

## HEALTH AND SPORT COMMITTEE

### SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

#### SUBMISSION FROM Glasgow Life

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

In Glasgow there are 3 main physical activity programmes that form a physical activity pathway for health practitioners to refer and signpost into quality assured activities across the city:

Live Active Exercise Referral Scheme,  
Vitality classes (for people living with medical conditions) and  
Health Walks.

These programmes are jointly funded by Glasgow Life and NHSGGC (as well as Paths for All). They are well attended and we know that when people do take the first step to attend they are likely to stay. The challenge is around getting certain groups of people to take the first step.

#### **Live Active**

In 2018/19, Glasgow received 3871 referrals to exercise which was a 23% increase on referrals from 2017/18. Whilst we do not yet have the full 6 month adherence rate for the individuals referred last year, in Glasgow this rate is historically around 33% which would represent around 1160 people still engaged in the scheme at 24 weeks.

A project conducted with one particular practice in Glasgow (Parkhead) whereby the practice worked closely with the exercise referral team to target patients (rather than opportunistically refer) and to support the delivery of some aspects of the programme within the surgery, produced greater adherence rates than the general programme. Whilst the adherence rates at 6 months usually track at around 33%, this project, albeit with smaller numbers (17 participants), had 76% of participants still engaged at this point. This project delivered positive outcomes in terms of sustained participation in physical activity, this level of intervention, whilst cost effective, is not scalable across over 100 practices with only 8 exercise referral advisors covering the city.

#### **Vitality**

The report, 'NHS Greater Glasgow & Clyde Evaluation of Vitality' (McCall et al., 2015), found the overwhelming majority of respondents had been attending the classes for some time. Almost two thirds of respondents (66%) had been attending Vitality classes for over 12 months with (12%) of respondents attending classes between 6 – 12 months.

#### **Health Walks**

From the 2018 health walker survey (no. of respondents= 231) we know:  
84% of respondents had been attending health walks for 6 months or more with 60% attending for more than 2 years.

52% of respondents resided in SIMD areas 1 and 2.

41% attend two or more walks a week.

88% of walkers report they achieve the recommended physical activity levels of 150 minutes per week.

91% of respondents report they are more active as a result of joining the health walks.

## **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)**

As an organisation with much to offer in terms of activities (physical and non-physical) our current engagement with social prescribing is primarily through referrals to the Live Active programme and signposting to Vitality (medical conditions class) and Health Walks. This is almost always by GPs although work has been undertaken recently to widen this to Community Link Practitioners (CLPs) and other health professionals.

The definition of social prescribing provided by the inquiry committee explicitly identifies the process as operating through 'link workers'. We do not believe that social prescribing is, or should be, limited to this process.

We agree that referrals need to be made '... with good knowledge of patient needs...' in the case of healthcare staff. But we also believe that colleagues in other 'anchor organisations' such as housing associations, addiction support services and mental health groups also possess detailed understanding of their participants' and service users' needs within their immediate communities.

Staff in such organisations are perhaps more likely to have the time to discuss issues with individuals than GP's and health professionals already under time pressures. They will also have had an opportunity to develop relationships of trust and continuity over a continuous period of time where physical activity can be deliberated and followed up on.

Physical activity in these contexts may also form part of an ongoing more holistic programme of support in line with recovery, rehabilitation, treatment and support programmes rather than in isolation. By having the ability to refer to activity, these organisations could support the prevention agenda by tackling the issue further upstream before health professional input is required. We would welcome opportunities to deliberate this further.

Colleagues at NHSGGC have referenced in their submission [HS/S5/19/SP/19] socio-economic, ethnic, age and gender bias for formal referral and self-referral physical activity programmes. We concur that without targeted formal referral there is a risk that health inequalities within the Glasgow area could widen.

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

We believe there are a number of barriers that need to be addressed in order for healthcare and non-healthcare organisations to take the notion of social prescribing forward and implement effectively and deliver in true partnership.

The report of the Vitality programme (McCall et al., 2015) highlighted 2 of the biggest barriers to people acting upon their signpost from their health professional and participating in Vitality were:

- Lack of understanding by health practitioners of the programme classes and who they are targeted at.
- Lack of discussion with patients by health practitioners on the programme purpose, content and benefits.

