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Role Positioning and Competence Standards of Exercise Professionals in UK Exercise Referral: Implications for Social Sports Instructors in China

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Abstract: ***What responsibilities exercise professionals who receive referred clients should assume, what competences they should possess, and how their qualifications can be verified are questions that must be answered if exercise referral is to be rolled out in primary care and community settings. Drawing on theories of institution-based trust and occupational regulation, and based on primary documents of exercise referral in the UK, this study examines the institutional arrangements for UK exercise professionals across four links (risk stratification, role positioning, competence standards and qualification registration) and compares them with China's system of social sports instructors. The findings show that the UK assigns staff tiers according to clients' health risk, specifies responsibilities through assessable National Occupational Standards, and makes qualifications verifiable through industry registration. These three elements are bound to one another and are implemented mainly through service agreements, industry registration and professional liability insurance rather than statutory licensing. In China, by contrast, the grade system for social sports instructors is not linked to clients' health risk, and the system lacks both responsibilities that connect instructors with healthcare providers and channels through which their qualifications can be verified. It is recommended that an "exercise referral professional" post be established, under whose overall responsibility social sports instructors would lead sessions for low-risk clients. This arrangement should be implemented through specialized competence modules, designations in the information management system, referral protocols and government service-procurement contracts.***

Keywords: Exercise referral, Exercise professionals, Competence standards, Social sports instructors, Institution-based trust, Integration of sports and health.

1. Introduction

Exercise referral is a health intervention model initiated by the healthcare system and delivered by the physical activity service system. It refers to the process whereby a primary care or allied health professional, having assessed a person as sedentary or insufficiently active, refers that person to a physical activity specialist or service, which then conducts an individual assessment, determines an appropriate physical activity programme and provides opportunities to take part, with the aim of increasing the person's level of physical activity [1]. In 2025, the General Administration of Sport of China (GASC) issued the *Guiding Opinions on Promoting the High-Quality Development of Exercise for Health (hereafter the Guiding Opinions)*, which call for "supporting local pilots and the wider use of exercise prescription" and for "making full use of social sports instructors, medical and nursing staff and other professionals" [2]. By the end of 2025, China had a cumulative total of about 4 million social sports instructors [3], whereas only some 3,000 exercise prescribers had been trained nationwide by the end of 2023, nearly 1,600 of them in the medical system [4]. Given this limited supply of specialized personnel, whether—and in what capacity—social sports instructors can enter the referral chain becomes a question that must be answered if exercise referral is to take root in primary care and community settings. Whether doctors are willing to refer, and to whom, depends in turn on whether the competence of receiving practitioners can be confirmed in advance.

Chinese scholarship has examined exercise referral abroad in some depth. One strand of research has traced the policy evolution, service processes and operating models of exercise referral in countries such as the UK [5] and Australia [6]. Studies of Ireland's National Exercise Referral Framework have analysed its multi-stakeholder operational and evaluation architecture [7] or noted that the qualification requirements for service providers are tiered by participant category [8]. Other studies have drawn lessons from multi-country comparisons on policy support, referral criteria, workforce training, and supervision and evaluation [9], or have compared models of sport–medicine integration in the United States, Germany and the UK [4]. A second strand focuses on workforce training and professional certification. These studies propose drawing on the clinical exercise physiologist model to establish exercise prescriber as an occupation with "dual registration" in both the sports and the health sectors [10], or embedding sport–medicine integration throughout the full cycle of medical education [11]. They point out that, although the training of exercise prescribers in China has developed into a relatively complete training and certification system, it has not yet been recognized by the medical system [10], and that the prescribing authority of exercise and health professionals is likewise not recognized within the healthcare system [12]. In addition, studies of policy texts have analysed intergovernmental collaboration in sport–medicine integration [13] and the logic of its policy evolution [14], pointing to insufficient coordination between the sports and health authorities.

With regard to social sports instructors, one study proposes that people who need exercise be referred to community exercise resources "with specialized qualification certification", whereas fitness exercise for people without disease could be referred to "community resources with general-level certification" such as social sports instructors [15]. Another envisages exercise interventions delivered jointly by community sports instructors, family doctors and exercise prescribers, and describes community teams of doctors, nurses and social sports instructors in places such as

Jiading in Shanghai and Luyang in Hefei [9]. However, what responsibilities social sports instructors should bear in referral, what assessable competences they must possess and how their qualifications can be verified by the healthcare side have not yet been examined systematically on the basis of primary institutional documents. Accounts of UK exercise professionals have mostly been subsumed under discussions of training and certification [9], with little attention to the basis on which they are graded or the mechanisms through which they are recognized.

Referral entails the transfer of clients, and of part of the responsibility for them, between two occupational systems: healthcare and sport. Zucker distinguishes three modes of trust production—process-based, characteristic-based and institution-based—and argues that when exchanges cross group boundaries and trust cannot be sustained through long-standing interaction, formal structures such as professional certification become an important source of trust [16, pp. 53–111]. Research on occupational regulation suggests that, while licensing may raise service quality, it may also restrict the supply of practitioners and push up prices [17]. From this perspective, the problem of the receiving practitioner in exercise referral can be understood as how to enable the healthcare side to trust receiving practitioners through institutional means without unduly constraining supply. Drawing mainly on primary documents—the Department of Health's *Exercise Referral Systems: A National Quality Assurance Framework* (NQAF), the exercise referral toolkit produced by the BHF National Centre for Physical Activity and Health (BHFNC; hereafter the toolkit), guidance from the National Institute for Health and Care Excellence (NICE) and the National Occupational Standards (NOS)—this study examines the institutional arrangements for UK exercise professionals across four links: risk stratification, role positioning, competence standards and qualification registration. It then compares these arrangements with China's administrative measures, national occupational skill standard and Guangdong provincial training specifications for social sports instructors (Figure 1), with a view to informing the orderly participation of social sports instructors in exercise referral.

