

HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM Alison Trehwela, Yoga for Healthy Lower Backs

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

As a national social enterprise with over 20 qualified 'Yoga for Healthy Lower Backs' teachers in Scotland, we wish to submit information. I was the lead yoga consultant researcher for the University of York / Arthritis Research UK randomised control trial into yoga for back pain and continue to train yoga teachers in the programme.

We know many attendees from the once-off, specialised and specific 'Yoga for Healthy Lower Backs' 12-week evidence-based courses (associated with the afore-mentioned research trials) have:

- been enabled to begin participating in general yoga classes
- felt able to continue playing tennis or swimming regularly
- become confident about returning to the gym and/or to gym-based exercises
- got back to gardening
- been encouraged enough to feel able to go for walks more frequently
- managed to get back to active manual jobs and keep working happily.

It is likely that this specific yoga programme performs better than the average 'social prescription' with regards to health and well-being, due to yoga's mind-body approach and due to this programme's evidence-base of effectiveness ('Annals of Internal Medicine' 2011 plus 4 other published papers).

Course attendees are motivated to practise at home, daily to begin with and then the recommended twice a week. The aim of the 'Yoga for Healthy Lower Backs' programme is to encourage people to continue to practice yoga (mind and body exercise) at home and in daily life, which in turn enables them to maintain an active life.

Social prescribing projects will benefit from having some 'kitemarked' best practice, evidence-based programmes, such as 'Yoga for Healthy Lower Backs' or ESCAPE-Pain (hips and knees) to ensure more reliable positive outcomes.

It was mentioned in a social prescribing research study (Bertotti, Pilkington et al) that targeting specific populations (e.g. those with back pain), ideally with evidence-based programmes, would be most successful and would be easier to evaluate.

There is some evidence to show that to get sustained behavioural change, one should support people for at least 12 weeks. There is also evidence to show that it is not easy to get people to commit and attend exercise classes for 12 weeks, so offering specific programmes that are enjoyable and offer real evidenced benefits will be more likely to succeed.

We have some experience of offering our strongly evidence-based, enjoyable, gentle yoga programme under social prescribing in Cornwall. Below are results from a group case study relating to this ongoing social prescribing scheme:-

12-week 'Yoga for Healthy Lower Backs' Course; 1 Teacher for continuity; 8 'frequent attender' patients (with back pain + other issues, e.g. mental health); 100% referrals by social prescribing link worker/GPs.

78% Attendance rate; Patients each contributed £100 to course costs.

FINDINGS:

71% improvement in coping with pain on own

64% improvement in biopsychosocial function

62% decrease in pain

45% less depression

25% less anxiety

8/10 positive benefits on back pain

8/10 positive benefits on general health

8/10 yoga impacting on daily life

Attendee quotes "Helped majorly. Off ALL medications for pain and de-stressed." "Feel more at peace."

From the above, you can see that people have been given a hand up into participating more fully in life.

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)

There is some research to show that giving some Patient Choice (but ideally keeping to evidence-based options) will give improved outcomes. Therefore, education of the referrers (GPs, physios., link workers and general public) about the kinds of programmes available under social prescribing and then educating about the choices would be preferable, e.g. example referral criteria, what the programme is, how much supervision will there be, etc.

There are many presentations at GP surgeries where the GP is fairly certain that nothing medical (treatment / diagnostic) needs to be done, but where they know that the person is generally unhappy and would benefit from doing something to help themselves. It is worth noting that GPs are much happier to refer patients, when there is something with rigorous and robust evidence behind it, so it is therefore essential that social prescribing schemes offer several of this kind of evidence-based activities.

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

One big barrier is that patients are not yet certain that social prescribing of any sort is 'good enough' to help them, especially when they are probably expecting tablets, diagnostics, medications, surgery, injections, etc.. Therefore, GPs need to sound convincing when they prescribe these options (see Michael Moseley's TV programme regarding GPs sounding convinced when talking to patients about sugar pills for back pain). Giving patients evidence-based options that are specific for specific populations of people and the referrers saying they know this has helped many people before can be helpful (or may even be crucial to success).

Another barrier is that patients will often prefer to 'pop a pill' rather than make efforts to change behaviour / improve their lifestyle. Education is required.

Link workers would benefit from knowing that certain physical activity programmes have more value, i.e. they may give better outcomes, but may cost more. Some social prescribers may otherwise be tempted to save budgets by always suggesting the 'free' options, which may not 'work'. In this regard, it is worth noting the Department of Health, Arthritis Research UK, Public Health England, NHS England document '*Providing Physical Activity Interventions for those with Musculoskeletal Conditions*' where it describes a pyramid with 4 tiers to types of physical activity offerings (ranging from self-led to one-to-one individual sessions with a physiotherapist). 'Yoga for Healthy Lower Backs' would be just below the one-to-one top level in the pyramid, as it offers a specific course where people begin and end at the same time-point, are taught by a specialised yoga teacher, and are empowered to continue to exercise themselves with increased skills after the course.

With the 'Yoga for Healthy Lower Backs' programme, it would be easier for referrers to know that it will be appropriate, safe and effective for a specific population. Comparatively, referrers and patients might not be certain about whether someone with, for example, back pain or hip pain would get on well with an aerobics class or swimming.

Having sufficient high quality physical activity programmes, e.g. a portfolio on offer, will help with the success of any social prescribing and will help the GPs, link workers and patients.

Sometimes, patients get 'stuck' with the social prescriber, leading to more and more reliance on that prescriber, clogging up of the system preventing others from seeing the social prescriber, and the patients not moving forwards to self-management and self-care and potential deepening of fear-avoidance behaviour, depression, anxiety. Therefore, where possible and appropriate, referrals out to activities should come sooner, rather than later.

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

There should be some pre- and post- programme outcome measuring wherever possible. Some physical activity programmes might be doing this evaluating work already, such as 'Yoga for Healthy Lower Backs' and ESCAPE-Pain.

Furthermore, programmes such as these two mentioned above are fairly standardised and prescriptive regarding exactly what will be taught, plus the quality of teaching and educational resources will already be monitored and high.

There could also usefully be some patient-initiated outcome measuring via electronic methods for longer-term outcome measure gathering.

Measuring how NHS resources are used less can be useful. Perhaps the Patient Activation Measure, or something similar, could be used, but would need a Trust who already has a licence helping to set this up.

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