously stated due to the specific aim of this study and the scope of the thesis, they are not explored here. This section first considers the 'power dynamics' that were apparent between participants at a strategic management level and with others within the ERS figuration.

### **6.2.2 Power Dynamics**

Throughout the interviews there was a sense of the power dynamics at play, through discussions regarding the organisation of ERSs (the figuration) and the participants'

perceived ability to influence this. Dunning (1999) suggested that power is tied to interdependence, is of a tensile state, and is therefore distributed such that it is not possessed by any single individual or group. The power struggles that were captured by those interviewed demonstrated the tensile status of the ability to change the figuration; for some this was captured in their perceived ability to demonstrate control over the decisions made within the ERS figuration, whilst others felt relatively less able to influence practice within the figuration and were therefore constrained by this. The impact of these unequal power balances was social division, which led to the production of 'we' groups versus 'they' groups (Loyal, 2011), and in some instances the formation of 'established' and 'outsider' groups followed (Elias and Scotson, 1994). By understanding the power dynamics that played out between those who were interviewed, it was possible to further explore the interdependent nature of these relationships and how this had influenced the ERS figuration. These ideas were first examined through the theme of accountability and how each individual perceived their own position within the structure of ERSs.

#### **6.2.2.1 Accountability**

Accountability captured how participants viewed their own position in relation to others, for example who was accountable to them and to whom they were accountable. The understanding of this by all those interviewed was apparent and it was interesting to note that, in the most part, this was accepted as the 'norm'. The ERS figuration could be considered to have its own group habitus, and accountability was one mechanism by which these social norms were reproduced. Each participant was able to provide a factual account of who they believed they were accountable to

and who they believed was accountable to them, however it was apparent that for some, these relationships were a little more complex, as Janet (district manager) explained:

*...I am actually employed by the District but funded by the County [council], I have a line manager within the district council, assistant director, director, all the usual sort of stuff internally, but ultimately as a funder, I am responsible to the county council.*

Janet (district manager) acknowledged the complexity of the position she was in, despite being employed by the district council and answerable to her own employer's infrastructure, she was ultimately responsible to the County Council (Public Health), as they had commissioned the ERS work she was responsible for. This suggested that power was perceived as being financially driven, as commissioned work received the funds to deliver initiatives such as ERSs and Janet believed this determined who she was primarily accountable to. Whilst Janet was essentially entwined within two separate figurations she was at least aware of these interdependency chains, however for others, this was less easily defined as one CSP representative, Sam, responded when asked who was accountable to them:

*I would say more of a moral responsibility than a, a business transaction... I suppose when you've got a relationship with somebody you expect that response... but certainly legally or from a service level agreement point of view I wouldn't say anybody's accountable to us.*

To identify a 'moral responsibility' was an interesting statement, Sam (CSP) never elaborated on this any further or really defined exactly what she meant by this but it was an unusual way to capture her perception of the CSP role. She proceeded to give examples of different tasks that the CSP were accountable for such as collecting data, arranging meetings and the reporting of any problems that had arisen from ERS

delivery. Both representatives from the CSP were fully aware that they were accountable to Public Health, indeed this appeared financially driven again, as Public Health had funded the CSP to take this role. No one, however, was identified as being accountable to the CSP. This reinforced the idea that accountability had become one of the mechanisms that contributed to the social norms of the figuration being reproduced, contributing to a group habitus for ERS. People knew their position and accepted this as the 'norm' regardless of whether this represented the actual situation or not. This also presented, however, somewhat of a contradiction. Positioning the CSP alongside Public Health in the hierarchical structure of ERSs suggested the CSP considered themselves to be at the apex of the hierarchy within the ERS figuration. At the same time, by their own admission, no one was accountable to them, which suggested a relatively less powerful position.

The concept of power is suggested to be inextricably tied to the interdependence of individuals, (Dunning, 1999) therefore, this means that power is more than just about what resources one group has over another, for example funding. The CSP's power may have therefore resided in the organisation's ability to manage and manipulate the relationships of others. Indeed, the CSP were in a powerful position to manipulate the structure of the ERS figuration by bringing people together, even though they may not have the capital to distribute it. The CSP, however, had not appeared to recognise this. Having established accountability, this provided some indication of the group habitus of the ERS and the acceptance that a hierarchy of relational power existed. This awareness of accountability had provided a platform for control and how control could be exerted by one over another.



### 6.2.2.2 Control

Throughout the interviews, it was apparent that some individuals exerted control over others, demonstrating their own position in relation to ERSs. One example of this was Paul (Public Health), as a health improvement manager, and responsible for the dissemination of funding, Paul expressed his feelings on his own position:

*I have a viewpoint. As a commissioner I defined what... (pause)...working with sports partnership and with providers, they define the how at local level.*

Paul (Public Health) was quick to affirm his position of control, in which he considered himself responsible for commissioning the ERS provision, and suggested that in his role it was down to him to identify 'what' ERSs should be. The 'what' however was not outlined or the way in which this was communicated to others, within the ERS figuration. It did, however, exemplify the control that he felt he had in the leadership of ERS provision. Paul also followed this comment by identifying his approach when those delivering ERS had deviated from his vision, as he explained:

*...the current model gives a degree of freedom and opportunities as well... I've had a few strange requests... and therefore you know, we've reined a few folks in.*

Paul (Public Health), again emphasised his control over the approach taken by some ERS providers in the delivery of schemes, especially if this had deviated from what he deemed appropriate. Elias's (1978) description of the 'triad of controls' identified three balances, one of which was the inter-human or the control of people over each other, the others being the control of each person over themselves, and the control of humanity over natural elements. In conceptualising these relations Wouters (2014) suggested there could be a blend of competition and cooperation. Paul's

comments were less reflective of a cooperative relationship and more of a competitive state between Public Health and those delivering ERSs. Paul felt it necessary to take action when an ERS provider had deviated from perhaps what he felt needed 'reining in'. Dunning (1999) suggested that there was a tendency for established groups to perceive outsiders as 'law breakers' or 'status violators' (p.188). Although Paul had not claimed that anyone had broken any laws it was nevertheless apparent that he negatively labelled such behaviour by ERS providers over whom he considered himself able to exert authority. This highlighted some interesting power dynamics. Public Health appeared to offer ERS providers the flexibility to interpret delivery processes as they saw fit and yet when this was disapproved of, for reasons that were not specified, then action was taken. How this action was taken was also not made clear, as Paul was not in a position to withdraw funds within contract arrangements or fire staff.

These dynamics played out in a network meeting attended by the researcher on 10<sup>th</sup> March 2016. The group was discussing the decommissioning process and how plans were to be put into place. A Public Health representative asked when the district managers and ERS coordinators would be informing their HPs of the imminent changes. A number of the group admitted to having already done this and this admission was not well received. The Public Health representative had believed that no contact would be made until an official date had been agreed, whereas other districts believed they needed to preserve their relationships with HPs if their own ERS was to have any future after decommissioning. The researcher recalled feeling embarrassed and awkward as the debate continued for some time. The Public Health

representative appeared annoyed by what was said, when faced with someone whom was perceived to have deviated from what the Public Health representative was believed to be in control of.

The behaviour at the network meeting alongside the response Paul (Public Health) provided at interview implied that he perceived the ERS to be tightly managed. On the other hand, however, staff in the CSP had a different view. For example, Christine from the CSP reflected on this in relation to her own approach to management, she recalled:

*You know when we've managed... when I've managed contracts in the past we've been allowed to be a little more forceful.*

Indeed, participants from the CSP suggested that different styles of management would have been employed, had they been in Paul's position, which included the use of a more 'forceful' approach. Between Public Health and the CSP, there were contrasting opinions about the level of control upper management possessed over the service delivery of ERSs, and how this was executed. It was interesting to note that it was the CSP who advocated a more coercive approach, particularly when they had acknowledged their own perceived lack of power. This sentiment was perhaps best echoed by Sam (CSP), who explained how their own 'control' had changed:

*But the role [of the CSP] has changed over the years. It used to be very much more authoritarian... now it's much more support driven.*

Sam's (CSP) suggestion seemed to outline how the primary avenue through which the CSP could influence the ERS figuration was through 'support', for example to facilitate the communication between schemes across the county or the central

management of data for schemes. Comments from both Public Health and the CSP demonstrated that power could be enacted in different ways. For some it was through accountability, yet for others like the CSP, power was softer through the maintenance and support of ERSs. What should be highlighted however was how these participants perceived this power in relation to their ability to influence the ERS figuration. Evidently, each perceived their role and influence differently, which implied a figuration in flux. Within a figuration, all individuals have impact, this could be greater or lesser, but there is impact nonetheless. Such impact was noted in the form of division, 'we' and 'they' groups that had developed, which further demonstrated the tensile balances of power that existed.

#### **6.2.2.3 Division**

Division was identified throughout all interviews and was reflected in a number of ways between different groups throughout the tiers of ERS provision. Division was perhaps best highlighted when discussing the communication that occurred between those at a strategic level in ERSs and those who delivered schemes. Paul (Public Health) described whom he interacted with:

*I've spent a lot of... at a higher level more than down at a lower layer. I sent my team off to talk to people.*

Paul (Public Health) explained that he had little interaction with those individuals at the ground level who delivered ERSs or patients who had attended schemes, and instead inferred he had 'members of his team' who assisted him to liaise with them. He suggested that he had 'engaged' with GPs regularly and this was presumed to be the 'higher level' he had referred to. Such comments suggested that Paul remained

distanced from ERS processes and delivery. Despite ERSs being a service for which he was ultimately responsible, he appeared removed from the day-to-day occurrences. Paul's explanation was indicative of a 'we' and 'they' group, defined by professional roles, 'they' being those who were responsible for the delivery of ERSs and 'we', who not only included himself but possibly extended to the inclusion of GPs. Paul was not the only participant to see this separation of individuals according to role. The CSP also speculated on the ERS hierarchy, as Christine (CSP) explained:

*The interactions that we have are solely with the district leads or all of those who attend you know the exercise referral meetings. So whilst there are... there's a couple of instructors there a lot of them are you know for example [centre name], so we never really get to meet some of the instructors. Some of them are there but you know they're not the level... they're the level below.*

As Paul (Public Health) had, Christine (CSP) referred to those who delivered ERSs as being a 'level below' and admitted to little contact with them, even if they attended the same meeting. Christine seemingly perceived herself to be culturally similar to Public Health and therefore part of an established 'we' group, separating the CSP from the 'they' group who delivered ERSs. It was interesting that Christine should position the CSP high within the hierarchy of ERSs, and this reaffirmed the distance between their organisation and those who delivered ERS services. Elias and Scotson (1994) suggested that for groups within a figuration, an unequal power balance leads to the formation of 'we' and 'they' groups. Indeed, the 'we' group maintains a superior established position and perceive the 'they' group to be inferior outsiders, or in this instance the 'level below'. Established groups are also believed to use negative labelling when they feel exposed, as a means of maintaining their social superiority. Therefore, it was possible the CSP members felt they needed to reaffirm

their own position by marginalising others, as they perceived their role within the ERS figuration as being relatively less powerful, even if this was perhaps not the case. It is possible both Public Health and the CSP may not have considered their comments to be divisive, yet, in contrast, district manager Janet, considered the division between the management and delivery tier of ERS to be apparent. Janet (district manager) explained:

*It's not that you [Public Health] don't know, but you [Public Health] don't understand the ins and outs, and what really makes a programme tick as well, and I think they could have used that expertise to greater effect when they were putting together the [service] specification... not everyone can be experienced in it, I know that. The commissioners aren't all ex instructors, I know that, but use what you've got to make it the best it can be and I think maybe that's missing.*

Even as a district manager, which would be considered a strategic role, Janet believed that a division existed between those who commissioned and managed ERSs, Public Health, and those who delivered ERSs, which included herself. It was not clear whether Janet considered the CSP to be part of this group as well. The division that Janet described was attributed to a lack of understanding on Public Health's part and although Janet acknowledged that not all commissioners were or could be experts, she believed that Public Health had failed to take advantage of the expertise around them. Allen and colleagues (2004) had suggested that differences in: culture, goals, training and ethos could all effect interprofessional work in some way. Yet, Janet's comments appeared to challenge the assertions of an apparently established group. Lake (2013) suggested that a typical characteristic of an established-outsider figuration was the lack of means for outsiders to successfully challenge their position, whereas Janet (district lead) seemingly defied this notion. To try and provide

explanation for this, it is necessary to refer back to Elias's use of the figuration. What has not been acknowledged here is that Janet would have been part of other figurations, in a professional and personal context, which go beyond the scope of this research. In relation to those figurations, based on Janet's years of experience in ERSs, both in delivery and management, she would potentially be seen as part of an 'established' group, therefore enabling her to challenge assumptions in this way. It may also be possible that Janet had never had the opportunity to voice the above thoughts prior to being interviewed. Having asked for her thoughts on the management of ERSs specifically, Janet was accorded an opportunity to vocalise her experiences.

One comment from Sam (CSP) however suggested that we-they divisions were apparent further down the interdependency chain, as she commented:

*And of course it's very easy to know you next door neighbour isn't it and we hear that... we do get that from the coordinators as well, such and such haven't done this or that they're up to that...*

Sam's (CSP) comment implied there was tension between the ERS coordinators from other districts. Within Elias's (1978) use of game models, game dynamics suggest that when confronted with a stronger 'player,' weaker players rarely communicated with each other and as a result, there is a lesser ability to enact power, and therefore influence figural dynamics. Furthermore, if there was tension between weaker players this furthered the chances of the players gaining power (Mennell, 1992). There were seven districts within the county and if relationships were fractious as Sam (CSP) implied, their chances of power were diminished. This sense of division

was apparent in the network meetings attended by the researcher. District managers, ERS coordinators and some EPs from certain districts typically sat with the same personnel from other districts and rarely interacted beyond these groupings. Representatives from the CSP typically positioned themselves next to Public Health representatives and demonstrated little interaction with ERS district managers, ERS coordinators or EPs other than in the confines of the meeting itself. To the point where sometimes the researcher was often unsure where to sit, as she felt this would in some way demonstrate allegiance to a particular group. Loyal (2011) suggested that a group's cohesiveness and interdependent bonds are the cause of an unequal power ratio, which did appear to be the case in the present study.

#### **6.2.2.4 Disempowered**

At various points during the interviews the participants identified how they felt disempowered within their work due to the hierarchical nature of relationships within the ERS figuration. Christine (CSP), for example, explained what power the role of the CSP held:

*There is no power behind the role. For example we collate data, we look to analyse data, look at you know performance of different providers but if a provider hasn't input any data we could actually physically... we couldn't threaten them [ERS coordinators]... we can't do anything other than send a polite email to say please.*

Christine (CSP) alluded to the contract that the CSP held with Public Health and how there had never been any power behind it as the CSP was able to offer only a coordination role. It was interesting to note that the ability to collate and analyse data was perceived as being 'powerless'. Just because the CSP lacked the ability to



be coercive did not mean that they were powerless. The CSP was responsible for reporting performance data for the different districts which was a fundamental enactment of power, identifying those districts who were performing well, seeing the most patients complete, this could be considered to be very powerful. Nevertheless, this perception of feeling constrained and disempowered appeared to be an issue of contention for the CSP in relation to Public Health. These sentiments were echoed by Sam (CSP), who had also expressed that the CSP had aspirations of being able to contribute to strategic planning and yet this had not been possible. Power can be considered both relational and dynamic, which Jarvie and Maguire (1994) suggested is both enabling and constraining for the interactions of interdependent individuals. This appeared to be the case for the CSP and how they perceived their constrained relationship with Public Health. The CSP however was not the only organisation to feel disempowered by Public Health. Janet (district manager) believed that since her district's ERS funding had moved solely to Public Health, their own provision had been constrained, as she explained:

*As time has gone on and moved into local authority control, things have become more prescriptive, i.e. these are the conditions you will accept... there are certain things we are not allowed to do, things like cardiac rehab... if we want to make it part of our programme we have to do it off our own back which is a shame, because there is huge benefit and a huge amount of clients we cannot help. That is how it has changed and become more prescriptive.*

Evidently, Janet (district manager) had felt that her ability to provide 'her' ERS had been constrained by a change in management approach (discussed further in 6.2.3) and she no longer had the freedom to deliver a service that she felt was appropriate. The frustration demonstrated by Janet, from losing her ability to make decisions about the delivery of services, and indeed, the frustration of other ERS providers was

observed in a network meeting on 18<sup>th</sup> September 2012. The researcher had presented data regarding lower patient attrition for those districts who charged for the service. All in attendance, except for one representative from Public Health, were in agreement that if the data indicated better completion rates, then perhaps this was a model that all providers should have employed. The Public Health member of staff present was unprepared to agree to this and then suggested that perhaps all providers should no longer charge. At the time, the member of staff only seemed to offer this suggestion by way of playing devil's advocate yet it created obvious tension and the group became unsettled, with one-to-one whispers breaking out. The situation only settled when the Public Health member of staff agreed to go away and consider this further. The researcher found out some weeks later that the decision had been made to offer ERS as a free service across all districts in the county. Public Health had demonstrated its authority, and ultimately power, by making a decision that was seemingly not evidence-based. If there had been evidence, this was not something that had been openly shared.

Although Janet did not refer to the incident, the researcher was aware that Janet's district had charged for their ERS since its conception. This was a decision that could have constrained Janet's ability to manage her district in a way that she considered appropriate. Jarvie and Maguire (1994) suggested that within power balances there are elements of both cooperation and conflict that changed and altered depending on the situation. Power is complex and in this instance, it was viewed to be constraining the working practices of some within the ERS figuration. The ERS district manager (Janet) and the CSP (Sam and Christine) attributed their feelings of

disempowerment to Public Health, however, when interviewed, Susan (Public Health) also expressed feeling a loss of power but related this to a different source, as she commented:

*...sometimes there are political influences you know and certainly from our organisation's point of view, put to others sometimes they [ER providers] are seen as competition or there might be things going on in the background, that perhaps our chief execs are talking to theirs about other things and there's all sorts of influence like parks and gardens and leisure centres and you know there's a whole load of stuff that's sort of behind the scenes... that will affect what we do and what we don't do.*

Susan's (Public Health) comments highlighted that Public Health perceived the organisation to be disempowered by the management structure that existed above it. Their own practices were ultimately influenced by the actions and decisions of those who were considered to be in a more authoritative role than their own. When Quilley and Loyal (2005) discussed Elias's use of game models, the authors suggested that if the number of players increases then so did the interdependency between individuals. Public Health (Susan) identified that there were more 'players' in the game of ERS. Indeed, the length of interdependency chains perhaps extended longer than some were aware of. Quilley and Loyal (2005) also suggested that increased numbers leads to a reduction in the power ratio between people, so that no one person can fully determine the outcome of the 'game' but instead what emerges is a game dynamic that no one has intended. Therefore, ERSs could be likened to the game itself and what had emerged was the 'unintended outcome of the interweaving of a myriad of intended actions' (Jarvie and Maguire, 1994, 136).

The dynamics of power played out between those participants at the strategic level and appeared to extend down the interdependency chains. Participants had a perception of their role within the ERS figuration and this appeared to contour their perceived ability to influence the figuration itself. Positions within the figuration were shaped by accountability, to whom one answered to and to whom answered to one. Acknowledgement of these positions corresponded with those participants who perceived a high level of control accompanied by an ability to make decisions regarding the delivery of ERSs, ultimately shaping the ERS figuration. Such actions appeared divisive and led to the creation of 'we' and 'they' groups, which left some participants feeling unable to influence the delivery of schemes and therefore, constrained and disempowered. The balances of power perhaps went some way to explain why the leadership of ERS appeared fragmented, which will now be discussed.

### **6.2.3 Fragmented leadership**

The notion of 'fragmented leadership' captured a group of themes that highlighted issues regarding the perceived lack of coherent, strategic management of the ERS. At no one point did any of the participants interviewed suggest that the management or organisation of ERSs had failed in any way, yet it was apparent from responses that a clearer, more strategic approach to leadership was lacking, to steer ERS provision within the county. This was reflected in a number of ways, such as changes to the way ERSs were managed. Changes to the style of management had resulted in a resistance to change the approach to delivery, which had culminated in inconsistent provision of ERSs that appeared to go unchallenged. Some participants (Public

Health) appeared disengaged from the ERS process itself whilst others had become disenchanted (district manager), surrendering to the uncertainty of the future of ERS provision. This discussion of fragmented leadership begins with highlighting the lack of clarity surrounding the intended aims of ERSs.

### **6.2.3.1 Unclear Aims**

When asked about the original intentions and aims of ERSs on a broader level, participants presented conflicting ideas that suggested their understanding of ERSs' purpose lacked clarity. Paul (Public Health) who had commissioned ERSs out to district managers explained his understanding of the aims which should:

*...enable individuals to be more physically active. To enable them to experience physical activity that gives health benefits to alleviate their problems or just raise their quality of life.*

Paul (Public Health) implied that the service was designed to increase an individual's activity levels, which provided health benefits and could also improve a patient's overall quality of life. Susan (Public Health) however had a different viewpoint on this, as she commented:

*I think it says... exercise referral isn't a weight loss programme. I think when it began it probably was more of that... I think it's quite tied, it's obviously quite tied to that obesity agenda.*

In contrast, Susan believed that the origins of ERSs were introduced to tackle the obesity agenda, where the primary aim had been to support an individual's weight loss, although she admitted this aim had possibly changed over time. Paul provided little comment in relation to the obesity agenda other than that ERSs had failed to 'impact' on obesity levels within the county. How such impact was defined was not

stated but what was apparent, despite both participants working for the same team in Public Health, they believed schemes served different purposes. Indeed, both suggestions were somewhat vague, with clearly defined goals largely absent.

