HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM STREETGAMES

Contact: Paul Jarvis-Beesley, Head of Sport & Health

Paul.jarvis@streetgames.org

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

It is clear that there is currently a gap in the research for evidence of sustained participation linked to social prescription. If this outcome is measured, it is not widely reported. Reported outcomes are generally around changes to physical and mental health and wellbeing that may result from increased participation, as well as other types of intervention.

The likelihood of a social prescription leading to sustained participation in sport/PA is influenced by the same factors that predict adherence across all social prescriptions. These include: i) the approach of the community navigator or link worker (LW) – do they have enough time to spend with the service user, are they listening actively, are they empathetic etc? ii) the support the LW can offer – are they aware of and able to refer the service user to a range of services that match their needs, and, once referred, can they provide ongoing support and encouragement to attend? iii) how welcoming is the service provider, and how equipped are they to support behaviour change? And last but not least, iv) what level of autonomy does the service user have in choosing the service(s) they need and how closely does the social prescription match their expectations?

As part of the research plan attached to the national Youth Social Prescribing programme in England, led by StreetGames and the University of East London, we are collecting baseline and long-term follow-up data on participation in sport/PA. The report will be available in September 2020.

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 or self-referral)

By definition, the decision ultimately sits with the patient or service user. Social prescribing is all about helping people take more control over the decisions and factors that affect their health and wellbeing. Social prescriptions work best when decisions about ‘what next?’ are taken after the service user has had sufficient time to discuss, share and consider what has led them to this particular point in their lives, why they feel something needs to change, and what they feel able to do about it. It is quite likely to be a number of different things, so they will also need to prioritise. For example, they might need/want to get some help with a debt or housing issue, alongside making some lifestyle changes such as getting more active.
The point of a social prescribing process is that the GP does not have time to explore these issues with a patient. Likewise, if a referral is coming from another route, other than a GP, that professional eg a social worker, community worker, housing officer, or police officer, may not have the time or knowledge to have that discussion. The role of the LW in helping a service user to reach decisions themselves, and to access service from which, for whatever reason, they feel disconnected, is critical.

Arguably, a self-referral to sport/PA is simply someone turning up to play sport/PA. It cannot really be a social prescription unless someone has intervened in some way to help them get there. A social prescription service exists to connect people with services and activities that are already available in their local community, but from which they feel disconnected or disengaged: “not for me”

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

The barriers to effective social prescribing to sport/PA are, for the most part, the same as the barriers to sport/PA in general. For the service user to sustain their participation, the sport/PA offer must be available at the right time, in the right place, at the right cost and be delivered in the right style by the right people. This is particularly true when the service users are coming from highly disadvantaged backgrounds. They have most to gain, in terms of health and wellbeing, from a social prescription. But they are also likely to have the least affinity, based on a lack of prior positive experiences, with sport/PA. If it is not fun, ‘for me’ and on their doorstep, barriers will persist.

An additional factor in the SP context may be the experience and attitude of the LW to sport/PA. LWs will be trained to be impartial, unbiased and client-focused. Even if their own experience and attitude to sport/PA is not positive, they should be able to support a client in making that decision. We are all, however, prone to unconscious bias. Finally, the LW, acting as referrer, needs a good working knowledge of the broad range of sport/PA opportunities available in the service user’s immediate area, and how they can get involved.

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

Sport/PA should be available as an option with any social prescribing scheme, whatever age group it is set up to serve. However, all SP schemes must have a broad range of services and activities, to which users may be referred. These services and activities will include sport/PA alongside a range of other options. The scheme must be needs-led and focussed on the service user.

The monitoring and evaluation of sport/PA elements of a social prescribing scheme will require a mix of qualitative and quantitative data. We will want to know impact, based on baseline and long-term follow-ups, on participation and overall physical activity levels. We need to be wary, for example, of activity switching whereby a service user takes up a new
form of physical activity but at the expense of another, resulting in no net gain to overall PA levels.

We also need to know about the quality of their experience. What was it about the sport/PA that supported or prevented adherence: the timing, setting, promotion, cost, social aspects, skills acquisition, coaching etc?

We also want to know the impact on the community and the service provider. Have they undertaken additional training in order to facilitate social prescriptions? Have new volunteers come forward? Has additional social action resulted eg people setting up new sport/PA activities and groups of their own?

From this realist methodology of evaluation, it will be possible to draw up Theory of Change for future application and testing.