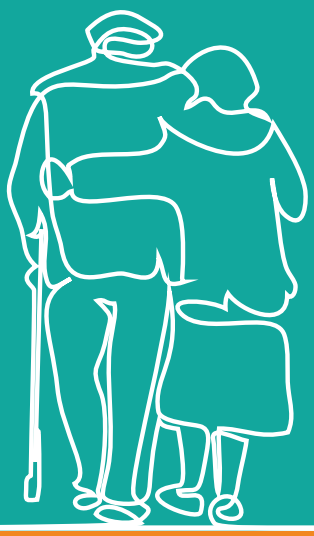
Together an Active Future

Influencing Systems

Understanding the strengths of the TaAF Lifestyle Hub

July 2023



Lifestyle Hub

Proper Active

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Summary

The Lifestyle Hub is Pennine Lancashire's central service for managing physical activity referrals (PARS). Until 2019, each local authority in Pennine Lancashire ran its own service and referrals. Data collection was inconsistent, and the evidence base was weak. Services were decommissioned by LCC in 2019 and, recognising the loss to the area, TaAF stepped in. The Lifestyle 'Hub' now brings together PARS for the 6 localities across Pennine Lancashire under a single referral pathway, making a simpler, more joined up offer for patients and referrers. It is currently funded to 2025.

The service has undergone significant redesign over the last 18 months, and the team wanted to review progress. Between May-July 2023, a review of literature, along with a series of interviews with key stakeholders, was undertaken to understand what is working well, what is tricky and how the Hub compares to what is offered elsewhere.

What we found

The literature review found that the evidence base for PARS remains patchy, referral criteria are typically broad, and there is inconsistency in what is measured across different schemes. This makes it difficult to ascertain what works, for who, in what context.

The evidence available suggests PARS is not universally effective, however, there are indications that it is powerful where the right conditions are created. In particular, a person-centred approach, as oppose to throughput-based KPIs, is critical, especially for those experiencing greatest inequalities, but likely to benefit most from being more active.

Against this backdrop, the Lifestyle Hub offers a major opportunity, both for Pennine Lancashire, and for establishing a stronger evidence base for PARS. The hope is to develop the service beyond leisure and become a one-stop shop for all community physical activity referrals in the area.

Significant progress has been made in the last 18 months, particularly in terms of the referral process, data collection & compliance. The service has a dedicated and expert team, who are confident working with a range of patient needs.

That said, the Hub is still on a journey and challenges remain, including confusion around data processes, tracking long-term behaviour change, and capacity creation for strategic thinking.

What next?

The ambitions for the service are high and there is significant work still to do to make the case for future investment (Mission 2025). This report identifies a phased approach to continued development. The overarching message is keep going – this work is on the cusp of something very special.

Do now: Work closely with the team to refine processes, build internal support structures, and consolidate the commitment to Mission 2025.

Do next: Create and implement an action plan to maximise capacity, strengthen relationships with referrers, and widen the physical activity offer.

Do later: Develop long-term behaviour change support and measurement and grow the service into new healthy behaviours.

2. Introduction

2.1 Background

The Lifestyle Hub is an innovative shared way of working across Pennine Lancashire to deliver a more joined up approach to exercise referral. It brings together the leisure providers across the six local authorities of Pennine Lancashire (Figure 1), including Blackburn with Darwen's re:fresh programme, East Lancashire's Up and Active model, and Ribble Valley's Let's Live Life. They all provide 12-week guided exercise programmes undertaken through the local leisure trust.

Figure 1: Areas making up Pennine Lancashire

The Lifestyle Hub provides a structured and consistent single-entry point into exercise referral for people in Pennine Lancashire who need help and support to be more active but are unsure of where to start. It is designed to help people who are physically inactive or less active and/or have one or more long-term conditions that would benefit from increased activity levels.

The Hub accepts direct referrals from health care professionals, as well as self-referrals, across the geographic footprint. Hub Advisors triage referrals, which are then passed on to a Health Activator in the most suitable location for that person. Activators use a person-centred approach to understand more about the person's current needs and assess what help and support is most appropriate. They then connect the person to the right service within their local area.

The majority of referrals currently go into Up & Active (or equivalent programme in that area), however, there are long-term aspirations for the service to incorporate a wider range of community-based physical activity offers. Referral data and outcomes are captured using a standardised system (DCRS) which meets NHS data compliance. Funding for the Lifestyle Hub is in place until April 2025, and comes from Together an Active Future.

Prior to 2019, each locality ran its own service, with different leisure-based offers and processes operating in each. Data collection was inconsistent, and the evidence was weak. Services were decommissioned by LCC in 2019. Initially, the majority of resource was redeployed to community support during the Covid-19 pandemic in 2020, but as the region emerged from the worst of the crisis, TaAF recognised the loss of PARS from the region and stepped in to redesign the service.

2.2 About Together an Active Future (TaAF)

Together an Active Future (TaAF) is a place based collective of change leaders from different backgrounds and organisations across Pennine Lancashire. By working with partners across systems and places, the aim is to change the way things work to make being active easier for everyone. The approach is built on the core belief that change in behaviours of system partners leads to sustainable change in places.

