Social Prescribing and Physical Activity: Scoping an Agenda for Policy, Practice and Research

A working paper from the Advanced Wellbeing Research Centre Healthy and Active 100 theme

May 2022

1. Introduction

The Chief Medical Officer recommends that we should do at least 150 minutes of moderate physical activity a week to keep us healthy and promote our wellbeing. Whilst the percentage of people achieving this target has increased in recent years many people do not reach this level on a regular basis and levels of inactivity remain stubbornly high.[1] As it is well established that physical activity can contribute positively to an individual's physical wellbeing, mental wellbeing, personal development and social and community cohesion as well as national economic development, increasing physical active is now a worldwide priority[2] and it is widely acknowledged that more needs to be done to support and motivate those not currently meeting physical activity targets.

Over the past 20 years there has been growing interest in the role that health professionals can play in supporting people to be more physically active. This includes promoting physical activity as a positive health behaviour, identifying opportunities for patients to take part in physical activity, and helping patients to overcome barriers to participation. Exercise on Referral Schemes (ERS) are a prominent example of the types of interventions that have been put in place to support this goal. ERS involves a partnership between a physical activity or leisure provider and primary care to identify and refer people with mild chronic diseases to a time-limed person-centred exercise programmes with the goal of achieving a step-change in levels of physical activity. However, reviews of ERSs have raised concerns about its efficacy and suggest that its development has been constrained by the wide variety of activities and approaches on offer and weak evaluative evidence.[3]

In response to concerns about the efficacy of ERS there has been growing interest in the role that social prescribing could play in supporting people to become more physically active. Social prescribing is a way for local health professionals and other service providers to refer people to a link worker who spends time to understand 'what matters' to them based on their strengths and interests. Link workers are based in a range of settings including primary care, voluntary and community organisations and local authorities and NHS England has invested in a universal social prescribing model as part of the 2019 NHS Long Term Plan. Since 2019 each Primary Care Network (covering a population of 30,000-50,000 people) has been encouraged to employ a social prescribing link to connect patients to services, groups and activities in their community for practical and emotional support. There are wide range of community-based physical activity and exercise opportunities available for link workers to refer to, but currently very little is known about the extent to which this happening or whether it leads to higher levels of activity.

In 2022 ukactive, the membership body for the UK fitness and leisure sector published a report[4] outlining a wide range of roles their members play supporting people through social prescribing and

---

1 According to Sport England's 2018-19 Active Lives Survey a quarter of the population were 'inactive' – they did less than an average of 30 minutes of activity a week; and one in eight were 'fairly active' but didn't reach an average of 150 minutes a week.
2 World Health Organisation (2018) *Let's Be Active Global Action Plan*.
3 Downey, J., Shearn, K., Brown, N., Wadey, R. and Breckon, J. (2021) Behaviour change practices in exercise referral schemes: developing realist programme theory of implementation. *BMC Health Serv Res,* 21, 335. Available at: https://doi.org/10.1186/s12913-021-06349-9
4 ukactive (2020) *Social Prescribing within the Fitness and Leisure Sector*. Available at: https://www.ukactive.com/reports/leading-the-change/

made some recommendations about how this could be expanded. These included raising awareness of the role of gyms, pools and leisure centres in social prescribing; increasing the knowledge of social prescribing among the physical activity workforce; and connect more gyms, pools and leisure facilities to community networks. In support of these recommendations the sport and leisure sector has set the ambition of offering 500,000 hours of physical to NHS England - at no cost to the end user – to further embed physical activity and exercise in social prescribing services being delivered across England.

There are obvious parallels to be drawn between ERS and social prescribing. Both have undergone rapid scale-up following interest and investment from health services; both are wrought with natural variations in who accesses interventions, what they are and how they are developed; both have provoked criticism for their weak theoretical and evidential underpinnings; and both are complex interventions relying on partnership between community-based providers and health care practitioners. With these parallels and challenges in mind, this working paper aims to explore the current evidence for social prescribing and physical activity and identify transferrable lessons from ERS.[5] We hope that the insights presented will support the development of an agenda for future policy, practice and research on this topic and we look forward to working with key stakeholders to take this forward.