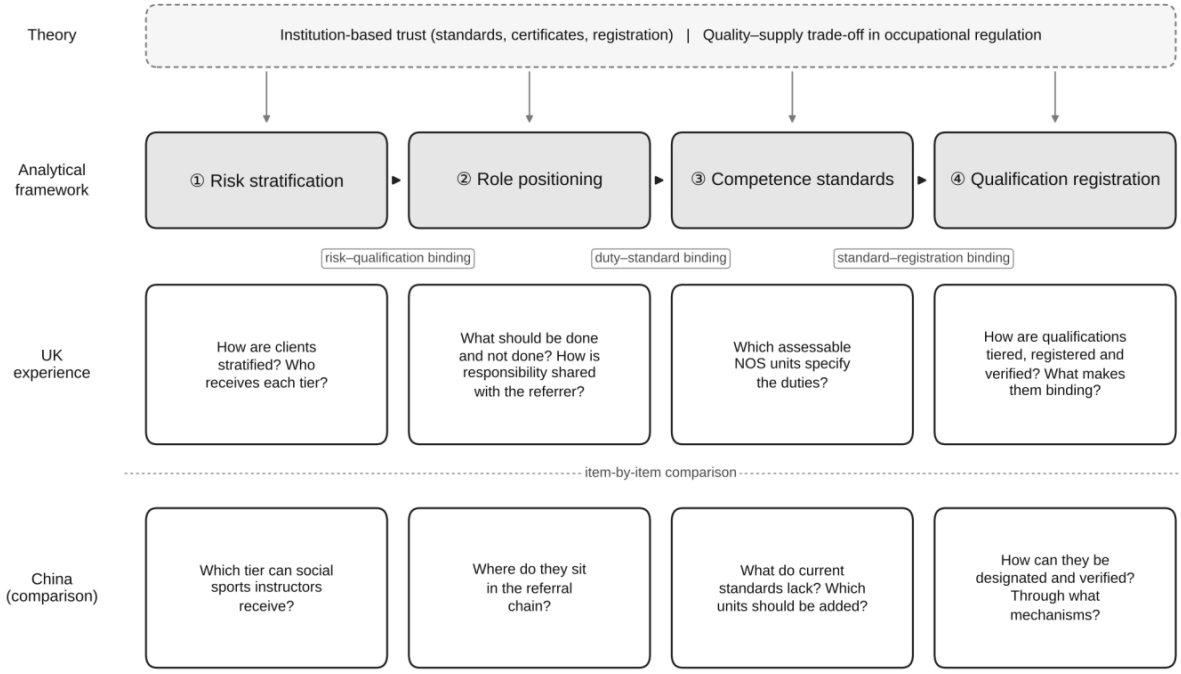


Figure 1: Analytical framework

2. Institutional Development of Exercise Referral in the UK and the Definition of Exercise Professionals

2.1 Institutional Development

The first exercise referral schemes in the UK appeared in the late 1980s and early 1990s [18]. The NQAF, published in 2001 and developed for the Department of Health by the British Association of Sport and Exercise Sciences (BASES) and other bodies, was intended to raise the standards of existing schemes and to help new schemes develop; it provided only guidance and recommended quality standards, without any national or regional procedures for approval, registration or monitoring [19]. Subsequent developments followed two lines (Table 1). First, the target population gradually narrowed to people with health problems: in 2014, NICE guideline PH54 restricted funding to people who are sedentary or inactive and have existing health conditions or other risk factors [1]. Second, the requirements for exercise professionals moved from general recommendations on qualifications towards tiered, condition-specific occupational standards. From 2005, the sector skills council SkillsActive and the Register of Exercise Professionals (REPs) jointly developed Level 4 standards for referred populations [20], and by 2007 these had become Level 4 NOS covering conditions such as coronary heart disease, obesity/diabetes and post-stroke care [21]. In 2010, the exercise referral NOS were updated in line with the new REPs framework [18], and in 2025 new standards were issued separately for low-risk and high-risk conditions [22]. REPs itself was merged into the Chartered Institute for the Management of Sport and Physical Activity (CIMSPA) in 2020 [23]. Throughout, the system has rested mainly on guidance documents and industry mechanisms, and the toolkit expressly describes itself as "not policy" [18].

Table 1: Key UK exercise referral documents and their provisions for exercise professionals

Year	Document or event	Issued by	Key points relating to exercise professionals
2001	*Exercise Referral Systems: A National Quality Assurance Framework* (NQAF)	Department of Health (developed by BASES and others)	Provides guidance and recommended quality standards, with no approval, registration or monitoring procedures; uses a pyramid to match population risk to tiers of exercise professionals; requires exercise professionals to be registered and to hold professional liability insurance
2006	Public Health Intervention Guidance No. 2	NICE	Exercise referral intended to promote physical activity should be used only within controlled studies
2007	Best-practice statement on exercise referral	Department of Health	The above restriction applies only to schemes aimed solely at promoting physical activity; schemes for disease management, falls prevention and the like are unaffected
2007	Level 4 NOS in health and physical activity	SkillsActive (developed with REPs)	Cover coronary heart disease, mental health, obesity/diabetes, frail older people/falls prevention, post-stroke and low back pain
2010	Exercise referral toolkit (including the *Exercise Referral Qualifications and Training Guide*)	BHFNC	Describes itself as "not policy"; the Level 3 exercise referral instructor retains overall responsibility for the programme and may, under specified conditions, delegate the leading of low-risk clients to other instructors; Level 3 exercise referral qualifications align with D463 and D464
2014	PH54 *Physical Activity: Exercise Referral Schemes*	NICE	Funding only for sedentary or inactive people with existing health conditions or risk factors; schemes should use core behaviour change techniques and collect data
2020	Agreement between CIMSPA and UK Coaching	CIMSPA, UK Coaching	REPs merged into the CIMSPA directory; CIMSPA membership to become the only professional recognition employers need to check
2025	SKAER1–6 NOS	SkillsActive	Separate "collaborate–design–deliver" units for low-risk and high-risk conditions; the corresponding occupation is advanced personal trainer

Sources: 2001, reference [19]; 2006, the 2007 statement and 2010, reference [18]; the 2007 standards, references [20] and [21]; 2014, reference [1]; 2020, reference [23]; 2025, reference [22].