A lack of clarity regarding ERSs' primary aim continued to emerge, following interviews with the other participants from the CSP and the district manager. Each provided their own interpretation of what they believed the original aims of ERSs were. Some of the responses given could be traced back to the National Quality Assurance Framework (NQAF) (Department of Health [DoH], 2001) as a point of reference; therefore perhaps no one was completely wrong in their explanation, however, their differing ideas demonstrated a lack of common goals. Huxham and Vangen (2000) suggested that practitioners believed having a clear set of aims supported partners in working together more effectively, particularly when implementing policies. Yet for all of these participants who operated at a strategic management level for ERSs, there appeared no agreed aims as to what ERS should have achieved. If there were no clear aims agreed from the outset, then this held implications for ERS provision. In some ways, this could have been a reflection of the origins of ERS provision within the county. This was an initiative that had developed at district level from the 'ground-up', where a clear chain of command only really came into place years later. This was not unlike other schemes that had grown from a grass roots level (see Crone et al., 2004). It would be difficult to ascertain if this scheme emergence was the 'cause', but it did seem plausible. The movement of the Public Health portfolio from the National Health Service (NHS) into local authorities may have also had an impact as will be considered below.

### 6.2.3.2 Shift in Management Style

The participants reflected on how they felt there had been an obvious shift in the approach to management since Public Health had moved from the NHS into local authority control. This transition had also meant that Public Health had become the sole funder for ERS provision. Dunning (1999) considered power to be a structural characteristic of all relationships but it is also in a tensile state. For one person to be more powerful, another must be relatively less powerful. The changes that had been observed in management style were a reflection of an unequal power ratio. All those interviewed were in agreement about how the approach to management had changed. Paul (Public Health) was aware of how Public Health's approach to management had modified, he commented:

*...we got into a project management performance, management routine... so it's become less laissez faire... the goal is to be more typically structured than unstructured.*

No explanation as to why management of ERSs had to be more 'structured' was provided, or indeed, how this was implemented, but Paul recognised that the shift to a performance management approach was in stark contrast to how schemes had originally been managed. Janet (district manager) was also aware of how the working relationship with Public Health had changed, as she explained the increasing prescriptiveness:

*Yes, I'd say it has, probably because I have been involved for quite a long time. Initially the relationship was with the NHS [where Public Health sat] it was a much more fluid relationship so less prescriptive... As time has gone on and [Public Health] moved into local authority control, things have become more prescriptive...*

Janet believed that by having to move to a more prescriptive approach she was no longer able to support her clients in a way that she deemed appropriate; she felt constrained. Janet's district had originally offered an ERS of their own volition, in the early 2000's, prior to Public Health solely commissioning the work. The interdependencies of human actions within a figuration means that relationships can simultaneously be both enabling and constraining (Elias and Scotson, 1994; Evans and Crust, 2015). Public Health had made key organisational changes, which had demonstrated their ability to manipulate the ERS figuration and ultimately exhibit a relatively more powerful position. This had left Janet feeling constrained in her ability to deliver the scheme in a way she deemed best. The CSP suggested that taking this approach had been necessary to try to provide a standardised countywide service for ERS provision. As a service that had originally developed from small providers developing their own pockets of practice, as sole funders, perhaps it was unsurprising that Public Health, with the support of the CSP, had wanted to standardise the approach to ERSs for the whole county. Yet, equally, a more decentralised approach that enabled governance by network, as employed by Public Health (on the surface), could have played to the strengths of those professionals in the field (Grix, 2010). This was apparently not the case in Janet's opinion.

### **6.2.3.3 Resistance to Change**

Despite attempts to standardise the service, however, a resistance to change from those who delivered ERSs was apparent. Sam (CSP) was most aware of this, as she noted:



*I think the methods have probably changed, or it should have changed (laughs) I think in some places it would just be the same old school mechanism and I, unless you know, you won't stop that.*

Although Sam perceived that ERS coordinators and EPs were resistant to change and had maintained their original practices, there was no specific evidence provided to confirm this. What did appear to be widely acknowledged however, was the overall inconsistent nature of ERS delivery across the county.

#### **6.2.3.4 Inconsistent Service Provision**

Those interviewed, with the exception of Janet (district manager), suggested that the districts were delivering ERSs differently. Christine (CSP) commented:

*...it seems to be wild and woolly. It varies according to the provider and the relationship they have with their local GP practices.*

Christine (CSP), within her organisational role, suggested that an inconsistent service was being provided and this differed depending on who the provider was and the relationship they had with the referring HP, in this instance the GPs. Christine was not alone in having recognised this; Sam, also from the CSP, was similarly aware of inconsistencies, as she explained:

*...whether it's changed on the ground in that time or not is probably a bit questionable in some areas. So I'd say there's still lots of disparity between the quality ... coherence and certain competence of the instructors as well as the experience, the choice, the price... it's still very, very varied.*

In some ways, the suggestion of inconsistency was unsurprising for the researcher, having reflected back on a network meeting on 4<sup>th</sup> March 2014. A Public Health representative had requested that each district determine their own target ERS

numbers for the coming year. This was based on what Public Health funded per person for those patients who attended the ERS. Each district appeared to arbitrarily determine their own figures based on their numbers from the previous year. What then followed was a discussion on how some districts were funded by one payment upfront, some were paid per head once the patient had attended the first week, whilst others were only paid when a patient completed the twelve-week programme. The researcher was bewildered when confronted with a process of negotiated targets that appeared arbitrary. What seemed even stranger was that the cost per patient could differ by up to twenty-five pounds depending on which district the patient attended for the ERS. Therefore, it seemed unsurprising that a culture of inconsistency had evolved if this was a process that appeared inadvertently endorsed by those in a managerial position. Sam (CSP), in addition to acknowledging the inconsistencies of ERS provision, also suggested that such variation went broader than the overall experience and that this extended to the overall quality of the service as well. Despite being in a position that required her to ensure a standardised service was provided across the county, Sam recognised that this was far from the case and went on to explain the impact and implications of such inconsistencies. She considered:

*...the negatives are of course is that it is so varied and you can't, you can never control quality in this sort of environment... and you just never would unless you're going to police it. And if you're going to police it you'd have to spend an awful lot of money on the policing of it and then you lose your delivery money.*

Sam (CSP) perceived that a varied ERS service was ultimately detrimental to the overall quality of what was being provided and in her mind, this was impossible to

'police' or regulate without sufficient funds to do so. All of those interviewed from the CSP and Public Health identified that the quality of the service was not of a standard they would have wanted and yet such local delivery mechanisms remained unquestioned. To stigmatise others in such a way was akin to ideas of established and outsider groups presented by Elias and Scotson (1994), who suggested that in order for the established group to maintain its identity and assert its superiority, stigmatisation becomes a powerful weapon to ensure outsiders remain in their place. Indeed, Elias and Scotson (1994) referred to this as 'blame gossip', where examples of 'bad behaviour' from a minority within the 'outsider' group are portrayed as being typical of the whole group (Lake, 2011; Soeters and van Iterson, 2002). This was an interesting situation as although a number of participants from Public Health and the CSP were quick to 'blame gossip' about the inconsistent delivery of schemes, not one of these individuals appeared to have challenged this. Furthermore, nobody had suggested that an attempt should be made to try and further standardise delivery, or that complete standardisation would be better. Failure to control and homogenise the ERS could have potentially been viewed as a weakness to those outside of the service, but equally it could be argued that heterogeneity across districts actually played to local conditions and contexts. It was difficult to conclude which was the case.

The researcher had observed this more generally from the network meetings attended. Issues of inconsistency were never raised or discussed. Despite the perception that inconsistent delivery was so prevalent, no one actually challenged it, it was almost accepted and considered the norm. There is the possibility, as alluded

to previously, that this was a deliberate, conscious decision by Public Health, allowing those who delivered ERSs to interpret delivery as they saw fit, due to their knowledge of the local context, whilst Public Health maintained control of the budget. Yet, this could be likened to Grix's (2010) description regarding the governance of sport policy, where outwardly power appears dispersed amongst multi-agencies responsible for the delivery of policies, and yet in reality it is central government who are 'pulling the strings' (p.166). Whilst governance by network appeared to be the way in which ERSs were managed, power appeared more centralised by Public Health, primarily through financial budgets.

#### **6.2.3.5 Question Management's Role**

Despite the perceived problems of consistency remaining unchallenged, no one from either phase of the research had openly challenged the quality of support provided by the CSP or Public Health. The CSP (Sam and Christine) described their role to be network facilitators and partnership builders at the county level, and cited the creation of the county network meetings, that all those at EP level and higher attended, as evidence. Janet (district manager) however, did not view this in the same way, as she questioned the role of the CSP:

*Difficult to say because I am not sure what it [CSP] brings – I understand they are commissioned to provide coordination... obviously they coordinate meetings which takes time, and the outcomes from the meetings, but it doesn't have to be that organisation that does it as anyone could perform the function in my opinion.*

Janet (district manager) challenged the role of the CSP in terms of the function it provided, suggesting that the CSP generated just an additional layer of unnecessary

coordination. Janet was not the only one to question the CSP's role. Susan (Public Health) also identified an unnecessary layer of bureaucracy and believed that the presence of the CSP implied there were two organisations in charge of ERSs. She reflected:

*...how it is now I see it [CSP] as perhaps an unnecessary layer... and I think there's a little bit of... sort of two lines of accountability perhaps or... you know two generals sort of running the army.*

Although Susan held a strategic management role in the organisation of ERSs, it was interesting to note how she challenged the contribution of the CSP. Susan implied that the CSP might have perceived that it was also responsible for the management of schemes, placing it in equal status to Public Health, however, evidently Susan (Public Health) did not agree with this. Janet (district manager) had also suggested that any another group could have taken responsibility for the contribution made by the CSP. Both opinions suggested a lack of clarity regarding the role and responsibility of the CSP at a strategic level. Hence, there appeared some uncertainty over what the CSP offered to ERSs amongst strategic staff, and the CSP were considered 'outsiders' to the ERS figuration.

The researcher had observed this interesting dynamic at the network meetings. The CSP announced each agenda item, summarised any actions going forward but contributed very little to the overall content of the meetings. As the meetings moved from the close of 2015 into early 2016, the researcher noted that as the issue of decommissioning became a higher priority, the CSP had even less to contribute. There were some awkward silences that highlighted they had little to offer to these

discussions and the peripheral role the CSP held. The CSP did not commission or deliver ERSs; Christine (CSP) had even admitted that the CSP had 'no power' in the management of ERSs, therefore it was perhaps unsurprising that other individuals such as Susan and Janet, reacted to the role of the CSP so critically. Elias and Scotson (1994) noted that in distinguishing an outsider group from an established group, the established groups' predominant source of power is their stronger bonds of association, which in part is due to a longer duration within a particular figuration. Bonds that entwine these individuals together, over long periods of time, help build cohesion and facilitate the operation of the established groups' position of power (Lake, 2013). Janet (district manager) had been involved in ERSs long before the CSP had become involved, or even prior to Public Health taking a formal lead. Hence, despite the CSP's strategic position in ERS management, other 'we' groups within the existing delivery pathway of the ERS viewed them as recent interlopers, to whom they were not directly accountable.

#### **6.2.3.6 Feedback**

The sharing of best practice and feedback, facilitated by those at a strategic level, had also become a contentious issue and highlighted the limited face-to-face interactions between the 'we' groups of the ERS figuration. All participants discussed feedback and how important it was, and they detailed from whom they received feedback and how useful this was. Yet, this process was mostly dictated by role and with whom individuals interacted on a professional basis. What perhaps was more enlightening however was where feedback was deliberately not received or sought by individuals, which could have been construed as disengagement from the

processes of ERSs. When Susan (Public Health) was asked whether she received any feedback regarding ERSs, she responded:

*Not automatically no ... there's no mechanism for it... feedback would largely go to the sports partnership because they've had that sort of odd role.*

Susan (Public Health) suggested that no mechanism was available for feedback as this was presumed to be facilitated through the CSP. When asked the same question the CSPs' (via Sam) response focused on patients and identified that they did not get feedback from patients nor had they held anything to facilitate this, such as patient user groups. Paul (Public Health) suggested that the county network meetings were an opportunity to communicate with the district leads for ERS and implied that this was an opportunity for feedback and best practice to be shared. Janet (district manager), however, did not agree:

*It is rather an odd one [the county network meetings] – I have always wondered why they [Public Health] do not set up as managers or instructors or contract managers. It is a mixture. I may be sat around the table with a sub-contractor or provider or someone who is directly responsible for how money is spent...It is a bugbear for me, particularly when I have not been at a meeting, when messages have gone to staff that really I could have done with knowing first – it is not the best vehicle, sometimes aimed in the wrong direction.*

The county network meetings were supposedly an opportunity for feedback to be shared and from a variety of representatives from ERSs. Janet (district lead) perceived this differently, however, and questioned the purpose of the meetings. She perceived how these gatherings did little to facilitate the operations of her own ERS. She also opposed the sharing of information that, she considered, was not suitable or relevant for all who attended, fearing she was wasting their time. She felt that this

could be attributed to a lack of clear terms of reference for the meetings, which had never been fully considered.

The network meetings were attended by a variety of individuals from ERSs; Public Health, the CSP, but also district level which included; district managers, ERS coordinators and some EPs. At the start of each meeting each district would provide an overview for the previous three months. One could be a district manager who reflected on the number of patients who had started or completed, the next could have been an EP who talked about a recent activity they held at the gym. The meetings proved a strange eclectic mix of professionals from all levels of service provision. Wouters (2014) suggested that in characterising relationships between groups and individuals, there could be a balance between formalisation and informalisation. Wouters (2014) highlighted that there is a dominant trend to more informalised behaviour. Indeed, based on the mix of professionals who attended the network meetings, the gradient between formal and informal relations appeared skewed towards informality (Wouters, 2014). Furthermore, clear boundaries between job roles and competencies were blurred, so although meetings were held in a professional manner, the lines of accountability (and therefore power balances) remained opaque due to the lack of established bonds of association between all present. Subsequently, meetings failed to produce a countywide 'we' group in ERSs that could supersede district affiliation. Furthermore, the lack of cohesiveness only further highlighted the disjuncture between strategic management and the processes that occurred at the operational level.



### 6.2.3.7 Disengaged

If, as suggested, the network meetings were not providing a forum for the effective sharing of feedback and best practice, then this implied a possible lack of knowledge for what took place at the ground level. Even some of Janet's (district manager) comments, as she suggested '*they [Public Health] don't understand the ins and outs*', implied there was an arms-length approach to management and that those who had commissioned ERSs were disengaged from what took place at a ground level. This did not necessarily have to be perceived as a negative, indeed, if an overarching policy was in place and objectives were being met, there would be no need for strategic management to be involved at this level (see Grix, 2010). Yet, it has already been stated, clear goals appeared largely absent and the mechanisms for feedback were limited, therefore this had the potential to become a greater problem.

Janet's comment also appeared to again challenge the boundaries between established and outsider groups, commensurate with Elias and Scotson's (1994) formulation. Janet perceived herself to be culturally similar to the EPs, rather than Public Health and the CSP, therefore from these organisations' perspective she could also have been considered an outsider. For Janet to have challenged the 'established' in such a way would be considered untypical of an outsider position (Lake, 2013). This may, in part, be attributed to Janet (district management) being 'established' within other professional figurations or that, in the interview conducted for this study, she had been given an opportunity to reflect and voice these thoughts.

Fragmented leadership in the management of ERS was captured through a number of themes. The suggestion was first implied when individuals perceived differing understandings of the purpose of ERSs. Whilst this could have been an unintended consequence of a problem that had plagued the evolution of the county's ERS it also appeared to be a reflection of no one person taking a strategic lead of the scheme. Changes in the approach to management of the ERS had also highlighted some issues and emphasised the constrained nature of some relationships within the ERS figuration. Subsequently, inconsistent provision of schemes had become apparent and yet, such practices went unchallenged by those in a management role. Although this may have characterised fragmented leadership, it could also be interpreted as 'blame gossip' in an attempt to shame some, whilst maintaining an established position for others. For some, who considered themselves to be in a position of authority (the CSP), this left them open to further criticism where a lack of clarity in regards to roles and responsibilities was apparent. Moreover, others (Public Health) were perceived (by district management) to be disengaged and unaware of what took place at an operational level. Overall fragmented leadership presented established-outsider relations for a group of interdependent individuals. The ERS figuration, was a figuration in flux and what transpired was a series of unintended outcomes that questioned the sustainability of the ERS service, which will now be considered.

#### **6.2.4 Questionable Sustainability**

One further, consistent theme which emerged in interviews was uncertainty surrounding the future sustainability of ERS provision within the county. Exploration

of these ideas highlighted a plethora of reasons that had contributed to this uncertainty, ranging from issues regarding the physical delivery of the service through to changes in preventative health agendas. In some ways these ideas were difficult to detach from the local political backdrop within which discussions over ERS provision were set. At the time of interview there was uncertainty about whether further funding was going to be made available for ERSs over the long-term. It was therefore perhaps unsurprising that participants focused upon the sustainability of ERSs. This uncertainty seemed to originate from a lack of clarity about when and how decisions about the future of the service would be made. Mennell (1992) suggested that people were not always aware of the full extent of interdependency chains within the figurations that they are part of, so when individual actions are taken they may not fully foresee the resultant consequences. Some of these consequences are discussed here which collectively provided some insight as to why the future of the county's ERS remained in question.

#### **6.2.4.1 Constrained Delivery**

The theme of constrained delivery went broader than what has already been discussed in the previous sections. Indeed, constraining relationships appeared to resonate from an increasingly coercive exercise of power by Public Health. Janet (district manager), had felt that her district's working practices had been constrained and this had been dictated by what Public Health had allowed her to use her funding for, she explained:

*...so now it's 'these are the conditions you'll accept, anything outside of that isn't within the funding or the remit', so there are certain things that we used to do that we are not allowed to do really, things like cardiac rehab for*

*example phase IV intervention, it isn't something that Public Health want to fund.*

Public Health's conditions of funding was contrary to Janet's (district manager) experience of the service. She saw significant potential in the ERS and extensions of this service to increase engagement, but this was only if funds remained available. The allocation of funds seemed pivotal to constraining Janet's work and appeared to be Public Health exercising their coercive power. Outwardly ERSs appeared governed by network, yet in reality there was a centralisation of power (see Grix, 2010). The CSP had also identified feelings of constraint, via resources, in the services they managed, Sam explained:

*...we just don't have the funds or the reach or actually the capacity to deal with those people even if they were all referred.*

Sam (CSP) also reflected on possible ways she would have liked to have seen ERS provision develop in the future. She recognised, however, factors that constrained delivery which, according to Sam, were dictated by resource limitations attributed to commissioners' perceptions of differing priorities. Consequently, Sam felt marginalised. She suggested that both the quality and reach of ERSs was limited, which in turn weakened the service provided.

#### **6.2.4.2 Limited Scale of Provision**

One explanation for a weakened service, could have been the limited scale of the ERS, which was identified as an issue by Public Health, Paul (Public Health) suggested that due to the scale of the county's ERS there was a lack of demonstrable 'impact', as he reflected:

*The goal was to try and reduce some disease levels and even our [the county's] obesity levels but the scale isn't big enough for that.*

In terms of an ideological perspective, Paul (Public Health) appeared to define the ERS's impact at a population level, according to the prevalence of 'disease' and 'obesity' on a countywide basis. Interestingly, no one else had suggested this as a goal of the ERS nor had Paul, when he had initially been asked about the aims of ERSs. Despite previous accounts (patients and EPs) provided in the first phase of study regarding behaviour change, little emphasis was placed upon the individual benefits that could be gained from participating in the scheme. Both those in Public Health and the CSP agreed that any successes had only been 'small scale'. Yet how this was quantified and by what measures were never disclosed, despite the CSP being responsible for collating and holding all districts' data centrally.

The level of scale was, in part, blamed on the local rural context and the dispersed population across the county. In the main, however, the ERS was considered 'insufficient' to have delivered changes to population health. At a strategic level (excluding the district manager) the impact of ERSs appeared to have crossed a threshold of acceptability that was defined by budgets rather than evidence. Such ideas were reinforced during the researcher's attendance at a meeting on 14<sup>th</sup> January 2016. A Public Health representative presented data regarding the Quality Adjusted Life Years (QALY) for engaging in an ERS (4.2 years) in comparison to smoking cessation (7 years). The comment that followed was that 'the numbers simply did not add up', they believed smoking cessation was the better investment and the group was informed that on this basis it would be difficult to see how ERSs

would be commissioned for another year. This was the first time such metrics had been discussed and there was a definite sense of unrest and frustration within the group following this announcement. It appeared to the researcher that this 'evidence' could be used to rationalise a decision that was due to be made the following month, or even possibly a decision that had already been made, based on the way the 'numbers' were presented.

