HEALTH AND SPORT COMMITTEE
SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT
SUBMISSION FROM NHS Greater Glasgow and Clyde

The NHS Greater Glasgow & Clyde (NHSGGC) response to the Health and Sport Committee of the Scottish Parliament who are seeking views on social prescribing’s ability to tackle physical and mental wellbeing issues across Scotland, is as follows:

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

The evidence that participation in physical activity is beneficial and potentially as effective as pharmaceutical intervention for some chronic conditions is well established. Recent evidence points towards inactivity as a global public health concern. However, there is little high-quality evidence available specifically on the long term effects of social prescription and sustained participation in securing sustained physical activity.

Evidence from wider aspects of physical activity promotion which involve connecting individuals to physical activity opportunities which is relevant and the Health And Sport Committee should consider evidence relating to: individual and community based physical activity interventions, rehabilitation programmes, and exercise referral and link to the systems based approach advocated by World Health Organization.

Whilst the use of social prescribing as a model for wider health promotion has become more popular, a recent editorial in British Journal of General Practice urges caution and calls for more robust evaluation “social prescribing has proliferated without a concomitant evidence base. This is partly due to resource limitations on evaluators and partly due to difficulties in conceptualising what social prescribing is and what good evidence for a complex service might look like.”

Barriers to the lack of evidence in this field include:

5. NICE (2018) Physical Activity and the Environment (NG90)
7. NICE (2013) Physical Activity: Brief Advice for adults in Primary Care (PH44)
A lack of clear definition for social prescribing and its inherent heterogeneity means the term is used interchangeably to describe a range of different interventions which offer a varied level of support for individuals i.e. the provision of a leaflet for a local health walk (commonly referred to as signposting) and health professional referral to a 12 month, one-to-one, behavioural change support service could both be described as social prescribing. This makes robust evaluation in this field problematic, however both can be effective when patient centred.

The significant variation in nature, duration and data collection of ‘lifestyle and physical activity’ interventions provided under the heading of exercise referral for example significantly limits robust systematic evaluation. A further difficulty with many ‘on referral’ schemes is that initiatives are generally short in duration (<12 weeks) and as such are unable to demonstrate sustained behaviour change\textsuperscript{10}.

NHSGGC provide the biggest Exercise Referral scheme in Scotland (Live Active) with 7,060 referrals annually. The scheme is delivered in partnership with local leisure trusts and provides patients with one-to-one, personalised behavioural change support from a trained advisor for up to 12 months.

Local evaluation has demonstrated that ongoing contact from advisors promotes adherence and that there are self-reported health benefits for patients participating in the scheme, including: increased physical activity levels; reduced blood pressure; weight loss; improved mental health; and improved social health. Over two thirds of patients who were retained in Live Active, felt that participation in the scheme had given them the confidence to exercise independently. Even 18 months after their first appointment, most patients reported maintenance of physical activity behaviour and felt that the scheme had a positive impact on their physical and mental health, and on their ability to exercise independently. However more robust evaluation is needed to understand how different groups of patients respond to the intervention and how to enhance retention in the scheme \textsuperscript{11}

Local evaluation has also identified limitations to a behavioural intervention only model with the need to embed actual physical activity participation as a core element of the delivery model providing improved levels of actual physical activity. In areas where advisors offer integrated physical activity classes and health walks, a greater proportion of patients remain engaged with the scheme to 12 months. It is possible that these classes provide both practical and social support for clients and an opportunity to engage in PA in a non-threatening environment. This aligns with findings from the weight loss intervention, Football Fans in Training\textsuperscript{12} which notes that coach-led physical activity training and mutual encouragement were central to the intervention’s success. Data from Leisure Trusts membership and gate entry systems could be used to demonstrate the connection between


\textsuperscript{11} FMR Research Ltd (2009) Live Active Referral Scheme 2005

the behavioural components and longer term physical activity levels when clients choose to participate in local authority facilities.

The potential to undertake longer term follow up of patients after a social prescription (particularly in the context of community based activities) is limited. The Scottish Physical Activity Research Connections (SPARC) Network and the Scottish Collaboration for Public Health Research (SCPHRP) may be well placed to assist with the development of a more comprehensive evaluation framework. Realist evaluation approaches which consider the wider system and pathway of social prescribing as well as the efficacy of individual interventions is crucial to developing a better understanding of successful models.

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)

A successful social prescription is dependent on the ‘readiness’ of the individual to engage. Many individuals who require support to participate in physical activity i.e. are inactive will need considerable support just to remove barriers (cost / confidence /stigma etc) to accessing services/opportunities as well as motivational intervention and information.

Individuals most likely to ‘seek out’ opportunities tend to be more ‘ready to engage’; will have less social and financial barriers and more likely to be moderately active/ or previously active. The purpose of a referral scheme or prescription is to reflect the needs of the individual and reduce barriers to access. This approach is key if we are to address the current inequalities in physical activity in the population.

