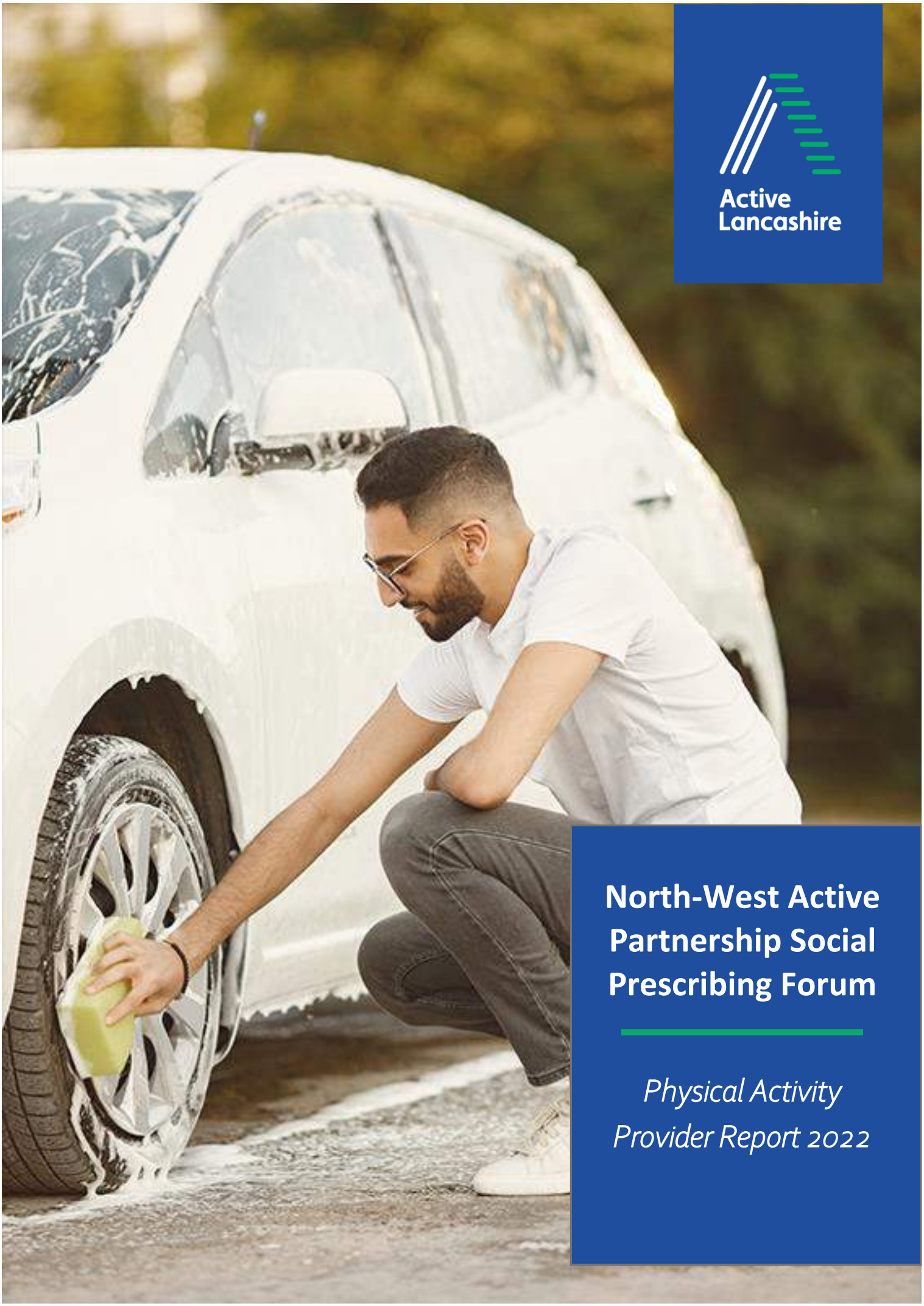


Active Lancashire

North-West Active Partnership Social Prescribing Forum

Physical Activity Provider Report 2022

North-West Active Partnership Social Prescribing Forum

Physical Activity - Provider Report 2022

Thank you:

Active Lancashire has worked in collaboration with a great many organisations and individuals to produce this report, as was similarly the case with the related North-West Physical Activity Link Worker Survey. In view of this contribution, it felt important to show gratitude to those who come together more generally, both formally and informally, serving as a broad and very necessary multidisciplinary and multi-level team. In this instance, the aim of this collaboration was to gather data that will assist relevant leads to promote and embed social prescribing amongst the wide range of stakeholders that exist across the different geographies, systems and levels of seniority. While it has not been possible to name all those who supported this piece of work, it is hoped this message will reach and be recognised by the intended recipients. Thank you again.

- **Collaboration:** Greater Sport, MSP, Active Cheshire, Active Cumbria, alongside the Sport England local delivery pilots, Together an Active Future and GM Moving.
- **Consultation:** National Academy for Social Prescribing (North-West Regional Team), the Applied Research Collaboration (ARC) North West Coast, The Activity Alliance (North-West/North East) and London Sport.
- **Survey promotion:** the various Councils for Voluntary Service (CVSs), Link Workers, social prescribing scheme leads, National Governing Bodies and football trusts from across the North-West.
- **Participation:** finally, the multitude of physical activity providers within the region that kindly gave their time to complete the survey.

For all enquiries relating to this report, please contact Benjamin Fatimilehin at Active Lancashire, email: bfatimilehin@activelancashire.org.uk

North-West Active Partnership Social Prescribing Forum

Contents

Section	Page
Introduction	
Purpose	4
Approach	4
Outcomes	5
Potential Factors	6
Respondent Profile	
Characteristics	8
Nature of activities	10
Capability	
Potential factors	13
Capability outcomes	20
Potential factors at the county and ICS level	27
Opportunity	
Potential factors and outcomes	30
Potential factors at the county and ICS level	38
Motivation	
Potential factors and outcomes	41
Conclusions	44
Appendices: peer learning	46

Introduction

Report purpose:

This report may help physical activity, health, and social prescribing leads identify areas of interest and focus for subsequent exploration and intervention in social prescribing systems across the North-West. The report is not intended to serve as a standalone commentary, rather it seeks to prompt subsequent discussion as to where the greatest opportunities might exist for improvement and to capitalise on existing good practice, to achieve the sought outcomes detailed below. Ultimately, this report tentatively explores what might need to happen to ensure physical activity providers can effectively engage in, develop their contribution to, and remain involved in social prescribing. Furthermore, it asks where does most potential currently lie, to improve the performance of physical activity providers, in relation to social prescribing? Finally, it considers how referral pathways might be shored up to ensure social prescribing is sufficiently integrated in to all appropriate areas of the physical activity sector, in order to maximise the achievement of desired participant outcomes (e.g. physical and mental health, social connectedness and so on). The intent is not to provide definitive answers, but illuminate avenues for further joint investigation and testing by relevant stakeholders.

218 respondents from across the North-West took part in the survey, which were divided into four cohorts. Due to the response sizes being limited for those participants that used to engage with social prescribing (C) and those who were not interested (D), this report primarily focuses on those providers currently engaged in social prescribing (A) and those not currently involved but interested in becoming so and learning more (B).

Cohorts:

A. Currently involved in social prescribing
B. Not involved in social prescribing but interested
C. Used to be involved in social prescribing
D. Not involved in social prescribing and not interested

Approach:

A number of stakeholder groups will have direct contact with social prescribing service users during their journeys and for each a different set of outcomes can be identified and pursued. It has been attempted below to outline a comprehensive menu of outcomes, relevant specifically to physical activity providers, that if achieved it is hoped would ensure service users receive an effective social prescribing offer. The COM-B behaviour change model provides a framework for this broad range of considerations, which might critically influence provider performance and engagement with social prescribing. Presenting the data in such a framework where it falls under broader headings, such as capability, opportunity, and motivation, it is hoped will help practitioners consider and respond to the wide variety of components that may require attention. Whilst many factors could affect the pursuit and achievement of the outcomes detailed, it has only been possible to consider some of these within this report. Once physical activity leads have focused in on areas of interest, the measures provided may help to baseline these potential factors and outcomes to gauge the impact of subsequent interventions. To complement the largely quantitative findings of the

survey, limited discussions were had with providers new to social prescribing delivery in a group interview format. This may provide helpful context and detail beyond the limits of the survey format and this report that could be used in subsequent discussions.

Otherwise, the commentary in this report provides observations concerning the results only, rather than deriving what the results mean, in terms of whether the presence of a particular factor (such as level of collaboration) then determines the achievement of an outcome or attempting to establish whether differences are significant. The aspiration is that this report might encourage further investigation and 'live' exploration of the themes outlined, that then produces much more definitive answers in terms of the differences observed and which factors might exert greatest influence on the achievement of desired outcomes. Further county and Integrated Care System (ICS) level data can be sought from the relevant Active Partnerships that cover the North-West.

Outcomes:

As above, the overarching ambition for the wider piece of work associated with this report is that organisations can engage in social prescribing and once they have done so, develop their contribution, while being able to sustain provision of a quality physical activity offer in the long-term. Therefore, it needs to be considered:

- Whether providers possess the relevant skills and knowledge to do so?
- If the context in which they operate provides the necessary opportunities (e.g. resources, networking and so on), to support their involvement in social prescribing?
- And how providers' goals, motivations, and aspirations, might align with, benefit from and contribute to those of social prescribing drives?

Beyond providers having a reasonable grasp of what social prescribing is, having the capacity to accommodate additional attendees and an awareness of what the profile of social prescribing clients might look like and their needs, it is crucial that they have the capability to respond to these needs as well. Their ability to do so may be greatly enhanced by the development of good quality relationships (e.g. information sharing) with the relevant social prescribing service/s in their locale. The formation of such relationships relies on both a provider's own capability and the opportunities presented. Good relationships between providers and Link Workers help to ensure that jointly, they continue to meet the needs of clients during handover (referral and reception).

To meet the diverse needs of social prescribing clients, it is likely the physical activity offer in any given location will need to demonstrate corresponding variety. Therefore, it is proposed that a range of organisation types, employing a menu of delivery methods and targeting a variety of social groups, can engage in social prescribing. As a result, it should be considered whether the full range of physical activity providers can access sufficient support and resource to engage in social prescribing provision and that barriers have been addressed. Finally, in terms of motivation, only touched on modestly in this report, while promoting the measurement of physical activity and health, leads are also encouraged to help providers recognise that their existing activities may already respond to the wider needs of social prescribing clients (e.g. improved mental health and social connectedness) and to evidence this impact. Otherwise, while detailed, it has not been possible to explore the following outcomes detailed in grey.

Capability:

A. Providers have a good understanding of social prescribing.
B. Providers are aware of the additional needs of social prescribing referrals.
C. Providers feel confident they can meet the additional needs of their participants and/or social prescribing referrals, to aid engagement of inactive groups/individuals (e.g. provision is welcoming, safe and inclusive).
D. Enough providers have spare capacity to accept referrals at any given time.
E. Good rates of first attendance following referral, as are rates of sustained engagement.
F. Provision takes place as close as possible, to where participants live and work (**covered by Link Worker Survey**).
G. Providers encourage and emphasise the importance of movement in participant's everyday life, both in organised and unguided activities (such as active travel or undertaking chores around the home - **covered by Link Worker Survey**).

Opportunity:

H. Providers know or feel confident they could identify their respective Link Worker/s.
I. Link Workers provide a range of handover support to clients, when referring into activities.
J. Providers receive sufficient referral information detailing clients' needs, avoiding potential issues.
K. Providers have sufficient resources and support, to become/remain engaged in social prescribing.
L. Social prescribing attracts and is accessible to a diverse range of organisation/activity types, operating at various scales and catering for a range of target audiences, particularly those that are most inactive.

Motivation:

M. Providers measure levels of physical activity, mental wellbeing and other relevant outcomes, and where appropriate physical health.
N. Providers appreciate not only the wide range of benefits physical activity has on physical health, but also those that relate to mental wellbeing, social connectedness and so on.
O. Providers recognise that physical activity and their provision, may already respond to many of the principal needs social prescribing seeks to address (stress/anxiety, low mood and loneliness), so that the existing goals of their organisation (say to reduce inactivity), might simultaneously align with and help achieve the broader health aspirations for the local population.

Potential Factors:

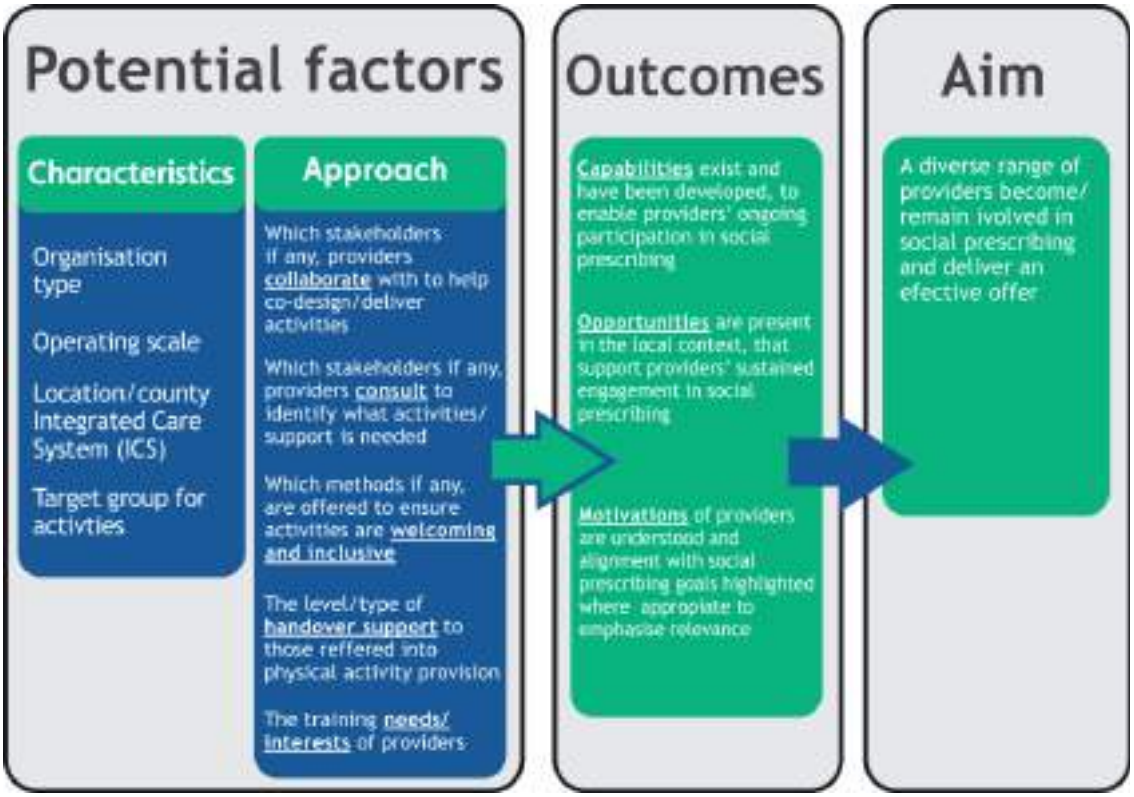
A number of factors have been proposed which may help organisations engage in social prescribing provision and provide an effective physical activity offer. In order to identify the factors that are likely candidates to influence the achievement of the outcomes, the data were analysed from different perspectives. Firstly, might the factors be more common amongst those that are already involved in social prescribing? Secondly, do providers who demonstrate these factors appear to more readily achieve the desired outcomes? Then, for some factors, amongst which stakeholder groups do these features seem most/least prevalent? For example, amongst certain organisation types (e.g. charities), this to identify potential sources of learning and foci for improvement.

Additionally, as the purpose of this study was to help physical activity/health leads identify possible opportunities for intervention (e.g. test and learn), the prevalence of these features was also considered at the county and ICS level so that practitioners could identify where geographically they might wish to hone in on and explore further.

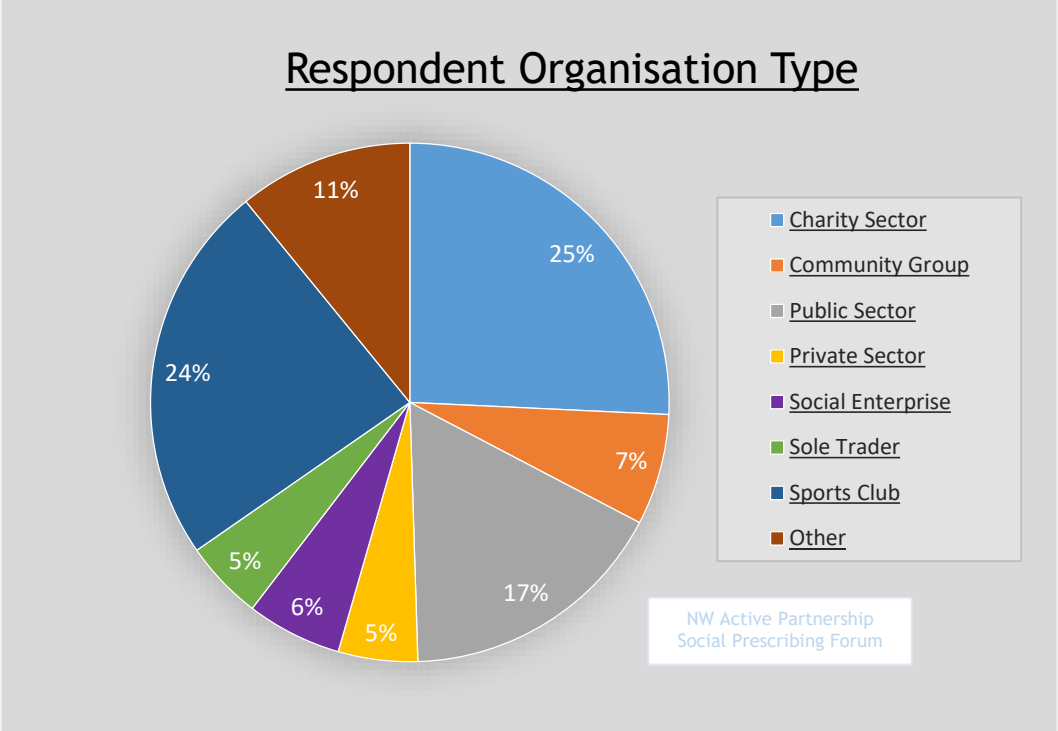
Finally, the report more broadly attempts to identify and suggest potential existing good practice and learning, so that recognised approaches might be encouraged elsewhere, and possible exemplars might be involved in the design/delivery of subsequent interventions. A modest effort has been made at the end of this report to begin the process of sharing learning. Again, it is not possible to say conclusively if the factors detailed resulted in greater achievement of the sought outcomes. Where there appears greatest potential and some relationship might exist then these themes could be examined in the interventions that follow by firstly baselining providers existing performance, before promoting such factors with the resulting change (outcome achievement) then measured, and attribution established.

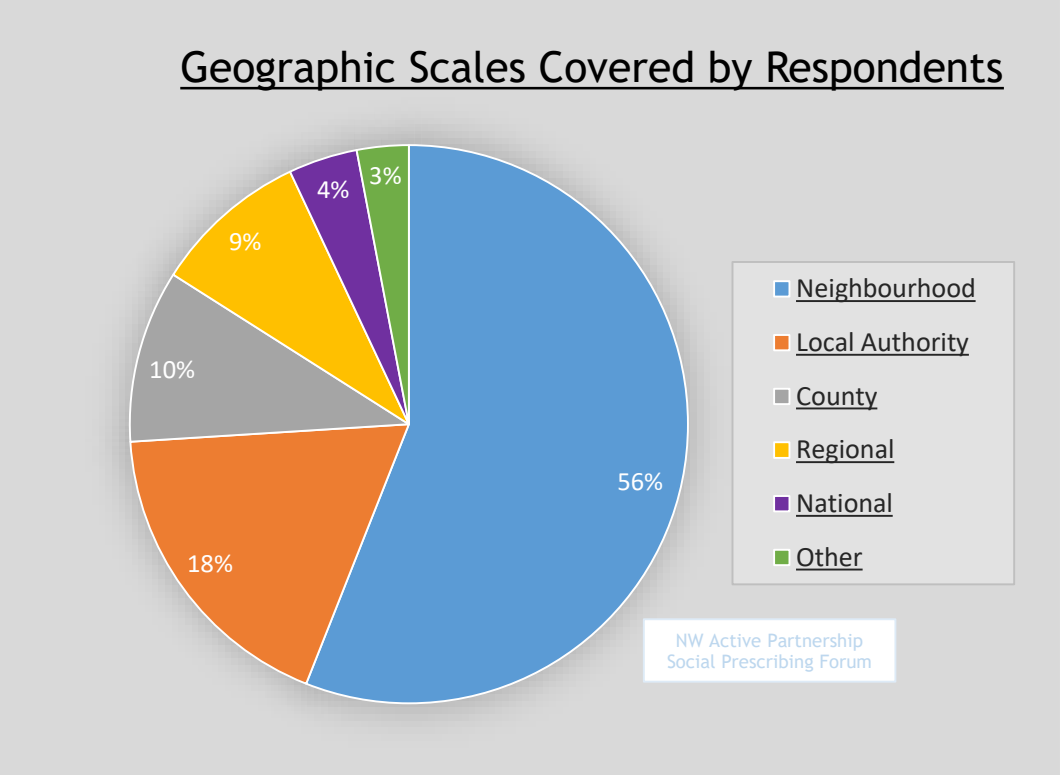
Exploration of possible factors:

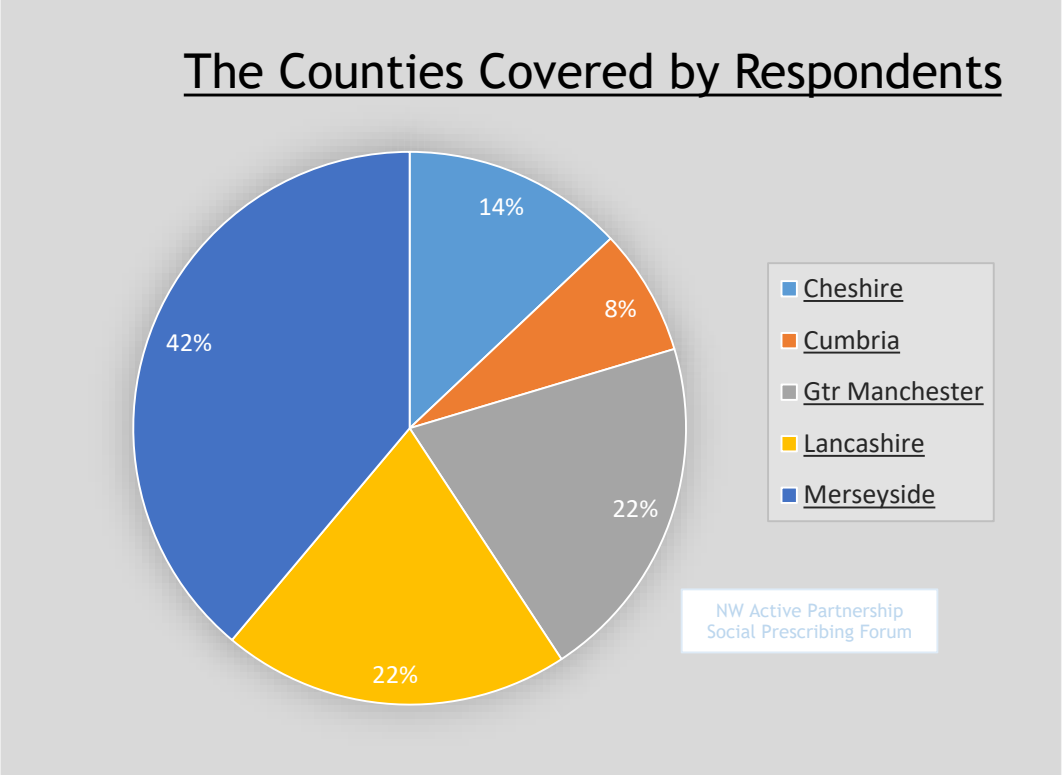
(i) Might the detailed factors be more prevalent amongst those providers already involved in social prescribing?
(ii) Whether providers who demonstrate the factors, appear to achieve the sought outcomes more readily?
(iii) Amongst which stakeholders do these factors appear most/least prevalent?
(iv) Where the highest/lowest incidences of a given factor might appear geographically?
(v) Have potential instances of existing good practice/performance been identified that could provide a future source of learning?