#### **6.2.4.3 Questionable Quality and Lack of Endorsement**

The consequences of limited resources and apparent small scale impact became clear, and blame for the scheme's failure quickly followed; however, there were different perceptions as to what was to blame. Christine (CSP) emphasised how the overall 'failure' of ERS provision was due to poor local service quality, and she explained:

*I can't see that the county council are going to support it [ERSs] for the future whereas if it had been absolutely fantastic they would have no reason not to support it.*

Christine (CSP) felt that it was failures at a local level that would ultimately affect the county council's decision on whether to recommission the service. Christine (CSP) failed to acknowledge however that her own organisation was a key part of delivering an effective service and made no comment as to what the CSP's role was within these suggested failures. Sam (CSP) believed that the blame resided with those in national strategic positions, as she reflected:

*If NICE [National Institute of Health and Clinical Excellence] ever decided to have a decent opinion about it, it would be quite worthwhile but they've been ambivalent and maintain their ambivalence and I can't quite figure out why.*

In Sam's (CSP) opinion, the blame for the failure of the scheme resided at a national level and not with those operating at a local level. Perhaps there was some truth in Sam's comments. Previous guidance published by NICE (2006; 2014) regarding ERSs had claimed there was a lack of evidence in demonstrating scheme effectiveness and although dated, this could have still indirectly influenced decisions at a commissioning level. Similar ideas were presented by Lake (2013) in his exploration of social exclusion in British tennis. In understanding these chains of interdependence and the inherent power relations, the instability and unpredictability of the micro-level outcomes indeed stemmed from macro level developments (Lake, 2013). Regardless of blame, the lack of endorsement was apparent at both a local and national level, and was further evidence why the future of the scheme had remained in question, although it could be argued the fate of the scheme was already apparent.

#### **6.2.4.4 Uncertainty**

The uncertainty that faced the future of ERSs at the time of the interviews was apparent through many of the responses provided. Although Public Health, via the network meetings, had communicated about the possibility of decommissioning ERSs, some participants had already drawn their own conclusions and become disenchanted by the prospect of the potential future of ERSs. Christine (CSP) appeared to have resigned herself to the fate of the scheme:

*...I don't think the numbers are big enough to... not to warrant continuation of it.*

Christine's (CSP) comment may have seemed practical based on financial considerations, but these 'numbers' were never defined or contextualised. It was presumed that Christine had been referring to the number of participants accessing the ERS, however, whether this could be considered an appropriate measure of health impact could be questioned. Any such benefits at an individual level were overlooked. It could be suggested that the uncertainty that shrouded ERSs was an unintended outcome of the decisions made by those at a strategic management level, in this case Public Health. That is not to say autocratic governance would have been more preferable, but it could be argued, that had a clearer remit of the ERSs service existed with defined objectives, the situation may have been different. Yet the situation was not and Janet (district manager), who had worked in ERSs for a considerable number of years, believed the future of ERSs was clear and that the service would come to an end and consequently she would lose her job. She concluded:

*For the county I think it is bleak because it [ERSs] is one of those things that has become a luxury, as have many lifestyle programmes, a luxury most local authorities cannot afford in the main.*

Janet (district manager) believed there would be only one outcome for ERSs and recognised that schemes had become rationalised as an unaffordable 'luxury'. This could be considered a strange statement to make, to refer to a service that helped improve the public's health as a 'luxury'. The financial connotations of Janet's comment were also noted, perhaps reflective of the internalisation of a wider political agenda of austerity. It would be difficult to suggest whether Janet's conclusion had resulted from the myriad of actions of many from the ERS figuration,



yet the question remained, how did the county's ERS get to this point? Mennell (1992) suggested that outcomes are neither planned nor foreseen and are instead, unintended, resulting from the intended actions of others. Indeed, Mennell (1992) argued that these actions are often based on the inadequate knowledge of the figuration of which these individuals are a part. This could be attributed to the complexities of the interdependencies of the figuration, as Allen et al. (2004) suggested, as complexity increases the likelihood of having access to all the relevant information is compromised. This further demonstrated that interdependence, and indeed power, are structural characteristics of all relationships. Of those interviewed each had presented her/his own ideas as to what may have contributed to the uncertainty regarding the sustainability of ERS provision. Ideas such as the unclear value of schemes, the questionable quality, and the lack of cost effectiveness of the service were all raised. What perhaps has then been considered in more detail here was the constrained delivery of ERSs and how this had led to a limited scale of provision with a perceived lack of impact. Many of these issues could, in the most part, be attributed to the actions of others, and this appeared to be the case according to the participants. Yet, it could be argued that this was more about the norms of a possibly wider health figuration, which was set against a political agenda of austerity, acting upon the local setting. These wider agendas could have been internalised by those at a strategic level, creating a threshold of unacceptability in relation to service provision. Exploration of the interdependencies of those individuals at a strategic level and the power balances between participants, had gone some way to illustrate the complex and contested nature of ERSs and how this had shaped scheme provision in some very unintended ways.

### 6.2.5 Concluding Thoughts

The purpose of this chapter was to examine the themes that emerged from interviews with those individuals who were responsible for the management and overall organisation of the county's ERS provision. The primary research aim for this second phase was to explore the perceptions of ERSs from the perspective of those who operated at a strategic management level, and more importantly, to try and understand the power balances at play within the figuration of ERS. The first phase suggested that data were both conflicting and inconsistent, and participants' differing opinions appeared to shape the county's ERS provision. The purpose of the current phase was to examine these ideas further and explore if and how the power balances had influenced the scheme's provision.

To understand power and the influence of power balances, process sociology was employed as a framework that allowed data to be contextualised and theorised. This included some of Elias's earlier work, such as conceptualisation of the figuration, '*The Established and Outsiders*' (Elias and Scotson, 1994) but also more recent interpretations (e.g. Wouters, 2014; Lake, 2013). From the data, conclusions could be made that the way in which the county's ERS was delivered was the unintended outcome of a series of intended actions, carried out by those enmeshed in the ERS figuration. The dynamism of power was exemplified through the perceptions and actions of those participants at a strategic level. This power was directed toward each other but also toward those individuals lower in the hierarchical structure of the scheme (e.g. EPs). Indeed, some exhibited their control, whilst for others this was experienced as divisive and some participants were left feeling disempowered.

These imbalances seemed to serve as explanation for the apparent fragmented leadership, where the data suggested that ERSs had failed to be effectively steered at a management level. This had been evidenced through a change in the approach to management, which appeared to influence the delivery of an inconsistent service, where those responsible for ERS delivery were perceived to have interpreted a model of delivery that they saw fit. Even amongst those at a strategic level, professional roles were contested and some believed that those in a management position were disengaged, unaware of what was taking place at a delivery level. What emerged from this complex figuration were the unintended outcomes captured through expressions of constrained delivery, a lack of impact and endorsement, and ultimately a growing uncertainty regarding the future of ERSs. Data from interviews were supported by the observations made by the researcher who had seen much of this played out through the county network meetings.

The county's ERS provision appeared to be managed through a hierarchical structure; a structure that may have existed in principle but one that was acted out through the interdependency of the individuals concerned. These interdependencies were of a tensile state plagued by an unequal balance of power. Those who were relatively more powerful belonged to the 'established', the positively labelled 'we' group, in contrast to the weaker 'outsiders'. By exploring these power relationships, it was possible to observe how the intended actions of some interacted with the provision of ERSs and led to unintended outcomes. Combining the findings of this second phase with those from the first phase, it is possible to propose answers to the main research objectives for this study.

## **CHAPTER 7**

### **GENERAL DISCUSSION**

The previous chapter explored the perspectives of those individuals central to exercise referral schemes (ERSs), examining how they defined ERSs, how they perceived their role within, and their ability to influence the delivery of schemes. The focus on each of the phases discussed in Chapter 6 was to explore the perceptions of different individuals and groups at different levels within the ERS hierarchy. It is therefore pertinent to bring these two separate phases together to demonstrate how the research aim and objectives of this study have been addressed overall. The three key objectives of the research will firstly be outlined and how the use of process sociology has been used as a theoretical lens to address these. Detailing each objective in turn, findings will be collectively explored from both phase one and two, with salient examples to provide an overall understanding of the ERS figuration. This is in addition to identifying the groups and individuals within the figuration and their perceived ability to influence this. These findings will then be summarised in order to present a theoretical analysis of ERSs and how this addresses the gap in the current body of ERS literature.

#### **7.1 Overview**

The purpose of this study was to explore one county's ERS and provide an understanding of the structural context within which ERSs operate. As noted in the literature review, previous ERS literature identified that the effectiveness of ERSs remained unclear (Pavey et al., 2011; National Institute for Health and Clinical

Excellence [NICE], 2006; 2014). It was also noted, however, this literature has been mostly dominated by outcome evaluations which rarely pay sufficient attention to the complexity of context (Pawson, 2013). For those studies that have considered individuals' experiences of ERSs, these have primarily focused on the patient perspective (e.g. Moore et al., 2013; Stathi et al., 2004; Hardcastle and Taylor, 2001), whilst the role of the HP (Graham et al., 2005) and the EP perspective (Moore et al., 2013) have remained largely overlooked, including the perspectives of those in a strategic management position. Even less attention has been paid, notably, to how the interpretations of ERSs by all of the above individuals are co-produced, according to their interactions, and how this has influenced service delivery and ultimately scheme impact. Therefore, the purpose of the current study was to try and address these lacunae and explore sociologically these complex group dynamics, to provide richer, deeper understandings of ERSs and to frame these understandings theoretically.

In order to produce such knowledge a process sociological theoretical framework was adopted. Baur and Ernst (2011) suggested that Elias argued for real, dynamic research that was based on figurations and sought to move past the 'false dichotomy' of synchronic and diachronic explanations. Indeed, the use of process sociology was deemed appropriate in this context to understand how the perceptions and actions of all individuals within the ERS network could influence the scheme's delivery processes. Elias argued that sociological theory should be employed in such a way that it guides empirical research and researchers should declare the level of theoretical abstraction used. This study worked at the Middle-range level of

theoretical abstraction, which concentrates on a specific thematic field that was contextualised by a particular historical period and a given geographical region (see Baur and Ernst, 2011), in this instance: ERSs, within a chosen county during the 21<sup>st</sup> century. This level of abstraction focused on key individuals central to ERSs and allowed their interdependencies to be explored. It also enabled detailed examination of participants' perceptions of their own position within the figuration and their ability to influence it.

Within process sociology Baur and Ernst (2011) described that process-oriented methodology consists of three possible steps: reconstructing the micro-level, reconstructing the macro level and reconstructing the sociogenesis of the figuration. This thesis primarily focused on the micro level; the individuals' placement within the figuration, their perception of it and their ability to change it (Baur and Ernst, 2011). Mindful of these steps and the existing ERS literature, the following three objectives were developed in relation to the case-study ERS; to:

1. Characterise the figuration of the ERS by exploring the figuration's power hierarchy.
2. Explore the 'we' and 'they' groups within the figuration and these groups' perceived ability to change the figuration.
3. Explore the 'I' and 'they' balance within the ERS figuration.

The use of process of sociology was pertinent to answer these objectives, as the theoretical framework enabled the configuration of relationships between those key individuals associated with ERS to be explored and thus illustrate the way in which

power operated within the ERS figuration. Baur and Ernst (2011) suggested that understanding an individual's position within a figuration, together with their perceptions of their ability to influence their social position, enables analysis of how individual actions could have an impact on the rest of the figuration. Therefore, use of process sociology provided a useful framework to explore the figuration of one county's ERS and to examine how this particular scheme had evolved as a result of the individual actions of those central to this service. The remainder of this chapter draws upon the salient findings detailed in Chapter 6 and discusses this evidence specifically in response to the objectives of this study.

Before the relationship between these individuals and groups are discussed in further detail, it is important to be reminded of how the county's current ERS came to fruition in order to establish the configuration of service-delivery pathways that were in place prior to the one that is explored in this study. This was explained in greater detail in Chapter 4, although a brief summary is provided here as an aide memoire. The hierarchical structure of the ERS presented here (see Figure 7.1) was not created in, nor was it limited to, the present context. Instead it was created over time by the successive actions of individuals, an unintended consequence of the interaction of the intended actions of many. Indeed, ERSs had existed in the county since the year 2000 when a number of districts had originally created their own independent scheme, on receipt of limited local investment. These districts were able to deliver their ERS in a way that they deemed appropriate, with limited accountability to a higher level of authority.

Changes came into place in 2006 when the local National Health Service (NHS) had commissioned ERSs in a number of districts. The NHS (which later became local authority Public Health due to the abolition of primary care trusts) alongside support from the county sports partnership (CSP), wished to streamline the ERS provision that was offered in the different districts, in a bid to create a more consistent countywide service. Knowledge of the historical development of the county’s ERS was important, as this highlighted that prior to establishing the hierarchy that is presented here, many of the individuals working within schemes across the county had long-established bonds of association, with existing working relationships and existing, established and interdependent power relations. These bonds of association were shaped by these individuals’ own worldviews, perceptions of what ERS was and the most appropriate mechanisms through which ERSs should be delivered. Therefore, the county’s ERS was a figuration already in flux.

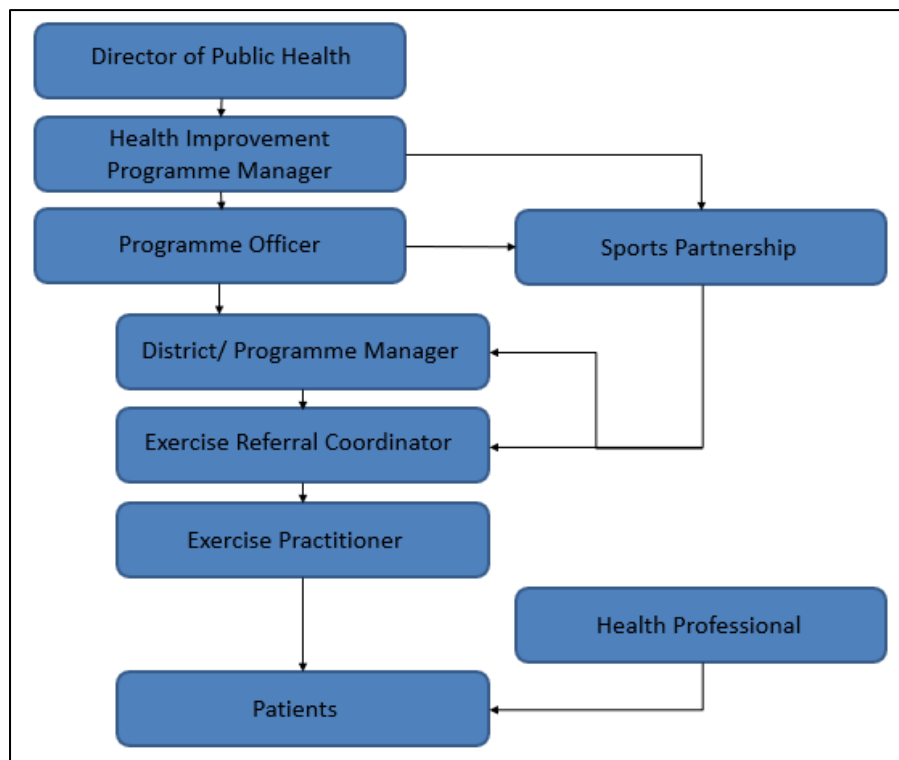


Figure 7.1 Hierarchical structure of county exercise referral scheme provision



In exploring the county's ERS it was necessary to determine the service delivery pathways in place to identify those individuals involved with service provision. Figure 7.1 illustrates a simplified linear hierarchical structure, which incorporated those individuals directly associated with ERSs, and was the information known prior to entering the field (as discussed in further detail in Chapter 4). This structure presents the managerial position of Public Health, which, as an organisation commissioned the service, right through to the patients who were in receipt of the service. The hierarchy presented here, however, did not depict the participants' perceptions of the structure of the professional interdependency chains, or bonds of association within the ERS figuration. Indeed, the power relations between individuals and groups conveyed something quite different and vis-a-vis the aim and objectives of this study, the figuration of ERSs is delineated in summary form below.

## **7.2 Exercise Referral Schemes: A Figuration in Flux**

The first objective of this study was to characterise the figuration of ERSs, exploring the 'I', 'we' and 'they' relationships. Elias (1978) believed all individuals are interdependent and use of a figural approach situates such 'I' identities within networks of 'we' and 'they' relationships (Evans et al., 2016). Examining the bonds of association between individuals in the case-study ERS enabled the impact that individual actions had upon the rest of the figuration to be analysed (see also Baur and Ernst, 2011). Whilst the ERS figuration was comprised of individuals, these people described identifiable 'we-groups' according to their role within the figuration. For example, separate 'we-groups' existed built around professional exercise practitioner (EP) or health professional (HP) identities. Similarly, Dolan

(2009) suggested that groups within a figuration were typically organised according to their interests or identities and the figuration of ERS was no exception. Indeed, those with shared identities highlighted 'I', 'we' and 'they' groups throughout the data. These groups became characterised by their often conflicting ideas of what ERSs actually were, in addition to competing agendas and differing priorities. Public Health's priorities, for example, were concerned with patient attendance numbers and targeting the county's population obesity levels. In contrast, EPs were more focused on the health benefits of physical activity at an individual level. Perceptions of ERSs may have been contrasting but they were also vague, with specifics such as target groups, goals or forms of activity largely absent. This lack of clarity regarding the purpose of ERSs was perhaps unsurprising, in that national policy and best practice guidelines that attempt to draw from the evidence-base have been considered to be somewhat vague by some authors (Oliver et al., 2016).

The tensile state of competing 'we' and 'they' groups within ERS provision was also evident in interview participants' perceptions about how 'they' groups understood ERSs. For example, EPs were highly critical of HPs, and considered them generally to be oblivious to the processes of ERSs and the benefits that the service offered. Whilst others such as Janet (district manager), believed that Public Health failed to fully appreciate or see the 'impact' of ERSs on patients' lives and could not be 'touched' by these experiences in the same way as the EPs were. Indeed, participants appeared to define their own role in relation to their perception of others within the figuration and such examples highlighted a professional divide. Hence, such evidence indicated that the linear chains of accountability presented in Figure 7.1 did not match the

interdependency chains and resultant power relations that played out within service provision, contrary to what the researcher had initially expected.

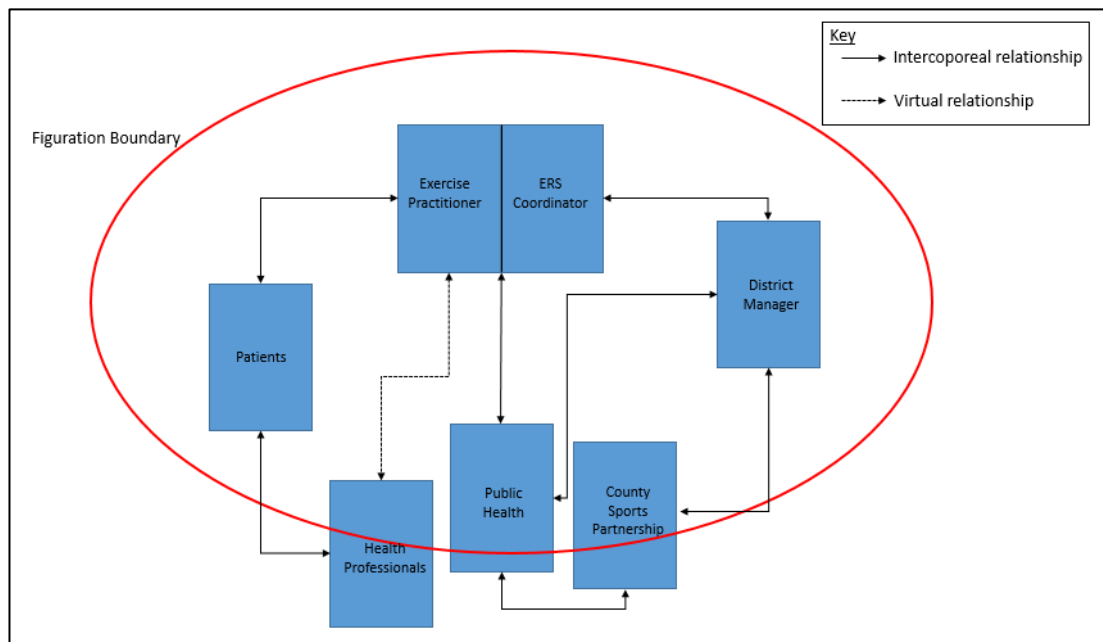


Figure 7.2 Exercise referral scheme figural framework

Figure 7.2 sought to illustrate the figuration based on the data collected in this study and highlighted the bonds of association between these groups, whether virtual or intercorporeal. Groups were positioned in relation to their centrality of the figuration. It is noted, that whilst the groups identified here are represented as solid blocks, these were not static and instead comprised of groups of individuals in dynamic relationships.

Within the figuration, the bonds of association within professional we-groups appeared to be stronger, whilst bonds between professional we-groups were mostly weaker on the whole, although there were some exceptions. EPs positioned themselves centrally within the ERS figuration, as they were considered key arbiters in defining the norms, goals and delivery structures of ERS provision. Indeed, this

group presented itself as an established 'we' group with the ability to define the norms of ERSs, using its agency to influence service provision at the level of delivery (discussed later in this chapter). ERS coordinators were also part of this group, as although they had responsibility to coordinate the ERS for their district or leisure centre, their primary professional role was that of an EP. The district manager (Janet) could be considered an extension of this 'we' group, because her role was to manage the district's ERS alongside other health initiatives. This meant making local level decisions and managing budgets. Despite this, Janet's career history had seen her progress from an EP to her current role and she still contributed to the delivery of ERS when possible; she therefore perceived herself to be culturally similar to EPs. The strength and density of this group's bonds of association could perhaps be attributed to their duration of existence (see Elias and Scotson, 1994), as this district was one of the first to deliver ERS in the region. Therefore, professional bonds were already well established and enabled the group to build cohesion and facilitate the operation of its established 'we' group's position of power (see Lake, 2013).

