HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM Dr Joel Rocha, Dr Rebecca Wade, Dr Corinne Jola, Dr Luis Calmeiro, Andrea Cameron, School of Applied Sciences, Abertay University

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

While a number of systematic reviews, including those examining a cost-benefit analysis have been conducted, it remains difficult to provide a definitive answer as to the long-term impact of the effectiveness of social prescribing and therefore this needs to be addressed. Limitations of research or exercise referral scheme reports often include relatively small sample sizes (i.e. less than 80), being less than 14 weeks duration, no follow-up, no cost analysis, no intention-to-treat analysis and reliance on just quantitative or qualitative methods instead of a mixed methods approach. Since practice clearly is ahead of the available evidence, we need to capitalise on existing practice whilst at the same time developing partnerships with research teams (e.g. within Universities and Colleges) that could contribute to a better understanding of how to implement theory-based approaches (e.g. health behaviour models) with a robust monitoring/evaluation process (e.g. impact of demand, cost-analysis, social outcomes). This process is in our opinion, important, because the extent to which social prescription is effective will depend primarily on who the target population is, on accurate evaluation of their values and needs, how the process is undertaken, what resources are available and how the evaluation/monitoring is used to improve/follow it up (i.e. there is not a one size fits all approach).

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)

Since social prescribing relies on recognising individuals' needs, providing them with support and connecting them with adequate services that can address such needs the decision of the suitability of such intervention should depend on the specific circumstances. We believe that with the exception of self-referral (this method would not fit within the above view of social prescription and other alternatives could be provided for those already wanting to become more active) all of the suggested examples may be appropriate as long as professionals have adequate training and time to engage in this process with the individual. Importantly, such an approach should not rely on or limit itself to imparting information (e.g., flyers) but rather expand health promotion practices to empower individuals to increase control over their own health (i.e. supporting and working in partnership with the individual). Indeed, we feel that potentially a question to who would be the primary target populations is warranted since, due to limited resources, this will also affect the way social prescribing would ultimately be undertaken. In this regard, generic criteria/guidelines to decide if social prescription for physical activity is the most appropriate intervention could be developed but they would need to depend on who the primary target population is and its application should not be reduced to a “tick box exercise” but rather a
needs analysis undertaken by a trained professional. In terms of the primary target population, we believe that the answer that most would agree would be to target those that need it the most, however, it is important to ensure that this identification goes beyond the biomedical model of health to include broader views of health promotion (e.g., salutogenic model, health assets, social-ecological model). We recognise that in practice the desirable is often not possible but there are still important improvements that can be made to some of the current approaches. For instance, initially referral schemes sat wholly with health care professionals (most often in primary care doing the referral) that are used to the biomedical model of health and sometimes reluctant to refer patients because of essentially outsourcing a ‘treatment protocol’ to non-professionally registered individuals (i.e. they can be uncomfortable with risk). In addition, health care professionals often do not have the time to adequately engage with this process and therefore link workers can have a very important role here. Indeed, it would be good to have social prescribing coordinators that could contact/meet the initially referred individuals (e.g. from GPs) to discuss their social issues/needs, identify appropriate services and have the capacity to provide follow-up and further support when required. Some local authorities, and potentially as part of Health and Social Care Integration have adopted alternate models of prescription that in our view are moving back towards health education and therefore likely to become just an information platform. For instance, in Angus, GPs no longer do referrals to facilities (the only health service referrals are e.g. Post-cardiac rehab, pulmonary rehab) – but the Angus Alive website will be signposted if it’s thought that patients in this geographic area would benefit from a more active lifestyle. The patient then self refers to one (or more) of the Angus Alive activities (there are downloadable forms they can complete) where they can access the activities at a reduced tariff for an introductory period. NHS Tayside would recommend that new organisations looking to engage with social prescription link into Angus Alive if they want to start working with more clinical populations. Whilst we do not negate the usefulness of these type of platforms for individuals with resources and ready to engage in physical activity it is important to recognise their limitations.

