HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM: NHS Lothian Department of Public Health and Health Policy

1. To what extent does social prescribing for physical activity and sport increase sustained participation in physical activity and sport for health and wellbeing?

Whilst the evidence base around the efficacy of social prescribing in relation to physical activity is growing, it is currently limited. Results from evaluated UK schemes do show a number of positive outcomes for participants as per these ten key findings which emerged from Thomson et al's summary of the evidence:

1. ‘Increase in self-esteem and confidence, sense of control and empowerment
2. Improvements in psychological or mental wellbeing, and positive mood
3. Reduction in symptoms of anxiety and/or depression, and negative mood
4. Improvements in physical health and a healthier lifestyle
5. Reduction in number of visits to a GP, referring health professional, and primary or secondary care services
6. GPs provided with a range of options to complement medical care using a more holistic approach
7. Increases in sociability, communication skills and making social connections
8. Reduction in social isolation and loneliness, support for hard-to-reach people
9. Improvements in motivation and meaning in life, provided hope and optimism about the future
10. Acquisition of learning, new interests and skills.’

Systems, structures and opportunities in relation to social prescribing for physical activity are currently variable but evidence from associated interventions, such as: exercise referral programmes; mental health focused and green health interventions, indicate that there is an increased likelihood of sustained participation in physical activity and sport for health and wellbeing if programmes are delivered in a planned, cohesive and effective manner. In developing social prescribing programmes it is important to recognise that support and investment is required to ensure a ‘whole-system’ approach where each aspect of the process is resourced to function efficiently.

For example, those responsible for making referrals are supported to fully understand and value the process. The referral process has clear criteria and pathways are straightforward. Skilled link workers, whose value in supporting inequalities based approaches is highlighted by Scottish Government’s Community Link Worker Programme, are in place, have access

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to good quality information, are connected to community networks and have high quality services/facilities that can provide the support required\(^2\). A person-centred approach is taken where the value and benefits of the process of assessing needs and identifying interventions and sources of support are clearly communicated, and structured and personalised planning is supported through a co-production approach. Community and voluntary sector projects and programmes must be resourced adequately and sustainably to provide a range of supportive activities for which there is evidence of benefit. Organisations must be grounded in and have the trust of the communities they serve as well as trust of staff in statutory bodies. It should be clear that the GP practice provides clinical oversight but staff will often require practical support, education and training and an escalation procedure for rapid access to a specialist health professional where a patient’s condition deteriorates. Information sharing agreements that enable relevant information to be shared securely and the extent to which individuals are benefiting, as well as services being delivered to appropriate standards, are essential. At organisational level, they should be linked into Health and Social Care Partnerships as well as other public sector commissioning and funding programmes. Current evidence indicates that all of these elements should be present for the best chance of success but the level of variation in referral, provision, funding etc. means that further work is required to identify an optimal model and to determine whether the social prescribing model of connecting individuals with tailored voluntary and community sector resources is effective and cost effective\(^3\).

While social marketing approaches can raise awareness of the potential for support, and support for health literacy can enable people to understand and make choices about what to engage with, a direct referral from a trusted health professional or similar is likely to have a more motivating effect and can help reduce the stigma associated with asking for help. It is also essential that barriers to accessing support and services are addressed in an evidence based and systematic way to enable people to engage. People suffering from chronic ill-health, disability, social and mental health problems, etc. have an increased risk of being or feeling socially isolated. Participation in an activity (especially group based activity) has the potential to help ameliorate this and to provide the benefits that even small increases in physical activity are shown to confer. Although poor self-esteem, low self-confidence, social anxiety, depression, low levels of resilience and feelings of vulnerability and stress are all symptoms which can be associated with social isolation. Any of these may tend to inhibit someone’s ability to take on new and unfamiliar challenges. Hence it is critical that link workers are skilled to understand and support people who might have complex social and emotional as well as psychological and physical health issues.


For someone to engage in a new activity they may need to be accompanied to assist them getting ‘over the threshold’ as well as for a further period while they become oriented and sufficiently confident to sustain engagement. Signposting, like information giving, may be necessary but are not sufficient and have the potential to increase inequalities.

Collaborative, goal oriented planning can provide the basis for both individuals and organisations to quantify outcomes and assess and review progress.

As to where people can be referred to, there needs to be a broad range of opportunities within local communities to ensure equity of opportunity for people of all abilities, genders, ages and ethnicities. Allied to this is the need to have easily accessible and up to date information of which activities are available, where and when they happen, who they’re suitable for and what they cost (particularly given the promising evidence of the benefit of free access to leisure facilities)\(^4\).