In contrast to the above, groups such as Public Health and the CSP could be considered relative outsiders, despite possessing relatively authoritative positions at the strategic management level for ERS provision within the county. Moreover, these groups, whilst not always in agreement with the EPs, still appeared to reproduce the established norms relating to service delivery set by the EPs, contributing to the development of an ERS habitus, in figurational terms. This implied relatively cooperative bonds of association between the two groups, but this was also blended with competition (see Wouters, 2014), particularly in relation to accountability.

Indeed, the CSP members whilst perceiving themselves to be equal to Public Health, were actually viewed as recent interlopers, whose role was questioned by other 'we' groups within the existing delivery pathways of ERSs, including Public Health.

HPs were also outsiders on the fringe of the ERS figuration. HPs had little involvement in the provision of ERSs other than to refer patients to the service and demonstrated relatively weaker bonds of association within the group, due to their more isolated working practices. The HP 'they' group was often characterised by others (mainly EPs) for its lack of understanding regarding ERS delivery, often to the point of identifying perceived ineptitude and group-level failings. In contrast, patients formed their own 'we' group and demonstrated stronger cooperative bonds of association. The duration of these bonds was perhaps not as extensive as that of some other groups, but there was a shared culture between these individuals in their experience of ERSs, and the marginalisation of their 'frail' bodies. Indeed, Elias's (1978) description of the balance between human control over nature (extra-human) was exemplified in the patients' control over ill health and disease. The patients' relationship with EPs was also worth noting, with a balance of power skewed towards the EPs, due to the high level of dependency patients had developed with this group.

In conceptualising the relationships within and between 'I', 'we' and 'they' groups, Wouters (2014) suggested seven balances that could be used for determining these tensions and conflict, where multiple tensions could be present at the same time. A number of these were pertinent to the data. All relations are suggested to be relations of power embedded within webs of interdependence (Wouters, 2014) and

the balance of power was evident within and between 'we-they' groups. For example, EPs perceived their ability to control the decisions made within the ERS figuration, whilst others, such as the CSP, felt relatively less able to influence practice within the figuration, and were therefore constrained by this. This was typified by the EPs subversion of the ERS processes of delivery, in ways that suited their own needs (e.g. accepting multiple referrals for the same patients). Largely, these actions went unchallenged by those in strategic management positions. For example, the CSP was aware of what went on but appeared to do nothing about it or was unable to. Contrary to the actions of EPs, Paul (Public Health) perceived the role of Public Health to be one that exerted control; for example, he suggested that he decided the 'what' in the way ERSs were delivered, yet such ideas seemingly failed to translate in practice. These are just two examples, but balances of power were evidenced between all of those within the figuration and influenced by the strength of the bonds of association within and between groups.

Another balance between group relations was that of formalisation and informalisation. Indeed, in the approach to management of ERSs, the gradient between formal and informal relations appeared more skewed toward informal bonds of association. Paul (Public Health), for example, had employed a more flexible, self-regulated style of management, the kind that Wouters (2014) considered more characteristic of informalised processes. Paul had even admitted that there was freedom to interpret service provision at a local level. Adopting a more decentralised management approach was not necessarily a criticism, indeed, governance by network should play to the strengths of those professionals in the

field (Grix, 2010). Yet, this would be dependent on the clarity of policy, in addition to clearly identified aims and objectives. There is the suggestion that ambiguous policy or guidance that lacks specificity can give rise to a myriad of interpretations in practice (Matland, 1995). Exploration of the data highlighted that this had been the case and the chosen style of management had impacted on service provision. Hence, EPs often delivered their own version of ERSs, whether considered acceptable or not by those in authority, and Public Health, alongside the CSP, were frustrated at the inconsistency of service delivery that occurred across the county. Within professional networks, as in wider figurations, Evans et al. (2016) demonstrated how the intentional actions of individuals created unintended consequences for all within the figuration, as they were connected through interdependency chains. Having adopted a particular style of management, the repercussions of such a choice were evidenced in tensions between groups but also in resultant service provision pathways. It is also worth questioning whether the approach to management was truly decentralised, as power appeared more centralised by Public Health, through the use of financial budgets; indeed, this was where they appeared to 'pull the strings' (see Grix, 2010).

To summarise, the figuration of ERSs for this particular county was one characterised by 'I', 'we' and 'they' groups, with stronger bonds of association within groups compared to weaker bonds between groups. The relations within and between these groups were in a tensile state marked by balances of power, but also other balances such as competition and cooperation, as well as formalisation and informalisation. These balances influenced individual and group perceptions of ERSs, which subsequently led to individuals interpreting ERS delivery processes as they saw fit. As

the unplanned social order of the ERS figuration played out, the actions of some became the unintentional outcomes for all who were enmeshed within the figuration. It is therefore important to consider the roles of these groups and their perceived ability to change the figuration.

### **7.3 'We have no power', 'We-They' Balances and Their Ability to Influence**

The second objective of this thesis was to characterise groups' perceptions of the figuration and their ability to change or influence the figuration itself. In the exploration of professional networks, Evans et al. (2016) described the relationships between individuals and groups as both fluid and dynamic, which were considered to be both constraining and enabling. Indeed, these balances were exemplified in the data by 'we' and 'they' groups, as groups described how they perceived their own role and their ability to change service provision. As previously stated, the 'we' group of EPs appeared to have few constraints on their role as part of their day-to-day practice, as they were able to freely make decisions regarding service provision. Despite this, it can be suggested that all groups were constrained in some way. For example, funding was perhaps one of the key ways in which EPs felt constrained and this led to issues such as limited staff and a restriction on the number of referrals that could be received. It was Public Health that had the authority to control the aforementioned issues, it decided who received funding, which was vital for the continuation of the scheme, and how that funding was spent. Ultimately, Public Health had the authority to decommission the ERS service, which had far greater implications.



The EPs believed they provided a service for vulnerable patients that offered significant health benefits and this was reflected in the chain of interdependency between these two groups. It could be argued that there was a balance of power between the EPs and patients, which skewed more towards the EPs. This resulted in the patients' apparently greater dependency on EPs. In contrast, EPs 'othered' HPs, as they perceived many HPs to be uninterested in the scheme and believed 'they' did not understand the processes of ERSs or the general benefits that exercise offered.

The complexity of 'we-they' groups further played out between the EPs, Public Health and the CSP. Public Health representative Paul suggested that what happened in ERSs was his decision. Indeed, staff from both Public Health and the CSP collectively made criticisms of 'they', the EPs, regarding their inconsistency of service delivery and inability to modify practice. Despite the position of authority held by Public Health, inconsistencies in service provision were not challenged by the organisation. Yet, consideration of the balance of formalisation and informalisation processes, as previously discussed, provided some explanation for why the EPs' behaviour was not questioned by Public Health.

Interestingly, from some of the shared opinions given by Public Health and the CSP, it could have been suggested that these two organisations were a collective 'we' group, yet this was not the case. Both members of staff from the CSP considered their position to be relatively constrained, with little ability to influence or change ERS service provision. Moreover, they also believed the CSP's role was to bring the districts together for meetings and to collect data, which was perceived to be a role

with no power. It could be argued, however, that such duties had powerful effects, but in a less obviously coercive manner. As an organisation that centrally held the data collected by each scheme in the district, it was the CSP that analysed these data quarterly and reported back to Public Health. It could be said, therefore, that it was the CSP which had the ability to define the 'impact' of the county's ERS. Regardless of the CSP's perception of its own power, the role of the CSP was questioned by both Sue (Public Health) and Janet (district manager), who were unclear as to what function the CSP provided.

From the data discussed, dynamic relationships both constrained (e.g. Public Health constrained the district manager and the CSP) and enabled (e.g. Public Health enabled EPs) the actions of agents within the ERS figuration, which gave rise to the creation of established and outsider groups. EPs presented themselves as the established group, setting the norms for the ERS figuration, changing and adapting ERS processes to suit their own needs. Indeed, these norms had become accepted as common practice by other EPs, and to some extent even those in strategic decision-making positions, such as Public Health. That is not to say, however, that some did not resist what had become the norm. For example, EPs had not provided feedback to HPs regarding their patients' experience of the scheme, as they believed HPs were uninterested and yet, HPs challenged this perception and suggested they would find feedback very useful and were disappointed not to have received further information. Such comments challenged EPs' perception of HPs as an outsider group. Indeed, such contestations of the EPs' actions implied that the HPs were perhaps not an outsider group at all, but instead, partial insiders to the figuration of ERSs.

Mennell (1992) suggested that an individual's knowledge of to whom they were connected within the figuration was far from perfect, often incomplete or even inaccurate, which meant that individuals' actions were based on inadequate knowledge. Indeed, as complexities within the figuration increase, access to relevant information is believed to be compromised (Allen et al., 2004). The EPs manipulation of service provision appeared to reflect this and was apparent to both Public Health and the CSP, who acknowledged that EPs were able to define how they delivered the scheme. Yet, the EPs remained largely unchallenged regarding their inconsistent practices and were allowed to continue. EPs as the established group, were further reinforced in the way they maintained a positive 'we-image' and created a negative 'they-image' for other groups in the figuration through negative labelling. For example, EPs recalled mistakes made by the HPs in relation to referral paperwork, and reinforced these 'minority examples' as though typical of all HPs. Only physiotherapists were excluded from this blame gossip and in figural terms were 'upgraded' (see Wouters, 2014). Indeed, the professionals' shared background of exercise appeared to encourage the EPs' increased identification with the physiotherapists (see Powell et al., 2014).

Another characteristic of established groups was stronger 'we' group bonds of association in comparison to outsiders, which was attributed to a shared identity and the bonds having developed over a longer period of time (see Elias and Scotson, 1994). As previously highlighted, the district EPs, including the ERS coordinators and district manager, had been some of the original staff to develop ERSs in the county, prior to Public Health commissioning ERS more widely. Public Health and the CSP had

only become more directly involved with ERSs years later. Therefore, the bonds of association between the EPs, ERS coordinators and the district manager, were more established and had become both denser and thicker.

There was evidence of 'we-they' group relationships amongst ERS stakeholders and patients alike. These could be viewed in the way groups perceived the figuration and their ability to change or influence it. Tensile power relations had given rise to the creation of established and outsider groups, where EPs (inclusive of ERS coordinators and the district manager to an extent) were viewed as the established, and considered themselves to be key arbiters in setting the norms for the figuration. This was in contrast to 'outsiders' such as HPs, who remained the 'minority of the worst'. Committing short-term actions, as demonstrated by the EPs, led to the long term unintended outcomes for the rest of figuration, which created a service that no one had perhaps planned or intended. Whilst these dynamics had been observed between the balance of 'we' and 'they' groups, the tensile state of 'I' and 'they' relationships was also apparent, and this corresponds with the final objective of this study.

#### **7.4 'They don't understand', The 'I – They' Balance**

The final objective of this thesis was to explore the 'I – they' balance, which examined individuals' positions in relation to other groups and within their own groups. Figurations are constituted of 'I' identities, but by understanding these in relation to 'they' groups, this further allowed the intricacies of the ERS figuration to be explored. Of the examples within the data, this was particularly evident with the district

manager, Janet, and how she perceived her own role in relation to others. Janet provided an emotive account of how she believed Public Health could never understand ERSs in the way that she could, as she felt they had not been 'touched' by the impact a scheme could have on a person's life. Janet felt constrained and marginalised by Public Health, in her ability to deliver the ERS according to her own ideas. Her funding was received solely from Public Health and she had been informed as to what this funding could be used for. Public Health funding had not extended to other services such as cardiac rehabilitation, which Janet had previously been able to deliver. Janet had been told what services she could and could not deliver and in this way felt constrained. This was an interesting notion as, as has already been stated, it was actually the EPs who largely considered themselves to be in a position to set professional norms regarding service delivery and ultimately the ERS figuration, rather than those in Public Health. Furthermore, Janet (district manager) saw herself as an extension of the EP group due to her previous roles and therefore perceived herself to be culturally similar in her outlook on ERSs. She had been an EP herself, delivered the scheme that she was now in charge of and had seen firsthand the difference the scheme had made to patients. So, Janet felt highly constrained in not being able to manage the scheme in the way she wished to.

Sam (CSP) was another example of someone who felt constrained by Public Health and had described similar emotions to Janet. She had her own ideas about how ERSs should be delivered but suggested that it was not part of her role. Sam made no suggestion that she had tried to share her ideas with Public Health at any point. Her comments focused more on her not having the ability to enforce any such ideas that

she might have had. Evidently, she perceived her own position to be relatively less powerful than that of Public Health and felt constrained by her contractual obligations.

The 'I-They' balance was also evident between one HP and the EPs. Hilary (HP) was critical of the EPs due to the lack of feedback they provided regarding patient experiences of the ERS. Hilary had suggested that despite completing paperwork to request feedback she was yet to receive any. This was in contrast to EPs' generic perception that all HPs were not interested in feedback. Lake (2013) suggested that the established group's power is determined by the extent of their ability to withhold something from another group, that is either needed or desired. It is possible that by withholding feedback from the HPs, the EPs had been able to maintain a more powerful position. Yet, for Hilary to challenge the established group in this way suggested that she was perhaps not an outsider but instead on the fringe of the figuration in her role as a HP.

The 'I-they' balance was apparent within groups as well as between groups. A key example of this was Fran (EP), she was critical of other EPs in their approach to the service provision of ERSs. Fran believed that EPs needed to be consistent in their style of delivery. This implied a threshold of acceptability for the way ERSs were delivered, to which, from Fran's perspective, not all EPs appeared to conform. The suggestion of inconsistency within service provision had been reinforced by both Public Health and the CSP. Yet, it was interesting to note how even within groups an 'I-they'

balance was apparent. Amongst the strongest bonds of association within the figuration, perceptions of ERSs were still contested.

## **7.5 Summary**

As discussed throughout this chapter, the ERS figuration constituted of 'I' identities that were connected by chains of interdependencies and enmeshed within 'we' and 'they' groups. Having explored the configuration of these relationships and the way in which power operated within the ERS figuration, it was possible to observe how these interdependencies led to the development of an unplanned social order that was neither planned nor intended. Elias (1978) presented these ideas through the use of game models, suggesting that the figuration takes on its own game sense or the 'order *sui generis*', which is beyond the control of any individual or group but shaped by the actions of all, intertwining to produce unintended outcomes. Indeed, it was the intended actions of all within the ERS figuration that had led to unintended outcomes, which had shaped the current ERS service provision. The interviews therefore provided an opportunity for individuals to reflect on how they perceived ERS provision. A number of the participants, such as EPs (inclusive of ERS coordinators), the district manager, HPs and patients, whilst offering some criticisms of the delivery of ERSs, were generally positive regarding participation in the scheme and identified a range of health benefits for those who attended. Public Health and the CSP however did not agree. They believed ERSs had failed to create 'impact' and the numbers did 'not add up'. Yet, the context of impact was never fully defined, nor were 'the numbers' articulated. What was clear, however, was the decision to decommission the county's ERS in early 2016. Speculation on the reasons that

resided behind the decision to decommission the county service was beyond the scope of this study, but it could be proposed that the decision was an unintentional outcome, which had followed a myriad of decisions that had been made throughout the delivery process.

The approach to management of the county's ERS by Public Health was also worth noting. On the surface, the county's scheme appeared to be governed through networks, yet defined goals and outcomes appeared largely absent, which meant that at times this management structure had appeared ineffective. In contrast, there were also examples of attempts to centralise governance by Public Health, particularly in relation to the funding of the scheme. Hence, this apparently contradictory and fragmented leadership of the ERS added to the already complex power dynamics within and potentially between districts. Powell et al. (2014) noted from their own research into the delivery of local health improvement initiatives, that even within a relatively small geographical area, complex interdependencies are likely to limit the ability of any one group to coordinate service delivery. It is possible that this was the case for this county's ERS.

What had transpired was an ERS that was enacted within the accepted health narratives of the wider health figuration, including a political agenda of austerity, which had potentially been internalised by Public Health and consequently acted upon the local setting. Indeed, Public Health appeared to make decisions according to more general health targets, defined at a national level, so that Public Health could then claim that there was a lack of 'impact' on a larger scale. This, however, is a



problem that plagues many exercise programmes, which are beset by errors (Kelly and Barker, 2016) and can fall guilty of 'lifestyle drift'. This is described as the tendency for policies to initially recognise a need for action 'upstream' to tackle the social determinants of health inequalities only to drift 'downstream' instead and focus on individual lifestyle factors (Popay et al., 2010).

Other participants (CSP, district manager) perceived failure somewhat differently and blamed a lack of leadership or each other for the scheme's failings. Yet, failure seemed complex to define, in that there appeared no critical success factors outlined by anyone within the figuration. On this basis, it could be argued, for the above reasons given, the apparent 'failure' of ERS was foreseeable and it was of little surprise that the county's ERS was decommissioned. Although districts were offered the opportunity to continue to deliver ERSs, this was only if they had the financial model that permitted them to do so, which meant schemes would only run at a cost to patients. Whilst some larger schemes were able to do this, other ERSs ceased.

In the current climate of austerity where Public Health funding remains limited (Baggott and Jones, 2014), the need to demonstrate the effectiveness of health interventions, such as ERSs, has become ever more prominent, particularly where many services are faced with potential decommissioning. Despite the widespread use of ERSs, the existing evidence base still questions the effectiveness of this particular physical activity intervention (e.g. Pavey et al., 2011; NICE, 2006). Indeed, NICE (2014) suggested that the evidence regarding these schemes to change physical activity behaviour, and for whom these schemes were effective for, lacked clarity.

Yet, in consideration of the existing literature, studies that have focused on outcome evaluation have tended to overlook the complexity of context (Pawson, 2013) therefore a broader range of evidence regarding the effectiveness of ERSs is still warranted, particularly in relation to determining the best approach to the delivery and development of schemes (Oliver et al., 2016).

Again, to be clear, the purpose of this study was not to demonstrate the effectiveness of ERSs, although the importance of this is acknowledged. Yet, before effectiveness can be explained, there is a need to understand the complex structural contexts within which schemes are delivered, a key area that has been largely overlooked within the existing ERS research. Indeed, 'effectiveness' studies that focus purely on physiological, psychological or even the socio-cultural impact of ERSs on patients, risk failing to understand how the perceptions, norms and beliefs of all those within schemes can fundamentally alter their nature from case-to-case, context to context.

Whilst the use of process sociology has already proved a useful theory within the context of sport, application to physical activity and health interventions is less well explored. Evans et al. (2016), for example, highlighted the benefits of such an approach when a single model was insufficient to encapsulate the complexity of the networks of sports governance. Whilst ERSs may not be sports-related, they do present similar complexities. Indeed, process sociology as a theoretical framework has enabled the researcher to demonstrate that one county's ERS was a figuration in flux. The qualitative findings of this study revealed the complexities, contested nature and unintended elements of ERSs, which highlighted that even within one

district, interpretations of a scheme could widely differ. Schemes were contoured by the interpretations of, and relationships between the patients and staff who operated at a district and strategic level. It is suggested that figurations are constituted by the people within them; thus from a figurational perspective, this ERS contained hierarchies, established and outsider groups, all of which were comprised of tensile, contested and changing bonds of association, in interdependency chains where the actions of all intertwined to create unintended impacts and outcomes (Elias and Schröter, 1991). Indeed the 'game' that played out demonstrated how the figuration of ERSs was not controlled by any one individual but actually shaped by all, which could be considered the very essence of programme emergence (Pawson, 2013).

Whilst the future of this county's ERS had already been decided, schemes in other counties could be faced with similar uncertainties. Yet, Beck et al. (2016) have argued that the current evidence base presents an unfair assessment of ERS' potential. Therefore, it was both timely and needed, that the figuration of ERSs was explored to examine the operational pragmatics of a 'real-world' intervention. The researcher has attempted to address this and provided an understanding of the complex structural context ERSs operate within and how this has influenced the delivery of ERSs. By understanding the power relationships within the ERS figuration it became possible to see how the intended actions of all interacted within the ERS service delivery, which created interesting but unintended consequences.

It is now possible to conclude this study.

## CHAPTER 8

### CONCLUSION

The issue central to this research was to understand exercise referral schemes (ERSs) from the perspective of those most closely associated with the service. As discussed in Chapter 2, development and delivery of ERSs has become widespread as an intervention to tackle poor health and physical inactivity since their conception in the early 1990s. Despite such growth and UK Government endorsement, however, research that has evaluated ERSs questioned the effectiveness of schemes and their impact on physical activity outcomes. Research designs employed to establish these findings have been criticised, suggesting there is a failure to understand ERSs as a 'real world' intervention (Dugdill et al., 2005). With a broader range of evidence warranted to support the development and delivery of ERSs (Oliver et al., 2016), it was important to develop further understanding of how the perceptions of the network of individuals within ERS contoured its working practices and impact.