To illustrate this point we can compare two NHSGGC physical activity interventions. The first, Live Active, requires a referral from a health professional (including a community link worker). The second, Vitality, is a self-referral therapeutic exercise class, which health professionals can ‘signpost’ patients to. The table below compares the profile of Live Active and Vitality participants against the board population. A formal referral process with clear purpose and criteria allows a more targeted approach without which, there is a risk that social prescribing in its most simple form (e.g. signposting) could widen health inequalities.

<table>
<thead>
<tr>
<th>Population Demographic</th>
<th>Percentage of Live Active Participants (%)</th>
<th>Percentage of Vitality Participants (%)</th>
<th>Percentage of NHSGGC Board Population (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% most deprived SIMD</td>
<td>43.0</td>
<td>11.0</td>
<td>35.9</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>12</td>
<td>3.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Over 60</td>
<td>26.3</td>
<td>86.0 (over 65 years)</td>
<td>24.4</td>
</tr>
<tr>
<td>Female</td>
<td>55</td>
<td>63.6</td>
<td>51.9</td>
</tr>
</tbody>
</table>
Whilst anyone working with communities can ‘raise the issue’ of physical activity with individuals and provide information on local opportunities is a core element of social prescribing, a targeted approach provided by health and social care professionals can also provide an effective intervention with onward referral for more intensive support.

Many patients at risk from inactivity are already within the NHS system, and in contact with health professionals. Within NHSGGC 2018-19 there were over 7,000 referrals to Live Active from a range of health and social care professionals. Whilst physical activity is beneficial for all patients, NICE recommends a formal referral for patients with pre-existing health conditions and for whom physical activity is recognised component of a treatment programme. Our own experience also suggests that health professionals in secondary care refer on discharge of a patient with 35% of referrals coming from secondary care.

The impact of intervention by a health professional regarding other aspects of behaviour change (alcohol, smoking etc) is well documented. One in four adults said they would be more active if advised to by a GP or nurse. (Health Survey for England, 2006).

Within NHSGGC Live Active scheme there is also the opportunity to patients who would be considered to be higher risk (e.g. those with high blood pressure, with established heart disease or post stroke) as part of a structured referral process. These patients would usually be excluded from physical activity programmes through self screening tools (e.g. PARQ) routinely used by leisure services which would potentially require additional GP advice prior to exercise which in itself is likely to be a significant barrier to the individual.

A social prescribing approach in general offers the opportunity for cross referral between a range of services and opportunities maximising their reach beyond physical activity.

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

In order to prescribe to sport or physical activity a ‘social prescriber’ requires a knowledge and understanding of the current opportunities that exist within a community. Our own experience in supporting health professionals to refer to physical activity suggests barriers to promotion remain similar to those found in NHS Health Scotland’s pilot, Energising Lives over a decade ago. To have confidence that the service will be suitable for their patient, health and social care professionals need some knowledge about physical activity, confidence that their advice is correct and a level of quality assurance. We have also demonstrated that there is a desire amongst health professionals within primary and secondary care to refer patients to a quality assured, physical activity programme, with an

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13 NICE(2014) Physical Activity: Exercise Referral Schemes (PH54)
increase of 75% in referrals following a promotional campaign to NHSGGC staff and simplification of referral mechanisms. NHSGGC is addressing this by providing health professionals with a dedicated website and phone number for quality assured, board wide physical activity opportunities.

The vast number of providers of physical activity is a huge asset however enabling effective local knowledge of current opportunities engages considerable resources in mapping activities with a number of websites/ apps/ directories occupying this space. Resources such as ALISS could be further developed, promoted and utilised to collate mapping exercises and provide an increased level of quality assurance to become a much more robust resource.

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

The opportunity to adopt a standardised evaluation framework for all types of social referral interventions including physical activity should be explored. The development of guidance on a 'core data set' would support the collection of basic data by multiple providers. Guidance on basic evaluation frameworks would also support further grass root evaluation of physical activity opportunities.

With regard to specific physical activity schemes such as exercise referral a national database for recording a core set of minimum, standardised measures taken before and after the intervention would enable practical cross programme evaluation and formal research studies.

A better understanding of referral/signposting numbers and uptake to gain an understanding of reach and numbers needed to treat would support more robust economic evaluation.

The potential to CHI link data (via safe haven arrangements) to explore more direct impact on patient outcomes would also be helpful to explore.

As noted earlier, there would be benefit in facilitating closer links between the research community and local providers to facilitate robust and useful evaluation work.

A core dataset should include:

- Demographic data
- Age
- Sex
- Ethnicity
- Disability
- Socio-economic status

Outcome measure of physical activity participation – using an agreed self-report measurement tool (which is sensitive to individual change) to collect total minutes of physical activity. Making the best use of attendance data from services (e.g. entry gate data from membership cards, participation in classes etc) would also enhance this.
Data linkage options should also be explored utilising CHI numbers and NHS Safe Haven for patient records which would allow assessment of whether social prescribing has an impact on GP attendance, hospital stays, pharmaceutical prescriptions and/or other physiological markers.

Optional measures may be collected, depending on the project’s objectives and based on patients’ own goals. These might include:

- confidence
- well-being
- self-esteem
- body image
- distress (‘using a distress thermometer’)
- ability to self-care