Table 2: Population tiers and exercise professionals in the NQAF pyramid

Tier	Health characteristics	Settings and typical services	Exercise professionals
General population	Apparently healthy, no physical limitations, no more than one coronary heart disease (CHD) risk factor	Advice or self-referral; indoor and outdoor community leisure settings; sport, strength and circuit training, exercise to music, aquatic exercise, walking, etc.	Exercise & Fitness Coach, Teacher, Instructor
Low risk	Minor, stable physical limitations, or no more than two CHD risk factors	Referral; indoor and outdoor community leisure settings and primary care settings; older people, pre- and postnatal women, people with disabilities, weight management, depression, mild anxiety, etc.	Advanced Instructor (Referred Populations 1)
Medium risk	Significant physical limitation related to chronic disease or disability	Referral; indoor and outdoor community leisure settings and primary care settings, with multidisciplinary involvement; phase IV cardiac rehabilitation, osteoporosis and falls prevention, arthritis, back pain, stroke, Parkinson's disease, etc.	Advanced Instructor (Referred Populations 2)
High risk	Current severe disease or disability requiring highly adapted physical activity under multidisciplinary supervision	Referral; hospital-based secondary and tertiary care settings with medical supervision; phase III cardiac rehabilitation, phase III osteoporosis, falls, intermittent claudication, stroke, dementia, palliative care, etc.	Advanced Instructor (Clinical Exercise)
Cross-tier coordination	All risk tiers	Tertiary, secondary and primary care settings; programme management and training	Clinical Exercise Programme Director

Source: compiled from Figure 1 of reference [19]; the figure is also reproduced in Appendix 4 to Part 4 of reference [18].

2.2 Definition of Exercise Professionals

Exercise professionals are the personnel responsible for designing physical activity programmes for referred clients in exercise referral. They are distinct from the registered health professionals who initiate referrals, from the scheme coordinators who organize schemes and verify staff qualifications, and from the commissioners who specify qualification requirements in service level agreements [18]. NICE refers to the party receiving referrals as a "physical activity specialist or service" [1]; in the toolkit, "exercise provider" denotes the organization or partner providing exercise services rather than an individual practitioner [18]. The 2025 NOS name the corresponding occupation "advanced personal trainer" and those who work with high-risk clients "exercise referral specialists" [22].

3. Role Positioning of Exercise Professionals under Risk Stratification

3.1 Determining tiers of Exercise Professionals by Risk Stratification

The pyramid diagram in the introduction to the NQAF, adapted from the 1995 edition of the American College of Sports Medicine (ACSM) *Guidelines for Exercise Testing and Prescription*, divides participants by increasing health risk into four tiers—the general population and low-, medium- and high-risk groups—and matches each tier with settings, typical services and exercise professionals (Table 2) [19]. Its essence is that required qualifications rise with risk: once referred, low- and medium-risk groups are the responsibility of advanced instructors in community and primary care settings, whereas high-risk groups receive medically supervised instruction in hospital settings. The Level 2, 3 and 4 classification that later became standard derives from REPs and the NOS system [18]. Nor did the NQAF provide uniform criteria for stratification; instead, it required each scheme to develop its own medically led selection criteria. As late as 2010, the toolkit still recommended using, for the time being, either the NQAF pyramid or the "traffic light" tool devised by Irwin and Morgan [18]. The pyramid thus offers a principle of correspondence rather than rigid criteria for classification.

3.2 Delimiting Role Boundaries Through the Transfer of Responsibility

NICE divides exercise referral into four components — identification, referral, assessment and programme determination, and the provision of opportunities to take part—of which the first two are undertaken by health professionals and the last two by a physical activity specialist

or service [1]. The NQAF distinguishes "referral" from "recommendation", in which patients take part on their own initiative and are responsible for their own behaviour, and defines referral as a health professional's deliberate act of directing a patient into an organized, supervised programme. It also sets procedural conditions for the transfer of responsibility: referrals may be initiated only by a medically qualified individual or by an allied health professional working within a protocol with delegated authority, and referral letters should state the reason for referral, a brief medical history and current medication. Exercise professionals are advised not to accept responsibility for a patient until the clinical information is available; only after it has been transferred does responsibility for the safe management, design and delivery of the exercise programme pass to them, and health professionals do not literally prescribe exercise [19]. The toolkit adds that the referrer owes the same duty of care as when referring a patient to any other third party for further treatment, and that the GP remains responsible for the overall management of the patient's clinical care [18]. Exercise professionals are thus positioned as delegates who are responsible for the exercise programme under the authorization of, and with information supplied by, the healthcare side, rather than as independent diagnosticians or prescribers.

3.3 Regulating the Service Process Through a Chain of Duties

Drawing on the NQAF, the toolkit breaks the duties of exercise professionals down into ten sequential steps (Figure 2), forming a duty chain with three features. The first is documentation: the referral form should be signed by the referrer, and a personalized programme should be produced in writing and agreed with the patient. The second is continuous monitoring: contraindications and responses to exercise are checked before, during and after every session, with reviews at the mid-point and at the end. The third is closed-loop feedback: the referrer is informed after the initial assessment, at the mid-point and at the end, so as to support them in discharging their clinical responsibility. These arrangements respond to the instability of adherence among referred clients, yet they are not fully implemented: adherence in the first five to six months is about 50%–80%, most dropouts occur within the first 12 weeks, and only about half of schemes conduct mid-point reviews [18].