Respondent Profile

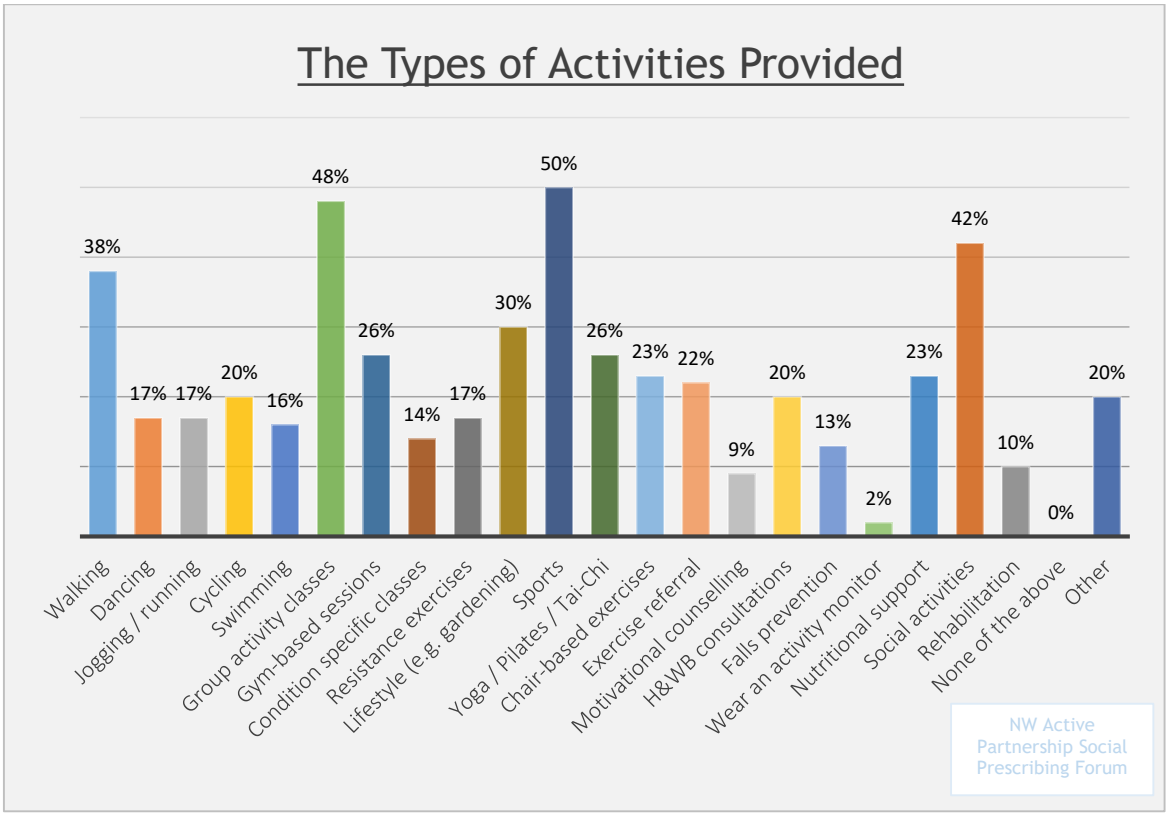


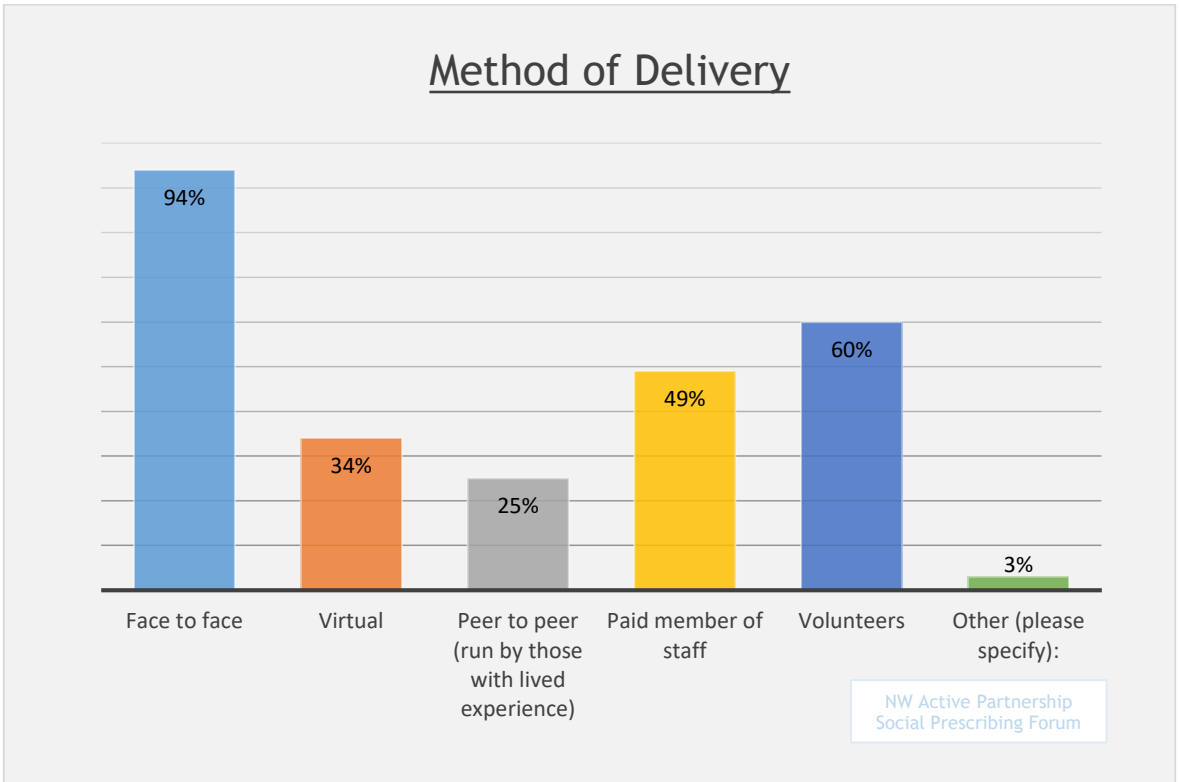


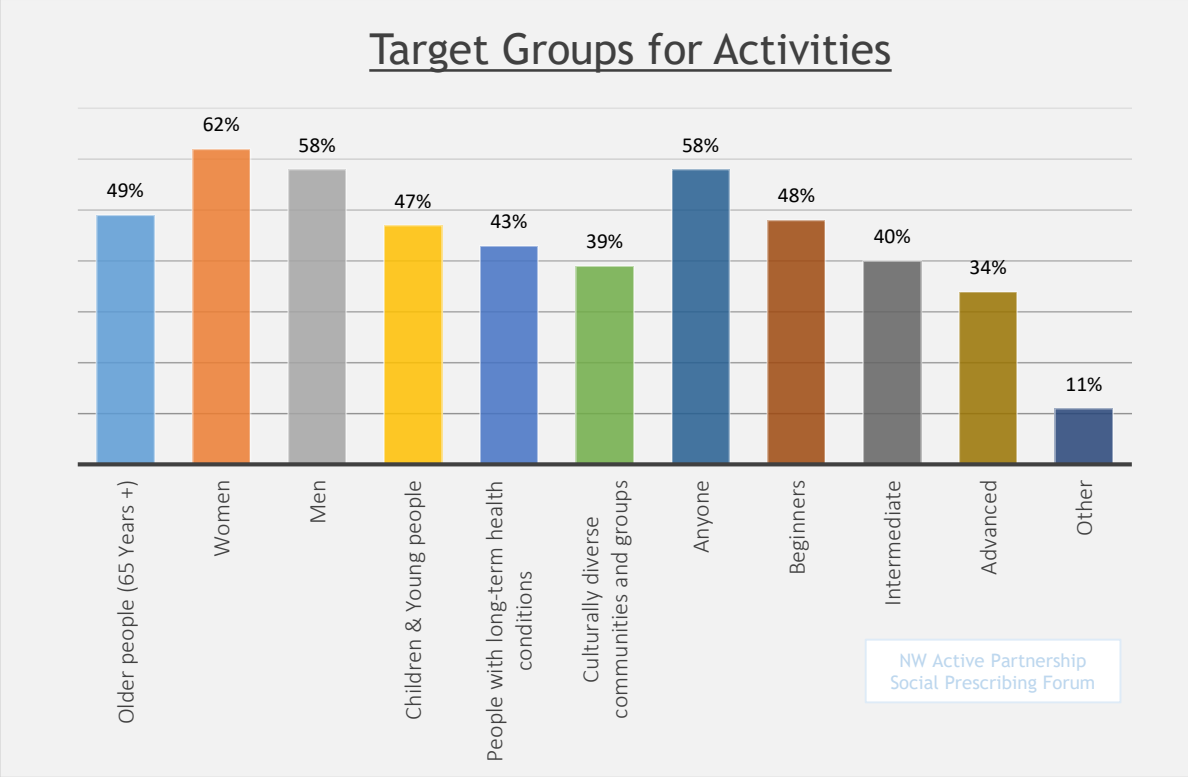


Consultation of a wide variety of organisation types was achieved through the survey. The largest responses coming from charities (a quarter), sports clubs (24%) and the public sector (17%), respectively. Respondents were also drawn from a range of geographic scales, the majority operating at the neighbourhood level, while just under a fifth at the local authority level and 10% countywide. Merseyside saw the greatest number of providers participate in the survey (42%), then Greater Manchester and Lancashire each with 22% and finally Cheshire and Cumbria, with 14% and 8%.

Nature of the activities:

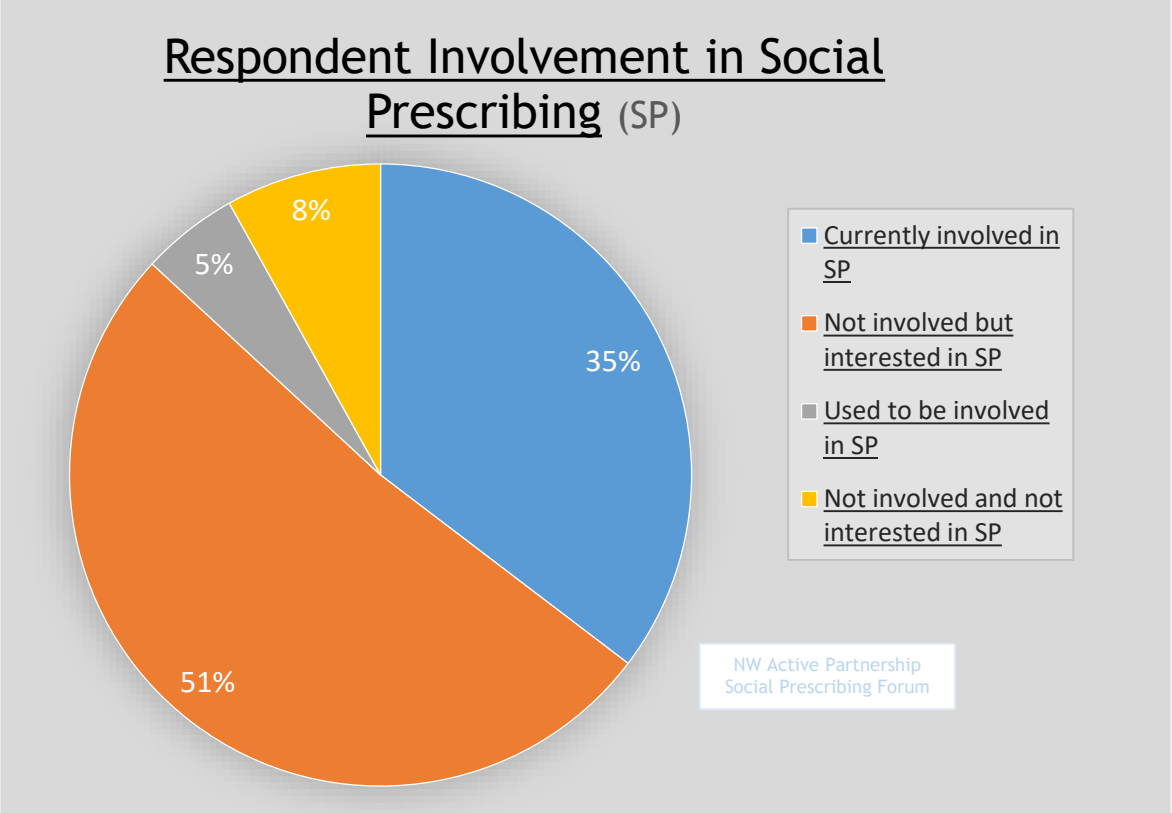






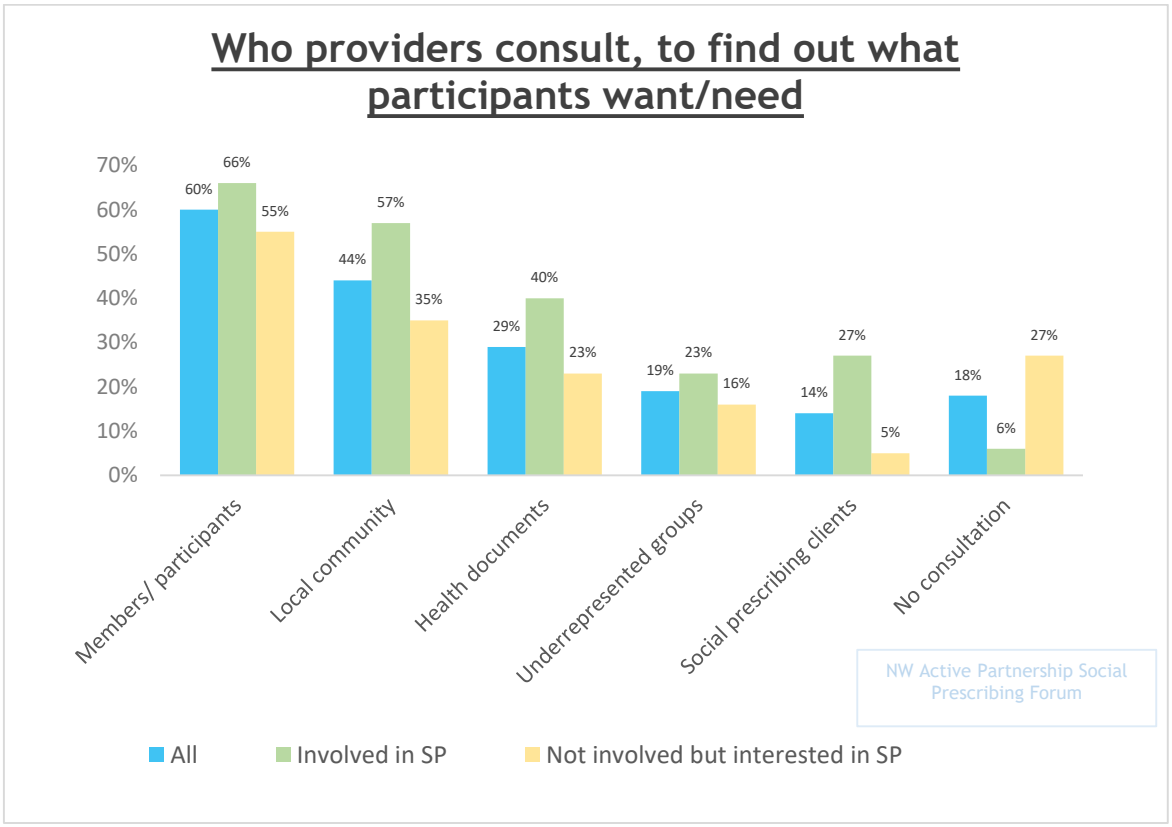
Similarly, the survey successfully attracted a wide range of respondents in terms of the activity types provided. Concerning the method of delivery, face to face provision was predominant (94%) with most activities delivered by volunteers (60%) and just under half by a paid member of staff (49%). This suggests a number of organisations utilise a mix of both paid and unpaid session leads with/without lived experience ('peer to peer' 25%). Those completing the survey reveal just over a third of sessions delivered virtually, this in conjunction with the other methods detailed, demonstrating a degree of flexibility exists within the physical activity offer.

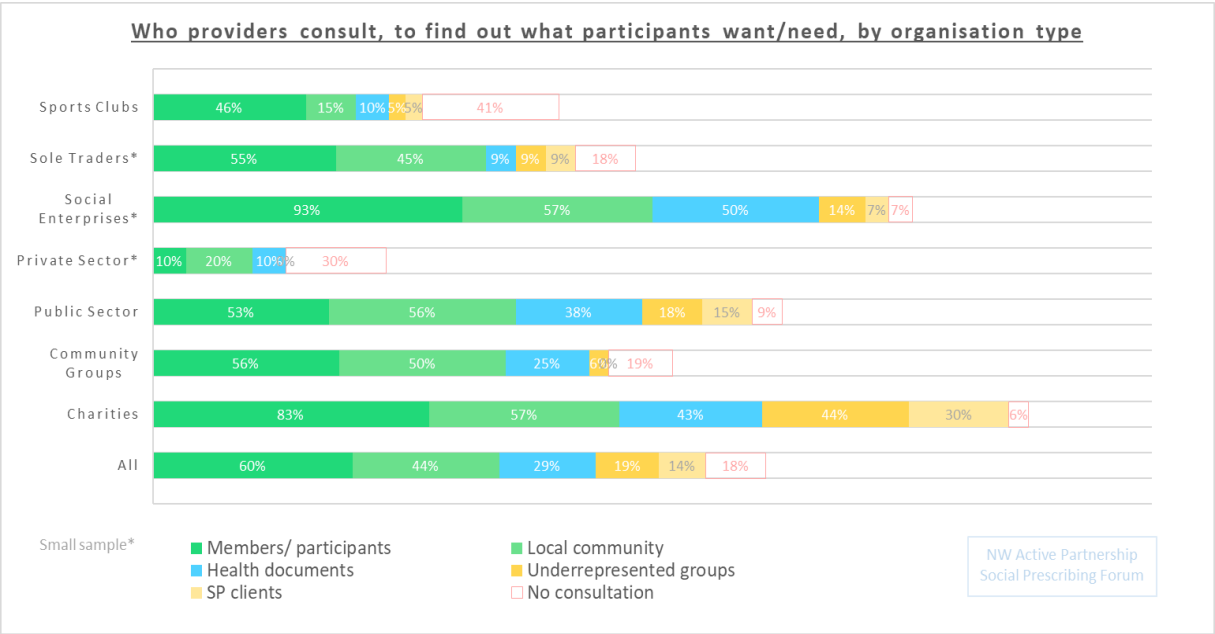
Most respondents (51%) were not involved in social prescribing but were interested in either becoming involved or learning more, while over a third (35%), were already involved in social prescribing and receiving referrals. 1 in 20 respondents had previously taken referrals but had stopped, leaving 8% of survey participants who declared they were not involved in social prescribing, nor did they have any desire to become involved.