2. Social prescribing and physical activity: taking stock of the evidence

The published – academic and grey – evidence on social prescribing and physical activity is relatively thin. The scoping review published alongside this working paper identified 34 studies where the relationship between a social prescription and physical activity was discussed in one way, shape or form. Given that social prescribing originated in the UK and has only recently gained international traction, the majority of studies identified were from the UK. The review concluded that the landscape of evidence associated with social prescribing and physical activity is currently more related to implementation of social prescribing schemes and the associated barriers and enablers, rather than directly attributing increased levels of physical activity to social prescribing activities.

The following section summarises the findings of the scoping review based on the main components of a social prescribing referral pathway.

Who is referred to social prescribing?

People being referred to social prescribing schemes for physical activity included adults in a general primary care population as well as those from deprived communities, people with mental health conditions, patients with long-term health conditions, patients at risk of cardiovascular problems or type 2 diabetes, and those at risk of social isolation. Very few schemes appear to focus on young people.

Who refers to social prescribing?

Most referrals are made by GPs or other health professionals in a primary care setting. However, there are some examples of referrals from non-medical and social care professionals, as well as self-referral.

What types of activities and interventions are people referred to?

The types of physical activity or exercise people are referred to included walking groups, running networks/groups, gardening, general sport and leisure centre activities such as swimming and gym classes, netball and football, and activities in outdoor green spaces. It is notable that many activities are free and outdoor.

What outcomes are associated with a social prescribing referral?

Very few studies focussed on quantifying outcomes through validated measures, self-reported means or data from medical records. Where outcomes were measured, they were not limited to physical activity, which is in line with social prescribing being a means to understand what matters most to a person and support those concerns as a priority. The breadth of outcomes was also related to how support was provided, for example through clubs and groups, which provide social contact as well

5 We have published two rapid scoping reviews alongside this working paper which provide more detail about the evidence base that supports our findings: https://www.shu.ac.uk/advanced-wellbeing-research-centre/projects/socialprescribing

as physical activity. Despite the limited number of studies, they do provide some indicators about the types of outcomes that can be associated with social prescribing referral to physical activity (Figure 1). Importantly, the findings of a number of studies suggest that a social prescribing referral can lead to increases in levels of physical activities but a lot more evidence is still needed on this and other outcomes.

Figure 1: Outcomes associated with a social prescribing referral for physical activity

What factors are associated with a successful social prescribing referral?

A number of barriers and enabling factors associated with a successful social prescribing referral were identified through the scoping review. These operate at three levels: the referrer, the link worker, and the individual (Figure 2).

Figure 2: Factors associated with a successful social prescribing referral

Referrers	Link Workers	Individuals
Time to build relationships and trust	Ability to support people with multiple and complex needs	Health literacy and attitude to physical activity
Knowledge and understanding about the benefits and risks of physical activity	Skills, training, and workforce development opportunities	Time and work-life balance
Awareness of and relationships with activity providers	Workload and emotional burden	Money
A practice culture that champions physical activity and social prescribing	Level of embeddedness in general practice	Accessibility and transport
Feedback loops about the progress of people referred	Awareness of and relationships with activity providers	Feeling supported, and not dictated to, through person-centred approaches
	A non-directive and non-judgemental approach	Time to build relationships and trust
	Time to build relationships and trust	Peer support and social connection

Of note, two factors were found to operate at multiple levels. These were having the time to building relationships and trust between referrers and link workers, and between link workers and individuals, and awareness of and relationships with activity providers. These factors, which both relate to the effective functioning of social prescribing as a pathway and part of the wider health system, appear to be key to the successful development of social prescribing as an approach to improving levels of physical activity.

Many of the factors identified point the need for wider system and policy change. For example, the current lack of education in the medical curriculum on the benefits of physical activity, nutrition and social prescribing mean that new medical professionals are not appropriately equipped to talk to their patients about physical activity. Furthermore, current practice in primary care makes it almost impossible to talk about social prescribing or build a rapport within such a short consultation time. This suggests that work is needed to educate healthcare professionals who are referring to social prescribing schemes on the benefits of physical activities for their patients and the nature of the discussion about this approach to managing health.