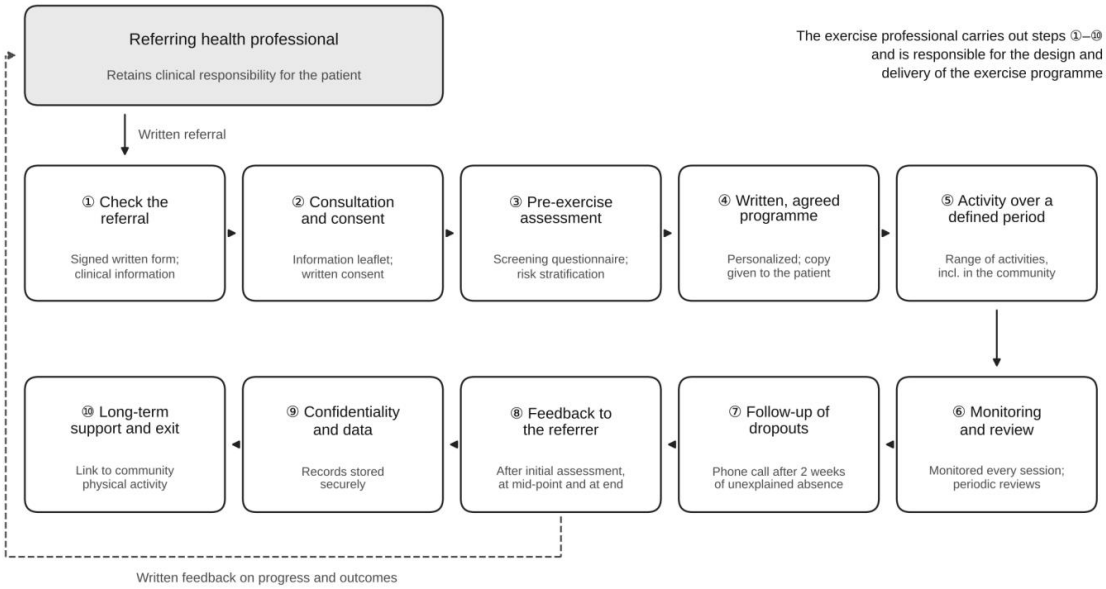


Figure 2: Chain of duties of exercise professionals in exercise referral

Source: compiled from Part 5 of reference [18].

3.4 Constraining the Client Population Through the Scope of Application

Role boundaries are also reflected in the range of clients served. High-risk patients with current severe disease or disability are "not considered suitable for a general exercise referral scheme" and should instead be referred to specialist services such as phase III or IV cardiac rehabilitation, stroke rehabilitation and rehabilitation for chronic obstructive pulmonary disease (COPD); people with absolute contraindications, such as a resting blood pressure ≥180/100 mmHg or unstable angina, should not exercise until their condition has been stabilized [18]. On the practice side, exercise professionals undertake only activities consistent with their training and competence and should refer clients back to the referrer when goals, activities or risks exceed their competence [18]; the 2025 standards likewise list knowing the limits of one's own scope of practice and referring higher-risk individuals to other professionals among the required knowledge and skills [22]. Exercise professionals in UK exercise referral are therefore "bounded delegates": they accept clients according to risk stratification, take responsibility for the exercise programme while leaving clinical responsibility with the referrer, and practise only within the scope recognized by their qualifications.

4. Competence Standards and the Qualification System for Exercise Professionals

The UK has no statutory licence to practise in exercise referral. The competence of exercise professionals is defined by the NOS, attested by qualifications, recognized through industry registration and written into scheme requirements through service commissioning.

4.1 Defining Competence Through the National Occupational Standards

As summarized in Part 9 of the toolkit, the *Exercise Referral Qualifications and Training Guide*, the NQAF recommends that those who design programmes hold, at a minimum, a Level 3 advanced instructor qualification, a recognized exercise referral qualification and a cardiopulmonary resuscitation (CPR) qualification. Before April 2010, exercise referral qualifications had to meet NOS unit D449, "Design, agree and adapt a physical activity programme with referred patients and clients", one of whose core components is the stratification of referred clients into low, medium and high risk [18]. From April 2010, Level 3 exercise referral qualifications were required to cover four core Level 3 standards, including C22, and to align with two exercise referral standards, D463 and D464; holding a Level 3 advanced instructor qualification was no longer a prerequisite [18]. The 2025 SKAER suite comprises six units organized around collaborating to determine needs and goals, designing the programme and delivering it; SKAER1–3 address individuals with low-risk health conditions and SKAER4–6 those with high-risk conditions. For the first time, the glossary defines risk: low risk refers to conditions that are stable and well controlled, with little likelihood of a serious adverse event, whereas heart disease, cancer, diabetes with complications and COPD, among others, are classed as high risk [22]. In 2010, COPD was still among the conditions that Level 3 exercise referral instructors could work with [18], so the allocation of conditions has shifted accordingly. Duties such as obtaining informed consent, screening for risk, reporting progress to the referrer and referring on when a case exceeds one's competence have also been written into performance criteria (Table 3) [22].