Respondent Involvement in Social Prescribing (SP)
8%
5%
35%
51%
Currently involved in SP
Not involved but interested in SP
Used to be involved in SP
Not involved and not interested in SP
NW Active Partnership Social Prescribing Forum

Capability

Potential capability factors:





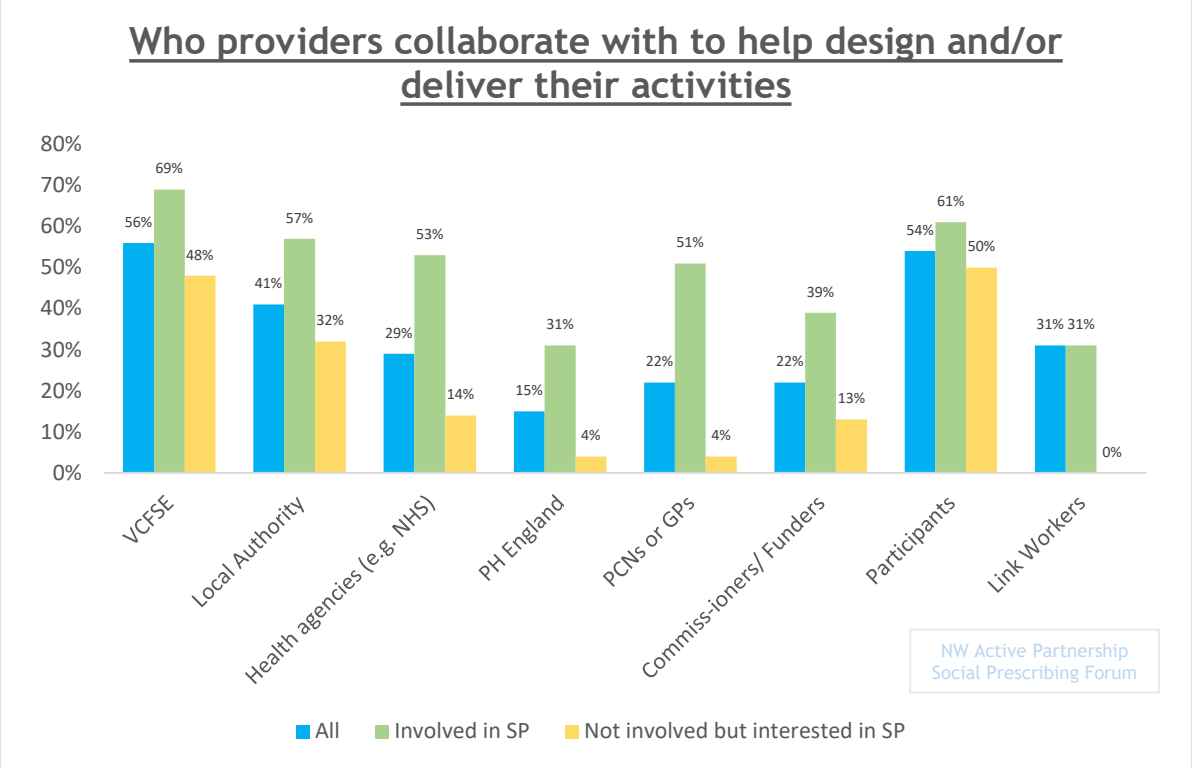
The consultation of, and collaboration with, stakeholders is well established best practice across numerous sectors and disciplines to aid the development and delivery of effective services. This often employs a range of methods including, but not limited to:

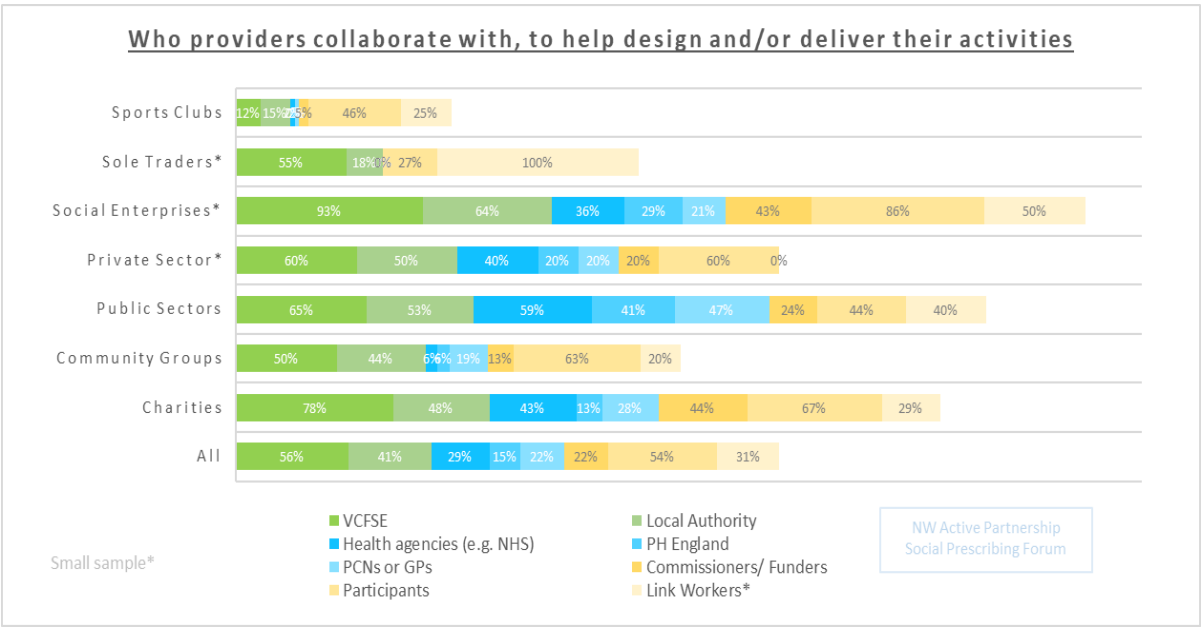
- The gathering of primary and secondary information (e.g. reports or online figures), both qualitative and quantitative data.
- Surveys, questionnaires, meetings/forums/events and group interviews.
- Time bound and ongoing conversations.
- The engagement of a broad range of stakeholders (such as with user-led design).

Without specifying the precise methods used, the provider survey attempted to detect potential relationships that may exist between provider consultation/ collaboration and performance.

Considering all survey respondents and the two cohorts of greatest interest (those involved in social prescribing and those not involved but interested in social prescribing), members/ participants and service users were the stakeholders that providers appeared to consult most. In every instance, more providers engaged in social prescribing than those not engaged, consulted with third parties to find out what participants wanted and needed. Excluding the consultation of social prescribing clients themselves, this difference was most pronounced concerning consultation of the local community and health documents, with 22% and 17% more involved providers consulting these sources respectively, than those not involved in social prescribing. Alternatively, underrepresented groups were consulted by the fewest providers receiving social prescribing referrals.

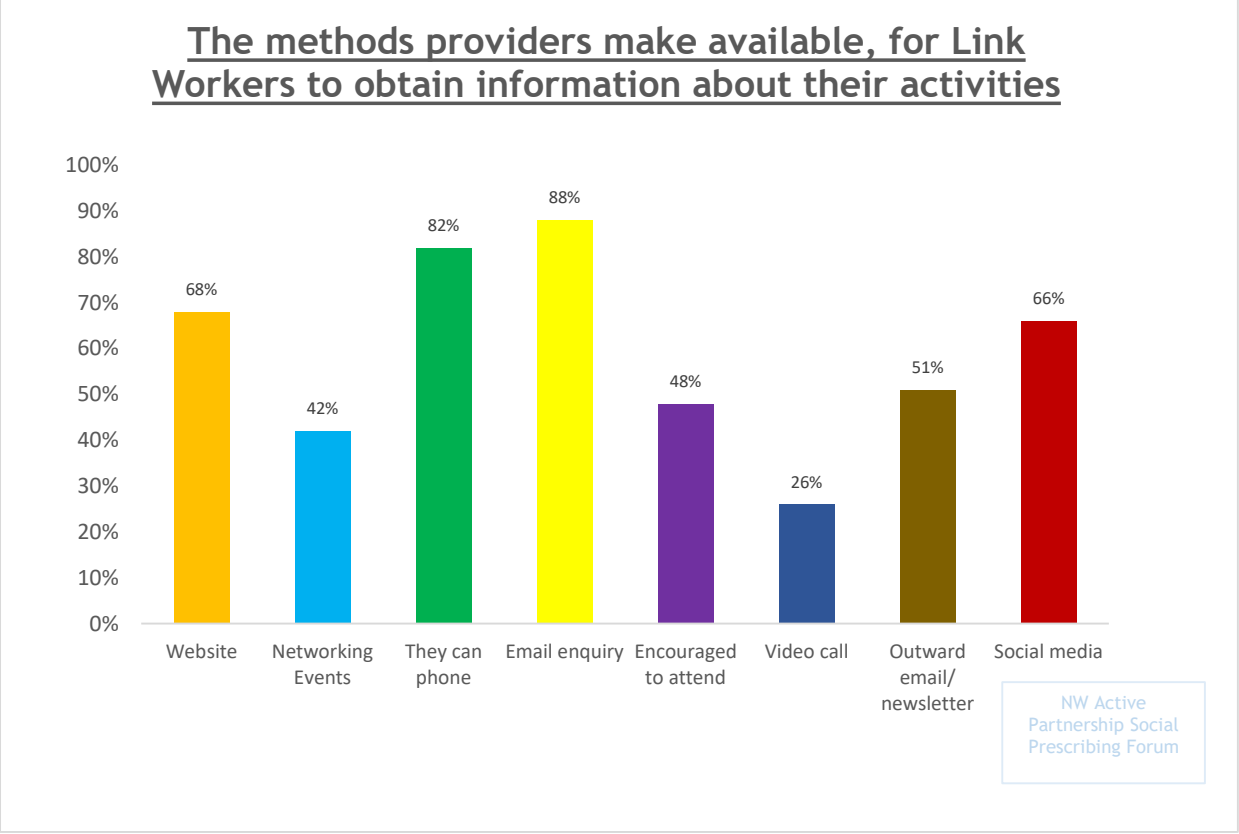
In combination, more charities than any other organisation type undertook consultation, followed by social enterprises and the public sector, in that order. While the organisations that consulted least were private businesses and then sports clubs.


Who providers collaborate with to help design and/or deliver their activities
80%
70%
60%
50%
40%
30%
20%
10%
0%
56% 69% 48%
41% 57% 32%
29% 53% 14%
15% 31% 4%
22% 51% 4%
22% 39% 13%
54% 61% 50%
31% 31% 0%
VCFSE
Local Authority
Health agencies (e.g. NHS)
PH England
PCNs or GPs
Commiss-ioners/ Funders
Participants
Link Workers
NW Active Partnership Social Prescribing Forum
All
Involved in SP
Not involved but interested in SP


Who providers collaborate with, to help design and/or deliver their activities
Sports Clubs 12% 15% 46% 25%
Sole Traders* 55% 18% 27% 100%
Social Enterprises* 93% 64% 36% 29% 21% 43% 86% 50%
Private Sector* 60% 50% 40% 20% 20% 20% 60% 0%
Public Sectors 65% 53% 59% 41% 47% 24% 44% 40%
Community Groups 50% 44% 6% 19% 13% 63% 20%
Charities 78% 48% 43% 13% 28% 44% 67% 29%
All 56% 41% 29% 15% 22% 22% 54% 31%
Small sample*
VCFSE
Local Authority
Health agencies (e.g. NHS)
PH England
PCNs or GPs
Commissioners/ Funders
Participants
Link Workers*
NW Active Partnership Social Prescribing Forum

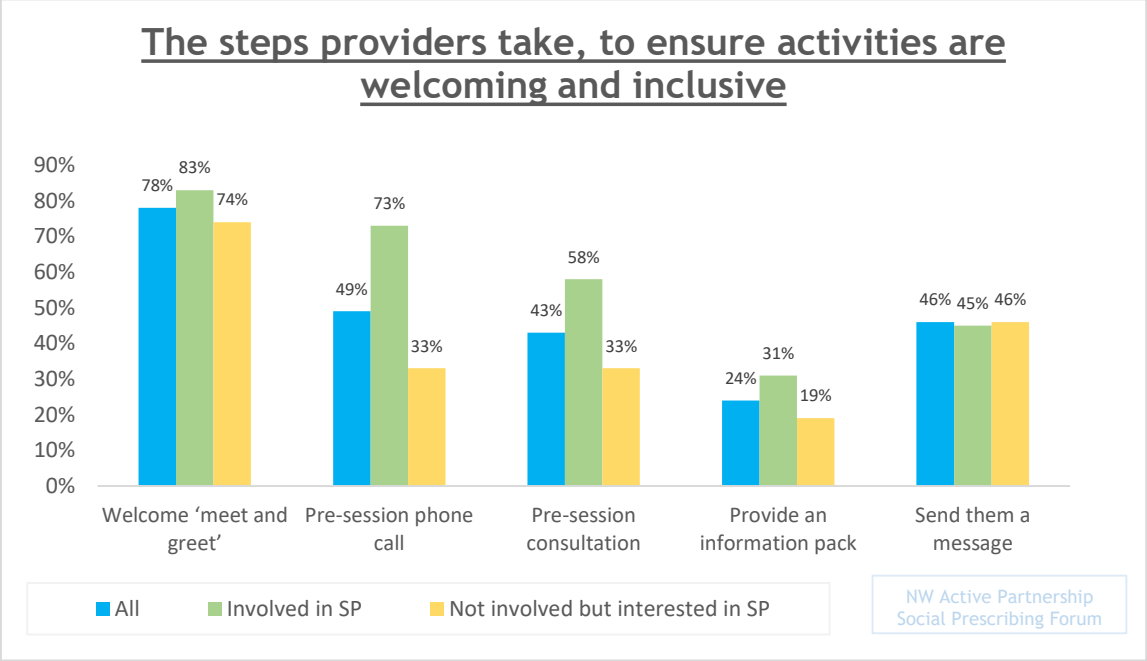
Overall, and for those already involved in social prescribing, most providers reported collaborating with the VCFSE sector - admittedly this forming a very broad category of stakeholders – whereas, other groups of actors were broken down more finely. For those not engaged in social prescribing service delivery, most commonly, respondents collaborated with their participants directly to design or deliver activities. The greatest disparities between the two cohorts were to be found in the collaboration with Primary Care Networks or doctor's surgeries (47%) and health agencies (39%), again with those providers involved in social prescribing collaborating more.

On this occasion, social enterprises seemed to collaborate most often with the broadest menu of stakeholders, with the public sector second and charities the third greatest collaborator. Sports clubs and then sole traders collaborated least often.



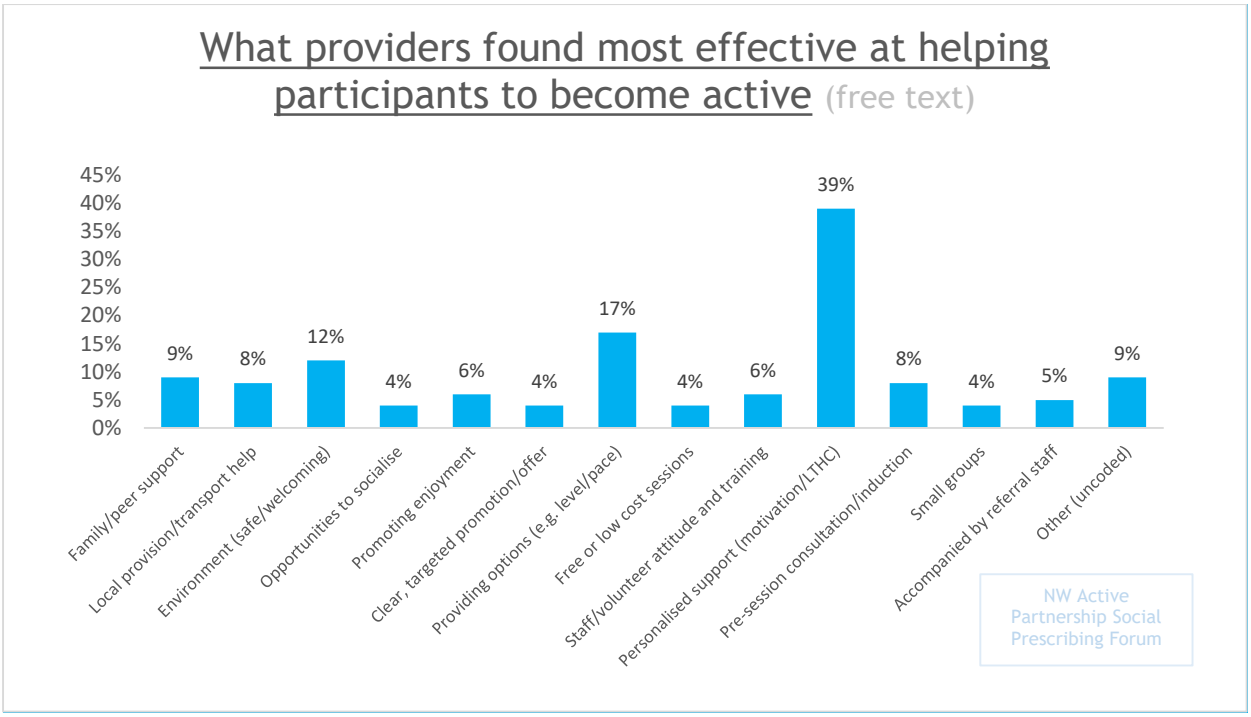
Other
'All of the above, we align with them in the same council dept'
'Elemental referral platform'
'I don't know all of the link workers and have different levels of comms with the ones I do know'
'I work with them'
'In surgery activity'
'Leaflets'
'We use a cloud based online secure referral portal [DELETED] where social prescribers can have their own log in to refer clients in easily, securely and safely'

In terms of the methods made available for Link Workers to obtain information about providers' activities, perhaps understandably, the least resource intensive and more general options dominated. While just under half of providers (48%) encouraged Link Workers to attend their activity and 42% made information available at networking events.



Other (selection)
A trial is required
Activity WhatsApp group in operation.
Capture detail of reasonable adjustments or health conditions the participant would like us to know prior the session, we follow up this data capture with a phone call where needed to ensure the activity is suitable for the individual
Could be all or some of above depending on individual needs
Encouraged to join WhatsApp group
Full engagement according to the needs of the individual or agency
Language support
Meet on arrival and introduce them to others playing
Our teachers are very used to community work with vulnerable clients and are very welcoming/accommodating
Participants access our classes in different ways so depending how they've contacted us prior to the class would depend on whether they've had a call, message or further information.
Promotion on social media

Registration forms to find out if they have any additional requirements before they attend. Always happy to sit and chat with someone before they attend.
This will depend on each club coach
We are committed to being an inclusive club but we do not have any specific welcoming activities other than expecting the team captain or coach to be aware of new starters and to make them welcome.

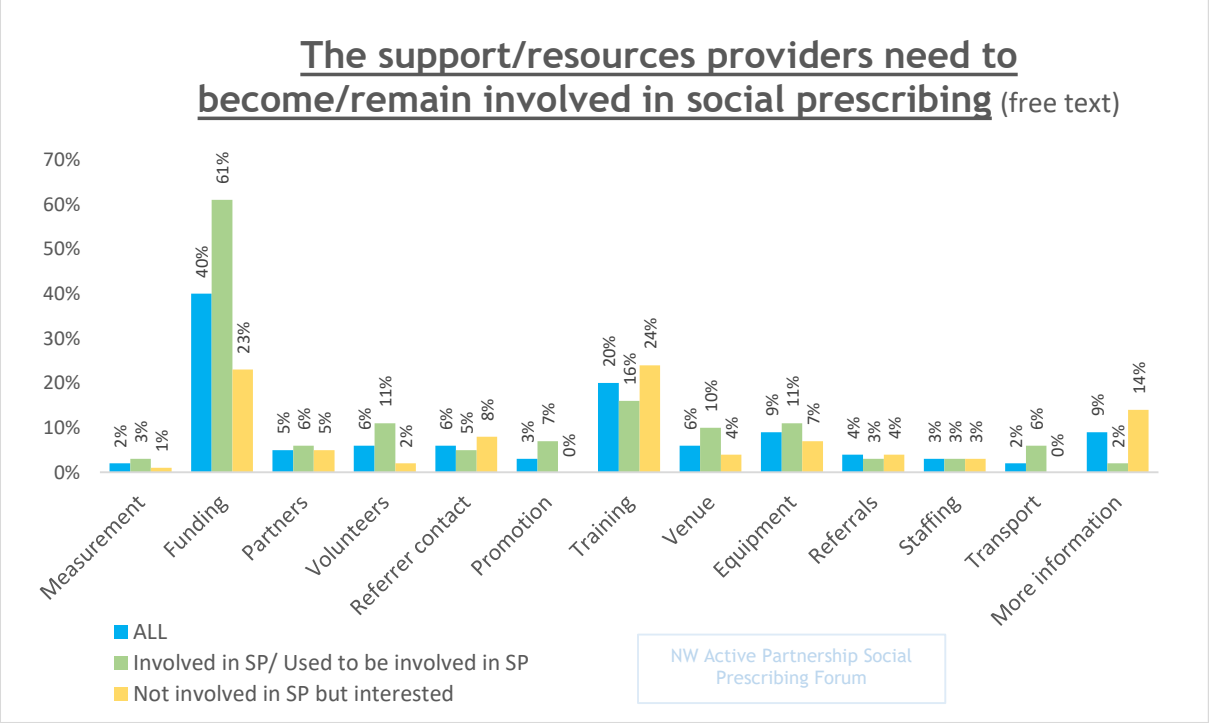


Other	Building a relationship with participant / emphasising the benefits of the activity / client readiness and timing of offer / readily available information for client at each step / encouragement / accessibility / incentives such as gym passes.

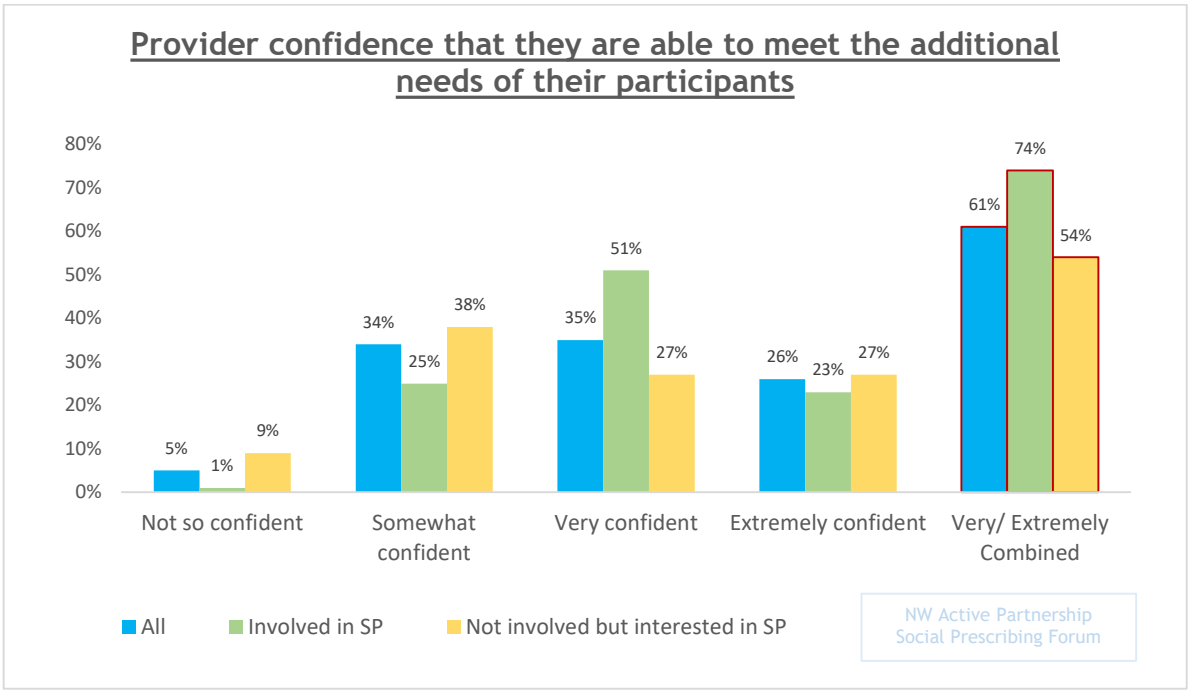
Reassuringly, all provider groups demonstrated an understanding of the importance of welcoming and including new attendees, with around three quarters and above undertaking some form of 'meet and greet'. However, those involved in social prescribing provision adopted processes taking place ahead of participants attending their first session, at just above/below twice the rate of their counterparts not yet delivering social prescribing services.