Due to a limited understanding of the context of ERSs and the lack of clear guidelines for how ERSs should be delivered, the initial aim of this study was exploratory by design. Following initial data collection, it became evident that there were a number of issues related to the working practices of individuals within the scheme and their relationships with each other. Indeed, data collection itself and early reading of transcripts from phase one of the study demonstrated conflicting and inconsistent perceptions of the ERS, which had shaped referral provision. Therefore, before any

attempt to evaluate an ERS could be made, the nature, and socio-cultural context of what an ERS is intended to be, must first be understood. In order to make sense of the data, use of a suitable theoretical framework was required and the use of process sociology was adopted. Using process sociology as a theoretical framework enabled the researcher to explore the configuration of the relationships between individuals central to the ERS, the complex group dynamics and the way in which power operated within the scheme. Use of this framework then informed the development of the following three research objectives in relation to the case-study ERS context:

1. Characterise the figuration of the ERS by exploring the figuration's power hierarchy.
2. Explore the 'we' and 'they' groups within the figuration and these groups' perceived ability to change the figuration.
3. Explore the 'I' and 'they' balance within the ERS figuration.

These objectives were explored to address the overarching research aim of the study and highlighted a figuration in flux. Chapter 7 drew together these key findings and highlighted the interdependencies of those individuals within the ERS figuration. Use of a figuration approach situated individual 'I' identities within networks of 'we' and 'they' relationships. Identifiable groups were formed according to individuals' perceived role within the figuration, which was mostly according to professional identities. Data highlighted how participant perceptions of these interdependency chains did not always reflect the generic hierarchical organisation of the ERS. These interdependencies were in a tensile state marked by power balances that had

impacted on service provision but also the associated meaning of ERSs. The exercise practitioner (EP) group appeared relatively more powerful in comparison to other groups within the figuration. EPs were able to change and adapt key referral processes, founded on their 'insider' knowledge, setting the norms for the ERS habitus. Indeed, EPs (inclusive of ERS coordinators) presented as the established 'we' group, which was, in part, rooted in their 'oldness of association' (see Elias and Scotson, 1994). EPs maintained a positive 'we' image through perceptions of their own behaviour and employed negative labeling of other groups, with selected negative examples treated as typical of all groups. It was difficult to claim whether other groups were truly outsiders as some, for example the health professionals (HPs), failed to conform to those characteristics typical of outsiders; such as an acceptance of their outsider position and a lack of means to question it (Lake, 2013). It was more likely that such groups remained on the fringe of the ERS figuration.

Shifting, contested power-balances and relationships were not the only features that characterised the relationships within the figuration. Consideration of Wouters' (2014) description of the seven concepts (as explained in 3.1) highlighted balances of competition and cooperation, as well as a balance between informalisation and formalisation between groups, particularly for those with professional interdependency chains. Characterisation of these balances further highlighted how 'I', 'we' and 'they' groups perceived the ERS figuration and their own position in relation to others. These relationships were both constraining and enabling, and further reinforced participants' perceptions of their ability to change or influence the figuration itself. For some, this led to individuals interpreting service provision as they

saw fit (e.g. EPs), whilst others perceived themselves to be at the mercy of others' decision making (e.g. the CSP and district manager at the mercy of Public Health). Indeed, from a figurational perspective, the ERS was constituted by the people themselves where hierarchies, established and outsider groups were all present and comprised of tensile, contested and changing bonds of association. These bonds existed within interdependency chains where the actions of all intertwined to create unintended outcomes and impacts for the scheme (Elias and Schröter, 1991). Indeed the 'game dynamic' that played out demonstrated that this particular ERS figuration was not controlled by any one individual but actually shaped by all. Examples included: EPs altering ERS delivery processes, Public Health employing a decentralised approach to management of the ERS and patients internalising ideas of corporeal frailty to become repeat users of the scheme.

On reflection of these findings it became possible to consider how the data contributed to the existing body of ERS literature. Dugdill and colleagues previously recognised a lack of 'real world' understanding of ERSs back in 2005 and many of these criticisms were rooted in the way evaluation had been approached. Beck et al. (2016) suggested that previous approaches to evaluation were an unfair assessment of the potential of ERSs. Yet, as noted above, the aim of this research was not to conduct an evaluation of an ERS or to consider the effectiveness of ERSs more generally, but to focus on understanding ERSs. Indeed, the focus was to provide new understandings of the complex domain of ERSs, based on qualitative research into one county's ERS. Presenting an understanding of ERSs, by exploring sociologically

complex group dynamics, provided a very novel perspective in relation to what is already known about ERSs.

Oliver et al. (2016) suggested that there was a level of complexity regarding ERSs and their delivery but literature had made few strides in trying to capture this. Indeed, in previous ERS literature where outcome evaluation and randomised control trial designs have been employed (e.g. Murphy et al., 2012; Pavey et al., 2011), Pawson (2013) is critical of these approaches, as not only do such designs rarely pay due attention to provider interpretation but also overlook the complexity of context. This study aimed to capture (as far as possible) these very complexities of ERSs. Indeed, the findings demonstrated that there were multi-directional interdependency chains of relationships which were both embodied and virtual, shaped by multiple tensile balances. It was these balances that then changed according to resources (both human and physical), all of which created considerable complexity as to how the scheme was then delivered.

Oliver et al. (2016) also argued that by their very nature, ERSs were sensitive to complex behavioural and social influences, which made it difficult to determine what worked, for whom and in what circumstances. These issues were in some way pertinent to the NICE (2014) recommendations for future research regarding ERSs. Although demonstrating effectiveness remained central to NICE recommendations, this could still be considered challenging if the 'what' lacked understanding and remained ill defined. Having gone some way to unpack the complexity of ERSs, exploring the interdependencies of the individuals associated with the scheme



enabled the impact that individual actions had on the rest of the figuration to be analysed and enabled understanding of how this had shaped service provision. This was an important step towards exploring the 'what' by providing a contextual understanding of ERSs in this way. Furthermore, with many UK schemes operating in a similar context, the findings presented here potentially offer a broader understanding of ERSs as a whole.

Through exploring the interdependencies of individuals within the ERs figuration, the research highlighted how some individual perceptions could influence individual actions, which had unintended consequences for all. Gidlow et al. (2008) previously identified that scheme development and delivery were dependent upon the agents who designed and delivered ERSs and argued that further investigation of these individuals and their contribution to ERS processes was warranted. Furthermore Thurston and Green (2004) identified the importance of the network of social relations generated by ERSs, which required further consideration. Although other scholars have since considered the role of the EP (e.g. Moore et al., 2011) and the type of information about patient experience that could be considered useful for commissioners (e.g. Morgan et al., 2016), the interdependencies between these groups in terms of service delivery has largely remained unidentified and unexplored. This study has not just brought these individuals together in understanding their perceptions of ERSs but also examined how individuals were interdependent and how the short-term actions of one had implications for all. It emerged that the delivery of the ERS was not a static process but instead it was the people involved who produced, enacted and interpreted the scheme, and who subsequently shaped

the delivery processes. Therefore, it was the interpretation of these individuals' perceptions and their relationships with each other that generated understanding of this complex intervention (see Pawson, 2013). Findings from this study have demonstrated that it could be highly problematic and shortsighted to overlook the bonds between these individuals and groups and how through their interdependencies there is the potential for individuals to alter, resist or even reinvent service provision, which has consequences for all.

Based on the evidence detailed above, whilst the key aim of this study was to understand one county's ERS from the perspective of those central to the service, this study has added to existing knowledge by:

- increasing understanding of the complex network within which ERSs operate;
- adding to existing literature on the perceptions and experiences of a range of individuals central to ERSs;
- increasing understanding of how individual perceptions can shape service provision for a widespread physical activity intervention;
- adding to theory by using process sociology to understand a complex social intervention, in an exercise and health context.

These findings may be of benefit to a wider ERS audience; despite ERSs being decommissioned in the particular county under study, there are important lessons to be learned for those schemes in the county that have chosen to continue and potentially for ERSs and other exercise and health based interventions across the UK.

This research purposely does not take the form of recommendations or suggestions as to how ERSs could be improved or developed. Indeed, Baur and Ernst (2011) suggested that Elias's primary theories were associated with the production of knowledge and this was not to be politicised, therefore it could be considered the responsibility of others to interpret this knowledge and act on it in a way that they feel appropriate. There has, however, been arguments to address such suggestions (see, for example, Dunne, 2009 or Mansfield, 2008) and it is important to acknowledge the relevance of this study's findings; how it may be of benefit to policy makers, commissioners working in Public Health or those delivering ERSs, to better understand the complexities of the service, which is now considered.

The implications of this research can be noted at a number of levels from policy through to practice. ERS policy has been described as vague (Oliver et al., 2016), providing little in the way of guidelines to support the development of ERS. Highlighted in the current research, such vagueness and ambiguity of policy appeared to trickle through to those acting at a strategic management level (e.g. Public Health and the CSP), where clearly defined aims and objectives were largely absent. The growth of ERSs from a grass roots level (Crone et al., 2004) to popular intervention, could be considered challenging to capture with a 'one size fits all' policy, however, the National Quality Assurance Framework (NQAF) documentation, published in 2001, now lacks currency and a review is long overdue. In writing any such policy where ERSs are the focal point or where reference is made to ERSs, consideration must be given to the translation of policy through to practice. Indeed, where policy is vague, there lacks a clear reference point for commissioners and

practitioners to work from, leaving practice open to multiple interpretations, and not always for the better. Therefore, policy must be clear on those issues where it can be, in an effort to avoid those at a strategic management level forming what may be ill-conceived interpretations, to the potential detriment of practice. This may sound simpler in theory than in practice and admittedly, it could be argued that a degree of flexibility would be needed in some instances. Where policy can be clearly defined, however, it must be, effectively to guide the practice of all stakeholders.

Key findings have also highlighted implications for those individuals in a commissioning role. In this study, the power balances at play resulted from interdependencies between individuals, characterised by competing agendas and priorities, where aims and objectives of the scheme appeared to be unclear. Yet this was combined with what appeared, on the surface, to be a decentralised approach to management. This could have been interpreted as enabling a level of flexibility at local level, indeed this should lend itself to the skills of the professionals in the field (Grix, 2010); however, this had unforeseen consequences, and created a relatively more powerful position for those at the forefront of scheme delivery, the EPs. A decentralisation of management does not have to be viewed negatively, but there were further consequences of such an approach which were not always to the benefit of the scheme or those in receipt of the scheme. For this reason, commissioners need to be clear in identifying their role within these initiatives. If they are choosing to take an approach of governance by network (as in the case of this case study), then commissioners must be able to articulate the aims and objectives of the scheme, and these must be shared with those relevant

stakeholders, in this instance district managers and ERS coordinators. Being clear on judgement criteria for what determines 'impact' and success must also be identified and shared, allowing all stakeholders to be aware of the targets they must meet, particularly if these criteria will be used to ensure the continuation of funding. Whilst these types of conversations are useful in the development of new schemes, it is also possible to suggest that these conversations are revisited once a scheme is up and running. Maintaining good levels of communication could potentially avoid the development of 'we-they' groups, creating divisive power relations between those at the forefront of delivery, EPs, and those at a strategic management level.

Implications for those central to the delivery processes of ERSs, specifically EPs and HPs, can also be considered. Exploration of 'we-they' groups demonstrated how perceptions could impact on service delivery processes and not always to the benefit of patients. Communication, therefore, between these two groups is key. Indeed, by EPs and HPs engaging in an ongoing dialogue, this could potentially address any preconceived ideas these groups have about each other and their working practices. Regular contact between these two groups would also provide opportunity to address any problems that arise, for example inappropriate referrals, incorrectly completed paperwork and a lack of feedback. If both groups had a greater understanding of the potential consequences of their actions, this may influence them to react differently and take an alternative course of action, particularly when there could otherwise be negative implications for service users, the very group it is so important to engage with.

There are also wider implications for the knowledge generated in this study that transcend ERSs, and are applicable to NHS and Public Health based interventions. Complex interventions, which are multi-component health technologies that also often involve multiple stakeholders and service users, are becoming more common practice in targeting a range of health conditions. Indeed, in a climate where the government exhorts that future health costs be reduced, a stronger focus on the collaborative commissioning of services and interventions, like the use of Social Prescribing, is becoming common practice (Thomson et al., 2015). The findings of this study have gone some way to highlight how, in such integrated services, these complexities play out operationally and the consequences of these, which is in essence how a programme evolves (Pawson, 2013). This suggests that for organisations such as the NHS or Public Health that are involved in the delivery of such multi-disciplinary interventions, care must be taken in how these stakeholders are brought together. Emphasis must remain on the need for communication, a clear approach to management and clearly defined aims, as previously identified.

Exploration of power relations in this study has also demonstrated how service delivery chains can be altered alongside the meanings associated with a programme (see Evans et al., 2016). Partners are advised to have a greater awareness of those with whom they are working and how their working practices can complement each other, rather than working in competition, particularly when their aims are shared. A detailed understanding of ERSs, as has been presented here, may therefore prove useful for those individuals working within the development and delivery of other such complex interventions, which involve multiple agencies and power relations

between them. Through an appreciation of individual interdependencies and the relationships amongst groups, this knowledge can be utilised by others working as part of multidisciplinary teams more generally, in terms of how the design and development of such interventions are conducted.

Whilst the value of such findings has been considered it is important to acknowledge the boundaries and limitations of this research and to indicate future directions that fellow researchers might wish to follow. Use of a case study approach can hold limitations. Hodge and Sharp (2016) suggest this centres around the idiosyncratic nature of the information that is gathered, which then in turn can potentially limit the 'generalisability' of study findings. This case study examined only one county's ERS, which in turn could potentially limit the comparisons that could be made with other ERSs in the UK. Furthermore, it is recognised that although the county in question is large geographically, it is sparsely populated and rural in nature. This would be in stark contrast to other, more urban counties, for example, making it difficult to compare ERS services. Despite this, it could be argued that the ERS delivery processes examined in this study may still reflect the generic delivery processes employed by other schemes in the country, as well as the hierarchy of staff, therefore allowing comparisons to be made. Relatively similar generic models of ERS delivery in other counties within the UK can be assumed, due to guidelines presented within the NQAF (DoH, 2001). Despite this, the variation amongst modes of scheme delivery was acknowledged in this study alone and therefore further development of these findings to incorporate other counties would provide a more comprehensive understanding of the wider ERS figuration.

Further research in this area would enable the comparison of this study's findings with the delivery of ERSs in other counties, including those schemes with potentially differing hierarchical structures. In extending future research to the wider figuration of ERSs, exploring higher up the chains of interdependency could also offer a valuable perspective. Indeed, inclusion of individuals pivotal to key funding decisions, for example the county's director of Public Health, and policymaking at a national level such as the lead for Public Health England, would offer alternative perspectives from those on the very fringe of the ERSs figuration. Exploring the development of policy through to practice in this way could generate further insight into the evolution of the wider ERS figuration.

In understanding the challenges of utilising a case study approach, the limitation of narrowing the study further to explore only one district within the chosen county, must be also be acknowledged. Although individuals positioned higher in the chains of accountability were the same for all districts, for district manager level and below, only one district out of seven was sampled, which potentially limited the understanding of the county as a whole. Despite this, the district in question had extensive experience in the delivery of ERSs, possessing one of the longest histories for scheme delivery within the county, a depth of insight that may not have been provided by other districts. It would however be fair to suggest that examining other districts could have presented a more complete understanding of the county as a whole.



The conducting of interviews as the primary method of data collection in this study also posed some limitations. Smith and Sparkes (2016) suggested interviewing is far from simple and this can particularly relate to the type of interview conducted. Telephone interviews were employed with the HP group, as at the time, this was the most effective way to ensure the group's participation. Whilst the researcher made every effort to establish a rapport with each individual prior to the date of interview, it was still felt that the interview process could have been hindered by the telephone mode. The exchange was somewhat shortened and a number of the HPs sometimes failed to elaborate on their responses, even when prompted. Whilst the researcher believed this to be more concerned with the time pressures the participant group were under, rather than the telephone *per se* as a barrier, it was nevertheless considered to affect the depth of the data collected.

The above limitation could have possibly been tempered had the researcher been able to recruit a greater number of HPs. Indeed, this was a limitation of the recruitment for this study. Although five HPs were recruited from the chosen district, not only was this a small representative of the total HPs in the area but the five participants also represented four different roles. Therefore, there was only one representative for the role of general practitioner (GP), physiotherapist and weight loss adviser. From a role perspective, this limited the depth of the data that could be gained.

The recruitment of participants also posed further limitations in relation to the HP and patient groups. Recruitment of both groups relied on individuals agreeing to

participate that had been triggered through the EPs. It was possible that those who agreed to participate in the study were more likely to be advocates of ERSs, which could have influenced their opinions of the service. For example, all HPs recruited were known to frequently refer patients to the ERS, therefore it could be argued that there was bias in their opinions. Indeed, it is possible to question whether the HPs who rarely chose to refer to the scheme would have held similar opinions. This suggestion could be extended to the patient group. Of the patients interviewed, all had at least passed the six week point of their twelve-week programme, whilst others were on their second twelve week programme. Again, it is possible to suggest that this particular group of patients could have been biased regarding their experiences of ERSs, and 'drop outs' would have provided a very different perspective. Despite the potential bias of these particular participant groups, the overall challenge of recruitment must be recognised. For example, in the case of the HPs, it proved difficult to recruit any, let alone those who were possibly less interested in ERS, so to have recruited five was to be considered a relatively positive outcome.

Finally, the limitations of the theory employed for this study cannot be overlooked. Whilst the use of process sociology provided a useful theoretical lens in the analysis of data, the theory did have limits in its use. Whilst process sociology considers the interdependencies between individuals and the resulting norms that evolve, it is less sophisticated at focusing on the micro-level interactions, for example. Exploring the social interactions of those central to ERSs would have provided another distinct and nuanced layer to the understanding of ERSs.

A further, important limitation is the low predictive value, of process sociology, which limits the recommendations that are based upon politicised knowledge. It has already been stated, earlier in this chapter, that process sociology is concerned with the production of knowledge which is not to be politicised and that the researcher is not to make claims beyond the data. Therefore, it would be inappropriate for the researcher to provide recommendations for others as to how ERSs should be delivered or indeed evaluated. Yet, providing such recommendations is often required in order to validate research evidence. By not providing clear recommendations, this might therefore be viewed as a limitation. Furthermore, in defence of the theoretical approach taken, it could be argued that it is not the place of a researcher in this kind of study to make such recommendations, particularly given the scope of the data presented here. Alternatively, as previously stated, the knowledge generated from this study can be made available so that others are able to apply these findings to their own situation and, where appropriate, their own contextual decision making.

Finally, limitations of the application of the theoretical framework, specifically *The Established and the Outsiders* must also be acknowledged. The researcher experienced some difficulty in applying some of the theoretical concepts to data. An example of this was Elias and Scotson's (1994) description of an outsider, indeed some participants did not conform to the given characteristics which challenged the application of theory. Such a limitation is one that has been previously recognised by Bloyce and Murphy (2007) and demonstrates how the theory has advanced since its conception.

In making recommendations for further research, in addition to those already highlighted, the wider use of employing process sociology as a theoretical framework cannot be overlooked. There is potential for this theory to be employed in consideration of other complex interventions, which rely on the involvement of multiple stakeholders. Evans et al. (2016) highlighted the benefits of such an approach to encapsulate the complexity of the networks of sports governance, whilst Powell and colleagues (2014) employed Elias's interpretation of power to explore partnerships delivering local health improvement initiatives. Indeed, similarities have been drawn with the complexities of ERSs. Therefore, other interventions within the physical activity and health setting could benefit from exploration via a process sociological lens.

Finally, whilst the wider figuration of ERSs remains of interest, questions exist regarding the future of this particular county's ERS and to what the unintended consequences of decommissioning may lead to. The researcher was aware of the privileged position she was in (as declared in 5.3); she had been involved with ERSs before the present structure had formed and had seen the transition the county's ERS had experienced. The researcher had observed the emergence of small pockets of practice across the county, which had later become one ERS service commissioned by Public Health. Following decommissioning, schemes were presented with an opportunity to return to their original state, but only those with a viable financial model were able to continue to deliver an ERS, but now at a cost to service users. Therefore the opportunity to explore this turbulent period in the county's ERSs would

offer an interesting insight into the evolution and/or transformation of the figuration of this county's ERSs.

In concluding this thesis, it can be suggested that this ERS was a figuration in flux. Dugdill et al. (2005) once expressed concerns that ERSs had become the 'panacea' for physical activity promotion based on their widespread use, yet this argument may have been tempered with the uncertainty regarding the effectiveness of schemes that has persisted. In an attempt to address the need for a broader range of evidence regarding ERSs, this research was timely and much needed. Through exploration into the working practices of one scheme, this study identified that the networks of relationships which individuals were situated within not only contoured participant experiences but shaped the actual delivery processes of ERSs. As the figuration of this county's ERS evolved, there were unintended consequences, which may have contributed to this particular service being decommissioned. Whilst, during the course of this study, the future of this county's ERS had already been decided, yet schemes in other counties may be faced with similar uncertainties, in a climate of austerity where Public Health funding remains limited. If perceptions of a 'wild and woolly' service are shared by ERS commissioners, this may do little to support the use of ERSs. Yet, whilst such interventions continue to be available for those with existing health conditions, any knowledge that can contribute to the understanding of ERSs has an important role to play.

The contribution to knowledge that this thesis makes is an original, theoretical insight into the complex networks within which ERSs operate, employing a process

sociological lens. This thesis has sought to enhance understanding, of not only the complexity of how ERSs are constructed but also the complexity of context in which schemes operate. By exploring ERSs through a process sociological lens, an understanding of the networks of relationships and the balances of power within ERSs has demonstrated that this can impact on service delivery, producing interesting, yet unexpected and unintended consequences.