Table 3: Units of the exercise referral competence standards mapped against the duty chain

Period	Unit	Unit title or main content	Steps in the duty chain
Before April 2010	D449	Design, agree and adapt a physical activity programme with referred patients and clients; one core component is identifying conditions by low, medium and high risk and stratifying referred clients	③④⑥
From April 2010: core Level 3 standards	C22	Promote health, safety and welfare in active leisure and recreation	⑤⑥
	C317	Work with clients to help them to develop and maintain adherence strategies	⑦⑩
	A335	Reflect on and develop own practice in providing exercise and physical activity	CPD
	D459	Evaluate exercise and physical activity programmes	⑥
From April 2010: exercise referral standards	D463	Design, manage and adapt a physical activity programme with referred patients/clients	③④⑥
	D464	Plan and instruct physical activities with referred patients/clients	⑤⑥
From 2025: low risk	SKAER1	Collaborate with individuals with health and medical conditions to determine and plan their physical activity needs and goals: obtain informed consent, determine the risk level through screening, liaise with other professionals about the information obtained, and agree action plans and goals	①②③
	SKAER2	Design a physical activity programme: agree programme content, evaluation methods and review dates with the individual, and record the programme	④⑥
	SKAER3	Deliver physical activity programmes: manage risk throughout, use behaviour change techniques, report progress to the referrer, refer on when beyond own competence, and promote long-term participation	⑤⑥⑧⑩
From 2025: high risk	SKAER4–6	Same steps as SKAER1–3, for individuals with high-risk health conditions; carried out by "exercise referral specialists" applying knowledge of high-risk conditions	As above

Note: Step numbers follow Figure 2 and were assigned by the author on the basis of unit titles and performance criteria. Sources: units up to 2010 compiled from Part 9 of reference [18]; units from 2025 compiled from reference [22].

The qualification pathway has continued into the CIMSPA era. The Active IQ Level 3 Diploma in Exercise Referral (now closed to new registrations) admitted learners holding qualifications such as Level 2 fitness instructing; it comprised six mandatory units totalling 38 credits and was assessed through a combination of multiple-choice examinations, practical assessment, assignments and a portfolio of evidence [24]. CIMSPA's career guidance lists qualification pathways that include the Level 3 Diploma in Exercise Referral and a Level 3 diploma focused on long-term conditions, and requires learners on the exercise referral diploma to hold a Level 3 personal trainer or Pilates qualification first [25]. The learning outcomes of the Level 3 exercise referral diploma course promoted by CIMSPA in 2025 still include risk stratification in exercise referral and the clinical features of referral-related conditions [26].

4.2 Delimiting Scope of Practice Through Tiered Qualifications

Drawing on the REPs registration categories, the toolkit distinguishes Level 2 instructors, "other instructors", Level 3 exercise referral instructors and Level 4 specialist instructors (Table 4). Level 3 exercise referral instructors are central: schemes must not operate without staff registered in this category and must not use only Level 2 fitness instructors, and the Level 3 instructor should design, agree, adapt and review the programme and retain overall responsibility for the referred client. Schemes that offer specialist whole classes for conditions such as cardiac rehabilitation, falls prevention and stroke must have programmes designed by staff holding the relevant Level 4 qualification [18].

Because of a shortage of qualified staff, activities such as yoga, tai chi and walking are led in many schemes by instructors who may not hold an exercise referral qualification. Rather than prohibiting this outright, the toolkit states that the practice does not represent national policy and applies only to schemes in which a qualified Level 3 professional is responsible for the programme, and it sets conditions for delegation: the Level 3 professional must confirm through documented risk stratification that the client is low risk, ensure that the instructor holds a qualification for the activity being taught and inform the client that the instructor holds no exercise referral qualification; medium-risk clients should be supervised by Level 3 or Level 4 staff at all times; and the toolkit strongly recommends that instructors have emergency first aid skills and insurance and be able to recognize adverse events such as hypoglycaemic episodes and asthma attacks [18].

Table 4: Qualification tiers and scope of practice in UK exercise referral

Category	Qualification and registration requirements	Clients served	Duties and limits
Level 2 instructor	Level 2 fitness instructing qualification	General population; may lead sessions as an "other instructor" in referral schemes	Does not design programmes for referred clients; schemes must not use only Level 2 instructors
"Other instructors" (leaders of yoga, tai chi, dance, swimming, walking, etc.)	Qualification in the activity taught and REPs registration; emergency first aid and insurance	Low-risk clients confirmed by documented risk stratification	Lead sessions under the overall responsibility of a Level 3 exercise referral instructor and do not design programmes; must understand role boundaries, contraindications and risk factors, and be able to recognize adverse events; must inform clients that they hold no exercise referral qualification
Level 3 exercise referral instructor	NQAF recommendation: Level 3 advanced instructor qualification + recognized exercise referral qualification + CPR qualification. Before April 2010 the referral qualification had to meet D449; thereafter it had to cover the core Level 3 standards and align with D463 and D464, and a prior Level 3 advanced instructor qualification was no longer required. Registration in the REPs Level 3 exercise referral category	Low- and medium-risk referred clients; may work with five groups of common conditions	Designs, agrees, adapts and reviews programmes and retains overall responsibility for clients; medium-risk clients must be supervised by this instructor or a Level 4 instructor at all times
Level 4 specialist instructor	Level 4 qualification for the relevant condition; registration in the corresponding REPs Level 4 category	Six condition areas: cardiac rehabilitation, falls prevention, low back pain, stroke, obesity and/or diabetes, and mental health	Responsible for programme design in specialist whole classes for these conditions; cardiac patients, regardless of individual risk, must be the responsibility of staff holding a Level 4 cardiac rehabilitation qualification

Source: compiled from Part 9 of reference [18].

4.3 Implementing Qualification Requirements Through Registration and Commissioning

Registration turns qualifications into a verifiable professional identity. The NQAF proposes that exercise professionals should join the Professional Register for Exercise and Fitness in England and hold professional liability insurance [19]; registration in the Level 3 exercise referral category signifies that the practitioner holds a referral qualification that meets the NOS, maintains competence through continuing professional development, is bound by a code of ethical practice and holds adequate insurance. Following the merger of REPs into CIMSPA, CIMSPA membership is to become the only professional recognition that employers need to check [23]. Commissioning, in turn, converts qualification requirements into contractual obligations and a basis for accountability. The toolkit recommends that commissioners specify the registration category of programme designers in service level agreements, set out in service specifications the action to be taken if standards are not met, and have coordinators verify registration status regularly; if a referred client suffers an adverse event in a session led by an instructor without the appropriate qualification, that instructor would be deemed to be working outside their code of practice and beyond their training and competence, and could be held liable [18].