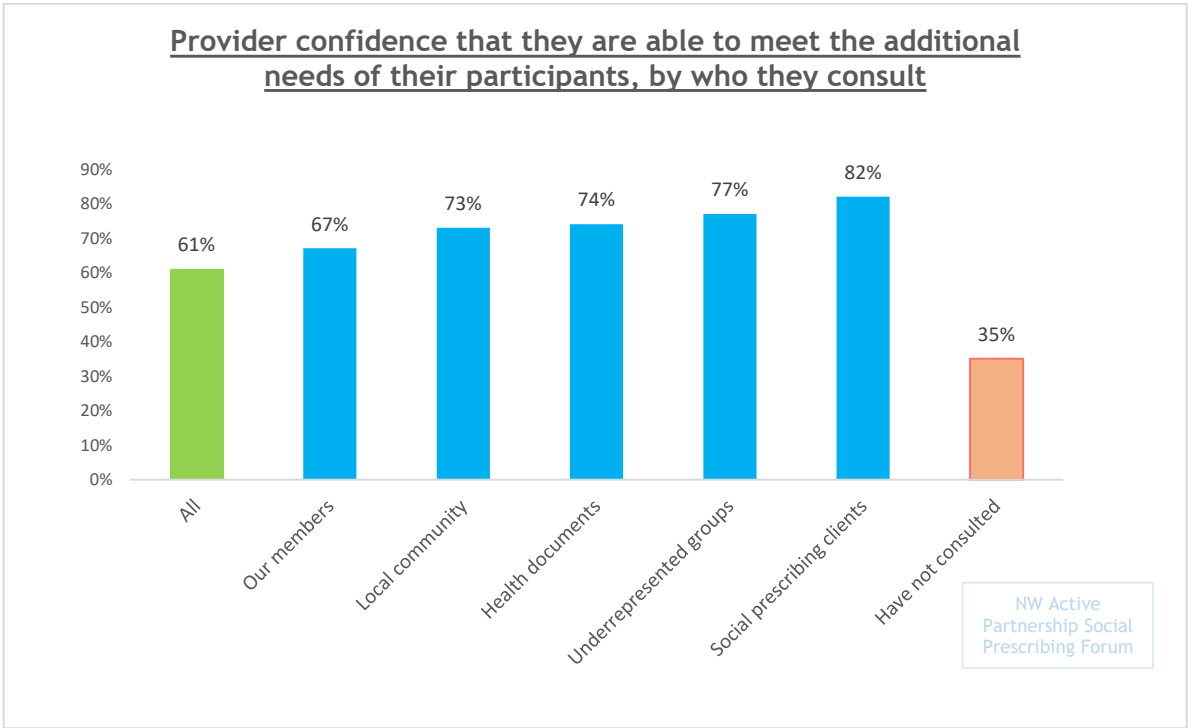
Feedback regarding what providers found most effective at helping participants become active revealed themes surrounding the importance of the flexibility of provision and its ability to respond to the needs of the individual, as opposed to being 'off-the-shelf'. This appeared to concern the personalised nature of delivery, whether the focus was to aid motivation or to provide participants with support relating to long-term health conditions. This theme continued with the second most utilised practice, ensuring the availability of options, such as the level and pace of activities.

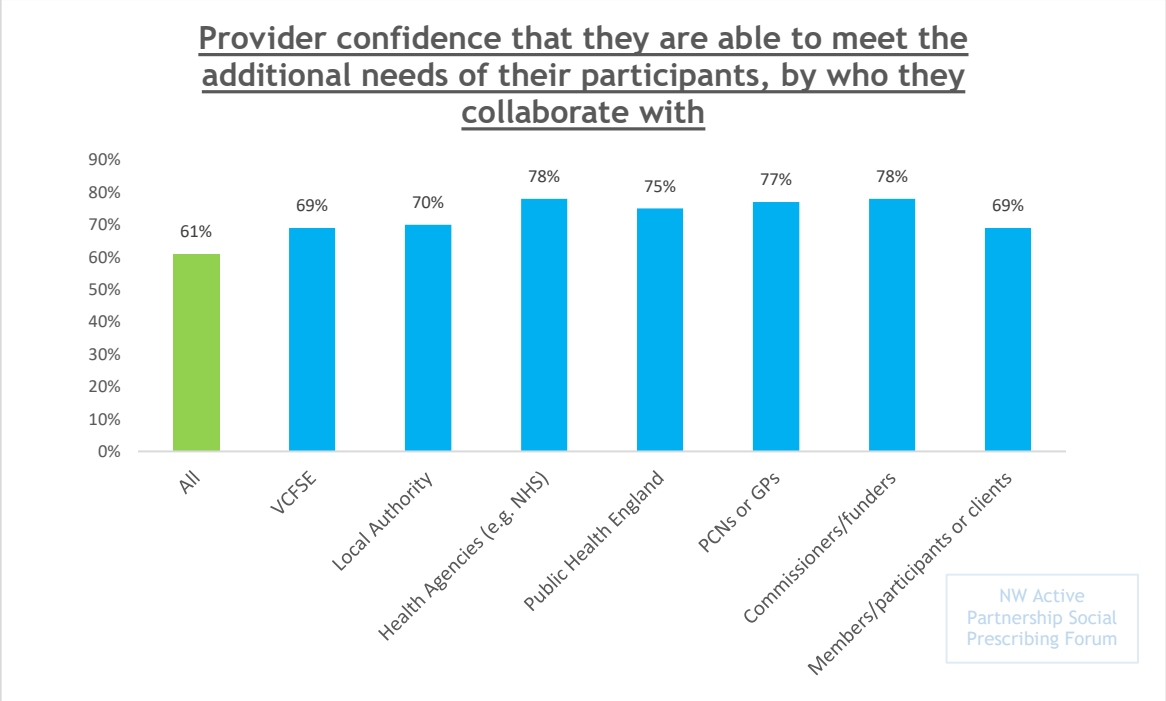
To continue to deliver the social prescribing services outlined above, when presented with a free text question and therefore unprompted, 63% of involved providers highlighted funding was necessary. By contrast, just 23% of uninvolved providers indicated the same. It is unclear whether this position changes following the on-boarding of new providers, perhaps with providers not being fully aware what social prescribing activity provision entails beforehand. However, in discussions with providers running alongside this report, there was indication that some form of funding had been anticipated once they began to receive referrals. Unsurprisingly, more uninvolved than involved providers, fed back the need for training (24%) and information (14%).



Capability outcomes:

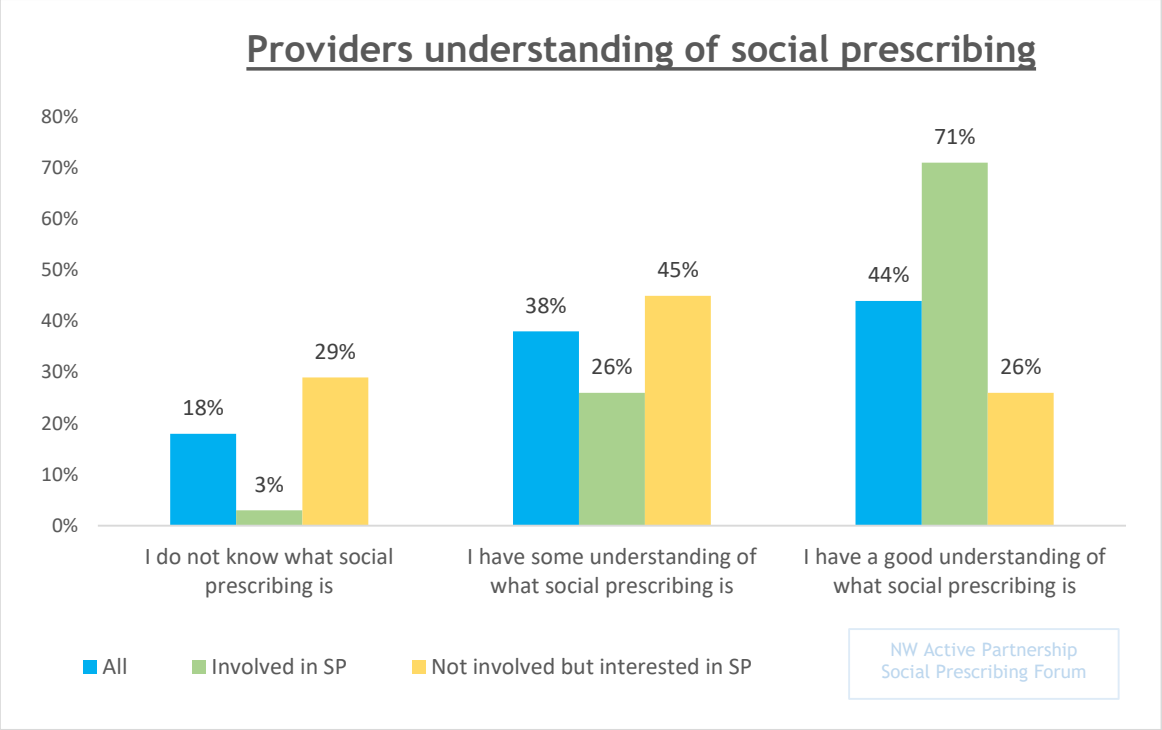


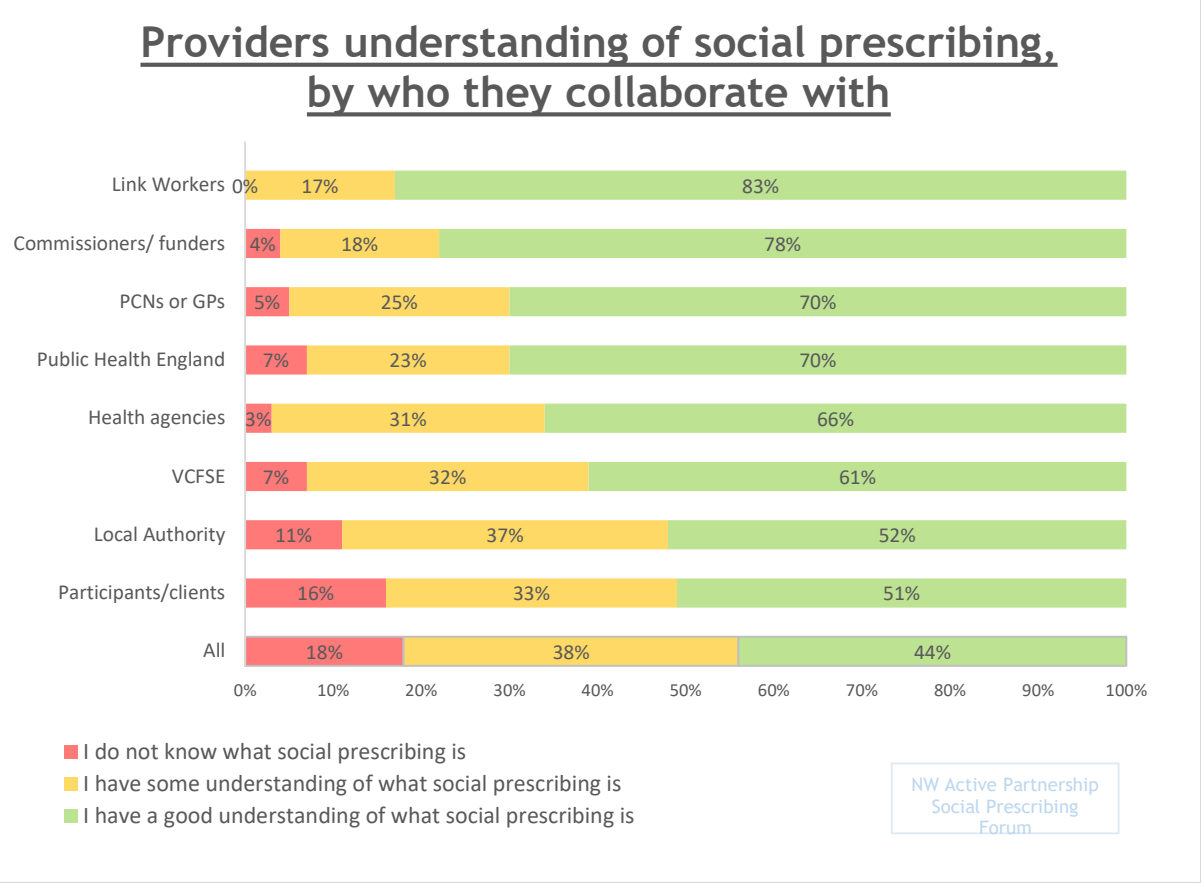




Twenty percent more of the organisations delivering social prescribing than organisations not delivering, felt very or extremely confident they could meet the additional needs of participants. If this is an accurate self-assessment, the results may suggest that amongst physical activity providers in general, those most capable of considering/meeting such needs find it easier to engage with social prescribing. As already stated, this report stops short of claiming causality because conversely it is possible training and experience in social prescribing itself, is to some extent responsible for the contrasting confidence levels. For example, 82% of those respondents who consult social prescribing clients are confident they can meet the additional needs of their participants more widely, demonstrating a considerable level of learning from clients may be going on amongst the involved cohort. This said, respondents consulting underrepresented groups (77%), health documents (74%) and the local community (73%), also fair comparatively well to the levels of confidence across the sample as a whole (61%). By contrast however, those providers that undertake no consultation display considerably lower rates of confidence that they can meet the additional needs of activity attendees, just 35%.

Considering levels of collaboration alongside meeting the additional needs of participants, providers collaborating with any of the stakeholder options provided, achieve rates of confidence of around 70% and above, with those partnering health agencies and commissioners/funders achieving the highest rates (78%). This compared to a 61% sample average.


Providers understanding of social prescribing
80%
70%
60%
50%
40%
30%
20%
10%
0%
18%
3%
29%
38%
26%
45%
44%
71%
26%
I do not know what social prescribing is
I have some understanding of what social prescribing is
I have a good understanding of what social prescribing is
All
Involved in SP
Not involved but interested in SP
NW Active Partnership Social Prescribing Forum

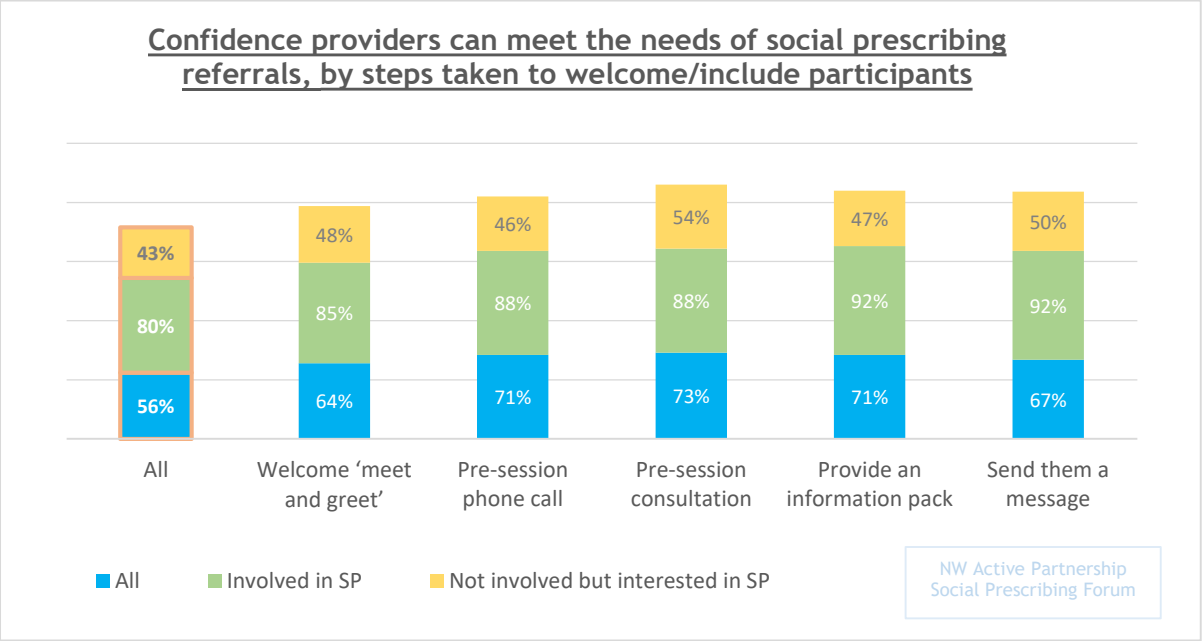

Providers understanding of social prescribing, by who they collaborate with
Link Workers 0% 17% 83%
Commissioners/ funders 4% 18% 78%
PCNs or GPs 5% 25% 70%
Public Health England 7% 23% 70%
Health agencies 3% 31% 66%
VCFSE 7% 32% 61%
Local Authority 11% 37% 52%
Participants/clients 16% 33% 51%
All 18% 38% 44%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
I do not know what social prescribing is
I have some understanding of what social prescribing is
I have a good understanding of what social prescribing is
NW Active Partnership Social Prescribing Forum

Provider knowledge of the broader challenges social prescribing clients might experience

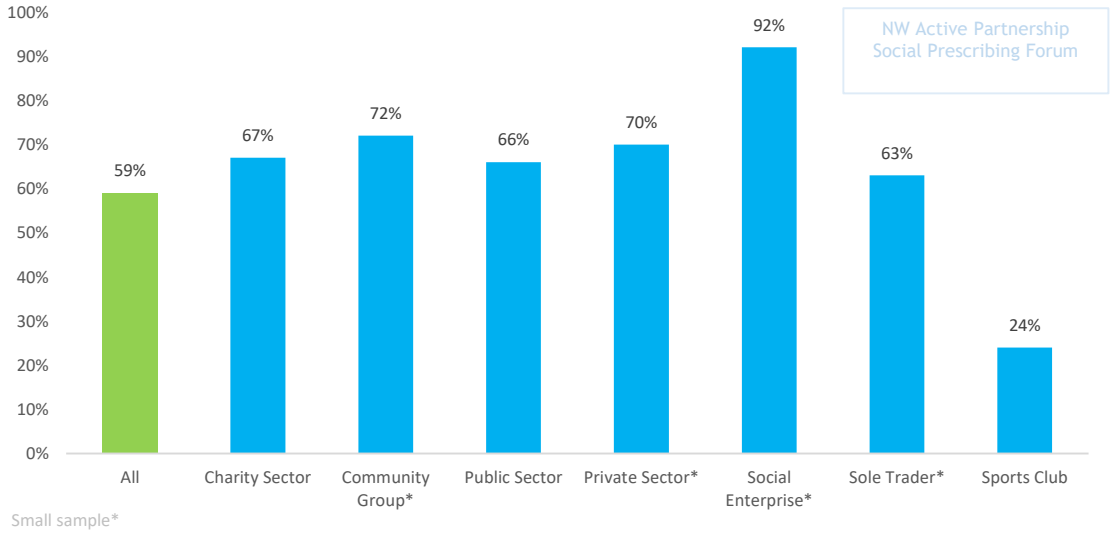
(Multiple choice, with only the responses of those not involved but interested in SP included)

	Percentage who got this question correct
All	36%
Those stating they had a good understanding of SP	55%

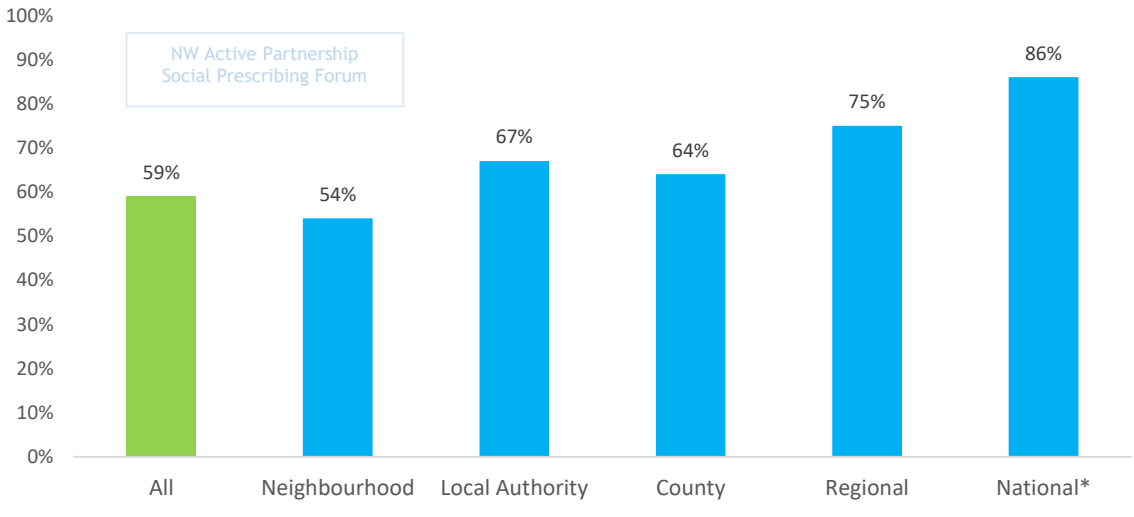
Looking at the extent social prescribing is understood amongst providers, when comparing the involved and uninvolved cohorts, there are few surprises. Those delivering social prescribing activities fed back they have a good understanding of the concept, at a rate of almost 3 to 1, when contrasted with those yet to be involved. Considering understanding of social prescribing, alongside who providers collaborate with, starkly reveals 83% of respondents collaborating with Link Workers claim to possess a good grasp but this could again be a result of involvement providing subsequent learning. Nevertheless, just 44% of those surveyed overall, fed back that they had a good understanding of social prescribing. A rudimentary gauge of how respondent 'perceived' understanding of social prescribing might compare with their actual knowledge was incorporated in the survey. This took the form of a multiple-choice question, enabling respondents to demonstrate their awareness of the breadth of challenges social prescribing clients might experience. Of those stating they had a good understanding of social prescribing, 55% got this question correct, compared to just 36% of the wider sample asked this question, so it would appear self-rated understanding may to some extent be meaningful.



