

## HEALTH AND SPORT COMMITTEE

### SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

#### SUBMISSION FROM DR KATIE WALTER GP AT CAIRN MEDICAL PRACTICE, INVERNESS

I am a GP in Inverness involved in a number of projects looking at promoting physical activity from a health care setting. I have been involved from the start with Cycling UK's WheelNess project. I have been involved with a research project with UHI which has not yet completed on attitudes of health care professionals around physical activity social prescribing. I am currently involved in Velocity's Active People Link Workers project. This is a one year funded project looking embedding link workers into GP surgeries with the express purpose of facilitating person-centred physical activity uptake. My practice is a ParkRun promoting practice. I also sit on the Highland Green Health Partnership and the HITRANS Active Travel Advisory Group.

#### **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 would be wise for the committee to commission an overview of the evidence as this is an area of research growth and recent new evidence might be emerging: previous reviews have not highlighted that social prescribing for physical activity is very effective for sustained participation. Multiple barriers have been identified. There is currently a plethora of projects underway designed to increase sustained participation in physical activity and sport (from ParkRun internationally, Active People link workers for us very locally in Inverness) and evidence should be emerging from these. This is an opportunity to shape the key research questions which such projects could help address through their monitoring and evaluation. It is key that a good quality review is undertaken as there have been previous misguided but well intentioned large spends which lacked any evidence base and were ineffective.

#### **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)**

Given the known effectiveness of physical activity as both primary and secondary prevention in health, across nearly all conditions both for physical and mental health, this is a matter for all health professionals. In fact, healthcare assistants might often be in a more privileged position to broach the conversation around physical activity. This is a public health issue similar to smoking: it should be everyone's business. As with smoking cessation, that patient journey towards stopping smoking is complex, and there are lessons to be learnt.

My answer to Q2 therefore would be "none of the above, but the patient" as in a person-centred approach, it will be the patient who decides whether a physical activity "prescription" (or referral on to a link worker or a specific project) is the most appropriate intervention. But we do need to be able to have health professionals who are comfortable with the very different motivational interviewing / brief intervention skills which are needed for talking about physical activity. This is crucial. A lot of the healthcare workforce has little training or supervision in effective motivational interviewing skills.

I have an ambivalence with the term “social prescribing” as it is a broad umbrella that maybe gathers a lot of disparate things: the most common form of “social prescribing” that I do in practice is having daily conversations about walking and cycling or taking the bus. None of these discussions feel like “social prescriptions”, and yet they are the most accessible, cheapest, most manageable changes to make for some people. From a health inequalities point of view, walking is the most accessible.

At the other end of the spectrum, I also have frequent conversations with people with complex mental or physical health needs for which it is very appropriate that it is a doctor or an advanced practitioner with a good knowledge of that patient who is able to tap in either directly to a relevant project with clear criteria, or to refer on to a link worker who holds up to date information. Projects come and go, criteria change, and it is not realistic to think that we can stay on top of these changes – link workers would be ideally suited for this.

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

Again, this question needs an up to date evidence review. Known barriers from previous reviews are multiple, patient- related, healthcare professional related, and societal barriers. I will focus on those relevant to me as a health professional.

Probably the biggest barrier is the environment that we live in that is now so conducive to driving, and so off putting for cycling, and cities and towns which have now most of their services and supermarkets on the outsides, rather than near where people live, which is a barrier to walking. This is a public health issue that needs political will to reclaim from local councils and their planning department. The infrastructure we live in is vital for a healthy population and for community building: it is time to entrench that in the laws of how we build our infrastructure. I cannot recommend someone to cycle if the streets or roads near them are not safe for that. There is a key issue around social inequalities here.

I am ambivalent about self-referral as self-referral destinations abound all around us and yet patients often do not take them up. A piece of paper rarely works, but being contacted by someone can. I have been involved in a number of projects where referral is either self-referral or via email to a third sector organisation, with the patient’s consent to share their contact details. The project worker then contacts the patient directly. This is perfectly acceptable to patients and is perfectly acceptable to me as a health professional (as the governance including data governance then sits with the third sector organisation). There is a risk that many will say “you can’t do that” and yet we have evidence that this is acceptable to patients and works well. Key to this is that patients are making the decision.

I personally feel that part of empowering patients is about us as health professionals learning to have a different approach to risk with patients. We rightly worry about governance in projects, and “handing over” our patients to such projects. Sometimes rightly so, when patients have complex needs or perhaps might struggle to identify themselves whether they are suitable for such projects. But equally, getting tied up in governance can be a barrier: I know many patients who tried walking or cycling groups but whose verdict was “they treated me like a 5 year old” “they were all wearing high viz jackets”. Let’s hand back a bit of personal responsibility for risk to patients to make their own decisions. This is Realistic Medicine.

A significant barrier is the short-term funding of a lot of great small local third sector projects meaning that they come and go and staying up to date with what local projects are still operational is impractical as a health professional. A good signposting agency such as a well resourced local third sector interface organisation or a link worker is key. ALISS has been defunct in our area for ages – no one uses it.

Probably the biggest barrier for health professionals is the very different type of consultation skills that are needed to have positive conversations with patients around self-management through physical activity. These require a person-centred approach, motivational interviewing skills, goal setting and action planning which are not skills that health professionals have been systematically trained in. The conversations around physical activity therefore often end up being negative for the patient and negative for the health professional with little chance of behaviour change. I suspect that a lot of the evidence base showing a lack of efficacy of social prescribing for physical activity might actually relate to the type of consultations that are had. A good research question.

As an aside, the term “sport” is a barrier for many.

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

This is perhaps the most crucial of these 4 questions as the previous 3 questions are really questions for an up to date literature review.

There are two aspects I would like to discuss:

##### **4.1 a standardised approach to Monitor and Evaluation**

There are a multitude of projects happening at the moment around physical activity and no coordinated approach around monitoring and evaluation. Many of these projects are funded on a short-term basis and gather monitoring and evaluation data to suit their funders. Interestingly, many of the projects I have been involved with are funded indirectly through Transport Scotland, though their intended benefits are not only about modal shift from cars to active travel, but also health benefits. Many of these projects have societal benefits as well.

It feels like the time is ripe to take a ground breaking, Scotland- wide, simplified and workable approach to monitoring and evaluation. If some simple core criteria could be agreed, which are relevant to the projects outcomes and not just the funders outcomes, and relevant to the key areas of research uncertainty, if a monitoring and evaluation framework and tools could be designed that are easily accessible and render evidence gathering easier for projects, thereby liberating project workers' time, a huge body of evidence could be gathered quite rapidly.

My experience of trying to tie in projects with formal research evaluation, seeking ethics approval, is that this adds layers of delay which are unrealistic with the funding time scale of projects.

Scotland is small enough to be develop a truly ground-breaking approach – now is the time to do so. I have had many conversations locally and nationally around this – there is an appetite for it that will need a political drive.

#### 4.2 The opportunity to evaluate these projects through formal quantitative and qualitative research

In order to generate a realistic evidence base, it is vital that not only quantitative data but also qualitative data is gathered.

These interventions are very amenable to pragmatic randomised controlled trials comparing “usual care” to “social prescribing”. Embedding economic analysis to this is vital, including evaluation on impact on benefits, medication use, and other physical and mental health outcomes.

It is also vital that good quality qualitative data is gathered to identify further the barriers to uptake. I suspect that the quality of the conversation and the ability (or not) to be truly patient-centred is key.