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# APPENDICES

## **APPENDIX A**

### **Example of personal reflection transcript**

These are reflections from an Exercise Referral County Network Meeting that I attended on 10 March in 2016. These self-elicited reflections were documented to make explicit my own positionality within the research and to support the data analysis process.

It was an interesting meeting. I remember thinking it would be an interesting meeting before I even got there because it was going to be the first meeting since the decommissioning of the referral service had been announced. I probably attended with some, um, possibly not anxiety, but with some curiosity, I guess, about what it might be like; how people were going to be with each other and what course the meeting was going to take, based on the decision to decommission.

I think when I got there the first thing that really struck me was 'attendance'. It was a really well attended meeting so there were a lot of people there, but it was mainly district managers, erm, and it was the first time in a long time that I had seen so many district managers there. Normally it was a mix of exercise referral scheme coordinators from a district and quite often a lot of exercise practitioners, but what struck me on that particular day was the number of district managers that were there, although there were always coordinators but mainly one or two practitioners, as well, but very few in comparison with previous meetings, but that in itself was quite interesting.

I remember the main discussion point of the meeting and what the meeting focused on, was it was dominated by the arrangements for decommissioning, so how that was going to be managed, when services were officially going to stop, or when the funding for those services would stop and how that information was going to be communicated to other people, to perhaps the referral patients on the service, but also GPs, health professionals that referred to the service as well. This I guess, for want of a better phrase, seemed to unleash a 'can of worms' because part of the

main conversation was when that end point was going to be, officially happen for all the districts, and how people like the health professionals were going to be informed, how they would be told the service was being decommissioned.

X from Public Health had, well I think he had, quite a clear idea of when he wanted that date to be. He made several references to, I think, 1 May, so coming towards end April - start of May, but at the same time he wasn't going to commit - wasn't going to commit to an official date as he wanted their people, their coordinators and district managers, to come together, I guess, in making a decision to say 'this is officially when this service ends'. What came out of this was the fact some districts had already informed their health professionals so they had already told them the service was going to end, and no longer funded by Public Health and whether they planned to continue or not, so whether they would offer their own version, if you like, of the exercise referral service. It was clear some had informed health professionals some time ago because they had pre-empted what was coming. I can't remember exactly but maybe a month before they had informed health professionals, whereas some districts had not communicated at all and not said anything to the health professionals. I think the ones that had told their health professionals and informed them there seemed to be a sense of, if we don't want the service to end and keep going we need to tell them now because if they hear it in couple of weeks from health professionals it may stop completely, so in order to safeguard that particular district then they were trying to do something about it, I guess, trying to put measures in place to make sure there were no problems.

One memory that stayed with me was that X from Public Health was not happy at all. He was visibly annoyed that some districts had chosen to 'jump the gun', to pre-empt, what is the word, to warn, if you like the health professionals of what was happening and I felt awkward and embarrassed - it really was quite an uncomfortable feeling to be sat in that meeting with these discussions going on because you had some districts trying to argue to safeguard the future of their scheme to make sure it could continue when funding had been taken from them, another district who was losing their jobs because their funding had come from Public Health in the first place,

without that they had no job - it was really just an uncomfortable situation. As I said X was not happy. It was something he appeared, a situation almost he felt he should be in control of, and that control had been taken away from him. It is probably the only way I can describe that, and as a result of this the meeting almost broke down, because it then led to a whole discussion about when was the official end date. So when should the district stop accepting referrals and move to, if that is what they were doing, a new financial model of where they would charge their patients for coming. And to, er, thinking back, I don't know how it spiralled; Public Health would not make a decision, the two representatives there wouldn't decide on an exact date for when the new model for districts would roll out, but then every district was coming out with a different date of what would work best for them. The conversation just broke down. It was back and forth - the Sports Partnership tried to step in, tried to say 'well let's try and agree a date that will work best for everyone, but didn't get anywhere, some were saying well we can't make that decision, I will have to phone my boss, I can't get hold of them, I think it might be okay it really was a bizarre situation of nobody making a clear decision either way and yet the room was notably frustrated; there were small mumblings of conversation breaking out amongst smaller subgroups in the room, and in the end they did manage to come to an agreement which was the 1 April would be the official kind of start date for those offering their own scheme and when they would start charging, but again X continued to outline his concerns about that date he felt it was a short timescale and he was annoyed. He was visibly irritated by what had transpired, which again made for a very uncomfortable situation, and I obviously wasn't directly involved with any one district, but I really as an outsider looking in - it was very strange.

And that really did take the best part of the meeting - there was very little discussion about other areas after that point. It was discussed about how much each district planned to charge for their new schemes if they were going to run one, which was again interesting varying from £15 through to up to £30 for 12 weeks of an exercise referral programme and the variety with costings and even number of weeks some districts suggested doing it over 16 weeks rather than 12 - it was like watching the scheme going full circle, having seen where the scheme had originally started in that



some charged and some didn't and inconsistent service provision which had moved to one that attempted to be consistent in that no one charged and now some years later it was back to districts doing their own thing without any real central coordination. So that - it was quite reflective I guess, in that sense I was privileged to see the scheme before Public Health had centrally funded it and the work the Sports Partnership had tried to do to develop a more consistent service and it almost felt a bit like back to square one in that everybody or every district was going to be doing it their own way.

I think the final thing to note from the meeting was of all times Public Health decided to announce the launch of their new initiative which was called 'One You' which was a Public Health England product aimed at 40-60 year olds to increase activity levels. There was going to be a whole new campaign for this and in some ways again I felt really awkward and uncomfortable because here was a meeting about how a service was ending how there was no longer funding available for this service, but at the same time districts were being asked whether they were interested in or contributing to being involved in this new 'One You' initiative that had been developed, and I remember being sat quite close to one district whose whole team had been made redundant due to the whole decommissioning process their funding had been pulled and therefore team being redundant and yet X was sat there talking about his new initiative, what it was trying to do and who might be interested in being involved and people sat in that room losing their jobs. It just felt really inappropriate that that should be being discussed in that forum. It felt wrong.

## APPENDIX B

### University of Lincoln Ethical Approval Form

Please note the form has been anonymised and this is the original electronic version pre-signatures.

# EA2

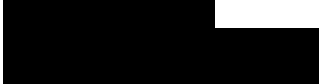
## Ethical Approval Form: Human Research

**Please word-process this form, handwritten applications will not be accepted**

This form must be completed for each piece of research activity whether conducted by academic staff, research staff, graduate students or undergraduates. The completed form must be approved by the designated authority within the Faculty.

**Please complete all sections.** If a section is not applicable, write N/A.

<b>1 Name of Applicant</b>	Hannah McGill	
	Department:	Faculty:
	Sport, Coaching & Exercise Science	Health, Life & Social Sciences
<b>2 Position in the University</b>	Senior Lecturer	
<b>3 Role in relation to this research</b>	Principal investigator	
<b>4 Brief statement of main Research Question</b>	To examine the delivery of physical activity referral schemes (PARS) and investigate their effectiveness as a mechanism for health promotion.	
<b>5 Brief Description of Project</b>	The study will employ a qualitative methodology based around interviews and focus groups to determine an initial understanding of the use and effectiveness of PARS, experienced by health professionals, exercise professionals and patients, within a case study example. This will inform the development of an intervention, within the referral process, to identify whether the identified scheme can be improved. Subsequent studies will look to evaluate whether this intervention has improved the effectiveness of scheme delivery, employing both quantitative and qualitative techniques. It is hoped	

	that a model of best practice can be developed which can be disseminated to other schemes and replicated successfully.
	Approximate Start Date:                      Approximate End Date: October 2007
<b>6 Name of Principal Investigator or Supervisor</b>	Hannah McGill
	Email address:                                      Telephone: hmcgill@lincoln.ac.uk                                      01522 837092
<b>7 Names of other researchers or student investigators involved</b>	1. 2. 3. 4.
<b>8 Location(s) at which project is to be carried out</b>	University of Lincoln 

<p><b>9 Statement of the ethical issues involved and how they are to be addressed –including a risk assessment of the project based on the vulnerability of participants, the extent to which it is likely to be harmful and whether there will be significant discomfort.</b></p> <p><b>(This will normally cover such issues as whether the risks/adverse effects associated with the project have been dealt with and whether the benefits of research outweigh the risks)</b></p>	<p>Data shall be collected from three participant groups; health professionals, exercise professionals and patients. All participants will be above the age of 18, although some elderly individuals may be involved, therefore classed as vulnerable. Informed consent will be provided and participants will be fully informed of the objectives of the study and how the data shall be used. They will be given the opportunity to withdraw at any point during the study.</p> <p>The information gathered from the participants may be recorded, which will be identified to those concerned prior to collection. All information will be treated as confidential and remain anonymous. Any recordings taken will be labelled with codes rather than names and be stored securely, until completion of the study, when they shall be destroyed.</p> <p>Any additional patient data used from the referral scheme, will be anonymous and accessed via a non-NHS source, the City Council.</p>
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The only anticipated demands on participants will be time.

#### Ethical Approval From Other Bodies

10 Does this research require the approval of an external body ?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	If "Yes", please state which body:- National Research Ethics Service (previous Central Office of Research Ethics Committees of NHS or COREC)	

11 Has ethical approval already been obtained from that body ?	Yes <input type="checkbox"/> -Please append documentary evidence to this form.
	No <input checked="" type="checkbox"/> If "No", please state why not:- Application ongoing
Please note that any such approvals must be obtained and documented before the project begins.	

#### APPLICANT SIGNATURE

I hereby request ethical approval for the research as described above.  
I certify that I have read the University's ETHICAL PRINCIPLES FOR CONDUCTING RESEARCH WITH HUMANS AND OTHER ANIMALS.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
PRINT NAME

#### FOR COMPLETION BY THE CHAIR OF THE FACULTY RESEARCH COMMITTEE

Please select ONE of A, B, C or D below:

A. The Faculty Research Committee gives ethical approval to this research.

B. The Faculty Research Committee gives conditional ethical approval to this research.

---

12 Please state the condition (inc. date by which condition must be satisfied if applicable)

---

C. The Faculty Research Committee can not give ethical approval to this research but refers the application to the University Research Ethics Committee for higher level consideration.

---

13 Please state the reason

---

D. The Faculty Research Committee can not give ethical approval to this research and recommends that the research should not proceed.

---

14 Please state the reason

---

Signature of Chair of Faculty Research Committee

\_\_\_\_\_

Chair of Faculty Research Committee

\_\_\_\_\_

Date

## APPENDIX C

### Confirmation of NHS Ethical Approval

  
**National Research Ethics Service**  
Trent Research Ethics Committee  
Research Ethics Office  
Derwent Shared Services  
Laurie House  
Cotyear Street  
Derby  
DE1 1LJ  
Telephone: 01332 888 905  
Amendment/ISSI queries 01332 888 842  
Facsimile: 01332 888 930

24 October 2008

Mrs Hannah McGill  
Senior Lecturer  
University of Lincoln  
Brayford Pool  
Lincoln  
LN6 7TS

Dear Mrs McGill

**Full title of study:** Physical Activity Referral Schemes; Understanding and Improving Referral Uptake.  
**REC reference number:** 08/H0405/38

Thank you for your letter of 01 September 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

**Confirmation of ethical opinion**

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

**Ethical review of research sites**

The Committee has designated this study as exempt from site-specific assessment (SSA). The favourable opinion for the study applies to all sites involved in the research. There is no requirement for other Local Research Ethics Committees to be informed or SSA to be carried out at each site.

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at <http://www.riforum.nhs.uk>.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.

### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Interview Topics for Health Professionals	V2	20 April 2008
Professor Sriwardena CV		08 April 2008
Interview Schedules/Topic Guides	V2	20 April 2008
Compensation Arrangements		06 October 2007
Peer Review		12 June 2008
Letter from Sponsor		11 June 2008
Summary/Synopsis	V2	31 March 2008
Covering Letter		06 June 2008
Protocol	V1	24 March 2008
Investigator CV		
Application	V 5.6	12 June 2008
Interview Topics for Exercise Professional	V2	20 April 2008
Response to Request for Further Information		01 September 2008
Participant Consent Form	3	28 August 2008
Participant Information Sheet: Health Professional PIS	2	28 August 2008
Participant Information Sheet: Exercise Professional PIS	2	28 August 2008
Participant Information Sheet: Patient PIS	2	28 August 2008
Letter of Invitation to Patients	2	28 August 2008
Letter of invitation to Exercise Professionals	2	28 August 2008
Letter of Invitation to Health Professionals	2	28 August 2008

### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

### After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

## APPENDIX D

### Phase One Questions

#### Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

#### TOPICS AND QUESTIONS FOR FOCUS GROUP/ INTERVIEWS

##### EXERCISE PROFESSIONALS:

##### Expectation and perceptions:

Q.1. what are your perceptions of physical activity referral?

Prompt:

- An effective mechanism for health promotion?
- An effective mechanism to increase physical activity?
- Benefits/ negatives of offering this type of service

##### Referral Process:

Q.2. how effective do you think the referral process is?

Prompt:

- Are you receiving the right type of patients?
- Do some health professionals refer more frequently than others?
- Is the paperwork suitable?

##### During the 10week programme:

Q.3. how do you feel about the way the 12-week programme is managed?

Prompt:

- Is 12 weeks long enough?
- Communication with health professional
- Communication with the patient

##### Completion of the programme:

Q.4. what are your thoughts on completion of the referral period?

Prompt:

- The right skills/ knowledge provided for patients to stay active?



- Positive effect on patients' physical activity status?
- Is the patient provided with sufficient options?

**Q.5. what are your overall opinions of PARS?**

Prompt:

- The positives/ overall benefits
- The negatives
- If anything, what could be been done better?

## Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

### TOPICS AND QUESTIONS FOR FOCUS GROUP

#### **PATIENTS:**

##### **Expectation and perceptions:**

Q.1. what was your understanding of physical activity referral schemes, when you were told you were being referred?

Q.2. what did you think about being referred?

Prompt:

- improve condition
- improve overall health
- change lifestyle
- time consuming

##### **Referral Process:**

Q.3. what were your feelings about the referral process?

Prompt:

- Communication by the health professional and/ or exercise professional e.g. why you have been referred
- Process clearly explained/ well organised
- Confidence in members of staff
- Unhappy and disinterested

##### **During the 10week programme:**

Q.4. how do you feel your 12-week referral went?

Prompt:

- did you feel supported throughout the process?
- did you have regular contact from the exercise professionals?
- did you enjoy/ not enjoy it?
- is there anything that could have helped?

##### **Completion of the programme (those who have):**

Q.5. how did you feel about coming to the end of your referral?

Prompt:

- were you informed of your options or given guidance on completion?

- did you feel you had gained the right skills/ knowledge to stay active but independently?
- has the programme encouraged you to stay active?
- Did you want to be referred again?

**Q.6. what are your overall opinions of PARS?**

Prompt:

- The positives/ overall benefits
- The negatives
- If anything, what could have been done better?

## Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

### TOPICS AND QUESTIONS FOR INTERVIEW

#### HEALTH PROFESSIONALS:

##### Expectation and perceptions:

Q.1. what is your understanding of physical activity referral schemes?

Q.2. what were your expectations of being involved in the referral process?

Prompt:

- Why did you become involved?
- Improve patients' condition, health and lifestyle
- Benefits/ negatives to the practice

##### Referral Process:

Q.3. what are your thoughts on the referral process?

Prompt:

- Is it simple to determine which patients are appropriate for referral?
- Do you find the referral process an additional 'burden'?
- Could, if anything, make the process easier?

##### During the 10week programme:

Q.4. what is your understanding of what takes place during the referral period?

Prompt:

- are you aware of who takes up the referral/ who completes/ patient feedback?
- do you/ would you find this information useful?

##### Completion of the programme:

Q.5. what are your thoughts on completion of the referral period?

Prompt:

- Is 12 weeks long enough?
- Does the programme encourage patients to stay active?
- Are they provided with the right skills/ knowledge to independently exercise?
- Do you receive patient feedback?
- Communication with the exercise professional

**Q.6. what are your overall opinions of PARS?**

Prompt:

- The positives/ overall benefits
- The negatives
- If anything, what could be been done better?

## APPENDIX E

### Phase Two Participant Questions

#### Understanding Exercise Referral Schemes

#### QUESTIONS FOR INTERVIEW

##### **Public Health/ County Sports Partnership/ District Manager:**

##### **Role:**

Q.1. What is your role in relation to ER?

Prompts:

- Who are they accountable to?
- Who is accountable to them?
- What does it contribute to ER?
- Has this changed, if so how?

##### **Role of others:**

Q.2. What do you feel is the role of Lincolnshire Sport/ Public Health?

Prompt:

- Who are they accountable to?
- Who is accountable to them?
- What does it contribute to ER?
- Has this changed, if so how?
- Positive/ less positive aspects of this?

Q.3. What are your relationships/interactions with others involved with exercise referral?

Prompts:

- Identify roles such as referral co-ordinators, exercise instructors, patients
- How effective are these relationships/ interactions?

##### **Referral Process:**

Q.5. What is your understanding of the referral process?

Q.6. What is your input on the referral process and what is delivered?

Q.7. What are the positive or negative aspects of the current delivery model?

Q.8. What feedback do you receive about ER delivery?

Prompt:

- From whom?
- Formal/ informal mechanisms
- Usefulness of information

**Temporal:**

Q.9. What do you think were the original intentions and goals of exercise referral?

Q.10. What do think has been achieved/not achieved?

Q.11. How do you think exercise referral has changed over the course of time?

Q.12. What do you think is the future of exercise referral for the county and nationally?

## APPENDIX F

### Phase One Participant Letters of Invitation

#### Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

Dear Exercise Professional,

As an exercise professional who has been working with patients, prescribing exercise, as part of the [REDACTED] Physical Activity Referral Programme, we would like to invite you take part in our research project.

Our aim is to review the existing referral programme and enhance those services currently offered to the benefit of all those involved.

We are extremely interested in hearing about your views on all aspects of the programme. If this is something you feel you might be interested in and would like to take part, please read the enclosed information sheet and follow the instructions given.

Thank you in anticipation of your reply.

Hannah Rigby  
Project Manager



Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

Dear Patient,

As a patient, who has been referred to the [REDACTED] Physical Activity Referral Programme, we would like to invite you take part in our research project.

Our aim is to review the existing referral programme and enhance those services currently offered to the benefit of all those involved.

We are extremely interested in hearing about your views on all aspects of the programme. If this is something you feel you might be interested in and would like to take part, please read the enclosed information sheet and follow the instructions given.

Thank you in anticipation of your reply.

Hannah Rigby  
Project Manager

Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

Dear Health Professional,

As a health professional who has been referring patients to the [REDACTED] Physical Activity Referral Programme, we would like to invite you take part in our research project.

Our aim is to review the existing referral programme and enhance those services currently offered to the benefit of all those involved.

We are extremely interested in hearing about your views on all aspects of the programme. If this is something you feel you might be interested in and would like to take part, please read the enclosed information sheet and follow the instructions given.

Thank you in anticipation of your reply.

Hannah Rigby  
Project Manager

## APPENDIX G

### Phase One Participant Information Sheet

#### RESEARCH PARTICIPANT INFORMATION SHEET: EXERCISE PROFESSIONAL

#### Physical Activity Referral Schemes; Understanding and Improving Referral Uptake

Thank you for your interest in this research project. Before deciding whether to take part it is important for you to understand the reason for the research and what it will involve. Please take the time to read this information carefully and feel free to discuss it with others. If there is anything that is not clear or you would like more information please contact us. Please consider carefully whether or not you wish to take part.

#### **What is the purpose of the project?**

The aim of this project is to examine your opinions about Physical Activity Referral Schemes and see if they can be developed to better suit your needs. It is also being completed in part fulfilment of an academic qualification, which is sponsored by the University of Lincoln.

#### **Why have I been chosen?**

You have been chosen as you currently deliver physical activity to the patients referred to the [REDACTED] Physical Activity Referral Programme. We are interested in your views on how the patients are referred and the services you provide.

#### **Do I have to take part?**

Participation in the research is entirely voluntary. If you do decide to take part but later change your mind you can withdraw from the study at any time, without having to give reason. If you decide not to take part your standard of care will not be affected.

#### **What will happen to me if I take part?**

On returning the signed consent form you will be invited to take part in a focus group or individual interview. The focus group will be a small group of 6 people, all of whom deliver physical activity to referred patients. The focus group will last for about 1 hour and will be led by a member of the research team. Alternatively, you may be

invited for a short interview with one of the research team, which will last about 30 minutes.

All focus groups or interviews will be recorded in order to ensure all points made are captured. Recordings will then be typed out, with participants only identified as unique numbers. Only those researchers leading the focus groups and interviews and the researcher transcribing the recordings will have access to the participants and their number. No information which could identify you will be used in the final research. All data will be stored securely, either in a locked cabinet or password protected computer and all recordings shall be destroyed on completion of the study.

### **What are the possible benefits of taking part?**

There are no immediate benefits for those participating in the research however it is hoped that the findings will help improve the delivery and services offered by the [REDACTED] Physical Activity Referral Programme, which will improve the service received by patients in the future.

### **What if something goes wrong?**

If you have any concerns or complaints regarding the way that you are treated by the researchers these can be addressed to: Hannah Rigby, Dept of Sport, Coaching and Exercise Science, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS.