5. The internal Logic of the UK Experience

5.1 Binding Risk to Qualifications

Who receives a referred client depends on the client's health risk, not on the instructor's sport or years of practice. From the tier matching of the NQAF pyramid [19], through the division of labour between Level 3 and Level 4 staff and delegation restricted to low-risk clients [18], to the 2025 standards with separate units for low and high risk [22], client risk has consistently been the basis for allocating personnel, so that the qualifications of receiving practitioners are commensurate with the risks of their clients. Ireland's tiering of service-provider qualifications by participant category [8] reflects the same logic.

5.2 Binding Duties to Standards

Most steps in the duty chain can be matched to assessable units in the NOS (Table 3). Once duties are codified in standards, training and assessment acquire a common basis and qualifications acquire a definite meaning, so the healthcare side need not get to know each instructor individually.

5.3 Binding Standards to Registration

Registration turns "meeting the standards" into a verifiable status. For doctors, registration signifies that the receiving practitioner's qualifications meet the NOS, that the practitioner undertakes continuing professional development and that he or she is insured; for commissioners and coordinators, registration is a requirement written into service level agreements and a basis for periodic checks. The transfer of the register from REPs to CIMSPA has not changed the practice of verifying professional recognition through registration.

5.4 Producing Institutionalized Trust Through Soft Constraints

What the triple binding produces is precisely institution-based trust. Doctors and community exercise instructors rarely have long-standing working relationships, so the trust that referral requires comes mainly from formal structures such as standards, certificates and registration. Training eases doctors' concerns about litigation [1], and registration allays their worries about being held to account professionally [18]. Because practitioners accept only clients whose risk matches their qualifications, and because responsibility for the exercise programme and clinical responsibility are divided at the point of referral, qualifications and registration provide a basis for judging whether an instructor has overstepped his or

her remit if an adverse event occurs [18]. None of these bindings relies on statutory licensing. The NQAF has no approval or monitoring procedures [19], and REPs is not a statutory regulator; acceptance of its registrants on the healthcare side rested on recognition by the Department of Health and a statement by the General Medical Council. What actually operates are three kinds of soft constraint: qualification clauses in service level agreements, industry registration combined with continuing professional development, and professional insurance [18]. From the perspective of occupational regulation, the absence of licensing reduces restrictions on workforce supply, conditional delegation allows schemes to run when qualified staff are scarce, and the successive adjustments to entry thresholds can likewise be understood as trade-offs between assuring competence and maintaining supply.

6. Implications for Social Sports Instructors in China

Social sports instructors in China have developed along two tracks. The first comprises volunteer social sports instructors, who are awarded technical grades under the *Measures for the Administration of Social Sports Instructors*; their work is characterized as national fitness volunteer service "not undertaken for remuneration", and they are graded, from lowest to highest, as Level 3, Level 2, Level 1 and National Level [27]. The second comprises occupational social sports instructors, who are assessed under the *National Occupational Skill Standard: Social Sports Instructor (2020 Edition)* and graded from Level 5 (lowest) to Level 1 (highest) [28]. Measured against the triple binding, both tracks still fall short (Table 5).

6.1 Current Status and Gaps Measured Against the Triple Binding

6.1.1 Risk and qualifications: grades are not linked to clients' health risk

Grades on both tracks mainly reflect technical proficiency and years of practice. All 11 activities included in Guangdong's first batch of technical training specifications are sports, and promotion depends on how long a certificate has been held [29]; eligibility for each level on the occupational track likewise rests mainly on years of work experience [28]. The occupational standard does touch on health risk: Level 4 requires the ability to identify "the exercise risk level of the person being instructed", and Level 1 requires the ability to "cooperate with medical advice and provide medically adjunctive fitness instruction" [28]. These, however, are requirements for individual knowledge and skills; they do not specify which level of instructor should receive clients at which level of risk. The key skills marked with "★" in the standard are defined as "key skills for instruction in high-risk sports" [28], and the 2021 edition of the *National Catalogue of Vocational Qualifications* retains only social sports instructors working in high-risk sports [30]. "Risk" in the Chinese system thus refers mainly to the hazards of the sport itself, whereas risk in UK exercise referral refers to the client's health risk.

6.1.2 Duties and standards: training centres on sport-specific technique and lacks interfaces with the healthcare side

Training on the volunteer track focuses on sport-specific technique. The Guangdong specifications set centralized theory training at 8 class hours for every grade and technical training at 12–24 class hours; health-related content is limited to topics such as the prevention and treatment of common sports injuries, fat loss and, at Level 1, "exercise therapy for common chronic diseases", with no first aid or risk screening [29]. Requirements on the occupational track are more complete: Level 4 requires CPR and Level 3 the use of an automated external defibrillator (AED). Yet the standard contains nothing on referral, informed consent, feedback to doctors or the confidentiality of health information [28]—precisely the steps in the UK duty chain that connect with the healthcare side (Figure 2). Capacity on the healthcare side is also limited. Interviews with general practitioners in primary care show that their ability to issue exercise prescriptions is weak and that relevant training is scarce [31]; although doctors are entitled to prescribe exercise, some lack the relevant educational background, while the prescribing authority of exercise and health professionals is not recognized by the healthcare system [12]. With gaps in capacity at both ends of the referral, the duties of receiving practitioners need all the more to be defined in advance.

