HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM Western Isles Health Board

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

Recent UK and International evidence from randomised controlled trials indicates prescribing physical activity for Long Term Conditions (LTCs) results in significant levels of sustained improvements after 12 months and at 3 year follow up. Behavioural support is an important factor. Where the main activity is walking, research results include increased total walking, increased levels of intensity and a reduction in sedentary behaviour. Longer term research has not been carried out at local level in the Western Isles. Our most recent social prescribing programme, ‘Move More’ addressing all LTCs has been live for almost 1 year now and begins 12 month follow-ups for participants next month. Programmes tend to be measured at 6 to 12 weeks. However evidence from GP Exercise referral programmes, Paths for All’s Health Walk networks and campaigns supports the UK and international findings and suggest that sustained participation beyond 12 months is achievable. The proportion of participants who achieve these improvements is dependent upon the referral pathway, behavioural support, facilities and local environment. There is evidence that activities targeting older people, such as dancing, have increased participation and engagement over longer periods when peer support is encouraged.

Recent reviews have concluded that walking is the activity most likely to achieve positive outcomes over time but variety can help maintenance.

There is good evidence of sustained increases in physical activity levels in those who complete exercise programmes, especially longer duration programmes (20 plus weeks).

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, self-referral)

A clear pathway to a variety of levels of intervention is required. There are currently local criteria based upon 3 levels of intervention. The three levels of possible referral are:

1. Those patients who would generally benefit from a more “active living” change in lifestyle with gentle physical activity and exercise. This might be someone that:
   - Has a family history of Coronary Heart Disease
   - Has asthma
   - Is a smoker
   - Suffers from physiological stress, depression or anxiety.

2. Those who would specifically benefit from a prescribed regime of physical activity and exercise as part of a programme to treat their clinical condition, or reduce their risk to specific disease. These include patients who have:
   - High cholesterol


Late onset of diabetes
- Obesity
- Moderate hypertension
- Impaired mobility.

3. Those following cardiac or clinical rehabilitation programmes, or those who have undergone surgery for potential life threatening conditions or diseases.

This includes those:
- Who might need to lose weight for an upcoming operation e.g. hip or knee replacement
- Who have had a heart attack or heart bypass surgery.

This latter group for more intense interventions requires referral based on specialist knowledge from suitably qualified healthcare professionals (e.g. doctors, nurses and Allied Health Professionals) with knowledge of a patient’s medical history and more so for clients with one or more long term condition (e.g. Move More).

It is important to ensure easy access to level 1 interventions by having a wide variety of organisations and partners involved in the social prescribing discussions locally e.g. Health, Education, Social Care, care homes, housing associations, voluntary organisations, community land trusts, community groups and social enterprise organisations. Community Link Workers and other voluntary sector agencies, such as mental health groups should be able to refer directly to physical activity interventions such as walking groups, cycling groups and horticulture projects.

The level of intervention is important in referral. Referring to a highly structured and more resource intense intervention such as GP Exercise or Move More could result in a larger number of initial assessments than the resource available.

A single initial triage assessment stage would be beneficial as well as opportunities to refer inter-agency and through levels would ensure participants are moving from less intensive interventions that are more easily accessed. There is strong evidence that a variety and range of activities produces improved outcomes for individuals and that moving from inactivity to any activity is the most beneficial in terms of health outcomes while continual increases in frequency and intensity continue to accrue health gains.

Research indicates that sedentary individuals are less likely to achieve moderate activity outcomes, though the health gains from any increase in activity are larger than other sections of the population. Less structured approaches may be more suitable for this group. Those who are slightly active, older adults and the overweight but not obese are more likely to achieve the recommended weekly activity levels.

Self-referral is important when thinking about the person-centred approach and ensuring easy access.

**What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?**
Evidence suggests that the main barriers to more effective interventions include: time to participate and timings of sessions; the cost of participating including transport; location of facilities or activity; intimidating environment including gym/sports centres and equipment. Support of providers, other attendees/peers and family are important in making exercise a habit post programme.

Local issues and solutions are listed below:
- Those ‘prescribing’ may persuade clients to join an activity based on their own personal preference or relationships

*Clear and widely promoted referral pathway can assist with this*
- Agencies not understanding ‘social prescribing’ and realising they have a role to play

*Awareness raising in agencies and in the wider public (for self referral) is important*
- Agencies not working together and so missing opportunities for recognising need and referral

*The Outer Hebrides Community Planning Partnership brings agencies together for common aims under the Local Outcomes Improvement Plan – one of which is improving the quality of life and wellbeing that encompasses physical activity.*
- Group furthest away from services

*Working with a wide range of partners and groups increases the reach of all agencies and supports greater involvement in communities*
- People not realising they can help themselves through behaviour change e.g. physical activity to promote mental wellness

*Awareness raising in the wider public of the potential benefits of actions*
- Gaps in local statutory and voluntary sector provision

*Working to build relationships across and between agencies;*

*L o k Workers working closely with Voluntary Sector*
- Activity required locally not provided / lack of consistency of services

*Working to make community based services the easier option to ensure services go to communities*
- Lack of funding for projects required locally

*Proposals for funding are encouraged to consider total costs not only staffing costs*
- Ensuring the safeguarding of clients

*Application of Board adult and child protection policies, ensuring all staff receive training in these areas*
- Lack of priority on physical activity/health behaviour change from referrer may exclude physical activity from the options being offered

*Awareness raising on benefits*

*Health Behaviour Change training*

*Wide referral pathway*
- There is no ‘one size fits all’
Local approach required

- There is potential for Link Workers to raise awareness of physical activity projects/initiatives with clients, fully explaining options so the client can make an informed decision on whether to participate or not and find the most appropriate activity for them. Link Workers can discuss barriers to participation with clients and look at how these can be overcome. Link Workers can connect clients with the activity lead prior to participation or take the client along to the project if the client is anxious about starting something new.

- There is potential for digital platforms to promote connections and introduce people to physical activity. Locally we have a link project that is developing personal assessment and referral, but is also exploring initial digital connections, peer support and self assessment (mPower). There is also a text support system (Florence) which in other situations and for medical conditions acts as a prompt, monitoring and support system.

- People who have a positive experience with social prescribing will share this with the people they meet – growing the communities of social activities (and enhancing positive messages on the social media they use.

- Participants may wish to ‘give back’ and become a volunteer at the activity they attend.

- There is a potential for an inequalities bias in social prescribing as sports centres and other facilities tend to be used by more affluent and able individuals. It will be important to develop locally appropriate methods to ensure accessibility for all based on need.

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

The systematic assessment and follow-up of patients who take part in 12 week to 24 week programmes is in place and recommended. A consistent database should be established on a national basis.

It is more difficult to monitor and assess lighter touch interventions and associating patient and personal outcomes and directly attributing them to the activity. Recording of engagement levels from participants and physical activity initiatives is a starting point.

In general though it is advised to:

- Gather baseline data and reassess the data post intervention from initiatives such as:
  - Paths for All Health Walks e.g. new walker forms and walk registers
  - Parkrun
  - Step count challenges
  - Walking Clubs
  - Walking Football
  - Independent activity providers
  - Sports Clubs
  - Mental health voluntary orgs

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By working in partnership with these agencies we can also gain some more qualitative understanding of outcomes– asking them to monitor the effectiveness of social prescribing on their clients e.g. effects on health, health behaviours, employment, education and volunteering.

References