Confidence providers can meet the needs of social prescribing referrals, by organisation type



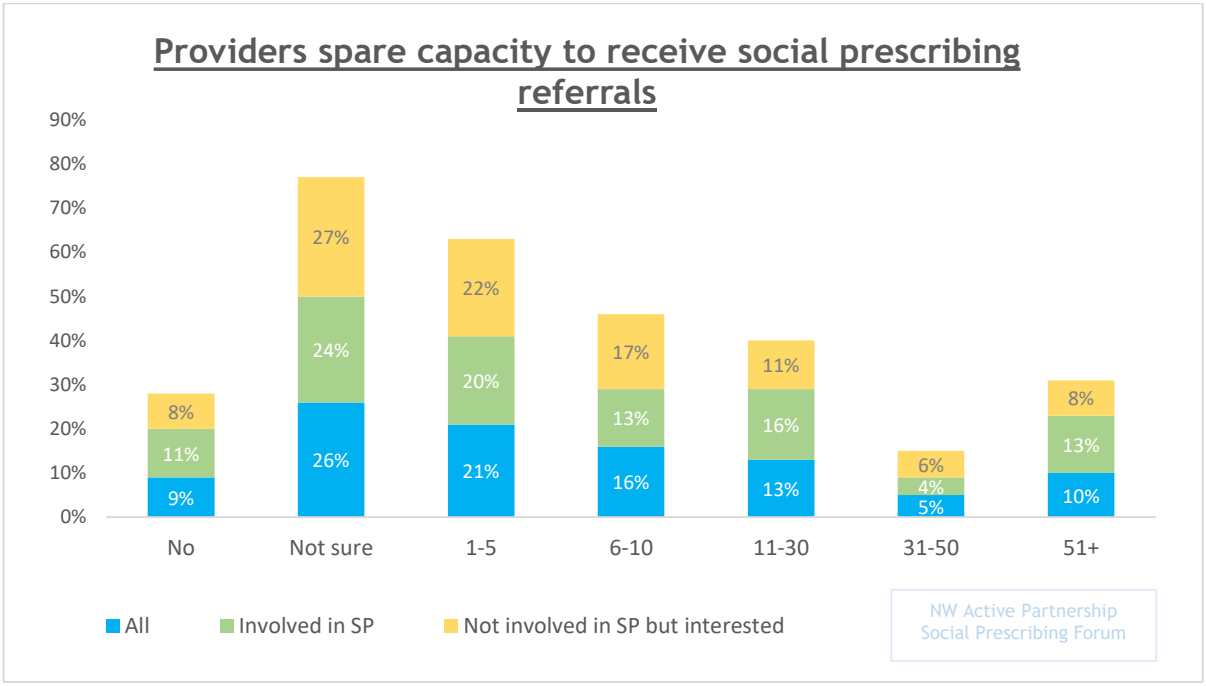
Confidence providers can meet the needs of social prescribing referrals, by geographic scale covered



Considering providers' efforts to welcome and include new attendees to activities reveals further variations across the involved and uninvolved cohorts. In each instance where inclusion methods were adopted, existing social prescribing service providers' confidence levels exceeded those of their uninvolved counterparts. The measures looked at in combination and across the cohorts show those conducting pre-session consultations (involved 88% and uninvolved 54%), providing information packs (involved 92% / uninvolved 47%) and merely sending clients a message (involved 92% and uninvolved 50%) had greatest confidence in meeting the needs of social prescribing referrals. No obvious explanations are forthcoming, how confidence/an ability in meeting the needs of social prescribing referrals might just as easily translate into the practice of sending a message (or vice versa), as it does conducting a pre-session consultation. However, it is possible a great many of these methods might be considered good practice and used adaptably in conjunction with one another to meet client needs, this perhaps explaining the lack of clear distinction in the results.

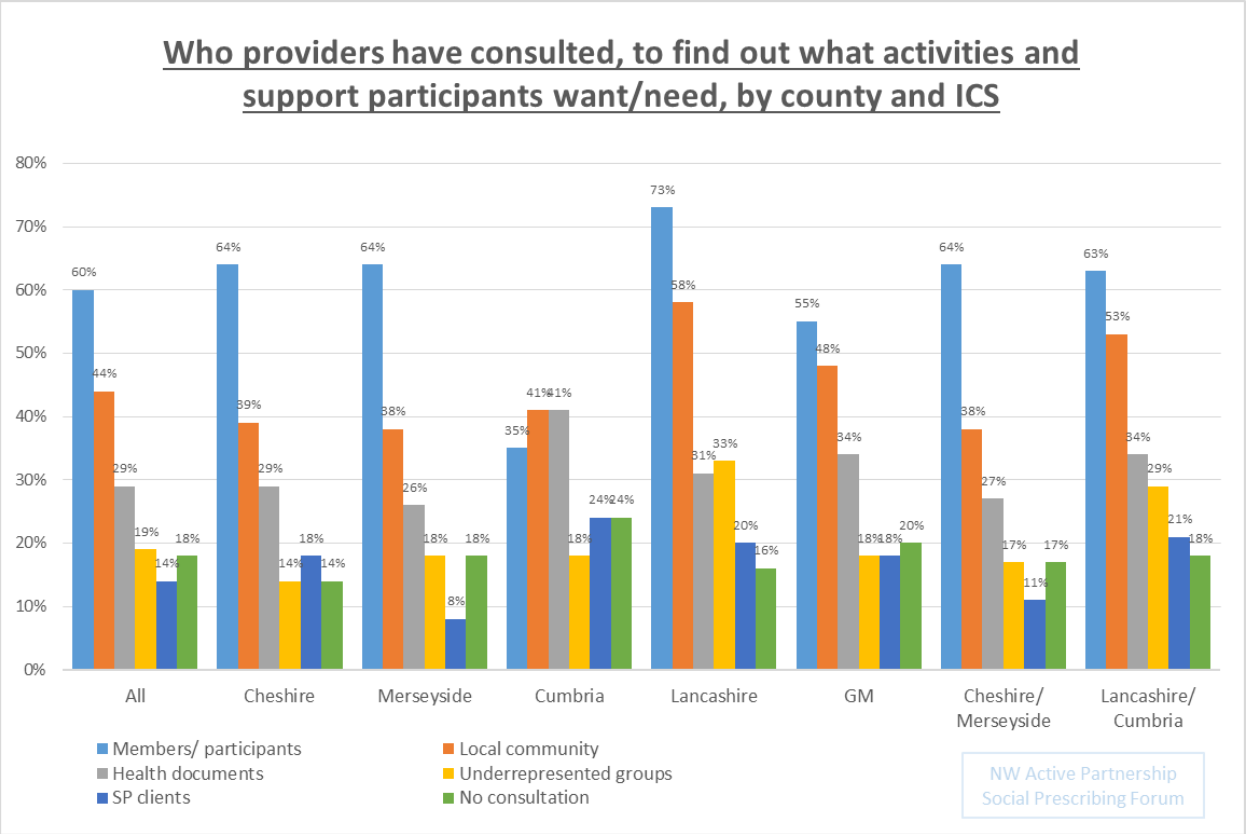
Otherwise, the rates of confidence in meeting the same needs, this time considered by organisation type, find all but 2 of the providers separated by less than 10%. Whereas, sports clubs (24%) showed much lower levels of confidence and social enterprises much higher, with 92% (small sample).

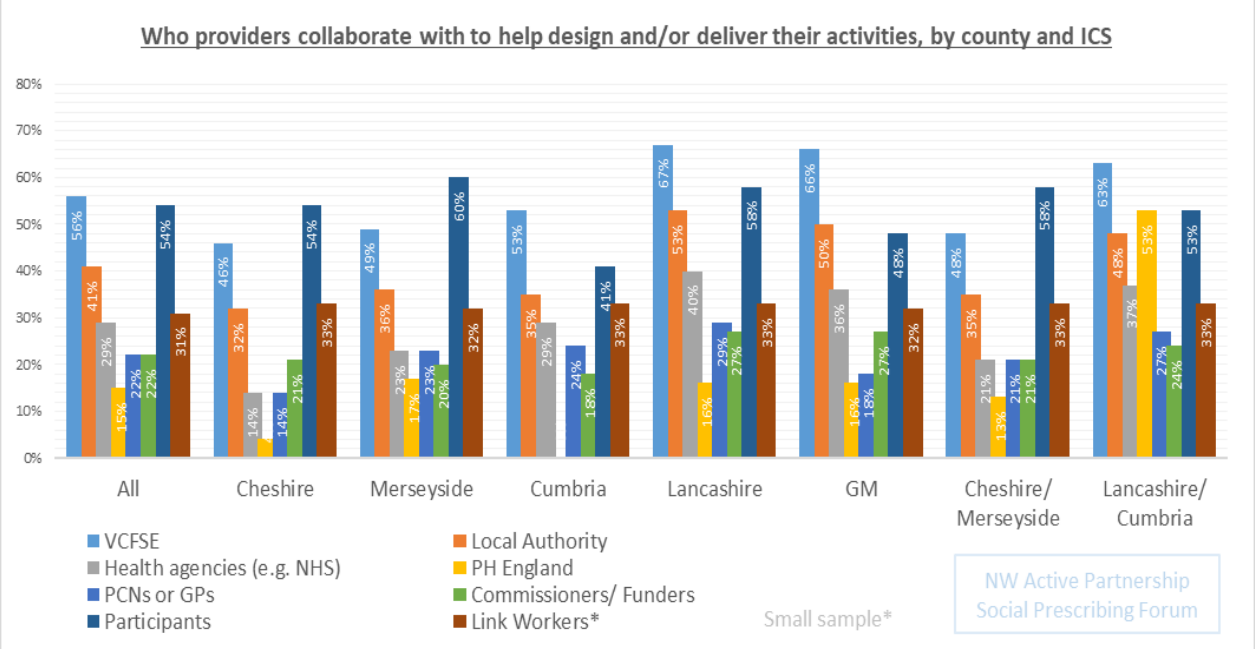
Finally, referring back to the earlier profile data, while 56% of respondents declared that they operated at the neighbourhood level (this possibly suggesting hyperlocal provision aspirations are being realised), respondents at this scale demonstrated the lowest confidence levels in being able to meet the needs of social prescribing referrals (54%), even lower than the sample average of 59%. So, despite the encouraging respondent numbers, this then perhaps serves to contest the notion that the sizeable engagement of organisations at this scale might represent a success. Rather, it is organisations operating at the largest scales (regional 75% and national 86%) that possess the greatest rates of confidence.



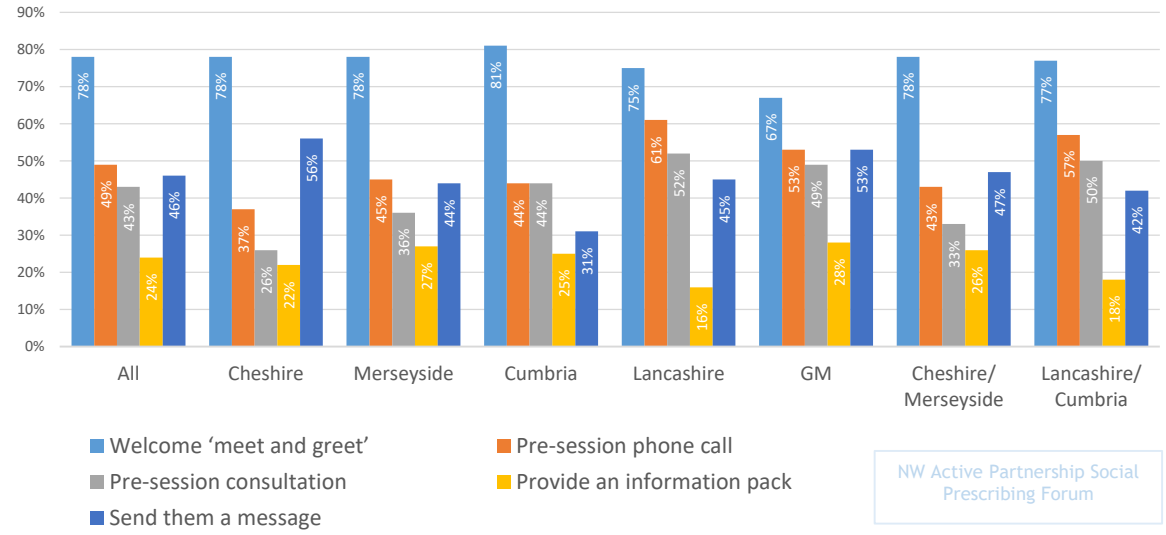
In terms of ability to accept social prescribing referrals, there was on this occasion little separating the various cohorts. Market-wide and in total, 65% of respondents fed back that they had capacity to accept anywhere from 1 to 51 plus referrals, leaving 35% who either could not admit social prescribing clients or were unsure.

Potential capability factors at the county/ICS level:

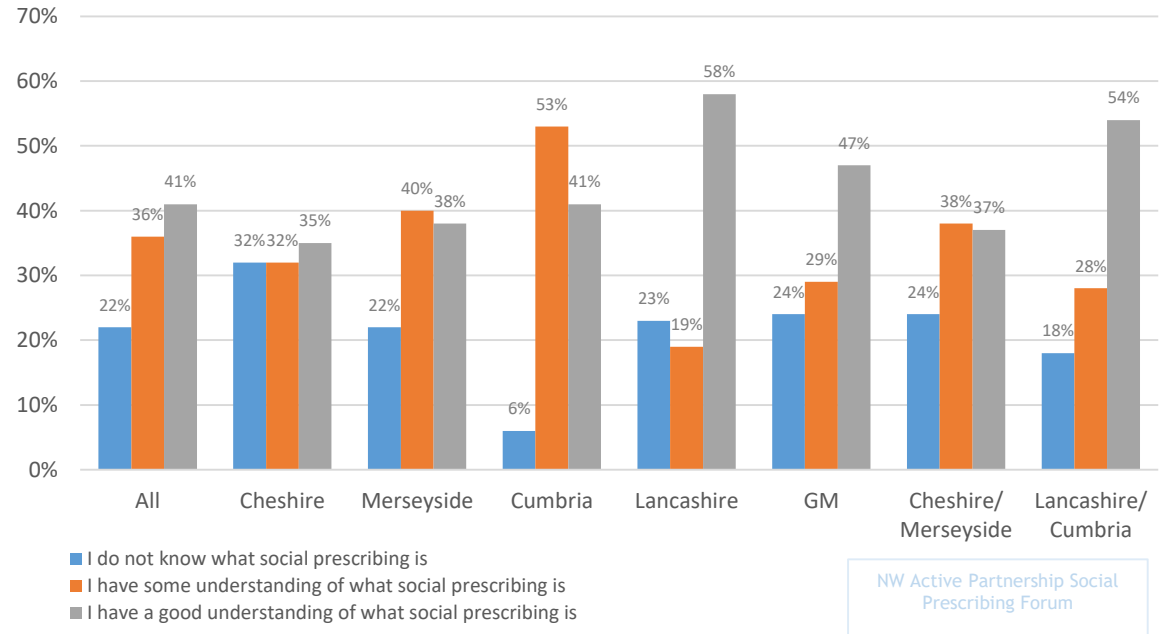




The steps providers take, to ensure activities are welcoming and inclusive, by county and ICS



Provider understanding of social prescribing, by county and ICS



While county-level statistics have been provided to aid exploration by leads at this scale, the analysis in this report focuses on the ICS level footprint. In this respect, providers in Merseyside-Cheshire ICS achieved the highest levels of engagement (64%), this with their participants. Out of the three ICSs, providers in Lancashire-Cumbria most readily consulted their local communities (53%), while 34% of respondents in Greater Manchester (an ICS in its own right), consulted health documents, this perhaps an acknowledgment of the strategic infrastructure in place in the city-region.

Greater Manchester providers reported the highest rates of collaboration with the VCFSE sector, Merseyside-Cheshire with their own participants (58%) and Lancashire-Cumbria with Public Health England (53% - please note it is thought that respondents may have included any public health agencies in their thinking).

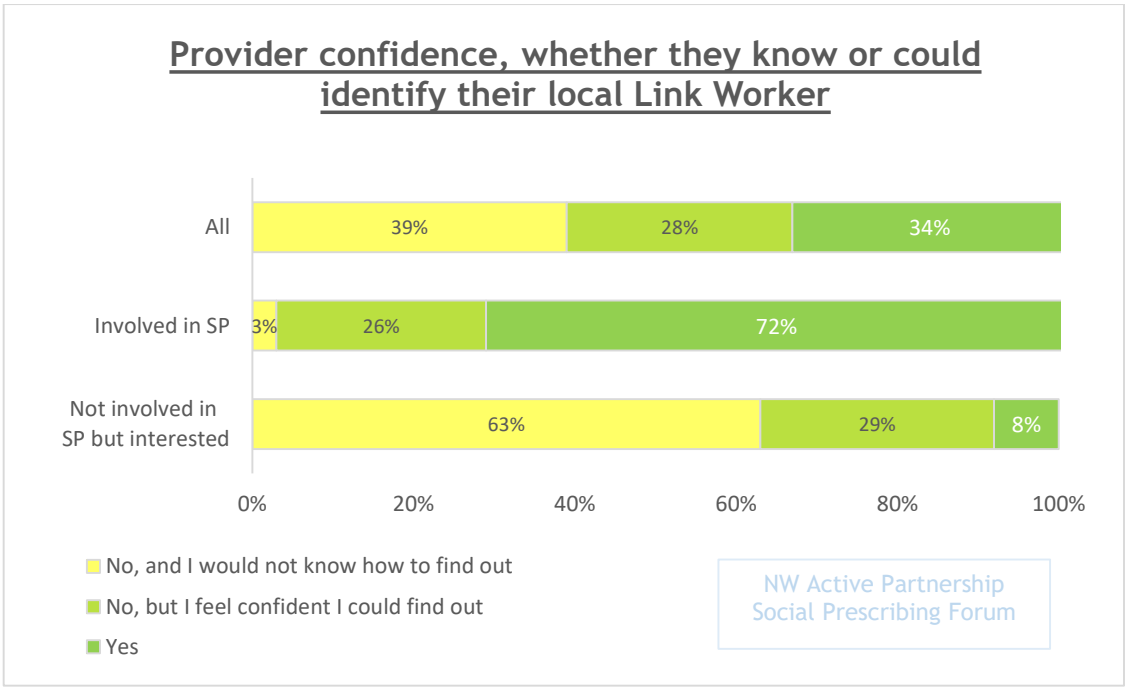
Considering the prevalent methods used to welcome and include attendees again across the ICSs, respondents in their greatest numbers fed back in Merseyside-Cheshire that they 'meet and greet' participants (78%). In Lancashire-Cumbria more commonly than elsewhere in the region, providers performed a pre-session consultation (57%) and in Greater Manchester, respondents were more likely to send a message than their peers in other ICSs (53%).

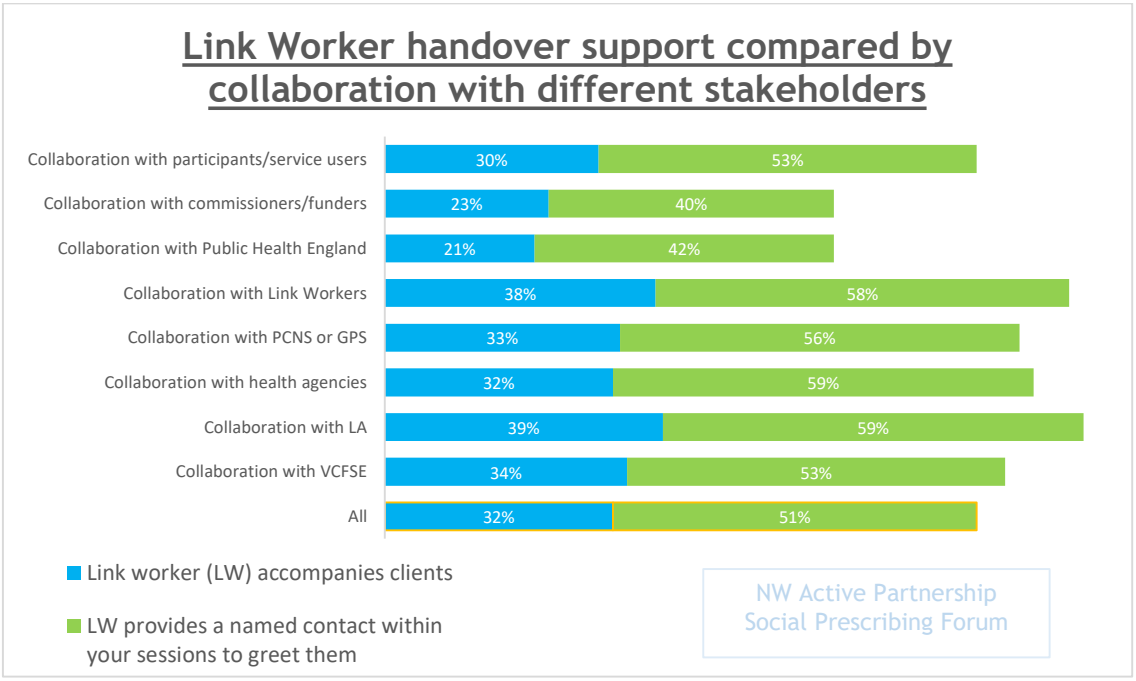
Finally, the highest levels of understanding social prescribing across the ICSs was to be found in Lancashire-Cumbria (54%), then Greater Manchester with 47% and subsequently Merseyside-Cheshire with 37%.