To enable all of this to function effectively requires a planned, structured approach that has clear and embedded governance and management functions.

2. **Who should decide whether a social prescription for physical activity is the most appropriate intervention, based on what criteria? (e.g. GP, other health professional, direct referral from Community Link Worker, self-referral)**

Ideally all health and social care professionals, clinical staff, allied health professionals, pharmacies, mental health services, social work staff, community organisations, families and self-referrals should be possible. This would be largely dependent on how effective the systems were to support social prescribing, as described. Particularly having a sufficient number of sufficiently skilled link workers, who are vital to the functioning of the whole process. As noted above, however, given that the target population is people with mental and physical health problems, low income, disability and complex social circumstances, it is important to be clear that the GP practice retains overall clinical responsibility for the patient and that escalation procedures are in place, should a person’s condition deteriorate.

3. **What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?**

Barriers to social prescribing include the perceptions of both professionals and public. The variation in models may mean that some medical professionals may feel that social prescribing is woolly, unfamiliar and clinically unproven. Patients may be unwilling to accept that a referral to a walking group for their hypertension or being referred to a gardening group for mild anxiety, as part of their treatment, is too novel or may perceive the

intervention as a cheap alternative to being prescribed something pharmaceutical. In reality, services designed to meet these needs have been available, intermittently, for many years\(^5\).

Workforce development, training and awareness raising would assist in enabling professionals to better understand the process and its benefits. Social marketing campaigns and health literacy programmes might assist in increasing public awareness and understanding of the benefits of these interventions, anchored within organisations with long-term funding.

Having the resources to deliver social prescribing effectively is also a potential barrier. It would be useful to look at how a network of peer support volunteers could be engaged and supported to work alongside skilled and connected link workers to support vulnerable people to engage in activities and sustain that engagement. Commitment to the process by Community Planning Partnerships, particularly Integration Joint Boards, Health Boards and Local Authorities, is also crucial. A national and local compact with third sector organisations is required to ensure that they are embedded in localities. This will require a strategic shift in resource use to invest in a more preventative and community based approach where third sector and voluntary organisations receive longer term funding as part of a planned commissioning process to develop social prescribing opportunities.

4. **How should social prescribing for physical activity and sport initiatives be monitored and evaluated?**

The evaluation of complex community interventions should be the subject of a specific public health call by Chief Scientist Office, mirroring NIHR/MRC programmes at UK level and learning from similar programmes in North America, Australia/New Zealand and Europe. Since the 2006 MRC/NIHR guidance is being updated in 2019\(^6\), this would be timely. This would also have the potential to reduce the research waste associated with repeated small scale evaluation of variable quality undertaken outside of standard public health and research governance arrangements. Currently, there are trials and evaluations of social prescribing being undertaken in England\(^2,3\) and other countries, that use the existing framework and undertake this as core public health applied research. Until the new framework is available for use, we have set out some of the practical problems below.

Evaluation of social prescribing for physical activity and sport initiatives is complicated by the likelihood of there being a diverse range of stakeholders involved, all of whom may have different perspectives and expectations of what should be measured and what qualifies as a valid outcome. Thus, a mixed-methods approach may need to be employed, combining quantitative methods to evaluate the effects on health and healthcare services with qualitative ethnographic methods to observe how patients engage with social prescribing. For partners, measures of success might be as varied as numbers of sessions.

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attended, weight lost, levels of happiness, minutes spent being moderately active, reduction in medication, forestry skills developed, blood pressure levels, reduction in clinical visits, increased self-confidence, participation in activities beyond the referral, engagement in pathways to training or work, reduction in treatment costs, reduced prescribing budget; all of which might be produced in the form of data and spreadsheets or case studies and stories. Importantly both evaluation and monitoring must consider longer term effects of social prescribing as an intervention, for example sustaining various of the short term measures above and validated measures of longer term wellbeing.

What is monitored and evaluated is likely to be dependent on who the key stakeholders in the process are. Outcomes and measures should be negotiated at the outset of a programme and reviewed regularly. Whilst structured person-centred plans with stated outcomes for participants may assist in providing data on the efficacy of the programme at participant level, measures for process evaluation, overall outcomes and cost effectiveness etc. should be designed through consultation and negotiation.

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The closing date for receipt of submissions is Friday 30 August.