HEALTH AND SPORT COMMITTEE SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT
SUBMISSION FROM
Physical Activity for Health Research Centre (PAHRC), University of Edinburgh

PAHRC is a research centre within the Institute of Sport, Physical Education and Health Sciences in Moray House School of Education and Sport which aims to provide evidence of how to encourage people of all ages to ‘sit less and move more’. We welcome the opportunity to respond to this consultation and would be happy to offer further information on our response or wider work.

Our response to the Health and Sport Committee of the Scottish Parliament who are seeking views on social prescribing’s ability to tackle physical and mental wellbeing issues across Scotland, is as follows:

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

Social Prescribing has a long history in enabling individuals to make changes which may address underlying determinants of health such as poverty, housing, healthy lifestyle choices or a lack of educational opportunities. The current definition of social prescribing used in this consultation limits this to the work of a community link worker. We believe this is not in line with current usage of the term. It is currently being used informally to describe any activity whereby a health or social care professional suggests a patient may benefit from an activity which is non-pharmacological/invasive. This is part in response to the growth in popularity of the term and potential funding associated with it. A lack of clear definition for social prescribing means the term is used interchangeably to describe a range of different interventions which offer a varied level of support for individuals. This makes any systematic examination of evidence and evaluation difficult. Indeed the social prescribing landscape across Scotland is complex and varied without a coherent approach.

Whilst the use of social prescribing as a model for wider health promotion has become more popular, a recent editorial in British Journal of General Practice urges caution and calls for more robust evaluation “social prescribing has proliferated without a concomitant evidence base. This is partly due to resource limitations on evaluators and partly due to difficulties in conceptualising what social prescribing is and what good evidence for a complex service might look like.”

The evidence that participation in physical activity has wide ranging benefits for physical, mental and social health are well established. It can be as effective as pharmaceutical intervention for some chronic conditions. Recent evidence points towards inactivity as a global public health concern. However, there is little robust evidence available specifically on the long-term effects of social prescription and sustained participation in securing sustained independent physical activity. Evidence from wider aspects of physical activity promotion which involve connecting individuals to physical activity opportunities which is

---

relevant and the Health and Sport Committee should consider evidence relating to; individual and community based physical activity interventions, rehabilitation programmes, and exercise referral and link to the systems-based approach advocated by World Health Organization.

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)

We would welcome physical activity promotion to be a key activity of a variety of organisations and individuals, even beyond traditional health and social care settings, in line with a multi-systems approach advocated by WHO. However, ultimately self-determination of the patient is key for successful behaviour change. This aligns with the ethos of patient centred care and is echoed across theories within health psychology, leisure education and therapeutic recreation.

A successful social prescription is dependent on the ‘readiness’ of the individual to change and prioritisation of which issue to focus on. Physical activity may not always be the outcome of a social prescription and nor should it be. Many patients require support to participate in physical activity i.e. inactive populations may need considerable support to overcome barriers (motivation, confidence, stigma etc) to accessing opportunities as well as motivational intervention and information. Whilst anyone working with communities can ‘raise the issue’ of physical activity with individuals and provide information on local opportunities, a core element of social prescribing is a targeted approach with behavioural change support. Health and social care professionals are well placed to provide an effective brief intervention with onward referral for more intensive support (e.g. by a link worker or exercise referral specialist), but may lack the confidence, skills or capacity to do so.

Whilst self-referral is often touted as a mechanism of improving access to services and reducing bureaucracy, the inequalities in physical activity participation mean that targeted promotion, referral or prescriptions are required to reduce the risk of widening health inequalities. Individuals most likely to ‘seek out’ opportunities tend to be more ‘ready to engage’; will have less social and financial barriers and more likely to be moderately active or previously active. The purpose of a referral scheme or prescription is to reflect the needs of the individual and reduce barriers to access to facilitate sustained participation in health promoting activities.

---

5 NIHR (2019) Themed Review: Moving Matters - Interventions to Increase Physical Activity
6 NICE (2018) Physical Activity and the Environment (NG90)
7 NICE (2014) Physical Activity: Exercise Referral Schemes (PH54)
8 NICE (2013) Physical Activity: Brief Advice for adults in Primary Care (PH44)
3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?

Raising the issue of physical activity and onwards support for physical activity requires referrers to have behavioural change skills; knowledge of the wide-ranging benefits of physical activity; an understanding of local opportunities; as well as capacity and incentive to do this. There may be a need for additional resource in order to deliver this.

Even health professionals do not always have adequate knowledge and skills to have confidence to discuss physical activity with their patients. In 2017 it was reported that over 80% of GPs in England were unfamiliar with the UK Physical Activity Guidelines and over 70% did not discuss the health behaviour with their patients. Our own work demonstrates limited understanding of public health risk factors of inactivity amongst undergraduate medical students (over 85% did not know the recommended PA guidelines for adults and over 75% were not able to identify the recommended amounts for children). Medical students receive limited training on physical activity within medical curricula and it remains a challenge to increase provision.

There is a need for opportunities to signpost to that are accessible to all (inc with regards to cost, opening hours and/or geographical location, as well as physical access and social connectedness). Often physical activity, fitness or sports interventions are facility based which can be a barrier for many individuals. Evidence from Football Fans in Training suggests that the combination of behavioural change techniques, individual walking programme and coach-led physical activity sessions were central to the intervention’s success. Evidence from the Scottish Health Survey demonstrates that walking is the most popular mode of physical activity amongst the Scottish population, and that sports participation remains limited and uptake more inequitable. Successful interventions need to reflect these factors.

Organisations such as Paths for All and parkrun provide free, volunteer led, community-based activities which allow people to drop in informally. Both of these organisations have increased in popularity with inactive participants and have recently increased focus on linking with health and social care professionals to signpost patients to their services. The results of any evaluations of these initiatives will be useful in this anticipated.

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

The lack of robust evidence in this area makes designing or commissioning cost-effective services difficult. Evaluation of a complex intervention at this scale requires large scale research trials which would require to be funded via a specific public health research call (e.g. from the Chief Scientist Office (CSO) or one of the Research Councils UK). There is

an exciting potential to link patient data (via CHI and safe haven arrangements) to explore more direct impact on GP attendance, prescription usage and patient outcomes. Mixed methods and realist evaluation approaches may be particularly useful in this area to understand which aspects of the wider system and prescribing pathway are successful and why as well as assessing the efficacy of interventions.

There is also an opportunity to adopt a standardised evaluation framework for all types of social referral interventions including physical activity. The development of guidance on a ‘core data set’ would support the collection of basic data by multiple providers in a way which could support larger evaluations. This core data set could be added to by projects in order to reflect local needs and stakeholders’ interests. Guidance on pragmatic evaluation skills and frameworks would also build capacity within organisations for further process and outcome evaluation of physical activity opportunities. Some of this work is currently underway with NHS Health Scotland and PAHRC.