It is apparent that the highest rates of the various dimensions appear spread across the ICSs. This presents an opportunity for collective interrogation amongst leads, as to what might be the cause of these possible disparities in each respective county/ICS while also presenting opportunities to share valuable learning on an equal footing between stakeholders and infrastructure organisations, such as CVSs and Active Partnerships.

Opportunity

Potential opportunity factors and outcomes:





Other (Selection - based on relevance)
A mix of accompanying clients and advising on attending sessions.
Our [deleted] team meet and greet referrals
Physical activity referral form
Provide name and contact details by telephone and signpost them to us
Refers across to our telephone and digital support.
They give us clients contact details so that we can contact them & discuss their requirements.
Varies as there's more than one link worker and they all operate differently...
Varying levels of support

The handover support providers require to begin accepting social prescribing referrals

	They accompany clients	They provide a named contact within your sessions to greet them
Not involved but interested in SP	9%	39%

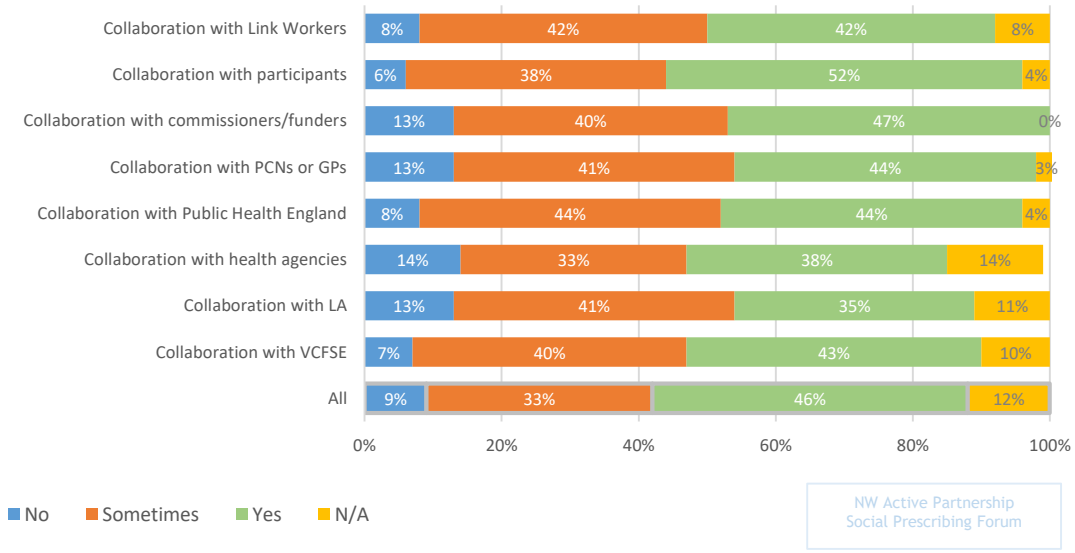
Other
A referral.
Any relevant medical information.
Client's contact details.
Contact details/ come into centre to provide them with registration forms.
Depends on the nature of the referrals - generally just provide named contacts if we are doing a series of [deleted] sessions.
It would depend on each client's individual needs.
It would depend on the persons needs and abilities - we are just volunteers with no skills in managing people who require a lot of support.
It would depend on which class & the individual participants needs.
Must be discussed and agreed on a case by case basis.
Possible to accompany the client depending on needs.
Potential financial support, if we need to recover their transport cost.
Potentially we could manage them without support.
To support with profile and medical forms, any safeguarding.
Would depend on the type of the referral and the needs of the client

Relatively buoyant numbers of providers involved in social prescribing know or could find out who their relevant Link Worker is, however for those interested in getting involved in provision, 63% do not know and believe they would be unable to identify them.

Those collaborating with Link Workers themselves and local authorities appeared to receive the greatest levels of handover support. Thirty-eight percent and 58% of the former, and 39% and 59% of the latter, seeing clients accompanied to activities and given a named contact within sessions.

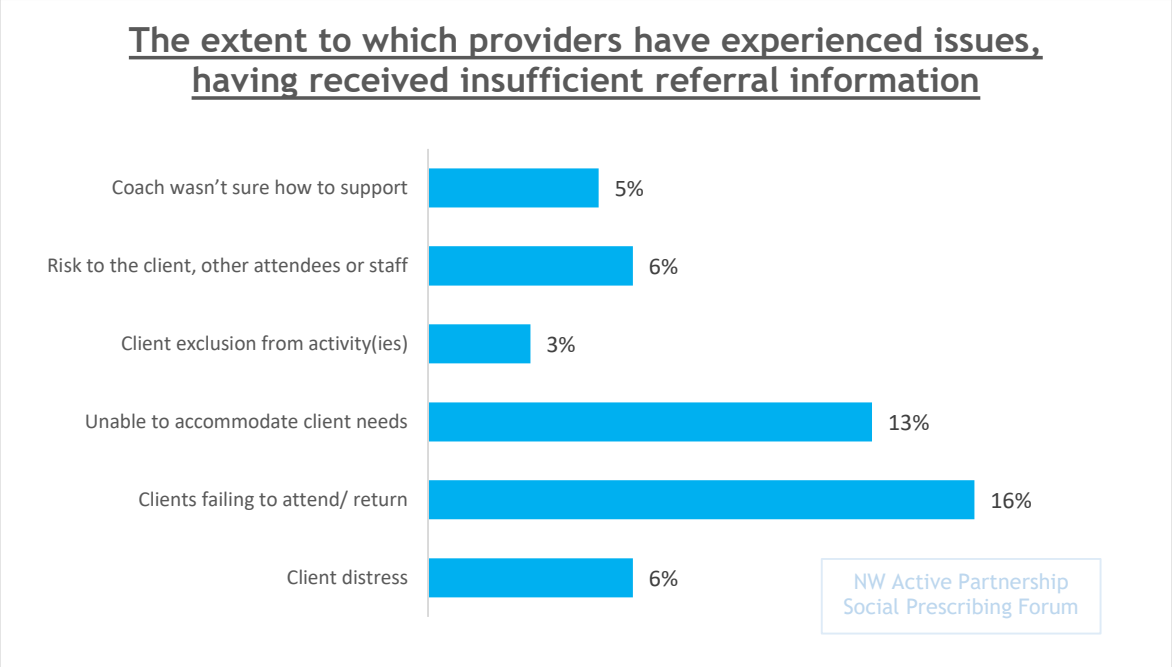
Of the organisations yet to begin providing social prescribing destinations, only 9% reported needing referrals to be accompanied in order to begin receiving referrals, compared with 39% requiring clients to be provided with a named contact. Again however, it may be the case that once providers become involved in social prescribing, the perception of their own operational needs might change, as was alluded to above concerning the ability of providers to anticipate the delivery context prior to entry and their corresponding funding needs.

Whether providers receive enough referral information, compared by collaboration



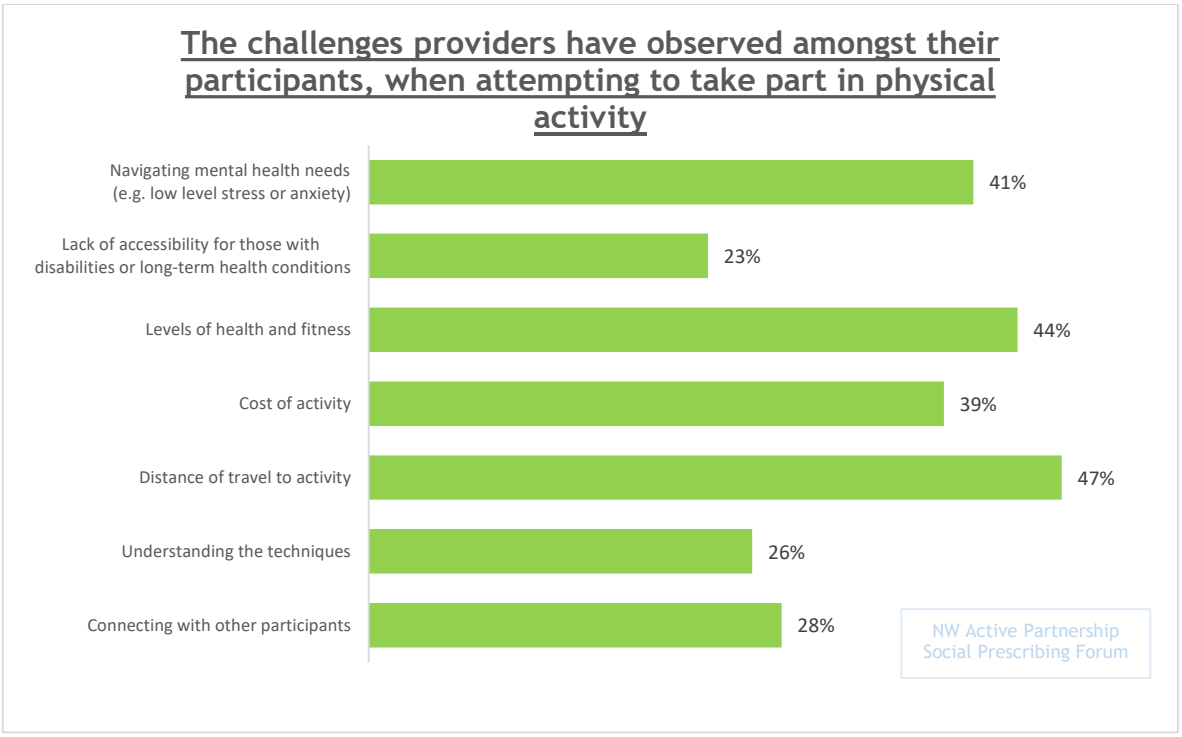
Whether providers have experienced issues, caused by a lack of referral information

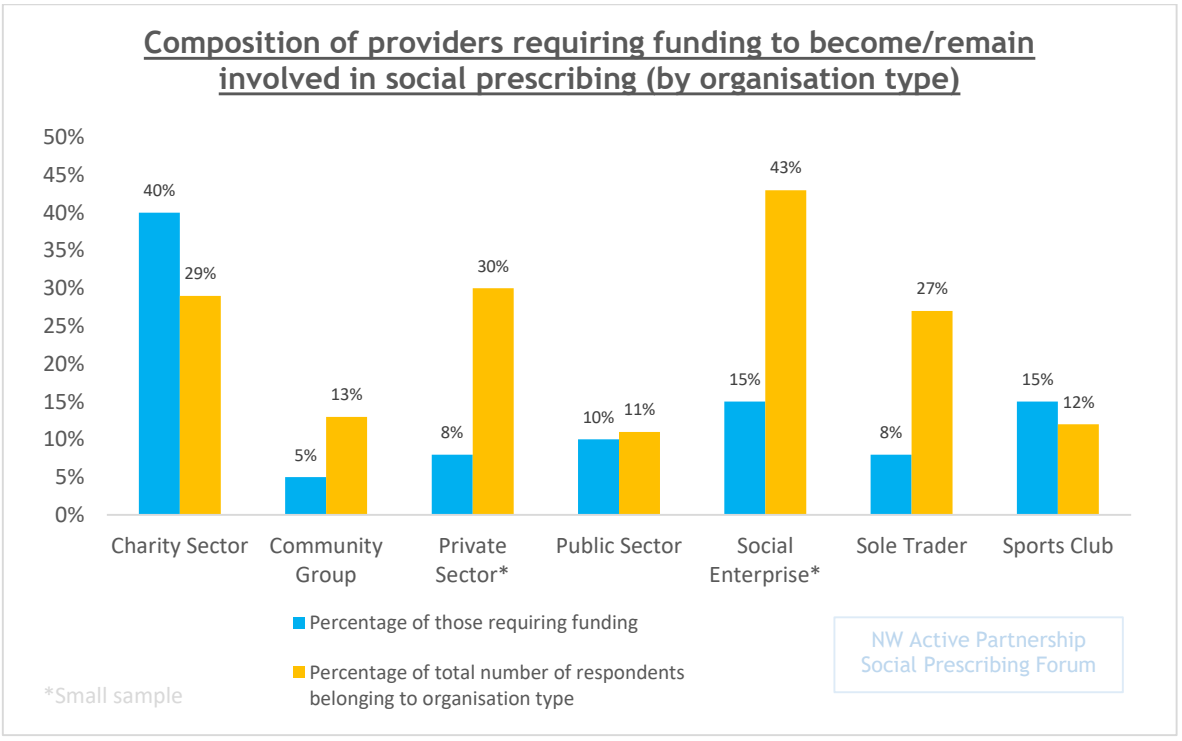
	No	Yes
All (Involved in SP / Used to be involved in SP)	68%	32%

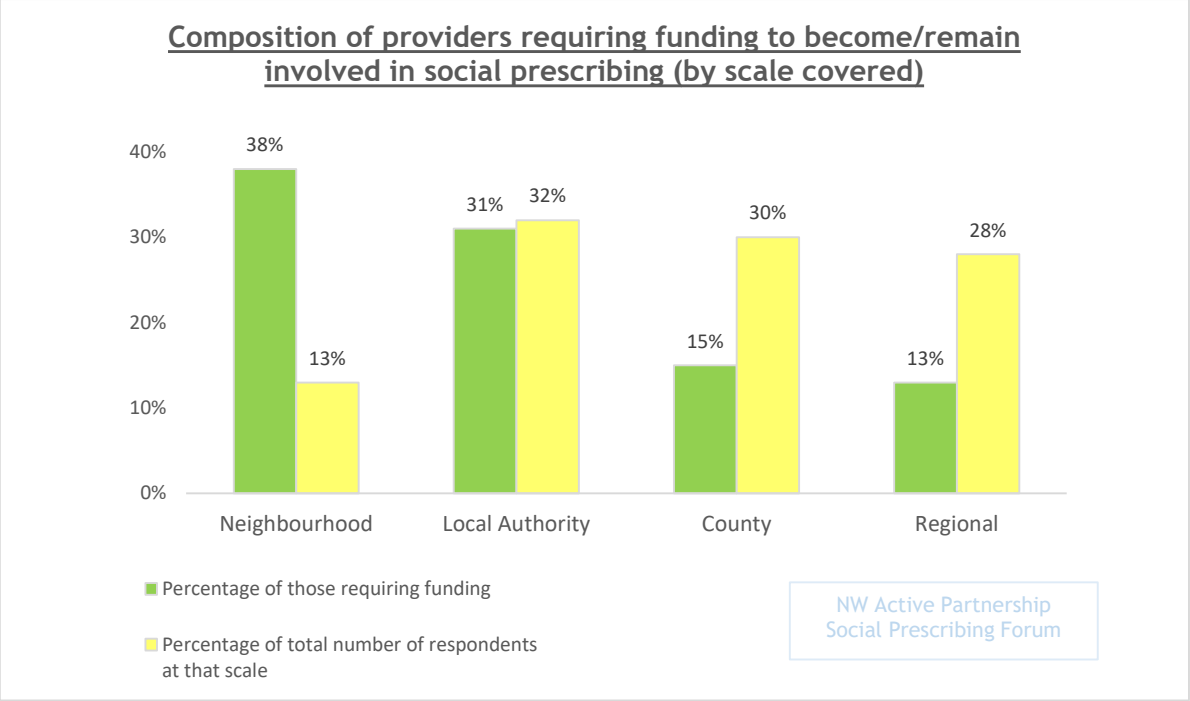


Providers collaborating with their participants, most frequently reported that they received adequate referral information. It may be the case that these actors are those most deft at building relationships with clients and so possibly during pre-session consultations or through other means, they are able to obtain the information they require directly from clients themselves. However, such a reliance may reveal vulnerabilities where clients are not forthcoming.

Most respondents reported no issues arising due to a lack of referral information. Although, this still leaves almost one third reporting insufficient detail has done so, the difficulty encountered most being clients failing to attend or return to sessions (16%) and 13% of providers left unable to accommodate client needs. These figures may not appear startling upon first review, however they represent the percentage of providers having experienced issues, not the frequency of occurrence, so the actual situation maybe of greater or lesser concern (e.g. should instances have been encountered repeatedly or only once).


The challenges providers have observed amongst their participants, when attempting to take part in physical activity
Navigating mental health needs (e.g. low level stress or anxiety)
41%
Lack of accessibility for those with disabilities or long-term health conditions
23%
Levels of health and fitness
44%
Cost of activity
39%
Distance of travel to activity
47%
Understanding the techniques
26%
Connecting with other participants
28%
NW Active Partnership Social Prescribing Forum

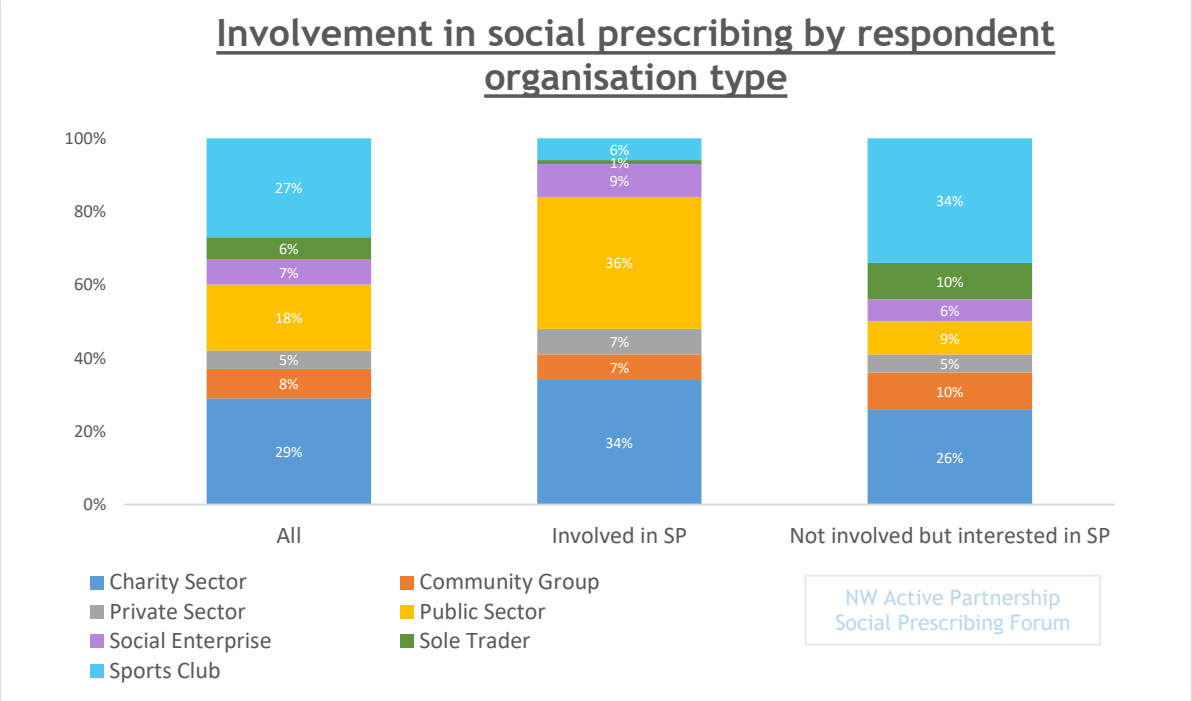

Composition of providers requiring funding to become/remain involved in social prescribing (by organisation type)
50%
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
40%
29%
5%
13%
8%
30%
10%
11%
15%
43%
8%
27%
15%
12%
Charity Sector
Community Group
Private Sector*
Public Sector
Social Enterprise*
Sole Trader
Sports Club
Percentage of those requiring funding
Percentage of total number of respondents belonging to organisation type
*Small sample
NW Active Partnership Social Prescribing Forum

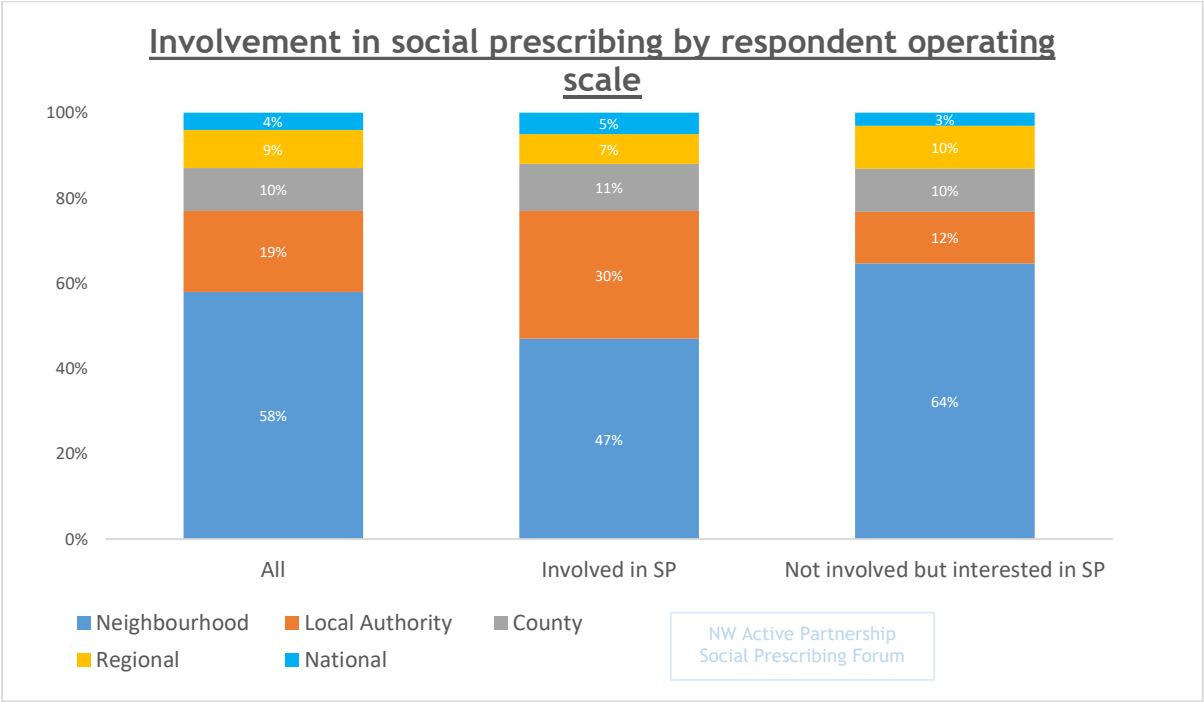


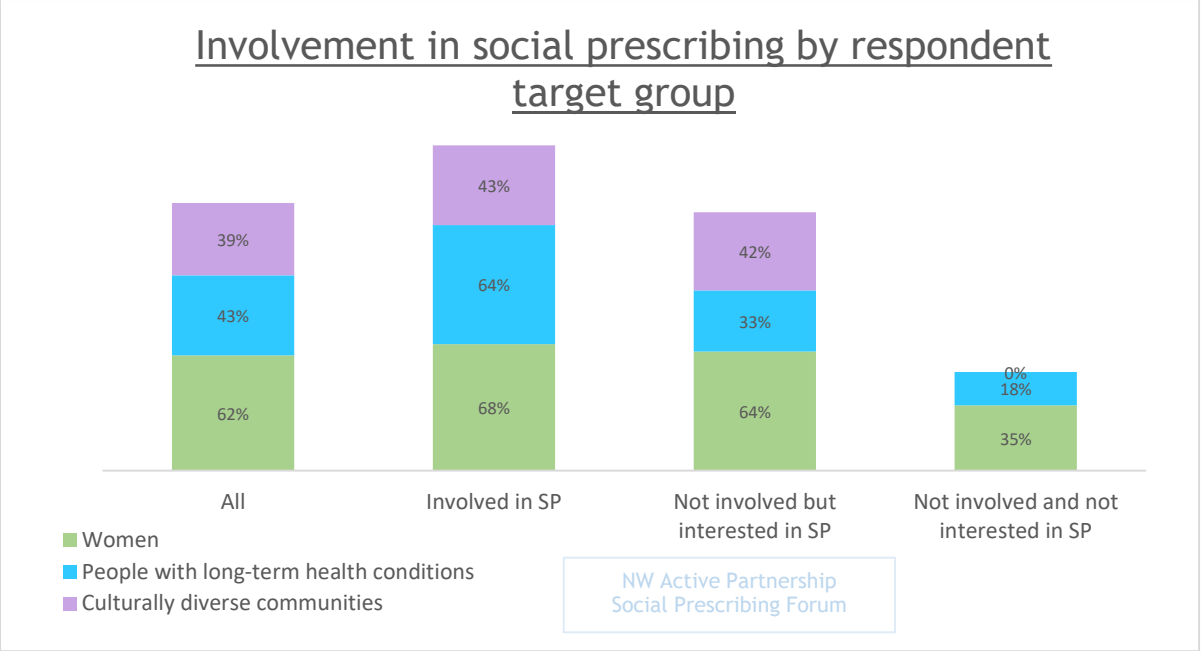
The greatest percentage of respondents (47%) advised that distance of travel to an activity was a challenge, this in succession followed by levels of health/fitness (44%), navigation of mental health needs (41%) and cost of activity (39%). Several of these barriers make regular appearances in discussions concerning the reduction of inactivity in the general population and those attempting to familiarise providers with common considerations, ahead of receiving social prescribing referrals. This observation draws attention to the potential relevance of providers developing appropriate responses to these concerns, whether they decide to deliver social prescribing activities or not.