As discussed in the introduction, exercise on referral schemes (ERS) have been active in many areas in the UK for a number of years. For the most part these schemes do not include a link worker and rely on an assumption that if a person is referred for an exercise intervention programme that they will then turn up and adhere to it. Evidence from social prescribing schemes shows that when a person talks to a link worker, the personalised approach enables the patient to reveal concerns that are of greater priority than physical activity. A proportion of people referred to social prescribing, therefore, will need other issues sorting out before they are likely to consider or adhere to increasing physical activity. This is an important point to note for practice and for future studies seeking to quantify changes to physical activity levels as physical activity may not be the most important outcome for every participant.

Challenges and limitations with the evidence base

A number of challenges were encountered when designing and implementing the scoping study which have led to limitations in findings presented here. These also highlight wider challenges and limitations associated with the current evidence

associated with social prescribing and physical activity. Whilst social prescribing as a term is now embedded in policy, it is not recognised as a key term in research databases which creates uncertainty that all relevant papers are captured through search criteria. Moreover, many studies may not call their social prescribing schemes by that name, so some evaluations have not been found. For this project, social prescribing, community referral and co-production were used to cast a wide net. Although previous social prescribing scoping reviews have used a wider range of terms around primary care, this can yield far too many studies than is practical to review. Similarly, physical activity can be referred to via many terms, so an extensive list of terms was needed.

3. Learning lessons from Exercise on Referral

Exercise on Referral Schemes (ERS) have been in operation for significantly longer than social prescribing and are implemented in many more countries around the world. As such, the evidence base on ERS is much larger and well established than that of social prescribing. Given the limited evidence about social prescribing and physical activity, our working hypothesis was that the ERS literature ought to provide some valuable pointers for social prescribing. The academic literature was screened, but not examined in-depth. Instead, the focus was key documents and best practice guidance which were purposefully sampled for their relevance and ability to populate programme theory. These guides proved fruitful for this review as they explicitly discuss the necessary conditions and practices required to achieve success, which was not widespread nor standardised historically.

The realist informed review highlighted four components of effective ERS (figure 2) which operate at various stages of the service pathway and capture the essential facets needed to create a system which can support PA. These are summarise in the following section.

Figure 3: Components of effective ERS

Person centredness

It is widely accepted that ERS should ensure that all practices, interactions, programme offers, and data collection are for the purposes of helping the patient towards an independent, physically active lifestyle. The material reviewed stressed the need for a person-centred environment in which patients could access individualised care, choice and counselling. The following statements highlight a number of factors identified as being particularly important.

i) If patients are given a 1-1 appointment, during which a co-created, holistic assessment and care plan are created, then there is a greater chance of a sustained change in physical activity because the service is tailored to them; they fully understand the process; they receive an agreeable dose of exercise; and the service is relevant to them, so they are more likely to commit.

ii) If patients can choose from a variety of quality assured schemes and are offered flexibility, including the option for social interaction, then adherence will improve because there will be fewer barriers to access, and patients will be more motivated through personal choice and enjoyment.

iii) If ERS embed behavioural counselling throughout the person's journey, then they will be more likely to improve and sustain physical

activity change because they will be empowered by having access to prudent tools (including relapse prevention, monitoring, feedback, education, continued support, and explicit exit strategies).

Partnerships

Relationships at key points in an ERS referral pathway were identified as vital to successful ERS and should be characterised by an alignment between needs and the pathway offer, communication, trust and shared commitment and responsibility. The relationships between the GP and the ERS practitioner is particularly important in this regard and without a shared agenda, clear roles and responsibilities, collaborative scheme development, mutual understanding and trust, ERSs will not operate optimally. The following statements highlight a number of factors about partnerships that should be taken into account.

iv) If referrers have a clear understanding of the nature and aims of the scheme, via training; clear, accessible guidance; and processes to support the alignment of needs and offers, then they will refer more appropriately (approach & people) because they will be aware of, and have processes to, access the scheme.

v) If all practitioners involved in a patient's care work in a partnership and communicate with each other in a timely, meaningful, and effective manner, then patients will experience better quality of care and outcomes, because continuity will improve, people referred will be suitable, and inter-professional cooperation and mutual value will improve.

vi) If all professionals involved in patients' care have mutual respect and trust for one another and schemes are quality assured and valued as part of the wider healthcare agenda, then referrers and ERS professionals will develop better partnerships and improve the quality of patient care because there will be greater cooperation, confidence, and perceived efficacy.

vii) If referrers and schemes take joint responsibility for supporting patients, with clear and appropriately assigned roles and responsibilities, then patients are more likely to engage with appropriate ERS schemes because there will be a sense of coherence, advocacy, and integration.