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

We are not culturally accustomed to social prescribing. The normal prescription is for medicine, medical intervention in response to an illness or ailment. Social prescribing of sport and activity can be preventative, pre-emptive as well as reactive. As a society we are conditioned to think in a reactive way, so a change is needed as being physically active throughout life can prevent illness and ill health (and protect against common medical conditions). Moreover there are concerns around risk, efficacy and who can deliver the screening – so capacity issues are barriers (beyond those linked to personal motivation of the individuals being given the prescription – hence why Readiness to Change is a key part of the pre-screening). In terms of overcoming these barriers, there are a host of sport and exercise graduates who could safely deliver social prescription and are a workforce that could be deployed.

Specific example: The Dundee Green Health Partnership has addressed the GP referral challenge by working with third sector groups to help remove the ‘barriers’ for GPs (e.g. GPs don’t have the time to find out what is available, don’t have appropriate or up-to-date
information, don’t know if the activity and its providers are ‘reliable’). Green Health prescriptions in Dundee are routed through a dial-up service where a trained volunteer can direct the prescription-holder to the most appropriate activity.

Community Link workers could also take a similar approach but the same barrier could apply – maintaining the confidence of the prescriber by supporting and resourcing the providers is important in addressing this.

A more joined-up approach to promoting activity for good health is needed.

A more joined-up approach to supporting prescribers, providers and prescription-holders is needed.

The first contact of a patient through the primary health care system will necessary involve a health professional (e.g., GP) who will decide on the appropriateness of physical activity. However, barriers to the prescription of physical activity by GPs are many and include lack of time and lack of skills to effectively promote behaviour change. Hence, one possible approach is to develop a protocol to (a) decrease the amount of time GPs require to assess the level of patients’ readiness to change their physical activity behaviour and (b) provide stage-matched strategies that the GP can apply. Such protocol has been tested and successfully applied by trained GPs (see, Physician-based Assessment & Counselling for Exercise, PACE project). Nevertheless, the demands for GPs are varied and resources often limited; hence, we suggest that a referral within the same health setting to a trained professional who can develop a working alliance with the client and empower him or her to change would be a desirable option. Although, social prescribing would be more effective with the involvement of trained professionals with time to engage with the process, this should be complemented with effective services made available in the community to address patients’ social needs. Otherwise what happens if existing services are not able to meet the social prescribing needs? Therefore, it is important to recognise that there is no point in identifying and referring individuals without investing in the services that will be meeting their needs.

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

First of all, we need to clearly characterise current practices and rigorously evaluate the process, the impact and intended outcomes. In addition, we need to engage in a variety of assessments (e.g., social, educational, ecological assessments) to determine the factors (predisposing, enabling and reinforcing) that influence physical activity within specific communities. Only then can we develop theory-based interventions tailored to the individual or the community. Evaluation requires resources (funding, staff time, training and support) and it would be useful to link practitioners, GPs, scientists, and Community Link workers for evaluation, monitoring, and knowledge transfer. This closer integration would allow us to learn quickly from social prescribing interventions and be able to share evidence about what is working in different contexts. Collaborations with Universities and Colleges could be an important pathway for developing and delivering monitoring and evaluation. This would still require support, FE and HE have to show funding against time just as other organisations do, but a collaborative approach could provide added benefits; enhance the
links between education institutions and their communities, provide applied training for the next generation of prescribers (GPs, nurses, mental health workers, link workers, social care workers, planners etc.) via student projects and/or research/consultancy, capitalise on the monitoring and evaluation expertise already present in universities and colleges and on the formal and informal channels of communication already in place within health settings enhance the impact of research/teaching. Indeed, we need to be able to recognise that changes in health outcomes may potentially go beyond the funding timeframes and therefore sustained collaborations will be vital to maintain the implemented monitoring/evaluation strategies. Specifically these strategies should focus not only on the initial processes (i.e. screening, referral, connection with community services) but also what is happening within these services and what are the perspectives of the referred individuals. Ideally it would be good to collect data at all stages and be able to track how the process worked at the individual level as this would allow us to gather knowledge of how social prescribing is working for different groups. Potentially some sort of shared database that allows all involved to input information on their part/contribution to the social prescribing process (e.g. logging an individual as being given a social prescription and keeping information about engagement, health outcomes, feedback and follow-up/support meetings) but with different levels of access to ensure compliance with Data Protection Act 2018.