Although social enterprises make up a small sample size, they had the greatest need of funding with 43% advising this was the case, while private businesses (30%) and sole traders (27%) then most commonly reporting the need for funding.

The operating scale at which most respondents advised they required funding was the neighbourhood level (38%) but however with these organisations also by far having the greatest levels of participation in the survey, considered as a proportion of the whole cohort, revealed that only 13% of neighbourhood operators required funding (the lowest demand). At all other scales, the rate of demand for funding hovered around the 30% mark. This finding may less speak of the availability of resources amongst stakeholders but more so the intensity of resource use and at which scales actors are best able to lever in in-kind support or voluntary input, as a proportion of overall organisation size.


Involvement in social prescribing by respondent organisation type
100%
80%
60%
40%
20%
0%
All
Involved in SP
Not involved but interested in SP
27%
6%
7%
18%
5%
8%
29%
6%
1%
9%
36%
7%
7%
34%
34%
10%
6%
9%
5%
10%
26%
Charity Sector
Community Group
Private Sector
Public Sector
Social Enterprise
Sole Trader
Sports Club
NW Active Partnership
Social Prescribing Forum


Involvement in social prescribing by respondent operating scale
100%
80%
60%
40%
20%
0%
All
Involved in SP
Not involved but interested in SP
4%
9%
10%
19%
58%
5%
7%
11%
30%
47%
3%
10%
10%
12%
64%
Neighbourhood
Local Authority
County
Regional
National
NW Active Partnership
Social Prescribing Forum

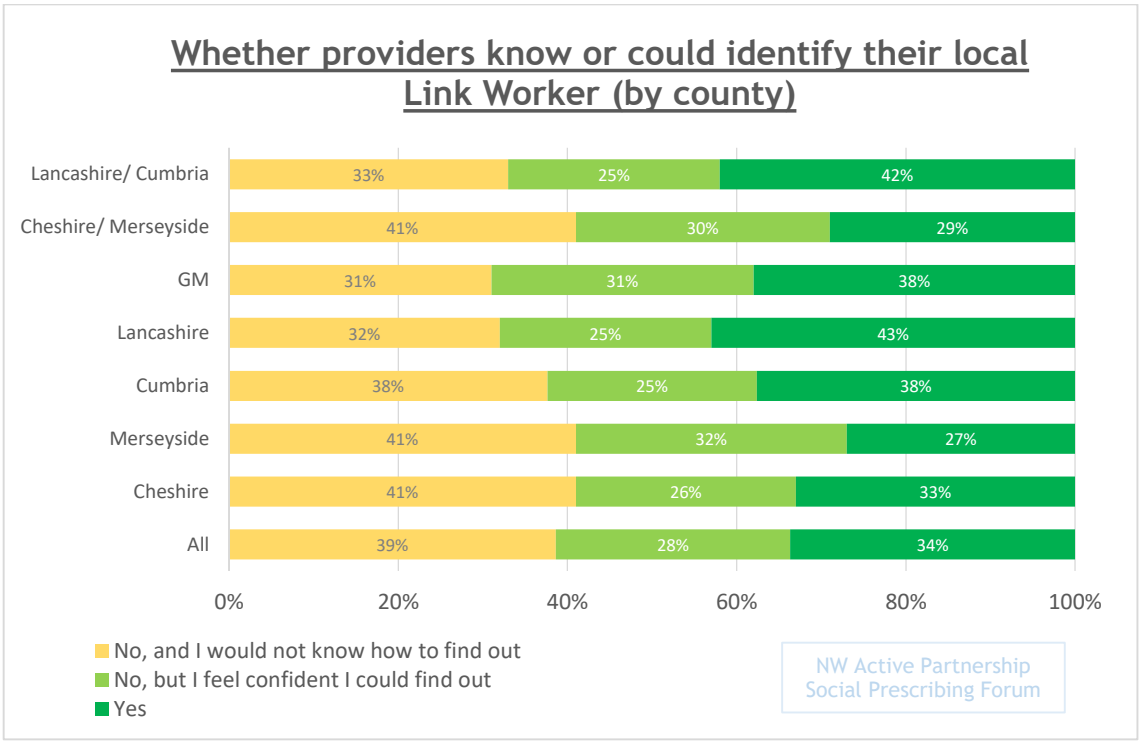


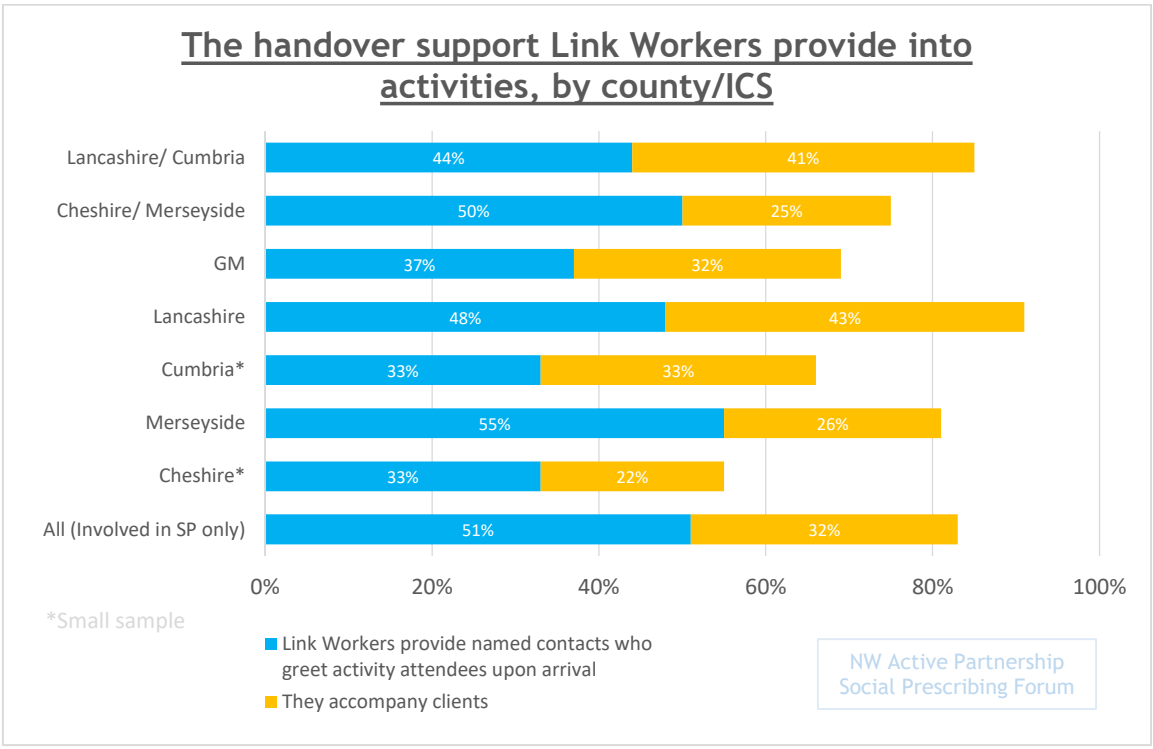
One of the outcome aspirations outlined earlier in this report is for social prescribing to attract a diverse range of organisations to respond to the various needs that might present amongst the client profile. Considering that the survey associated with this report was not randomised, it is susceptible to selection bias and may not be representative, but as before potential avenues of interest may be unearthed. In the case of take-up considered by organisation type, the public sector makes up 18% of all respondents, 9% of the cohort not involved in social prescribing and 36% of organisations that are involved.

This is almost the reverse predicament observed amongst sports clubs, where these respondents make up 27% of the total survey sample, 34% of those not involved in social prescribing, but just 6% of the organisations that are involved. This observation may suggest that the public sector (operating at the local authority level in the subsequent chart), may benefit from greater opportunity or ability to engage in social prescribing, while simultaneously sports clubs encounter some form of disadvantage or barrier.

Lastly, considering the three target groups frequently regarded as those most inactive, it is respondents providing activities for those with long-term health conditions that sees the greatest leap in terms of their representation across the whole sample when compared to that achieved in the involved cohort. Here, the aforementioned potential relationship between an organisation's mastery navigating the additional needs of their participants and the subsequent ease they are then able to respond to the needs of social prescribing clients, may be at play.

Potential opportunity factors at the county/ICS level:

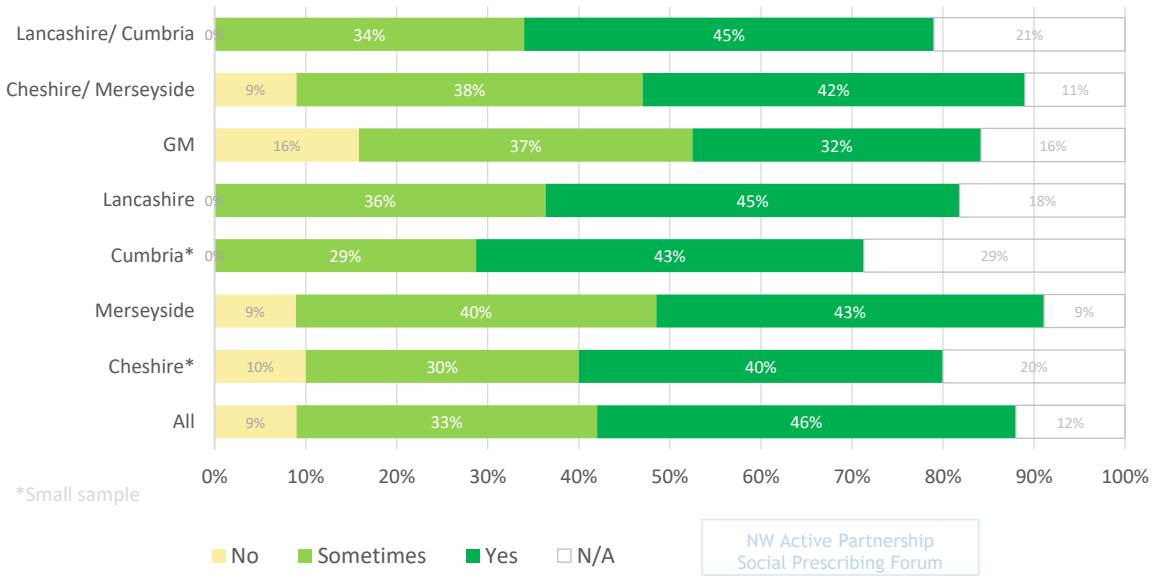




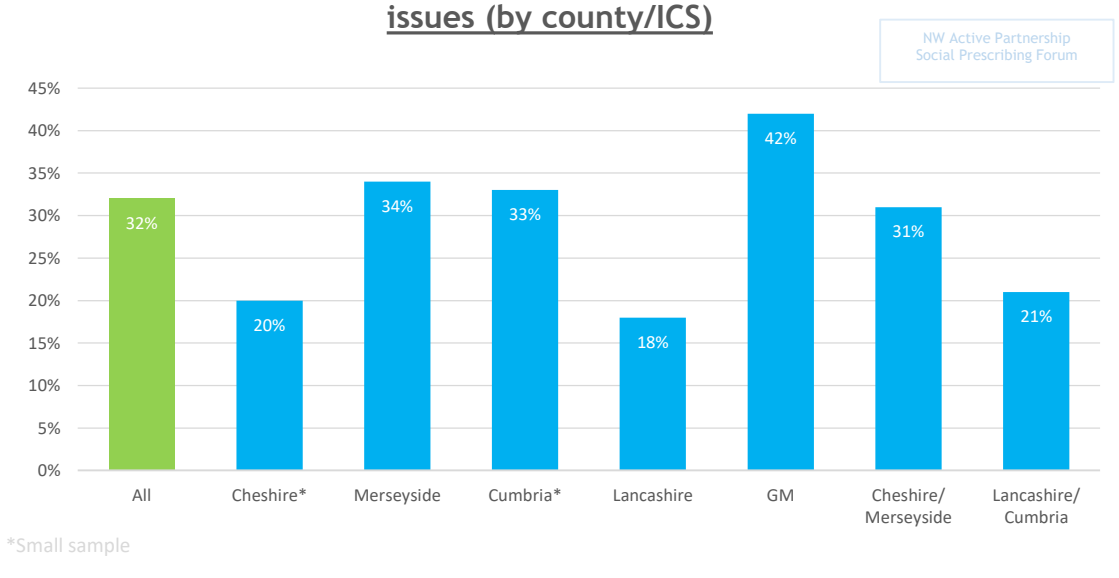
Most frequently across the counties, it is in Greater Manchester where respondents felt most able to identify and locate their local Link Worker (69% combined), while providers in the Merseyside-Cheshire ICS felt least able across the region (59% combined).

Lancashire-Cumbria respondents most often reported benefitting from Link Worker handover support (in sum), with 44% having had clients given a named contact within their sessions and 41% having seen clients accompanied by a Link Worker to their

Whether providers receive sufficient referral information detailing clients needs, by county/ICS

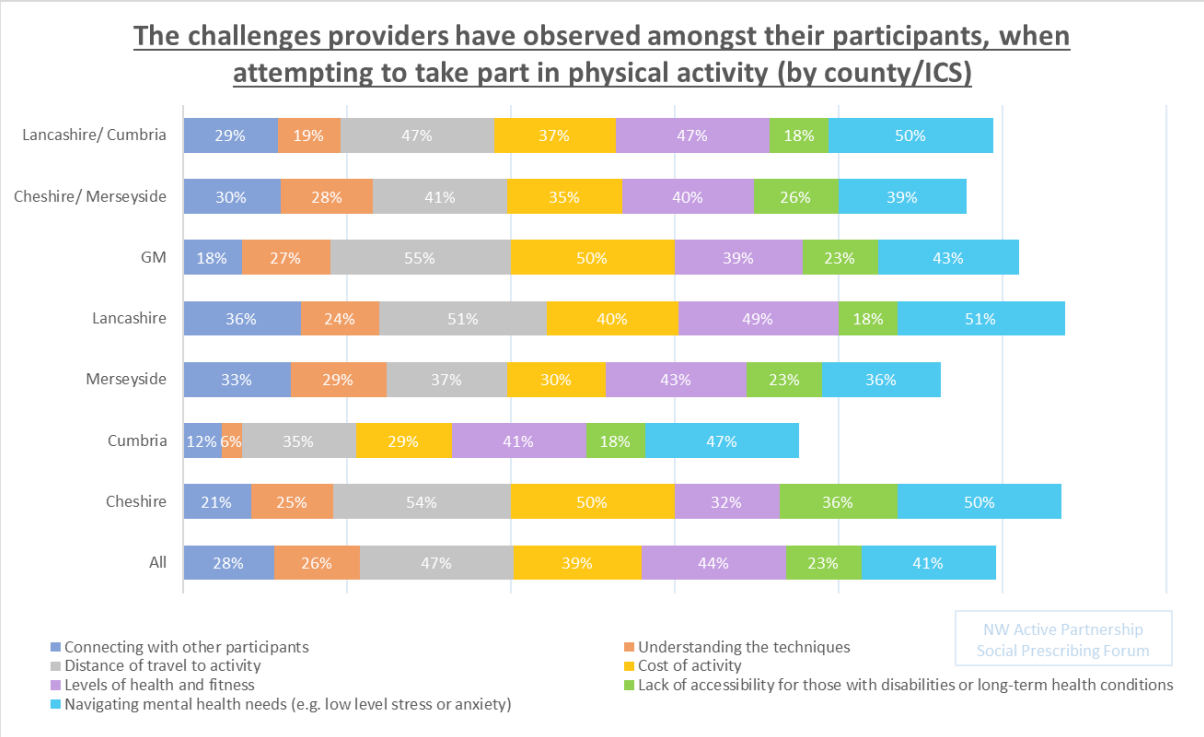


Providers reporting a lack of referral information has caused issues (by county/ICS)



Uniquely, amongst respondents operating in the Lancashire-Cumbria ICS footprint, none advised that they received insufficient referral information, whereas in Greater Manchester 16% did so (the highest rate). Again in Greater Manchester, the highest rate of respondents reported issues resulting from a lack of referral information was to be found (42%), whilst this was least-frequently reported in Lancashire-Cumbria, by just 21% of respondents.

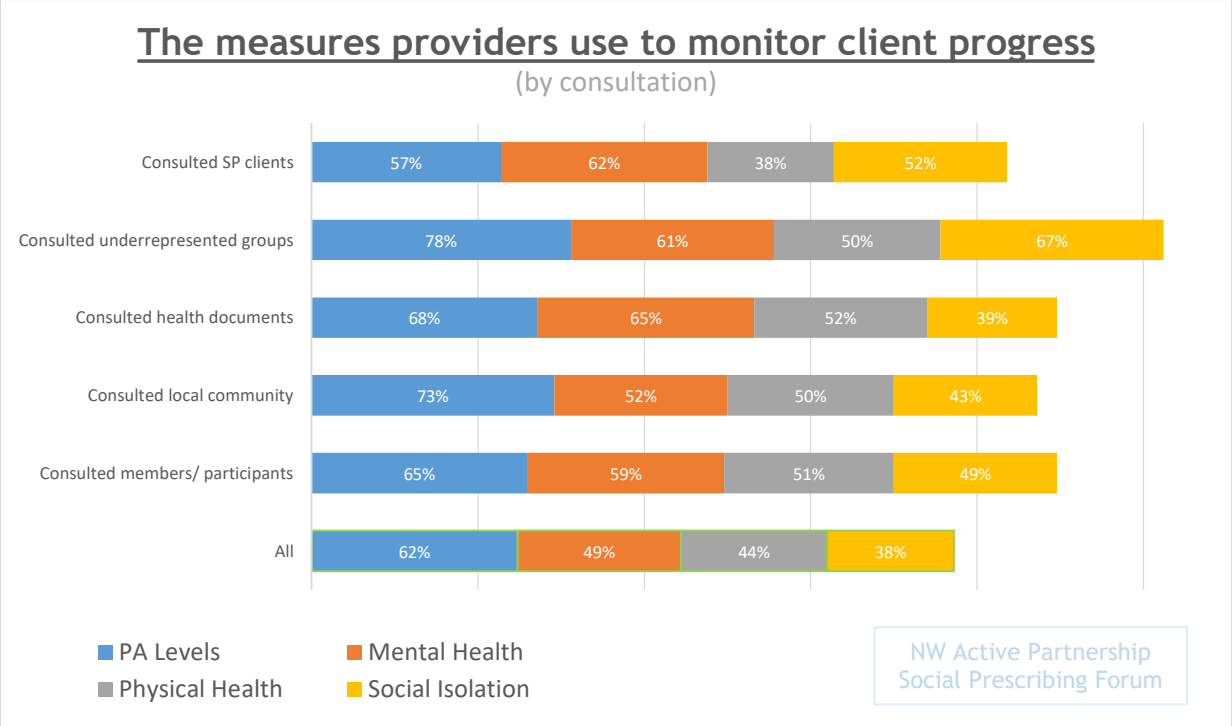
In Greater Manchester, the majority of survey participants (55%) fed back that distance of travel was a challenge for participants, while half cited cost as a barrier and in Lancashire-Cumbria, half again reported the navigation of mental health needs as a concern.