Standards of practice

The review highlighted concerns amongst GPS about the standards of practice within ERS, how these were regulated and therefore whether they could be certain that patients would receive an acceptable level of care. The following statements highlight how these barriers may be overcome.

viii) If exercise professionals were required to register with a statutory regulatory body, then the quality of ERSs would improve and health care professionals would be more likely to refer patients to the scheme. This is because it would be clearer that the exercise professionals would have the necessary competencies to deliver a safe and effective service; adhere to a code of practice; hold the necessary insurance; undertake regular appropriate continuing professional development (CPD); and work within their scope of practice as part of a multidisciplinary team.

ix) If all practitioners involved in patient care undertake CPD, personal reflection, and an annual review of their practice, then this will improve the quality of ERSs and integration with GPs. This is because CPD will focus on identifying gaps in skills and knowledge relating to standards of practice and transform thinking rather than consisting of arbitrary training.

Management of services

How ERS were developed and managed was identified as a key factor related to their success. Multi-stakeholder involvement in the (co-)design, implementation and evaluation of ERS, alongside effective local leadership, were considered particularly important. This is encapsulated by the following statements:

x) If schemes are designed collaboratively, with the goal of achieving long-term behaviour change and congruent monitoring, and evaluation processes are adopted, then efficacy will be higher and utilisation greater because schemes will be able to make formative changes, there will be clarity on what is expected, and schemes will be able to demonstrate their worth and safety.

xi) If there is a dedicated local leader who is responsible for coordinating stakeholders, arranging budget agreements, producing operational documentation, developing

formal agreement processes and duty of care procedures alongside supporting ERS staff to meet their practice and governance duties while supporting the implementation and evaluation of schemes, then schemes will be of higher quality and will be more likely to achieve greater impact. This is because the scheme will be driven in a direction consistent with best practice guidelines and they will be able to show compliance with health and safety and wider quality indicators valued by other stakeholder and all involved will be clear on the expectations of the scheme

Implications

The aim of this project was to scope the field of ERSs to identify key evidence about how community services accessed through social prescribing may influence physical activity. There is a need to understand the challenges and opportunities for social prescribing to support physical activity and the results from this review highlight key areas that need considering if implementation is to be successful. Social prescribing policymakers, commissioners, providers should consider how services attends to all aspects of the patient journey including the referral, intervention content, provider tasks, and practitioner practices.

The findings from this review provide some helpful pointers for effective social prescribing of physical activity.

- Partnerships that attend to trust, aligning needs with the pathways offer, communication, and shared commitment.
- Standards of practice that consider the regulation of staff and cross professional CPD.
- Management of schemes which explicitly plan the design and evaluation of schemes and have robust leadership.
- Schemes which are patient centred by their individualised practice, commitment to patient choice, and use of counselling approaches are paramount.

4. Implications for policy, practice and research

This working paper has explored the current evidence for social prescribing and physical activity and identified transferrable lessons from evidence about exercise on referral schemes (ERS). It is hoped that the findings will support the development of an agenda for future policy, practice and research that considers social prescribing as a key intervention for health creation by promoting and sustaining levels of physical activity.

Our findings point to some cross-cutting themes about effective practice and how barriers may be overcome. Three themes appear to be particularly important:

1) **Person centredness**: placing the patient at the heart of the process to understand their needs, capabilities and 'what matters' to them; and identifying appropriate support that might involve physical activity in combination with other forms of social and practical activities, advice and guidance.

2) **Partnerships** *(formal)* **and relationships** *(informal)*: there should be positive and equal relationships between stakeholders at key points along a social prescribing pathway based on collaboration. This includes between GPs and link workers, link workers and patients, link workers and physical activity providers, and the social prescribing service or system and physical activity providers. In some cases, it may be necessary for these partnerships to be formalised, but the key principle behind all these relationships should be trust and understanding.

