

## HEALTH AND SPORT COMMITTEE

### SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

**SUBMISSION FROM:** Dr Emily Oliver, on behalf of the Physical Activity Special Interest Group, Durham University. With contributions from Dr Coral Hanson, Dr Paul Kelly, and Dr Caroline Dodd-Reynolds.

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

The evidence base concerning social prescribing generally, and social prescribing for sport and PA specifically, is limited in a number of ways, including: relatively small-scale evaluations, a lack of control group comparisons, and most pertinently for this question, a lack of long-term (i.e., 12 months or more) follow up.

Where outcomes have been measured there is promising evidence of beneficial effects on health and wellbeing outcomes. In addition, there is some evidence that social prescribing impacts on outcomes that contribute to sustained physical activity (e.g., self-esteem, autonomy). Continued participation in sport or physical activity is rarely measured.

There is, however, logic in extrapolating from evidence we have about how to sustain participation in physical activity and sport through similar non-social prescribing routes (e.g., traditional exercise referral schemes). This is principally because participants in such samples often include those facing a range of barriers to physical activity (e.g., poor health, social isolation), similarly to those entering the social prescribing system.

This evidence base suggests we can successfully facilitate sustained participation but the *type* of activity and scheme accessed is likely to be vital in this regard. There are some examples of good practice, but less agreement on best practice. Recommendations for future evaluation methods will help in this regard (see point 4).

Work is still needed to isolate the impact of social prescribing as a specific entry route to physical activity and sport programmes as opposed to the impact of the differing physical activity and sport offerings themselves.

#### 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)**

To our knowledge, this has not yet been comprehensively investigated. Link workers appear critical, but the level of support needed is unclear.

In comparable systems (e.g., exercise on referral), there are differences in engagement and outcomes where entry routes, referring professionals, and referring organisations differ.

There is some evidence that referrals from secondary care work better than other routes, however, rather than being systematic, our data shows different routes work for different sub-groups of people.

This highlights a critical issue for consideration. Restricting entry routes has the potential to exacerbate inequalities in participation. For this reason, we recommend enabling and evaluating a broad range of routes including self-referral.

Lastly, multiple studies have demonstrated that GPs find social prescribing and lifestyle-based referrals challenging - support is needed for all professionals facilitating entry a social prescription.

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

There is an extensive evidence base concerning *barriers for individuals'* uptake and maintenance of physical activity generally, and for physical activity referral schemes.<sup>1</sup> It is likely that these barriers are also applicable to those accessing physical activity via social prescribing routes.

There is also a growing evidence base concerning *barriers for systems* aiming to support individuals' uptake and maintenance of physical activity.<sup>2</sup> It is likely that these barriers are also applicable to accessing physical activity via social prescribing. These include: knowledge and confidence of referring professionals (see point 2 above), knowledge and skills of the workforce (traditional sport sector in particular) when supporting individuals facing a range of complex challenges, and sharing of information across and between organisations. We have evidenced some success in terms of overcoming these barriers through: (i) prototyping of interventions, which involves live-refinement of both entry routes and the programmes themselves, and (ii) enabling locally-led tailoring and variation of offers/processes.

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<sup>1</sup> Examples include: Hanson, C.L., Oliver, E.J., Dodd-Reynolds, C. & Allin, L. (2019). How do participant experiences and characteristics influence engagement in exercise referral? A qualitative longitudinal study of a scheme in Northumberland, United Kingdom. *BMJ Open* 9(2): e024370; Kelly, M., Rae, G., Walker, D., Partington, S., Dodd-Reynolds C.J. & Caplin, N. (2016). Retrospective cohort study of the South Tyneside Exercise Referral Scheme 2009–14: Predictors of dropout and barriers to adherence. *Journal of Public Health*. 39, Issue 4, December 2017, Pages e257–e264; Hanson, C.L., Ellis, J.G., Allin, L.J. & Dodd-Reynolds, C.J. (2013). An evaluation of the efficacy of the exercise on referral scheme in Northumberland, UK: association with physical activity and predictors of engagement. A naturalistic observation study. *BMJ Open* 3(8): e002849.

<sup>2</sup> See: Oliver, E.J., Hanson, C.L., Lindsey, I.A. & Dodd-Reynolds, C.J. (2016). Exercise on referral: Evidence and complexity at the nexus of public health and sport policy. *International Journal of Sport Policy and Politics* 8(4): 731-736.

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

Data sharing is vital in this regard. Typically, within-scheme evaluations have occurred, allowing little understanding of how differences in delivery might impact on effectiveness.

Different models are possible. For example, whereas Wales operate a national referral scheme, England collates a centralised database enabling comparison of locally-led (and therefore more variable in terms of delivery) schemes.

Standard evaluation frameworks for physical-activity based programmes exist, however, these are often cumbersome and challenge the resource base of delivery organisations.

Simplistic and user-friendly taxonomies (including below, developed by researchers at Edinburgh, Edinburgh Napier, and Durham with practitioner input)<sup>3</sup> may be useful in facilitating the capture of comparative evaluation data.

<b>LEVEL 1a</b>	<b>Primary Classification</b>	Traditional Exercise Referral Schemes		Non-traditional Physical Activity Referral Schemes	
<b>LEVEL 1b</b>	<b>Provider</b>	Leisure Trust / Local Authority	Charity	Sport based	Commercial (e.g. David Lloyd, Pure Gym)
	<b>Setting</b>	Leisure Centre / Council facility	Outdoors / Green Gym	Sports club facility / Community facility	Private property
<b>LEVEL 1c</b>	<b>Referral reason</b>	CVD primary prevention (Hypertension)	CVD Secondary prevention (ACS, HF, Stroke)	Respiratory disease (COPD, Asthma)	Metabolic disease (e.g. Type 2 diabetes)
		Mental illness (anxiety and depression)	Musculoskeletal (back pain, OA)	Cancer (non-specific)	Cancer (specific - breast, bowel, etc.)
		Weight Loss or Weight maintenance	Falls Prevention	Dementia, Alzheimer's Parkinsons	Inactive / Sedentary
<b>LEVEL 1d</b>	<b>Activity type</b>	Gym based (cardiovascular, weights)	Specialised exercise class (e.g. circuit)	Walking	Jogging / running
		Swimming	Outdoor cycling, eBikes	Sports (e.g. badminton, walking football)	Mixed activities
		Generic facility based classes (e.g. yoga, zumba)	Gardening	Outdoor fitness class	Other

<sup>3</sup> Hanson, C.L., Oliver, E.J., Dodd-Reynolds, C.R., & Kelly, P. (under review). Towards a better understanding of the evidence for "Exercise Referral": A proposed Physical Activity Referral Scheme Taxonomy. *British Journal of Sports Medicine*.