Other barriers identified were:

- Inconsistency in approaches taken by practitioners when signposting programmes.
- Inconsistency in levels of support offered to participants with physiotherapists more likely to spend time positively reinforcing activity messages and other practitioners relying on leaflets.

Evidence also suggests that individuals may be more likely to participate in activity when the recommendations come from a health professional as part of a conversation on physical activity. However, where time cannot be spent by a health professional reinforcing the benefits of being physically active, an experienced physical activity professional should be able to provide advice and an effective intervention to advise on appropriate physical activity.

Other barriers are set out below:

- Definition of social prescribing – nationally

A clear, shared definition of social prescribing should be agreed at a national level. This definition needs to cover both the mechanisms used to engage ‘participants’ and the intervention activities offered.

Both of these areas are broad. Mechanisms can (and do cover) signposting, group work and more intense 1-to-1 support over the duration of programmes. Activities are necessarily wide and varied covering physical, social, creative, learning, advice, passive and participatory opportunities.

Should there be ‘levels’ of social prescribing based on participant needs?:

Straight to programme – by means of a basic ‘signposting’ approach

Supported introduction – an interim level of support perhaps including phone and at least one facilitated engagement

Intense 1-to-1 introduction and attendance – a buddy scheme of some description over recurring engagements.

- Definition of social prescribing – at organisational levels

Glasgow Life has some way to go in terms of understanding and defining social prescribing in relation to its offer beyond physical activity (Live Active). With this in mind Glasgow Life has recently made a proposal to NHSGGC HSCP to review social prescribing with a focus on culture and learning. We believe the results and findings of this review, or feasibility study, would provide opportunities to engage in discussions nationally on the impacts of social prescribing at population levels.

- Capacity at organisational level to respond.

Glasgow Life has setup a Health Working Group with the aim of aligning service provision and development more clearly and in response to community health and social care needs. Health has been on the GL agenda before and committed organisational leadership and responsibility is needed to see this through and should be encouraged through this inquiry.

- Communication on social prescribing as a whole system approach

It is difficult to know what is required from 'service providers'. Equally it is difficult to know what is on offer (and the quality of) in terms of suitable 'social prescribing' programmes. Consideration needs to be given to how this vital flow of information is enabled. As a large organisation we have been unable to engage with the 'Aliss' system because of the resources required to provide and update information.

- Interface between 'prescribers' and 'service providers'.

We would be interested in exploring how the current CLP-led social prescribing system could be better facilitated in terms of sharing information, priorities and connections.

- Difficulties in collating information as there are varying methods of measuring 'activity'.
- Inconsistent knowledge about the role of physical activity in improving health.
- Fears over safety (not aided by the medicalisation of physical activity), misconceptions around intensity and types of activity for health and lack of awareness of what support is available often generates reluctance to refer.

Large organisations like Glasgow Life can describe themselves as key city-wide 'anchor organisations'. Operating across 171 facilities in the city, GL offers significant potential at local levels. Understanding such a large offer (beyond that of physical activity) is a huge challenge. Perhaps locating CLPs (or similar) within these anchor organisations would help develop operational links to areas with CLPs in place and importantly those without.

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

Robust evaluation of current social prescribing is essential and has been identified in 'Evaluation of the Glasgow 'Deep End' Links Worker Programme' (Mercer et al., 2017), under recommendations. We would hope that as the CLP programme continues to expand; focus will be brought to measuring outcomes.

Standard definitions and descriptions of what constitutes physical activity need to be agreed so that information is useful. There are currently too many vague descriptions of activity or activity intensity.

Clyde Gateway are currently seeking to obtain CHI data for use in their east-end regeneration of Glasgow. Should this become a paradigm example of using health data to help measure health benefits of regeneration we would hope that social prescribing would also be considered as an appropriate population level intervention that can use this data.

We are aware of social prescribing programmes and support networks in England around culture such as the Culture Health and Wellbeing Alliance. We would welcome a forum in Scotland that could bring together prescribers and service providers (like Glasgow Life) in a bid to improve connections and develop more robust monitoring and evaluation of social prescribing (physical and non-physical).

A range of information is needed to make monitoring and evaluation relevant including: snap shot follow ups to monitor uptake, patient feedback and patient outcomes feedback.