3) **Knowledge, awareness and understanding of the benefits of** *a) physical activity* **and** *b) physical activity provision*: link workers and health professionals need to understand the circumstances in which a patients would benefit from being referred to physical activity, the types of physical activity that might be appropriate, and the range of activities available in their area that patients can be referred to.

Recommendations for policy and practice

Although the evidence about social prescribing and physical activity is still relatively limited our findings provide some pointers for policy makers and practitioners about how they could focus their efforts to further embed physical activity in social prescribing services and systems:

a) **Linking-up services, systems and activities**: there is a need to develop better links between social prescribing services and physical activity providers so that link workers know more about

physical activity provision in their area and how referrals can be made/received. Similarly, physical activity providers may need support to understand more about how social prescribing works and how they can receive higher numbers of referrals.

b) **Raise awareness of the benefits of physical activity**: there needs to be greater awareness amongst all social prescribing stakeholders of the benefits of physical, including who could benefit from different types of support. The recent consensus statement on the risks of physical activity for people living with long-term conditions ought to provide a helpful start point for this.[6]

c) **Invest in development and capacity**: provide training and resources for link workers to build knowledge, skills and understanding to make appropriate referrals to physical activities; and invest in physical activity providers to build their capacity and capability to take on more referrals.

Towards a research agenda

The scoping review undertaken in support of this working has highlighted how limited the evidence base about social prescribing and physical evidence is. Although the evidence about ERS is more established and provides some helpful pointers for social prescribing and physical activity, it is not sufficient to enable physical activity to be embedded in social prescribing across the board. In response, we propose the development of a whole systems research agenda around social prescribing and physical activity based on an exploration of access, experience, and outcomes at different stages a typical social prescribing pathway:

- **Referrals**: what is the volume of referrals to social prescribing; what types of patients are referred, for what reasons; and how do referrals patterns vary nationally and internationally?
- **Link workers**: to what extent do link workers understand the benefits of a physical activity referral and know about the range of activities available to their patients?
- **Patients**: what do patients feel about being referred to physical activity and what types of experiences do they have; what are the barriers to uptake and how can they be overcome; and what are the short- and long-term outcomes of a referral?[7]
- **Providers**: to what extent do physical activity providers understand and engage with social prescribing; what are the barriers to involved and how can these be overcome; and what are the resource and capacity implications of greater involvement (including ability to support greater numbers of participants)?

Research should focus on identifying mechanisms of change at key points along the social prescribing pathway. In order to generate learning that will be useful to social prescribing stakeholders it will be important to understand how, why and in what context change occurs.

---

6 Reid, H., Ridout, A.J., Tomaz, S.A., Kelly, P. and Jones, N. (2021) Benefits outweigh the risks: a consensus statement on the risks of physical activity for people living with long-term conditions. *British Journal of Sports Medicine*. Published Online First: 14 October 2021. doi: 10.1136/bjsports-2021-104281.

7 It will be important to understand the extent to which, and in what circumstances, a referral enables patients to meet the Chief Medical Officer's recommendation that people should do at least 150 minutes of moderate physical activity a week alongside a wider set of outcomes linked to the social determinants of health.

About the Advanced Wellbeing Research Centre

The Advance Wellbeing Research Centre (AWRC) at Sheffield Hallam University is dedicated to improving the health and wellbeing of the population through innovations that help people move. AWRC's mission is to prevent and treat chronic disease through co-designed research into physical activity.

Through our *Healthy and Active 100* research theme we aim to catalyse and develop research activity that supports people through 100 years of healthy and active life, irrespective of where they are born or their socioeconomic status. Research in the theme is intended address system-wide challenges across the life course, from providing every child with a healthy and active start in life, to community-based activity for people of all ages, through to promoting healthy and active ageing.

Authors

Chris Dayson, John Downey, Marie Polley, Abigail Sabey, Elena Golder

Contact

To discuss the contents of this working paper please contact:

Chis Dayson, Associate Professor, Theme lead for the Healthy and Active 100 research theme within the AWRC.
c.dayson@shu.ac.uk / 0114 2252846
@cdayson_shu | @SHU_AWRC | @CRESR_SHU

Sheffield Hallam University | Centre for Regional Economic and Social Research

PLYMOUTH MARJON UNIVERSITY

Meaningful Measures