### **What will happen to the results of the research project?**

The results from this research will be circulated within the [REDACTED] Health and Fitness Development team and the referring medical practices. Publication maybe sought in professional journals and the results will possibly be presented at conferences. The information collected during this research will be used for subsequent research.

### **Who has reviewed the project?**

This research has been reviewed by the University of Lincoln and the NHS Trent Research Ethics Committee.

### **Contact Information**

If you require any further information to help you to decide whether to take part, please contact Hannah Rigby at the University of Lincoln, Brayford Pool, Lincoln, LN6 7TS. Tel. 01522 837092.

### **What do I do now?**

If you are happy to take part or decide not to participate, please complete the relevant sections and return one copy of the enclosed consent form in the envelope provided within 14 days of receipt of this letter. A second copy of the consent form is enclosed for you to keep with this information sheet for reference.

**Thank you for taking an interest in this research project. We appreciate the time you have taken to read this information sheet.**

## RESEARCH PARTICIPANT INFORMATION SHEET: PATIENT

### **Physical Activity Referral Schemes; Understanding and Improving Referral Uptake**

Thank you for your interest in this research project. Before deciding whether to take part it is important for you to understand the reason for the research and what it will involve. Please take the time to read this information carefully and feel free to discuss it with others. If there is anything that is not clear or you would like more information please contact us. Please consider carefully whether or not you wish to take part.

#### **What is the purpose of the project?**

The aim of this project is to examine your opinions about Physical Activity Referral Schemes and see if they can be developed to better suit your needs. It is also being completed in part fulfilment of an academic qualification, which is sponsored by the University of Lincoln.

#### **Why have I been chosen?**

You have been chosen as you were referred to the [REDACTED] Physical Activity Referral Programme to take part in physical activity. We are interested in your views on the way you were referred and the service you received.

#### **Do I have to take part?**

Participation in the research is entirely voluntary. If you do decide to take part but later change your mind you can withdraw from the study at any time, without having to give reason. If you decide not to take part your standard of care will not be affected.

#### **What will happen to me if I take part?**

On returning the signed consent form you will be invited to take part in a focus group. The focus group will be a small group of 6 people, all of whom have been referred to the [REDACTED] Physical Activity Referral Programme. The focus group will last for about 1 hour and will be led by a member of the research team.

All focus groups will be recorded in order to ensure all points made are captured. Recordings will then be typed out, with participants only identified as unique numbers. Only those researchers leading the focus groups and the researcher transcribing the recordings will have access to the participants and their number. No information which could identify you will be used in the final research. All data will be stored securely, either in a locked cabinet or password protected computer and all recordings shall be destroyed on completion of the study.

### **What are the possible benefits of taking part?**

There are no immediate benefits for those participating in the research however it is hoped that the findings will help improve the delivery and services offered by the [REDACTED] Physical Activity Referral Programme, which will improve the service received by patients in the future.

### **What if something goes wrong?**

If you have any concerns or complaints regarding the way that you are treated by the researchers these can be addressed to: Hannah Rigby, Dept of Sport, Coaching and Exercise Science, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS.

### **What will happen to the results of the research project?**

The results from this research will be circulated within the Lincoln City Health and Fitness Development team and the referring medical practices. Publication may be sought in professional journals and the results possible presented at conferences. The information collected during this research will be used for subsequent research.

### **Who has reviewed the project?**

This research has been reviewed by the University of Lincoln and the NHS Trent Research Ethics Committee.

### **Contact Information**

If you require any further information to help you to decide whether to take part, please contact Hannah Rigby at the University of Lincoln, Brayford Pool, Lincoln, LN6 7TS. Tel. 01522 837092.

### **What do I do now?**

If you are happy to take part or decide not to participate, please complete the relevant sections and return one copy of the enclosed consent form in the envelope provided within 14 days of receipt of this letter. A second copy of the consent form is enclosed for you to keep with this information sheet for reference.

**Thank you for taking an interest in this research project. We appreciate the time you have taken to read this information sheet.**

## **RESEARCH PARTICIPANT INFORMATION SHEET: HEALTH PROFESSIONAL**

### **Physical Activity Referral Schemes; Understanding and Improving Referral Uptake**

Thank you for your interest in this research project. Before deciding whether to take part it is important for you to understand the reason for the research and what it will involve. Please take the time to read this information carefully and feel free to discuss it with others. If there is anything that is not clear or you would like more information please contact us. Please consider carefully whether or not you wish to take part.

#### **What is the purpose of the project?**

The aim of this project is to examine your opinions about Physical Activity Referral Schemes and see if they can be developed to better suit your needs. It is also being completed in part fulfilment of an academic qualification, which is sponsored by the University of Lincoln.

#### **Why have I been chosen?**

You have been chosen as you are responsible for referring patients to the [REDACTED] Physical Activity Referral Programme to take part in physical activity. We are interested in your views on the way referrals take place and the services offered.

#### **Do I have to take part?**

Participation in the research is entirely voluntary. If you do decide to take part but later change your mind you can withdraw from the study at any time, without having to give reason.

#### **What will happen to me if I take part?**

On returning the signed consent form you will be invited to take part in a phone interview. The interview will last for about 20minutes and will be led by a member of the research team.

All interviews will be recorded in order to ensure all points made are captured. Recordings will then be typed out, with participants only identified as unique numbers. Only those researchers leading the interviews and the researcher transcribing the recordings will have access to the participants and their number. No information which could identify you will be used in the final research. All data will be stored securely, either in a locked cabinet or password protected computer and all recordings shall be destroyed on completion of the study.



### **What are the possible benefits of taking part?**

There are no immediate benefits for those participating in the research however it is hoped that the findings will help improve the delivery and services offered by the [REDACTED] Physical Activity Referral Programme, which will improve the service received by patients in the future.

### **What if something goes wrong?**

If you have any concerns or complaints regarding the way that you are treated by the researchers these can be addressed to: Hannah Rigby, Dept of Sport, Coaching and Exercise Science, University of Lincoln, Brayford Pool, Lincoln, LN6 7TS.

### **What will happen to the results of the research project?**

The results from this research will be circulated within the [REDACTED] Health and Fitness Development team and the referring medical practices. Publication may be sought in professional journals and results will possibly be presented at conferences. The information collected during this research will be used for subsequent research.

### **Who has reviewed the project?**

This research has been reviewed by the University of Lincoln and the NHS Trent Research Ethics Committee.

### **Contact Information**

If you require any further information to help you to decide whether to take part, please contact Hannah Rigby at the University of Lincoln, Brayford Pool, Lincoln, LN6 7TS. Tel. 01522 837092.

### **What do I do now?**

If you are happy to take part or decide not to participate, please complete the relevant sections and return one copy of the enclosed consent form in the envelope provided within 14 days of receipt of this letter. A second copy of the consent form is enclosed for you to keep with this information sheet for reference.

**Thank you for taking an interest in this research project. We appreciate the time you have taken to read this information sheet.**

## APPENDIX H

### Phase One Participant Informed Consent

#### PARTICIPANT CONSENT FORM

**Title of Project:** Physical Activity Referral Schemes; understanding and improving referral uptake

**Name of Lead Researcher:** Miss. Hannah Rigby

**Participant Identification No. for this project:**

**Please initial box**

1. I confirm that I have read and understand the information sheet for the identified project.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason.

3. I understand that the responses I provide will be anonymised before analysis. I give my permission for members of the research team to access my anonymised responses.

4. I agree to the recording of the focus group/ interview

5. I agree to take part in the above project.

6. I do not agree to take part in the above project.

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## APPENDIX I

### Phase One Participant Profiles

<b>Pseudonym</b>	<b>Role</b>	<b>ERS Site (if relevant)</b>	<b>Additional information known</b>
Bruce	Patient	A	Referred by GP/ physiotherapist for bad back and needing to return to work. At the time of interview was on 1 <sup>st</sup> referral.
Eddie	Patient	A	Referred by physiotherapist due to joint pain and poor fitness. At time of interview was on week 10 of 1 <sup>st</sup> referral.
Gemma	Patient	A	Referred by GP and physiotherapist for osteoporosis and chronic obstructive pulmonary disorder. At the time of interview was at the end of 1 <sup>st</sup> referral.
Geoff	Patient	A	Referred by physiotherapist following operation on spine. At the time of interview was on week 3 of 2 <sup>nd</sup> referral.
James	Patient	A	Referred by GP for arthritic knee and to improve general fitness. At the time of interview was on 1 <sup>st</sup> referral.
Paul	Patient	A	Requested referral from GP, following treatment due to severe sciatica. At time of interview was near the end of 2 <sup>nd</sup> referral.
Simon	Patient	A	Referred by GP for poor back and mental health issues to restore fitness to return to work. At the time of interview was on 1 <sup>st</sup> referral.
Valerie	Patient	A	Referred by physiotherapist, following back care class after fracturing spine. At time of interview was on 1 <sup>st</sup> referral.
Beth	Patient	B	Told about referral by husband who was referred. Requested referral from GP. Reason not given.
Claire	Patient	B	Told about referral by daughter-in-law. Requested referral from GP to support weight loss.

Gordon	Patient	B	Told about referral by friend. Requested referral from GP following knee replacement.
Julian	Patient	B	Referred by GP for type 2 diabetes.
Lisa	Patient	B	Referred by weight loss advisor but also had high blood pressure multiple sclerosis.
Orla	Patient	B	Told about referral by friend. Requested referral from GP due to high blood pressure and high cholesterol.
Sarah	Patient	B	Referred by GP for mental health issues.
Malcolm	ERS coordinator/ exercise practitioner	B	Programme manager of fitness facilities (which included the exercise referral scheme) for nine years. Had previously worked as the sole exercise referral practitioner/ coordinator for the scheme but now had two other qualified practitioners to work with patients.
Natasha	ERS coordinator/ exercise practitioner	A	Physical activity officer for the city council for two years. Coordination of the exercise referral scheme was just one of her job roles, in addition to led health walks and Fit Kids (activity programme for overweight/ obese children).
Matt	ERS coordinator/ exercise practitioner	C	Fitness manager at council leisure centre. Coordinated referrals received to this site as part of a service level agreement with city council for the past 12months. Had previously worked as an exercise practitioner and continued to do so but to a lesser extent.
Aidan	Exercise practitioner	B	Exercise practitioner within the gym since graduation. He began working on the exercise referral scheme eighteen months prior to interview following qualification as an exercise referral practitioner.
Darren	Exercise practitioner	C	Gym based exercise practitioner for less than twelve months and had only recently qualified as an exercise referral practitioner.

David	Exercise practitioner	B	Gym based personal trainer who had been in post for five years, employed to assist with the development of the exercise referral scheme. He had qualified as an exercise referral practitioner four years previously.
Fran	Exercise practitioner	A	Physical activity officer for the city council for one year, which involved working as an exercise practitioner on the exercise referral scheme. She had obtained her exercise referral qualification the same year she started working for the council.
Tara	Health professional	Located near B	General practitioner
Pam	Health professional	Located near B	Practice nurse
Julie	Health professional	Located near B	Practice nurse
David	Health professional	Located within reach of all sites	Physiotherapist
Hilary	Health professional	Located within reach of all sites	Weight Loss advisor

## APPENDIX J

### Phase Two Participant Information Sheet

#### RESEARCH PARTICIPANT INFORMATION SHEET

##### Exercise Referral Schemes

Thank you for your interest in this research project. Before deciding whether to take part it is important for you to understand the reason for the research and what it will involve. Please take the time to read this information carefully and feel free to discuss it with others. If there is anything that is not clear or you would like more information please contact us. Please consider carefully whether or not you wish to take part.

##### **What is the purpose of the project?**

The aim of this research is to explore your experiences of exercise referral and how these operate in the county. It is also being completed in part fulfilment of an academic qualification, which is sponsored by the University of Lincoln.

##### **Why have I been chosen?**

You have been chosen as you are involved in [REDACTED] exercise referral scheme delivery. We are interested in your views on the way exercise referral operates within the county and the services that are offered.

##### **Do I have to take part?**

Participation in the research is entirely voluntary. If you do decide to take part but later change your mind you can withdraw from the study at any time, without having to give reason.

##### **What will happen to me if I take part?**

If you decide to take part you will be invited for interview, which will be led by a member of the research team. The interview is estimated to take no longer than an hour.

All interviews will be recorded in order to ensure all points made are captured. Recordings will then be typed out, with participants only identified by false names. Only the researcher leading the interviews and the researcher transcribing the recordings will have access to the participants and their number. No information which could identify you will be used in the final research. All data will be stored

securely, either in a locked cabinet or password protected computer and all recordings shall be destroyed on completion of the study.

### **What are the possible benefits of taking part?**

There are no immediate benefits for those participating in the research however it is hoped that the findings will help improve our overall understanding of exercise referral scheme delivery and the services offered. In turn this may lead to recommendations of how these types of services can be improved.

### **What if something goes wrong?**

If you have any concerns or complaints regarding the way that you are treated by the researcher these can be addressed to: Niro Siriwardena on email [nsiriwardena@lincoln.ac.uk](mailto:nsiriwardena@lincoln.ac.uk) or telephone 01522 886939.

### **What will happen to the results of the research project?**

The results from this research can be shared with yourself should you request it. Publication may be sought in professional journals and results will possibly be presented at conferences.

### **Who has reviewed the project?**

This research has been reviewed by the University of Lincoln Ethics Committee.

### **Contact Information**

If you require any further information to help you to decide whether to take part, please contact Hannah Henderson on email [hhenderson@lincoln.ac.uk](mailto:hhenderson@lincoln.ac.uk) or telephone 01522 837092.

### **What do I do now?**

If you are happy to take part or decide not to participate, please inform the researcher through the contact details they have provided you with. If you do want to participate you will be asked to complete a consent form and a time for interview will be arranged.

**Thank you for taking an interest in this research project. We appreciate the time you have taken to read this information sheet.**

## APPENDIX K

### Phase Two Participant Informed Consent

#### PARTICIPANT CONSENT FORM

**Title of Project:** Exercise Referral Schemes

**Name of Lead Researcher:** Mrs. Hannah Henderson

**Participant Identification No. for this project:**

- |   | <b>Please initial box</b> |
|---|---------------------------|
| 1. I confirm that I have read and understand the information sheet for the identified project.  | <input type="checkbox"/>  |
| 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving reason.  | <input type="checkbox"/>  |
| 3. I understand that the responses I provide will be anonymised before analysis. I give my permission for members of the research team to access my anonymised responses. | <input type="checkbox"/>  |
| 4. I agree to the recording of the interview  | <input type="checkbox"/>  |
| 5. I agree to take part in the above project.   | <input type="checkbox"/>  |
| 6. I do not agree to take part in the above project.  | <input type="checkbox"/>  |

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature

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## **APPENDIX L**

### **Phase Two Participant Profiles**

#### ***Paul* – Public Health**

Paul is a 56 year old male. His current title is Programme Manager for Health Improvement. Paul is currently responsible for a team of Health Improvement programme officers, co-ordination of commissioning responsibilities and support to the Public Health Consultant for Financial Challenge, Health and Well Being theme 1 and Joint Strategic Needs Assessment topics. Paul took up his role in 2004 and had been programme lead for the Choosing Health project and subsequently the Staying Healthy programme with an emphasis on obesity, physical activity and tobacco control. It was this programme that had included exercise referral schemes.

#### ***Susan* – Public Health**

Susan is a 47 year old female. Her current title is Health Improvement Programme Officer. She had been working on the exercise referral scheme for about a year prior to the service being decommissioned. She also took a lead role on the community health walks and Obesity, Food and Nutrition projects. Susan had only worked for Public Health for two and half years and had worked solely on Obesity, Food and Nutrition projects prior to taking on exercise referral schemes.

#### ***Sam* – County Sports Partnership**

Sam is a 35 year old female. Her current title is Client Manager for Health. Sam had been in post for seven years. Her role required her to work with health partners across the county and beyond to develop and deliver projects that increased physical activity levels among sedentary populations. Sarah had worked on exercise referral schemes in her previous role in another county, where she had worked as a co-ordinator for two years, and then from 2009 until 2015 in the case-study county. Sarah's current role was to support the various exercise referral schemes and try to bring some consistency, quality, training and evaluation

standards across the county. This included embedding national best practice, NICE guidelines, adopting validated tools and commissioning independent evaluation of the scheme.

### ***Christine – County Sports Partnership***

Christine is 53 year old female. Her current title is Resource Manager. Christine provided maternity cover for Sam for a period of twelve months. Christine as an experienced project manager who had worked in private, public and third sector organisations developing products and projects from inception through to fruition. Her background was in people development services, careers guidance, and European and national funded projects designed to contribute to the economic well-being of the county. She became involved in the development and management of sports/physical activity related projects in 2011, focussing on the case-study county and the county's specific health and well-being issues and needs of communities.

### ***Janet – District Manager***

Janet is a 36 year old female. At the time of the interview Janet worked for the City Council as Healthy Lifestyles Team Leader. Her team delivered a number of health improvement programmes commissioned by the County Council Public Health department as well as being the sub-contracted provider for a health improvement programme on behalf of a neighbouring district. Janet had held the above post since 2003 during which time she had grown her team, from a team of two providing small scale physical activity interventions with small grants, to a team of 13 providing multiple programmes with over a quarter of million pounds of funding. Early into the role Janet had been responsible for the delivery of a number of the interventions herself however since the team had grown her role had become more strategic.

## APPENDIX M

### Example of Coded Interview Transcript

Example taken from focus group 1 pages 1-5.

<p><b>Hannah:</b> I wanted to start off with a little bit about your expectations err perceptions of the scheme when you first started so err really they are just general questions opening up to all of you, what was your actual understanding of what a referral scheme, this physical activity referral scheme was when you were first told you were going to be referred</p> <p><b>Gemma:</b> <i>I had no idea, I didn't know what to expect at all. I sort of assumed that physio was going to be... you'd be lying down and somebody was going to be either pulling you around or massaging your muscles or something like that, I didn't know it would... I'd be err going to the gym. I never, never envisaged that at all... laughing</i></p> <p><b>Paul:</b> <i>It's nothing that's what's publicised like if, if I wasn't referred I wouldn't know about it all, this was a totally unknown thing and err it needs promoting because obviously there are a lot of people out there who are suffering and the doctor was... a bit non-plus about it</i></p> <p><b>Hannah:</b> Right...</p> <p><b>Gemma:</b> <i>I agree, didn't know about it.</i></p> <p><b>Paul:</b> Yes.</p> <p><b>Gemma:</b> <i>'til I came...</i></p> <p><b>Paul:</b> <i>I had to mention it first, the fact that the physiotherapist had put me to here, and he said 'oh you're on that scheme are you' err... and that's all he could say to me really erm... it's like everything else, education isn't it...</i></p> <p><b>Valerie:</b> <i>I thought I was quite lucky, I was referred by the doctor to 'physiotherapist' and she said to me about it and she actually sent me to the hospital for a bone scan because she was the one and I mean I'd be going to the hospital at that stage for six months oh and now I'd been fifteen, sixteen months getting to this stage and she was the one who, went to the doctors and said she needs to go to the hospital for a bone scan and they found out I had osteoporosis as well as the fractured spine so I</i></p>	<p>Don't know what to expect.</p> <p>Misconceptions.</p> <p>Don't know what to expect. GPs unaware of client attendance. Needs promotion.</p> <p>HPs don't know about referral.</p> <p>HPs know about referral.</p>
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<p><i>found... and she told me about coming here. She explained about the gym, she explained about the back class, she said I don't know if you'll be able to do the other things but like you know you'll see [exercise practitioner] and she said well give it a try. So that was really good. It's just the time, I think I'd have been at this stage three months earlier erm you know progressing more.</i></p>	<p>HPs explain the process.</p>
<p><b>Geoff:</b> <i>I think when you mention referral and you don't really know what it's about you're just happy that someone else is going to have a look at you and see if they can improve the situation you're in err yeah so I came in not really knowing what I was coming in to but err... yeah from what [exercise practitioner's] been doing it's been great.</i></p>	<p>Don't know what to expect. Helpful. Positive experience.</p>
<p><b>Paul:</b> <i>I'm, I'm diabetic as well and jokingly I said to the diabetic nurse about a year ago isn't it a pity I can't be referred to a gym and she laughed and said 'health service doesn't do things like that' and really that, what's happened is what I wanted to happen and yet they were totally negative in the fact that 'oh we don't do that anyway'.</i></p>	<p>HPs don't know about referral.</p>
<p><b>Valerie:</b> <i>When I went to the hospital, the consultant actually said to me a physio won't touch you until like you know you're walking and this that and the other which was true in a way but then nobody seemed to know about this at all and its link to the hospital nobody said to me 'oh you can go' and it was like the doctor referred me to the physio because I mean 'place' hospital do not promote this at all.</i></p>	<p>HPs don't know about referral.</p>
<p><b>Eddie:</b> <i>Like these I was at 'place' with the physio and I actually asked, well she was talking and I said I wish I could afford it on a limited budget that if I could I would join a gym and she said 'oh I can get you fifteen weeks for fifteen quid erm... and I said where's that and she said... I think she named about three or four places, this is probably the closest for me I just live down 'place' and she rang, she emailed [exercise practitioner], and then about a month later I had to ring [exercise practitioner] and err all I asked for was to just build me power up, breathing wise in particular, I've put a bit of weight on I was fifteen and a half stone got that down to about fourteen six now so that's improved, the breathings better, the muscles factors back err and I feel a lot stronger. But that was only by talking to the physiotherapist that I got here and talking to [exercise practitioner].</i></p>	<p>Cost as a barrier.</p> <p>HPs know about referral.</p> <p>Weight loss/ strength.</p>