6.1.3 Standards and registration: registration reflects service activity, and the healthcare side has no means of verification

The volunteer track has a relatively complete registration system: annual service registration is conditional on the number of service sessions and is conducted through GASC's information management system for social sports instructors [27]. Registration, however, reflects how active an instructor is rather than health-related competence. On the occupational track, after level-assessment vocational qualifications for skilled personnel were removed from the national catalogue, skill-level certification and the issuing of certificates passed to employers and social training and evaluation organizations [32]. Certificates on both tracks are therefore recognized within the sports system or the vocational skills evaluation system and have not yet been linked to the referral processes of medical institutions. There have been experiments in specialized fields: Health Qigong exercise prescribers, for example, are managed by grade, and those awarded a grade must register with the Chinese Health Qigong Association [33]; the China Sport Science Society has also run training and certification for exercise prescribers. Yet no "dual certification" across sport and healthcare has emerged, and the electronic registration information system of the National Health Commission does not include exercise prescribers [9]. The healthcare side therefore lacks a public channel for confirming the qualifications of receiving practitioners.

Table 5: Comparison of UK exercise professionals and social sports instructors in China

Dimension	UK exercise professionals	Volunteer social sports instructors (China)	Occupational social sports instructors (China)
Basis of grading	Client health risk (general, low, medium, high)	Technical grade; promotion depends on years of certification (Guangdong: Level 2 requires holding a Level 3 certificate for at least 2 years; Level 1 requires holding a Level 2 certificate for at least 3 years)	Occupational skill level; eligibility based mainly on years of work experience
Meaning of "risk"	Client health risk, stratified individually and in writing	Not specified	Mainly the hazards of the sport (★ marks key skills for high-risk sports); Level 4 must be able to identify the exercise risk level of the person instructed
Vehicle for competence standards	NOS units (SKAER suite from 2025)	Provincial technical training specifications (Guangdong's first batch of 11 sports)	National Occupational Skill Standard (2020 Edition)
Health and first-aid content	Risk stratification, common conditions, behaviour change; CPR qualification required	Sports injuries, fat loss, exercise therapy for chronic diseases (Level 1); no first aid	Indications and contraindications, cooperation with medical advice; ★CPR, ★AED
Training and assessment	Level 3 exercise referral diploma requires a prior fitness instructing qualification (CIMSPA now requires a Level 3 personal trainer or Pilates qualification); e.g., the Active IQ diploma: 6 mandatory units, 38 credits, assessed by written examination, practical assessment and evidence portfolio	8 theory hours + 12–24 technical hours + self-study; theory 40% + technique 60%; pass mark 60	At least 150 standard class hours per level; pass mark 60; failing any ★ item means failing the skills assessment
Registration and verification	Industry register (REPs, now CIMSPA); qualifications specified in service level agreements and checked regularly by coordinators	Registration in the information management system; annual service registration based on the number of service sessions	Skill-level certification, with certificates issued by employers and social training and evaluation organizations
Interface with the healthcare side	Exercise professionals responsible for the exercise programme, referrers retain clinical responsibility; the General Medical Council accepts registered professionals	No institutional arrangements	Level 1 must be able to "cooperate with medical advice"; no requirements on referral, feedback or confidentiality of information
Implementation mechanisms	Service level agreements, industry registration, professional insurance	Administrative award and registration; insurance where local conditions permit	Skill-level certification

Sources: the UK column is compiled from Tables 1–4, with the training and assessment row also drawing on references [24] and [25]; volunteer social sports instructors, references [27] and [29]; occupational social sports instructors, references [28] and [32].

6.2 Embedding the Triple Binding in Referral Protocols and Government Service Procurement

Learning from the UK does not mean copying it. Volunteer social sports instructors in China work mainly on an unpaid, voluntary basis and should not bear primary responsibility for programme design and safety management; on the other hand, making statutory licensing the entry threshold could constrain an already limited supply of personnel [17]. The 2025 *Guiding Opinions* call for "research on establishing training standards, post qualification certification and a training curriculum system for exercise-for-health guidance practitioners, and clarifying entry thresholds" [2]; the triple binding can serve as a reference for such post qualification certification.

6.2.1 Establishing an exercise referral professional post and delimiting receiving boundaries by risk stratification

An "exercise referral professional" post could be established among exercise-for-health guidance practitioners, responsible for pre-exercise assessment, drawing up written programmes, retaining overall responsibility for referred clients and reporting back to doctors. Holders could be drawn from occupational social sports instructors who have passed a specialized assessment, exercise prescribers, rehabilitation therapists and community health workers; certification would build on their existing occupational or professional and technical qualifications, with registration following a specialized exercise referral assessment and maintained through continuing training. On this basis, the receiving scope of each category of personnel would be delimited by risk stratification (Figure 3). The general population would be instructed directly by social sports instructors of all grades. Low-risk clients would be assessed by, and remain under the overall responsibility of, an exercise referral professional, with social sports instructors leading activities such as tai chi, Health Qigong and brisk walking on a delegated basis and keeping records and reporting back as required. Medium-risk clients would exercise under the supervision of exercise rehabilitation staff or health professionals, and social sports instructors would not lead them alone. High-risk clients would be referred to specialist services in medical institutions. This arrangement corresponds to the UK practice in which "other instructors" lead low-risk clients under the overall responsibility of a Level 3 exercise referral instructor [18], and it also fits the voluntary character and sport-specific expertise of volunteer social sports instructors. The teams organized in Shanghai around community physical fitness testing stations, each consisting of "one community doctor, one social sports instructor and two leaders of health self-management groups" [4], could provide an organizational basis for this division of labour.