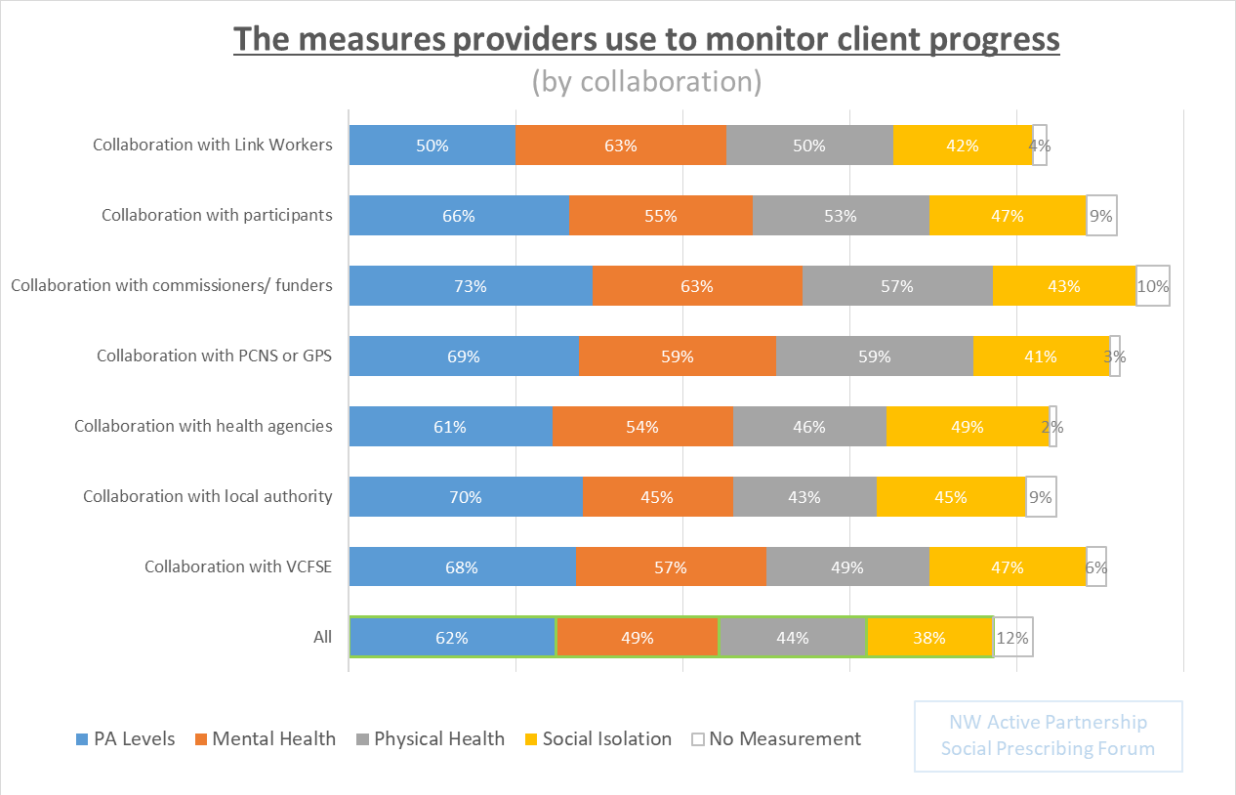


Motivation

Potential motivation factors and outcomes:

Please tell us the reasons that you have stopped receiving referrals? (Selection based on relevance to question)
Covid restrictions has impacted on our activities.
We have been constantly receiving referrals to maintain activities clubs but only now beginning to reintroduce clubs. We have massive demand for our [deleted] team but we are too short of funding to sustain and support the service-users.
Pilot project was not taken up by providers beyond that.
We only receive minimal referrals from this service, we tend to have a more word of mouth referral system from the GP's
It was hard because of health and safety and volunteers
We had initial meetings with [deleted] and provided information so that they could refer people to our programmes. There was no further contact after that. We'd be happy to learn more and work closer with the social prescribing schemes across the region but [deleted] specifically as we have staff focusing on that area.
Perhaps the age group we work with, and we deliver mentoring etc.
Due to pandemic, we have temporary limited the amount of people at our club.
We receive many referrals but stopped working with certain prescribers as they wanted to offload patients that needed professional mental help and never offered to pay for our services.
Club that is now has full membership with a waiting list.

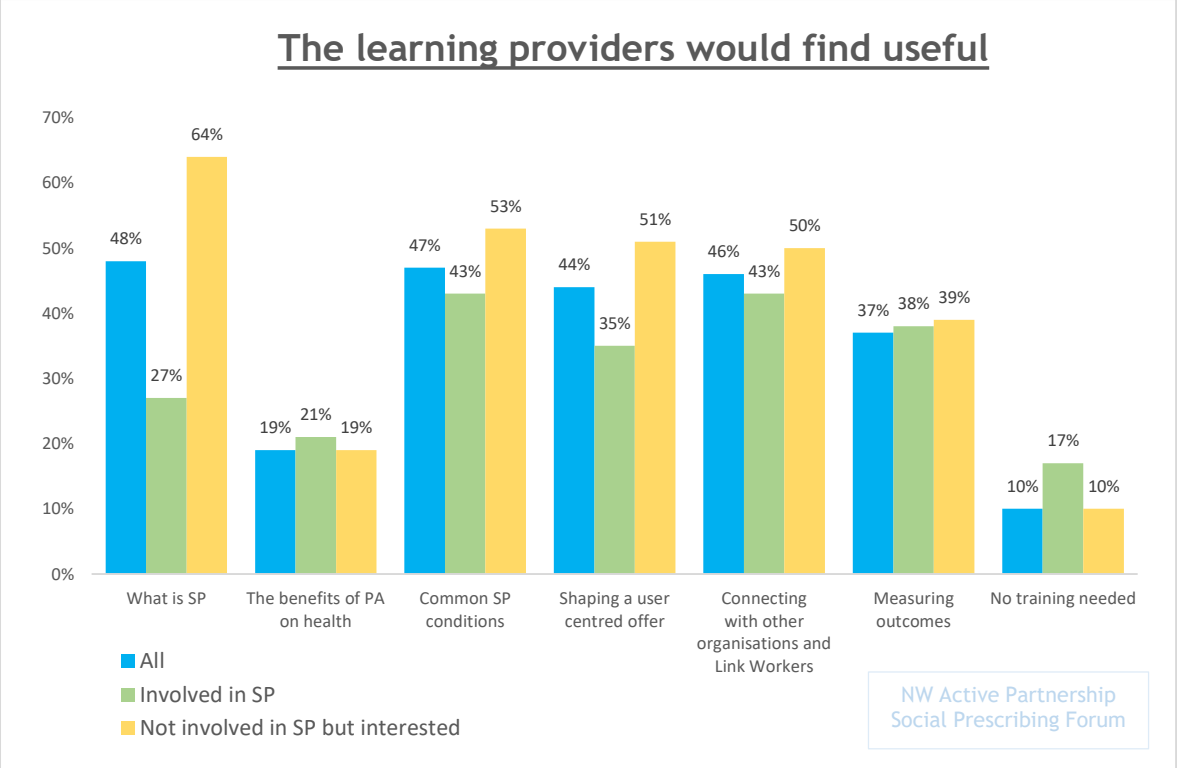




Reassuringly, there were no real patterns or prevalent themes explaining why providers ceased their involvement with social prescribing. Only two providers mentioned a lack of contact or referrals after commencement, two again mentioned possible health and safety issues, and one concerning inappropriate referrals due to the level of mental health need. While once more, there were only two mentions of funding/payment for services as being an issue.

Providers who consulted underrepresented groups appeared to use the widest range of measures most often (78% physical activity levels; 61% mental health; 50% physical health; and 67% social isolation), whereas those collaborating with commissioners and/or funders did so most readily otherwise.

Uninvolved respondents highlighted the learning that would prove most useful to them would be that covering what social prescribing is (64%), followed by coverage of the common conditions (53%), shaping a user centred offer (51%) and how to connect with organisations/Link Workers (50%). Amongst already involved organisations, predominant topics included coverage of common conditions and again connection development, each securing a response rate of 43%. These latter findings indicate that there still is a substantial learning demand amongst those already delivering social prescribing activities.


The learning providers would find useful
70%
60%
50%
40%
30%
20%
10%
0%
48%
27%
64%
19%
21%
19%
47%
43%
53%
44%
35%
51%
46%
43%
50%
37%
38%
39%
10%
17%
10%
What is SP
The benefits of PA on health
Common SP conditions
Shaping a user centred offer
Connecting with other organisations and Link Workers
Measuring outcomes
No training needed
All
Involved in SP
Not involved in SP but interested
NW Active Partnership Social Prescribing Forum

Conclusions

Collaboration, consultation and connections: Generally, whether consultation and collaboration takes place or not and with who, collaboration, consultation and connection appears to have some form of impact across the board, in terms of provider capability. Providers who are already involved and yet to engage with social prescribing call to be more effectively plugged in to social prescribing networks. Indeed, almost two thirds of the respondents interested in getting involved in social prescribing did not know who their relevant Link Worker was but also felt they could not find out. Furthermore, almost half of those already taking client referrals wanted to learn how to better connect with other organisations and Link Workers themselves. In brief, connections are important and as yet providers, even those providing social prescribing services, do not possess them in sufficient number. It is also to be determined, who providers might benefit most from being connected to and for what purpose.

Learning and funding needs: While it might be expected that substantial numbers of those about to enter the social prescribing marketplace might require fundamental training (such as, 'what is social prescribing'), surprisingly there was also great demand amongst those already supplying a physical activity offer. As mentioned, connection development was one topic organisations fed back that it would be useful to learn about, with another attracting equal interest concerning common conditions associated with social prescribing. Additionally, a third surrounded the creation of a user-centred offer. Furthermore, presented with a free text box, over 60% of those providers offering a social prescribing destination fed back that they required funding to continue to deliver services. These findings suggest there may still be sizeable work needed surrounding the availability of training and supply of learning opportunities, even for existing social prescribing contributors, who simultaneously may require financial support for ambitions of a high standard and sustainable physical activity offer to be realised.

Hyperlocal aspirations and confidence meeting additional needs: Although most respondents operated at the neighbourhood level (sub local authority), the rates at which organisations at this scale felt confident they could respond to the additional needs of social prescribing referrals was the lowest. Whilst at the same time, providers most often reported distance of travel to activities as a challenge for their participants. So whilst it may be the case that social prescribing is attracting providers who operate at the desired scale, the offer might not be local *enough* for many participants and opportunities may exist to improve the degree of support providers can offer. Additionally, sports clubs also demonstrated comparatively low rates of confidence meeting participant's additional needs and their take-up of social prescribing appeared to be suppressed when compared with their sample-wide numbers. Therefore, should leads wish to engage this organisation type more fully in social prescribing provision, further exploration may be required to respond to the unique needs of this stakeholder group.

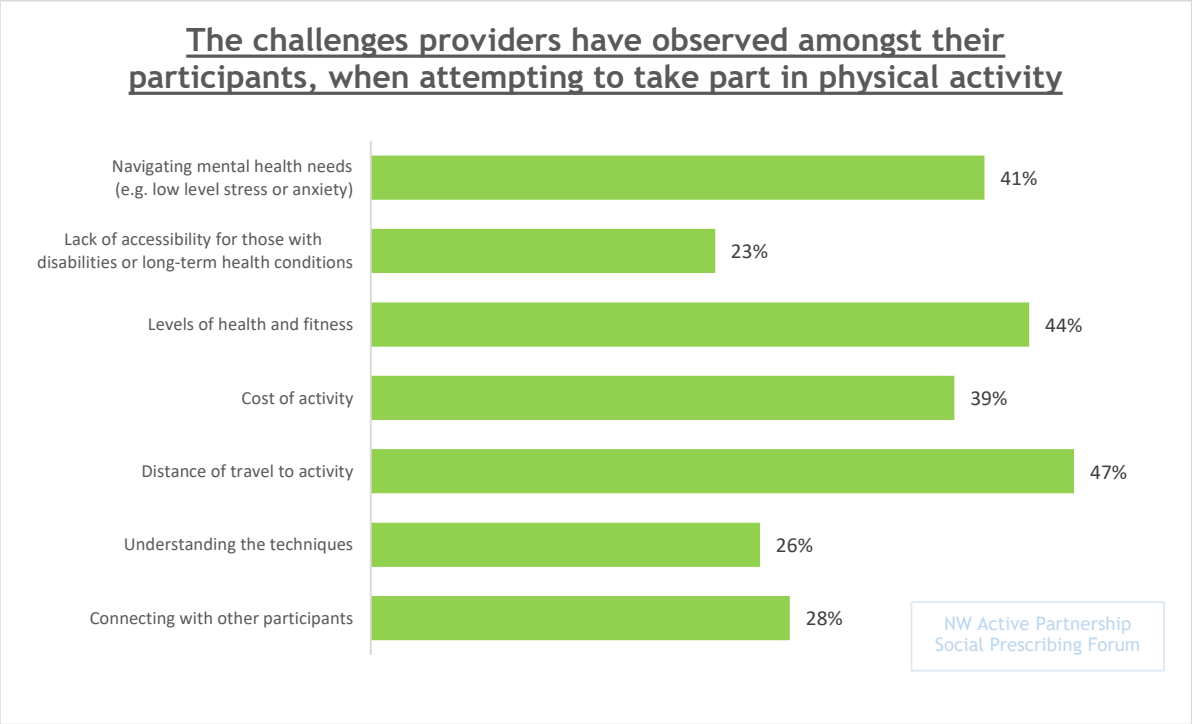
Handover, referrals and geography: Contact with participants ahead of them attending sessions appeared important. This is because those who undertook such approaches recorded higher rates of confidence that they could meet the needs of social prescribing clients. Whilst in Greater Manchester providers were most capable of identifying their Link Worker, they were also most likely to receive insufficient referral information which then results in issues. This presentation of mixed fortunes existed across the region more generally (Greater Manchester here given as just one example, while many existed elsewhere) with the incidence of factors and outcomes varying between ICSs, revealing opportunities for reciprocal learning between system leads and joint interrogation of the themes.

A personalised offer: Providers reported in their greatest numbers that the personalised nature of support and flexible options were most effective at helping participants to become active. These practices, responding to the individual needs of participants through open-ended conversations, share a great compatibility with a user-led (or client group/community centred) approach, which again was found to be a learning priority amongst respondents. This observation echoes earlier findings, which suggest that pre-session telephone calls and consultations are helpful, or more generally, the opportunity for provider-participant discussion is, to explore participants' needs.

Inclusion: There appears a considerable degree of overlap in terms of the support needed amongst social prescribing clients and that required by inactive groups, particularly those with long-term health conditions. Considerations surrounding social prescribing, inactivity, and wider inclusion, share a great deal of synergy. While statistical tests have not been carried out on the data, initial observations seem to suggest that the providers best able to meet the additional needs of their participants more broadly may gravitate towards (and find it easier to transition into) social prescribing delivery. This might be demonstrated in the above comparison on page 35, where greater take-up of social prescribing amongst providers targeting their services towards those with long-term health conditions exists. Therefore, the promotion of inclusionary themes, alongside the accommodation of additional needs within the wider physical activity sector, may produce sizeable benefits for both formal and informal social prescribing adoption by participants and providers alike.

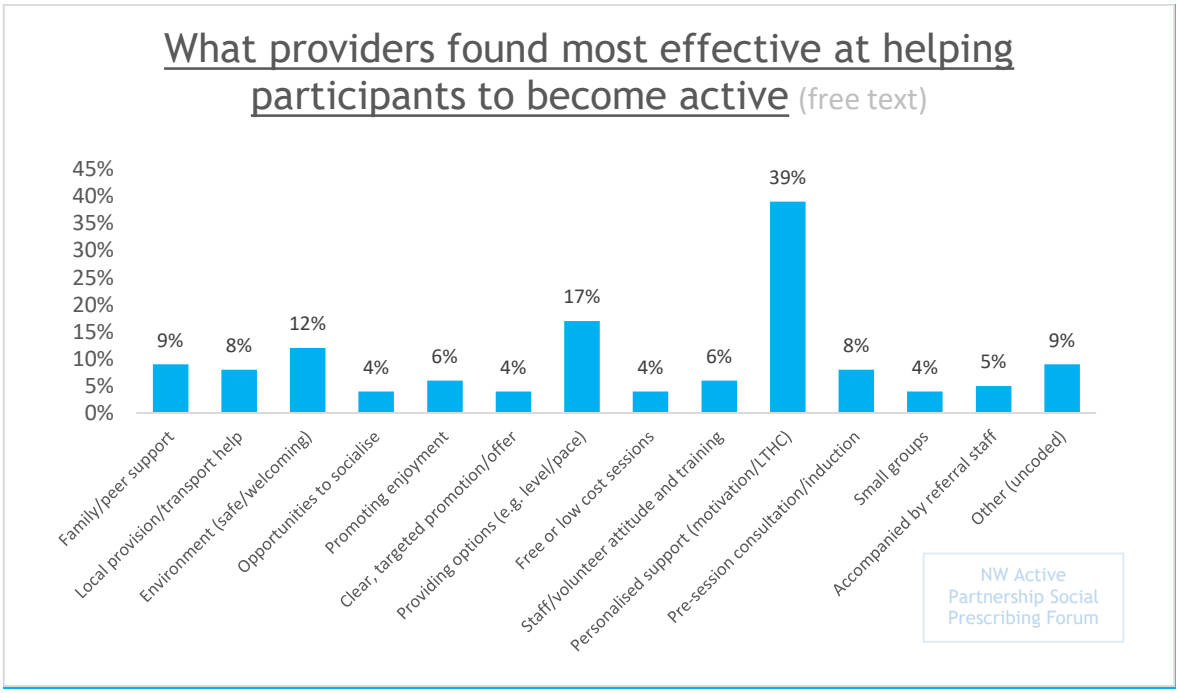
Appendices: peer learning

Supplied below is some potential preliminary learning gathered from the respondents completing the survey which may offer their peers broad ideas they could consider to compliment formal training and practice. These are to be assessed by the reader on their merits and if adopted, it is suggested that this is alongside all relevant due care and diligence, appropriate to the activities being delivered and operations undertaken. If in any doubt, please consult your local Active Partnership, CVS, governing body, funder/commissioner or seek other formal advice. Due to the following potentially aiding the exploration and accommodation of participants additional needs, there exists some relevance to social prescribing.



Other
A need for longer support from services they know and trust during the initial transition into a new activity.
Above and beyond our capabilities
All of the above occasionally, although I aim to make my classes accessible to all as far as possible
Also some older clients have no support.
Being aware of the actual provision
Buddy not participating in activity
Confidence
Could really say all of the above but have marked the more obvious ones thinking about participants who have come with a carer before.

Drug and alcohol use, restrictions of licence conditions/exclusion zones, safeguarding issues incl meetings they need to prioritise with social care, probation, courts, police.
Equipment
Inclement weather
Language barrier and not knowing how to access services.
Many of our sessions are free and some have a small cost.
Many of our sessions are online and some don't have access to digital. Those accessing face to face courses have requested assistance with cost of public transport.
Should an issue arise staff would advise and if the manager would assist to resolve
Sometimes an interpreter is required
Swimming ability
This is a question for the link workers really
This will depend on each club coach



Other	Building a relationship with participant / emphasising the benefits of the activity / client readiness and timing of offer / readily available information for client at each step / encouragement / accessibility / incentives such as gym passes.

Providing options and a welcoming environment
'Safe welcoming environment, focus on enjoyment of cycling, self-paced activity with options for breaks, being able to try more than one type of cycle. Staff who care.' *'Supply varied types of courses and courses that suit all levels of activity and courses that incorporate a social side too.'* *'Building a relationship with the individual.'*

'Create a welcoming environment to ensure when they are in the centre they feel comfortable.'

'Encouraging, motivating, providing a friendly environment, ensuring baby steps are taken and understanding client' 'to suit their individual needs.'

'Talking to them to find out what matters most to them. Giving them choices.'

'Connecting through Peer Support (lived experience mentors) and introducing them to sessions where they feel safe, are on a level playing field, are listened to and not judged.'

Communication and connecting with specific groups

'Appropriate and relevant info at their fingertips. Targeted to individual needs - listening to what the client needs not what you think they need.'

'Clearly advertised and specifying the target audience i.e. currently inactive over 55's.'

'Clear communication/ clear service offer/ consistent service offer/ providing individualised support/ training of all staff.'

'Once they see similar people to themselves trying - we find that helps them to settle in.'

'Promotion on social media. We promote our activities and what our participants have achieved to show people what they can also achieve.'

Personalised support

'Encouragement to participate [and] talking to existing members and explaining the situation without offering up any non-required personal information.'

'Have a consultation before exercising. Offer a range of ways of exercising.'

'Listening to their likes and dislikes and adapting active sessions to cater towards these preferences.'

'Having a good understanding of the specific activity and your client's suitability without excluding anyone from at least trying something, small taster sessions work well.'

'Co-created by participants to meet their needs.'

'We also find that some type of pre-engagement helps the client build confidence prior to attending.'

Cost, Transport and Outreach

'Providing sessions on outreach in communities, face to face and online for those anxious about leaving their home.'

'Low or free cost, near to home or good transport link, something they are keen to do, encourage them to go with a friend or family member.'

'Providing details of where and what will happen during the session. Help with travel is needed sometimes.' *'We work particularly with marginalised groups. We find going out to them to build trust and delivering at external VCSE locations and GP surgeries with the opportunity to move around and visit new places has been helpful when engaging people. Being flexible and having longer programs with routes into volunteering/continuing with some support rather than short interventions.'* *'Being able to offer reduced cost membership.'*
Socialising
'Making new friends along with keeping and getting fitter.' *'Making sure classes are welcoming places where they can feel included & nobody is judging them for what they can and can't do. All our class participants are encouraged to be friendly & welcome new people.'* *'Providing a welcoming environment, one where the emphasis isn't necessarily on physical activity but on social connection'* *'We believe a family member or volunteer is key to helping them with their first steps into activity. Social connections are important.'*
Promoting the wider benefits and opportunities
'Educate them on the positive outcomes of becoming more active. Highlighting that everyday activities count that do not cost anything.' *'Educating them around what 'active' means e.g. not just the gym or going for a run, but doing some gardening, cleaning - etc.'*