<p><b>Paul:</b> <i>There's only one negative thing I've got about it, you just reminded me, fifteen pounds wasn't it, I had to pay double.</i></p> <p><b>Valerie:</b> <i>So did I.</i></p> <p><b>Paul:</b> <i>...because I'm outside, a mile outside the [city] boundary, at [place] and really that's not fair and really... we're all in the same boat aren't... I'm a pensioner as well but why should I have to pay double?</i></p> <p><b>Valerie:</b> <i>I'm, I'm within the [city] boundary...</i></p> <p><b>Gemma:</b> <i>...so am I...</i></p> <p><b>Valerie:</b> <i>...and I had to pay thirty pounds for three month.</i></p> <p><b>Paul:</b> <i>They told me I had to pay double and it's not right and I think that's the only gripe I've got really...but there again it's got me to join the gym...so why is it?</i></p> <p><b>Hannah:</b> <i>That's not something I would be able to answer myself and I can't comment on but certainly...</i></p> <p><b>Eddie:</b> <i>Well my wife's here as well, she's not here today because unfortunately my eldest son is here, he's got trouble with work erm I was talking to [exercise practitioner], [wife] came and had a word with 'exercise practitioner' and she wrote to the doctors and said that can she come as, like this lady she got this COPD and our quack just filled the paperwork in and said there you go</i></p> <p><b>Paul:</b> <i>...and did you pay fifteen pounds for three months?</i></p> <p><b>Eddie:</b> <i>Yeah.</i></p> <p><b>Gemma:</b> <i>Maybe that's because you've gone through the doctors?</i></p> <p><b>Paul:</b> <i>No it's [city], you live in [city] don't you?</i></p> <p><b>Gemma:</b> <i>I do.</i></p> <p><b>Paul:</b> <i>See I'm [district].</i></p> <p><b>Geoff:</b> <i>Yeah, I'm [district].</i></p> <p><b>Eddie:</b> <i>That might be it.</i></p>	<p>Cost as a barrier.</p> <p>Charging dependent on postcode.</p> <p>Charging dependent on postcode.</p> <p>Clients asked to be referred.</p> <p>Charging dependent on postcode.</p>
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<p><b>Paul:</b> <i>But its right we should all pay the same.</i></p>	
<p><b>Hannah:</b> <i>So what, when you were initially told you were going to be referred what were your feelings about that, was it...</i></p>	
<p><b>Gemma:</b> <i>Good.</i></p>	
<p><b>Eddie:</b> <i>I thought if they can get me wind back, build me muscle back up because I looked dreadful I was ashamed to have my arms out because I've been an active man all my life and this is the first time, I'm 69 and the first time I've been ill since I was a baby so it was a bit of a shock erm and because I asked for what I asked for that seems to be fulfilling the ambitions I had in mind</i></p>	<p>Restorative. Used to exercise.</p>
<p><b>Valerie:</b> <i>I was again a very fit person, don't particularly look it now but I was I mean we had boarding kennels, walking dogs, lifting twenty-five kilo just chucking them on my shoulder as if it was nothing. Worked full-time in a science lab at school, everything, then I had this accident and like everything stopped I mean now I can get about, I can't sit for a long time, I can't walk for a long time but I'm getting better. I couldn't do it for a short time before, I couldn't have sat here on these chairs, no way erm so it's doing me a lot of good and it, it built up my confidence, now this sounds silly I daren't go out of the house because I thought 'gasp' if I freeze, my hips just freeze, I can't go and I thought oh! Now in the gym and everything I'm walking I'm getting my speed up now because it's flat, there's no holes, which I fell down, there's nothing so I feel it's really built me up to that.</i></p>	<p>Used to exercise.  Mobility  Confidence  Mobility</p>
<p><b>Geoff:</b> <i>To me the referral was an unknown as I said before, anything when you think somebody's going to help you...</i></p>	<p>Don't know what to expect. Helpful.</p>
<p><b>Valerie:</b> <i>...Oh yeah...</i></p>	
<p><b>Geoff:</b> <i>...is just, just a relief in a way.</i></p>	
<p><b>Paul:</b> <i>I mean a lot of times you ask and you don't get and it makes a pleasant change to get something like this which has helped us all.</i></p>	<p>Helpful.</p>
<p><b>Valerie:</b> <i>...and I think it should be continued for a lot more people don't you?</i></p>	<p>More could benefit.</p>
<p><b>Gemma:</b> <i>Yes.</i></p>	
<p><b>Valerie:</b> <i>I mean I know you have to put the effort in...</i></p>	<p>Requires effort.</p>

<p><b>Gemma:</b> Yes.</p> <p><b>Valerie:</b> ...You know but surely there's a lot of people out there who don't know about it who are prepared to put the effort in.</p> <p><b>Paul:</b> I had the same problem with the referral it took a long time I had to ring up myself in the end to chivvy it along.</p> <p><b>Hannah:</b> I was just going to touch upon this what were your feelings about the referral process overall so from the point of being referred and starting the programme, what were your feelings?</p> <p><b>Valerie:</b> Very slow.</p> <p><b>Eddie:</b> Like the lady said from someone saying to you I'll email A N other, they'll be in touch with you within twenty-one days or two weeks then it's six weeks down the line and you've heard nothing and then like the lady said that could be... paperwork goes amiss I know but like [exercise practitioner] she's only here couple a days a week or something like that so if the email comes the last minute she's leaving work it may be four days until she sees it err... then she probably takes it off sticks it in her to do list box...</p> <p><b>Valerie:</b> It does seem to me paperwork is clogging the system up...</p> <p><b>Eddie:</b> It always has done.</p> <p><b>Valerie:</b> It always has, it was far better when you had notes rather than computers, you know it's supposed to have speeded everything up but it doesn't it gets bogged down in there.</p> <p><b>Gemma:</b> You've got to read your emails, you've got to reply to them... <b>laughing...</b></p> <p><b>Paul:</b> I think your hopes is building up, oh great I've got on the scheme and then you sit there waiting.</p> <p><b>Valerie:</b> And waiting...</p> <p><b>Paul:</b> And you get a little bit conscious but other than that once you get started it's fine.</p> <p><b>Valerie:</b> Yeah.</p>	<p>More could benefit.</p> <p>Process is slow.</p> <p>Process is slow.</p> <p>Process is slow.</p> <p>Process is slow.</p> <p>Limited with staff.</p> <p>Paperwork slows the process.</p> <p>Paperwork slows the process.</p> <p>Process is slow.</p>
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<p><b>Hannah:</b> So it's literally, just to clarify, it's that point from referral through to beginning?</p> <p><b>Valerie:</b> <i>And then it's superb because she moves you on to different things.</i></p> <p><b>Geoff:</b> <i>That something, saw the physio, just before Christmas she was going to contact [exercise practitioner] and she said that it might be err... towards the end of January before [exercise practitioner] got in touch with me and in actual fact it was two weeks before then bearing in mind there's Christmas and New year and we were going on holiday for two weeks so I didn't really want to start something then have a break so, I mean the wait didn't really affect me.</i></p> <p><b>Gemma:</b> <i>It's got to depend on the workload that [exercise practitioner's] got. I mean she can't be having dozens of people coming all at the same time and needing help and err you know needing assistance with the equipment and things like that so if she's the only one that does this then obviously that's one of the reasons we would be waiting.</i></p> <p><b>Valerie:</b> <i>I'm sorry about that but I don't think that's what, I think it's the system that needs speeding up and I don't think it's anything to do with [exercise practitioner] she's fine.</i></p> <p><b>Gemma:</b> <i>Oh I'm not complaining about [exercise practitioner]'.</i></p> <p><b>Valerie:</b> <i>No, no I didn't mean that I meant she does all of these classes and I mean we go down to this err circuit training and there's supposed to be, there's eighteen, twenty on the books and sometimes you only get six but it was I think, mine was delayed more because I went to [place] for referral through [physiotherapist]. [Physiotherapist] had to get in touch with the surgery, the surgery had to get in touch with this system, I'm in [city] and then [exercise practitioner] was quite quick once I got, I was amazed but it was the rest of the journey that took eight week.</i></p>	<p>Positive experience.</p> <p>Process is quick.</p> <p>Limited with staff.</p> <p>One person to manage.</p> <p>Process is slow.</p> <p>Process is slow.</p>
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## APPENDIX N

### Phase One Thematic Table

Higher Order Themes	Themes	Codes
<b>EXPECTATIONS</b>	Benefits	It's beneficial
		Become 'normal' client
		Restorative
		Return to previous activity
		Weight loss
		Improve medical conditions
		Reduce medication
		Alternative to medication
		More than physical
		Long term change
	Environment	Safe environment
		Support clients
	Knowledge	HPs don't explain the scheme
		HPs explain the process
		Don't know what to expect
		Nervous
		Drop outs not had scheme explained
		Misconceptions
		Staff knowledge
		HPs know about referral
		HPs don't know about referral
		Solution
	Need for referral	
<b>RELATIONSHIPS</b>	Partnerships	Effective partnerships needed
		Good partnerships between delivering agents
		EPs must work together
		Good relationships
	Professional divide	
	Communication	Communication problems with HPs
		Only contact HPs if needed

		HPs lack information
	Targets	Hit funder's targets
		Unreasonable targets
	Funding	Funding dependent
		Funding for development
		Must make money
	Attitudes	HPs cautious of referral
		GPs lack confidence
		HPs lack trust
		Viewed negatively by GP
		Referral not taken seriously
		GPs too busy for referral
		Easy exit route for GPs
	Inconsistency	HPs don't explain the scheme
		HPs explain the process
		Paperwork incorrectly completed
		Paperwork straight forward
		HPs want feedback
		HPs don't want feedback
<b>PROCESS DELIVERY</b>	Advocate	Varies between referrers
		GP keenness varies
		Physios are keen
	Awareness	HPs don't know about referral
		GPs unaware of client attendance
		HPs lack information
	Capacity	Limited with staff
		One person to manage
		Small part of busy job role
		Increased numbers
		Numbers limited for gym
		More could benefit
	Choice	Not everyone enjoys the gym
		Clients want choice
		Develop exercise options
	Efficiency	Process works well
		Process is slow
		Process is quick
		Delays effect attendance

		Paperwork slows the process
		Works in theory
	Expansion	Expand to private sector
		Expansion of scheme
	Feedback	Should feedback to HPs
		HPs informed of patient completion
		HPs get feedback sometimes
		HPs don't get feedback
		HPs don't want feedback
		HPs want feedback
	Modernisation	Development of online referral
		Referral easier with online form
		GPs support online form development
	Organisation	Delivery varies
		Needs improving
		Must be run well
	Promotion	Not advertised
		Needs promotion
		Contact more GPs
	Streamlining	Client should self-refer
		Clients responsible for paperwork
	Suitability	Referrals are appropriate
		Referrals are inappropriate
		Don't want to be referred
		Clients need convincing
	Understanding	GPs don't understand importance of paperwork
		GPs don't understand referral process
		GPs don't understand exercise benefits
		Physios use exercise
		HPs need benefits explaining
		Paperwork incorrectly completed

		Paperwork straight forward
<b>PROCESS RECEIPT</b>	Adherence	Completers continue exercising
		Keep attending after referral
		Most complete
		Repeat referrals
	Benefits	Confidence
		Mood
		Positive attitude
		Exercising independently
		Manage stress
		Weight loss
		Mobility
		Fitness
		Strength
		Functional living
		Activity levels
		Control conditions
		Improved health
		Eases pain
		Understanding
		It's social
		Better in a group
	Commitment	Takes commitment
		Commitment can decline
		Programme requires effort
		Dependent on individual
	Cost	Cost as a barrier
		Abused for cheap membership
		Affordable option
		Gyms too expensive
		Charges dependent on postcode
	Enjoyment	Clients enjoy it
		Have a laugh
	Environment	Uncomfortable in typical gyms
		Smaller gyms are easier
		Wouldn't exercise at home
		Don't socialise in the gym

	Experience	Quality experience throughout
		Positive experience
	Habit forming	Becomes routine
		12 weeks is enough
		12 weeks too short
		Longer referral period needed
	Motivation	Motivational
		Clients ask to be referred
		Attendees already motivated
		Used to exercise
		Drop outs lose motivation
	Recommendation	Recommended
	Staff	Caring
		Friendly
		Helpful
		Knowledgeable
		Qualified
		Take an interest
		Watchful
	Support	Need 'counselling' support
		Continued support wanted
		Retention relies on personal service
		2 <sup>nd</sup> referral if needed
	Value	Charge to add value
		Drop outs don't value the scheme

## APPENDIX O

### Phase Two Thematic Table

Higher Order Themes	Theme	Code
Fragmented Leadership	Unclear aims	Alongside or alternative
		Introduction to activity
		Opportunity for all
		Improve many areas
		People using facilities
		Tied to obesity agenda
		Aim to be more active
		Make people more active
		ER was for weight loss
		Offered as alternative
		Supports the industry
		Aim to benefit health
		Formalise health and fitness
	Save NHS money	
	Helping people	
	Weight loss to fitness	
	Reduce disease	
	Reduce need for services	
	Unaware for ER history	
	Disenchanted	Not been clever
		Marketing has changed
		Wrongly aimed
		Numbers don't warrant continuation
It doesn't work		
Lifestyle programme are a luxury		
ER not fully utilised		
ER could be more dynamic		
Reluctance to change	Some remain unchanged	
	Methods should have changed	
	Delivery unchanged	
	Still doing the same	
	Freedom to self-manage	
Freedom to self-manage	Freedom to diversify	
	Model allows freedom	
	Partnership agreements vary	
	Unit costs negotiated	

		Flexible target setting
	Disengaged	PH lack qualitative feedback
		Feedback can be skewed
		No mechanism for feedback
		Don't know about patients experience
		No formal feedback
		No direct feedback
		Don't hear from drop outs
	Feedback	Instructors feedback
		Feedback from those doing well
		District council feedback
		Good channels of communication
		SP get feedback
		PH get informal feedback
		Feedback helps success
		Network meetings
		Networks meetings are useful
		Feedback from the same places
		Offer feedback
		Feedback is insightful
		Feedback from case studies
		Formal feedback is useful
	Shift in management style	Framework offered
		Contracted out
		Should be structured
		More structured approach
		More prescriptive
		More like project management
		Structure in place
		More robust approach
		Less prescriptive
		Laissez faire approach
		Relaxed at first
		Less laissez faire

		Contractual but not
		Contract management
		Loose organisation
		Excessive coordination
		Freedom in delivery
	Supportive networks	Share information
		PH advise
		Provide prompts
		Facilitate communication
		Organise training
		Build relationships
		Role to promote health
		Point of contact
		Coordinating role
		Glue in the networking
		Connecting people
		Promote activity to improve health
		Promote and commission
		Shared role to promote
		Implement best practice
		Broker to resolve problems
		Provide backbone
		Support driven
		Provide guidance
		We change forms
		Provide coordination
		Oversee performance
		Multiple roles
		Supportive role
		Monitored and supported
	Question management roles	SP has odd role
		SP unnecessary layer
		Questionable function
		Role unclear
		Strange interim support
		Two generals
		Terms of reference unclear
Power Struggles	Control	More force
		Should deliver
		Reined folks in
		PH defines what



		Used to being forceful
		Used to be authoritarian
		PH have influence
		Local authority like project management
	Division	Some don't get it
		Some hot some not
		Engage with GPs
		GPs forget
		GPs need prompting
		HPs don't understand
		HPs respected
		Presence with stakeholders
		Little contact with deliverers
		Instructors are level below
		Don't understand
		Team talks to others
		Varied contact with others
		Never met with patients
		Communicates at higher level
		Coordinators make comparisons
		Less stakeholder interaction
		Tiers of communication
		Taken advantage of
		Relationships vary
		Broad sector relationships
	Disempowered	No power
		No input
		Not interested in reports
		Information doesn't reach decision makers
		Preventative agenda sidelined
		Lack of political support for prevention
		Inability of politicians
		Behind the scenes
		No strong grounds

		Political influences
		Bureaucracy
	Accountability	No accountability
		Accountable for best practice
		Accountable to line manager
		DLs manage ER providers
		Accountable to county council
		Accountable to PH
		Accountable for data not numbers
		Accountable for communication
Belief in Commercialisation	Model can change	Model will change
		Commercial model can work
		Providers need economic model
		Develop commercial model
		Scope for commercial model
		Sell commercial model idea
		PA is lucrative
		Easy to sell
		Need to evolve to profit
	Need for partnerships	Need to take stock
		PH part of NHS
		Sectors need to work together
		More conversation between partners
		Need to develop links
		Agenda is PA
		Need to gather momentum
		Need culture change
		Need CCG backing
		ERS will evolve
	Development needs	Work to be done
		Needs positive marketing
		More activity orientated

		Needs to be broad
		Directed to interests
		Up to the leisure industry
		Sport is changing
		PA needs promoting
		Should link to obesity
		Should link to weight watchers
	Consequences of commercial model	PC will become burdened
		Some will carry on
		Failed opportunity
		Service will become patchy
		Motivation in self-care agenda
		Some can't afford to pay
		Won't go if can't afford it
		Could provide scattered service
Questionable Sustainability	Lack of endorsement	No reasons to support
		Well supported initially
		Key health improvement area
		Local level support
		Had support
		Lack of support
		Need support
		Stopped advocating
		NICE are ambivalent
		NICE don't rate it
		NICE wasn't thorough
	Lacks impact	Not worked well enough
		Not impacted on obesity
		Disease levels unchanged
		Not reduced obesity
	Uncertainty	Preparing for cuts
		No future for public sector funding
		HIPs will go
		Out of public sector
		Input will stop
		ER at risk
		Future is bleak
		Future is not optimistic

		Future is unclear
	Limited funding	Financial structures are complex
		Limited funding options
		Funding will go
		No funding available
		No funding for lifestyle
		Small budget
		Disseminate funding
		Drop in the ocean
		It comes to money
		Dependent on finance
		Small providers are vulnerable
		Fund preventative work
	Preventative agenda	Prevention agenda disappearing
		Preventative strategy
		Model for preventative work
		Preventative medicine is difficult
		Threats to preventative work
		NHS needs preventative side
		Work becoming short term
	Inconsistent service provision	Structure varies
		Referral is ad hoc
		Approaches vary
		Inconsistency
		Erratic in places
		Wild and woolly
		Differences
		Efficiency varies
		Service is varied
		Working towards consistency
		Ensure consistency
		Other programmes are better
	Regional variation	Different regions different priorities
		Other priorities

		Other authorities worse off
		Different across the country
	Constrained delivery	Limited by resources
		No capacity to expand
		Restricted delivery
		Greater capacity
	Adherence unclear	Engagement long term unclear
		Exit point is challenging
		Given an exit route
		Flaw in the system
		Lost in abyss
		Lose track
		Unaware of LT adherence
		Unclear what happens LT
		Lack of follow on
		Keeping majority active unclear
	Limited scale of provision	Only in urban areas
		Small by comparison
		Scale not big enough
		Large scale not possible
		Rural issues
	Difficulty monitoring	Don't monitor social improvement
		Data unclear
		Monitoring is a problem
		No logic to database
	Questionable quality	Degrees of competency
		Can't quality control
		Up their game
		Quality of small providers
		Should be consequences
		Risk working with companies
		Policing costs
		Big providers get it
		Push for excellence
	Not cost effective	Not cost effective
		ER not cost efficient
		Not costly if maintaining
	Value of ERS unclear	Better ways to spend money

		GPs value ER
		Other options better value
		Local level demonstrates value
		Poor value for money
	Established	Becoming established
		Running smoothly
		Good models
		Part of the GPs role
		Part of the practice
		Pretty much there
		ER is common
		More knowledgeable
		More experienced
	Local success	ERS met objectives
		Doing what it intended
		Exceeded national performance
		Good completion
		Effect is powerful
		ER success locally
		ER is impactful
Delivery Processes	Process of Referral	Initiated by HP
		Referral not explained
		Referral slow with MECC
		Young GPs refer
		MECC should lead to referral
		Patients unaware of ERS
		Don't know why they're there
		PA minded are motivated
		Recruit the right person
		Most are overweight
		GP makes referral
		Open minded GPs refer
		Majority obese in ER
		Obese use the system
		Majority not interested
	Model of Delivery	Unsure why 12 weeks
		Delivery good for figures
		Committed staff
		Can be group work
		Gym membership not ER
		Gyms are niche

		Gym is not social
		Model offers variety
		Personal vocation
		Demand supply balance
		Become gym members
		Transfers between districts
		Less personal approach
		Person centered approach
		Should be personalised
		ERS works
		Service is effective
		It's about convenience
	Barriers to model of delivery	Behaviour change needs longer
		ER more clinically led
		Admin heavy
		The word 'referral'
		Anxiety effects engagement
		Formality is a barrier
		Bad experience creates barriers
	Value	Paying provides incentive
		Paying adds value
Process Receipt	Health benefits	Quality of life
		Additional benefits being active
		Improves health
		Changes lives
		Gain health benefits
		Works for the majority
		Works for particular patients
		Achieve health benefits
		Presumption of health benefits
	Positive experience	The experience matters
		Like it and use it
		Need a good experience
		Customer satisfaction
		Experience is good
		It's about enjoyment
	Positive relationships	Positive relationships
		Good relationships

		It's about relationships
		Personal relationships
		Form great relationships

\*Those shaded highlight themes omitted from discussion of key findings.