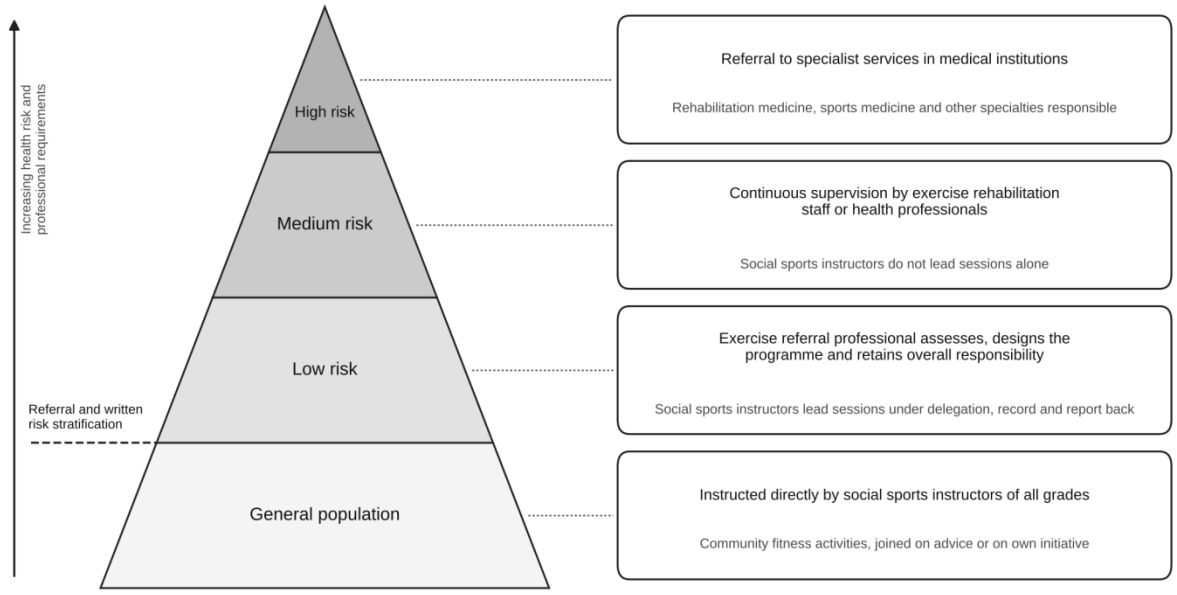


Figure 3: Proposed matching of risk tiers and personnel for exercise referral in China
Source: designed by the author with reference to the qualification tiers in Part 9 of reference [18].

6.2.2 Completing the duty chain with competence units

A specialized "exercise referral" module could be added to the occupational skill standard, with competence units organized, following the SKAER suite, around collaborative assessment, programme design, and delivery and feedback [22]. Its content would include pre-exercise screening and risk identification, key exercise considerations and contraindications for common chronic diseases, reading referral information and providing written feedback, behaviour change support and dropout follow-up, and CPR and AED use. The current standard applies the rule that failure to meet the requirement for any "★" key skill means failing the skills assessment [28]; screening, first aid and the handling of referral information could be designated key skills in the specialized module. On the volunteer track, first aid and risk screening could be made compulsory in provincial training specifications.

6.2.3 Achieving verifiability through registry designations and information rules

An "exercise referral" designation could be added in the information management system for social sports instructors for those who pass the specialized assessment, with queries opened to community health service centres and family doctor teams, and retention of the designation linked to continuing training and annual service registration [27]. This would create a mechanism similar to the UK practice of maintaining registration through continuing professional development [18]. It is consistent with proposals for a publicly searchable database of exercise prescribers [10], the difference being that it starts from an existing large-scale registration system. The transfer of health information in referral also needs clear rules. Under Articles 23, 28 and 29 of the *Personal Information Protection Law of the People's Republic of China*, medical and health information is sensitive personal information; its processing requires the individual's separate consent, and when it is provided to another processor the individual must also be informed of the recipient's name, the purpose of processing and the categories of information [34]. Referral forms could accordingly include a separate consent field and transmit only the diagnoses, medications and risk level relevant to exercise safety.

6.2.4 Assigning responsibility through referral protocols, service procurement and insurance

Implementing these requirements does not require new legislation. Within the working coordination mechanism called for by the *Guiding Opinions* [2], municipal sports and health authorities could jointly draw up community exercise referral protocols specifying risk stratification criteria, the format of referral forms, feedback points and the responsibilities of each party: the healthcare side retains clinical responsibility, the exercise referral professional is responsible for the exercise programme, and social sports instructors are responsible for the sessions they lead. As for funding, the assessment and programme stages could be incorporated, on an exploratory basis, into contracted family doctor services or local medical service fee schedules—Beijing, Hunan, Jiangsu and other places have already added items such as "exercise prescription" to their medical insurance fee schedules [4]—while the session-leading stage could be paid for by sports authorities through government service procurement, with contracts stipulating that personnel must hold the specialized designation. With regard to risk sharing, sport–medicine integration services currently lack a government-level risk-sharing mechanism, and the supply of relevant liability insurance does not match demand [4]. The *Measures for the Administration of Social Sports Instructors* already require localities, where conditions permit, to insure social sports instructors engaged in volunteer service [27]; this could be extended to exercise referral services, with service providers required to take out appropriate liability insurance. Guangdong could pilot the approach first in one or two prefecture-level cities, building on community health service

centres and exercise-for-health centres [2].

7. Conclusion

Exercise professionals in UK exercise referral are "bounded delegates": they accept clients according to risk stratification, take responsibility for the exercise programme while leaving clinical responsibility with the referrer, and practise only within the scope recognized by their qualifications. This role is underpinned by the triple binding of risk to qualifications, duties to standards and standards to registration, together with soft constraints such as service level agreements, industry registration and professional insurance, which provide the healthcare side with institutionalized trust without relying on statutory licensing. China has a very large workforce of social sports instructors, but their grades are not linked to clients' health risk, and they lack both duties that interface with the healthcare side and channels through which their qualifications can be verified. A reasonable starting point for their participation in exercise referral is to lead sessions for low-risk clients under the overall responsibility of exercise referral professionals, and then, through specialized competence modules, designations in the information system, referral protocols and service procurement contracts, to build step by step a triple binding suited to China's institutional context.

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