TaAF emerged in 2017 as one of 12 local delivery pilots, funded by Sport England, who were tasked with transforming the understanding, the value and the delivery of physical activity in their place. To date £10 million in funding has been received and further funding is in place to April 2025.

2.3 Report Aims

In order to grow the service, and to make the case for continued funding beyond April 2025, TaAF wanted to explore the unique characteristics of the Lifestyle Hub model, the strengths and challenges of a single point of entry, how it enables change in both organisational and individual behaviour, and how the service might be enhanced in the future. They also wanted to understand other models of referral which exist elsewhere, and how these compare to the Lifestyle Hub.

In May 2023, TaAF commissioned Proper Active to support them with this piece of work. The research will be predominantly used by the internal TaAF team. It will help them to:

- Know if they are focusing on the right things.
- Understand where the biggest opportunities to grow and develop the service lie.
- Understand how the Lifestyle Hub might work more effectively with other services within and beyond physical activity (merge/align/collaborate).
- Understand the priorities of the wider team.
- Bring everyone together behind the shared mission to make the service the best it can be and secure future investment.

Findings will also support the team to:

- Capture wider learnings which can be promoted outside Pennine Lancashire to help develop similar programmes in other areas.

This will be of particular interest to the programme funder, Sport England.

It is noteworthy that the broader evidence on the effectiveness of exercise referral is patchy at best.

> "Systematic review data… demonstrates many ERSs lack behaviour change components, fail to collect long-term outcome data, and report wide-ranging uptake (28%–100%) and adherence rates (12%–93%). Consequently, evidence of effectiveness is scarce and systematic reviews have been deemed an unfair assessment of the potential of ERSs to impact public health "
>
> **Buckeley *et al*, 2018**

Consequently, whilst not the main aim of this piece of work, where it has been identified, more recent evidence to this effect has been considered and presented. The main focus of the work, however, will be on the processes, relationships, and practicalities which support an effective referral service.

3. Methodology

Research took place between May and July 2023 and combined two main elements:

1. A review of available online sources, including published academic literature, practitioner reports and publications, and online information from trusted sources, such as The Kings Fund.
2. Qualitative interviews with a range of stakeholders involved in the Lifestyle Hub model.

This combination was selected to provide an understanding of both the current Hub model, and existing, alternative models which might demonstrate relevant learning.

3.1 Literature Review

Initial sources and search parameters were determined for the review, and it was agreed that the search would centre primarily on evidence which was:

- UK-based
- Published or written within the last 5 years (2018-2023)
- Discussing physical activity referral for health and wellbeing outcomes
- Focused on referral into community-based services

Given the synergies which exist between physical activity referral and social prescribing, it was also decided to search trusted sources (such as the National Academy for Social Prescribing) for evidence where physical activity has been recommended through social prescribing pathways.

Whilst every effort has been made to present a broad view of the available evidence, it should be noted that this is not a systematic review in and of itself and should not be viewed as comprehensive.

3.2 Qualitative Interviews

Interviews were conducted via Microsoft Teams, either with individuals or small groups (Table 1).

Table 1: Interviews undertaken

Role	Number	Type	Duration
Service Lead	1	Individual	2 x 1 hours
Referrers^	3	Individual	30 mins
Health Coach	1	Individual	45 mins
Locality Leads	3	Paired / Individual	45 mins
Hub Advisors	2	Paired	45 mins
Health Activators	4	Group	1 hour

^Pulmonary Rehab, Stroke Rehab, Social Prescribing

Interviews covered:

- the purpose of the Lifestyle Hub
- their role and day-to-day operations
- enablers and disablers of an effective service
- where they would like to see the service go in the future.

In addition to formal interviews with the Service Lead, regular meetings were held to discuss emerging themes and answer clarification questions.

4. Models of Physical Activity Referral

A Physical Activity Referral Service (PARS) is where an individual is referred to some form of exercise or physical activity in order to access health benefits. It is intended to target those who are currently inactive, or who are not undertaking sufficient physical activity to access the full range of health benefits. Whilst there is not an official definition, there seems to be general consensus that, in addition to the referral, it also involves some kind of 1:1 assessment prior to undertaking any new activity (See Figure 2).

Figure 2: Typical component of a Physical Activity Referral Service

There are parallels between the above and social prescribing in that, in social prescribing, initial referral and 1:1 assessment is with a Link Worker (also known as community connectors, community navigators, or health advisors) who's role is to understand what matters to the person and to link them with appropriate community support. See Appendix 2 for further definitions of PARS and social prescribing.

4.1 Lifestyle Hub Model

In the Hub, referrals are received through two main routes (Figure 3). Either from a healthcare professional, who auto-generates a referral form through the digital EMIS patient record system, and sends it to a dedicated email address. Alternatively, individuals can self-refer by calling a dedicated phone line, or completing an online self-referral form.

Hub Advisors pick-up referrals and enter them into DCRS, the digital record management system which underpins the Lifestyle Hub. Where essential information is missing, Hub Advisors may go back to the referrer to query. Otherwise Hub Advisors pass the referrals on to Health Activators within the relevant locality of Pennine Lancashire.

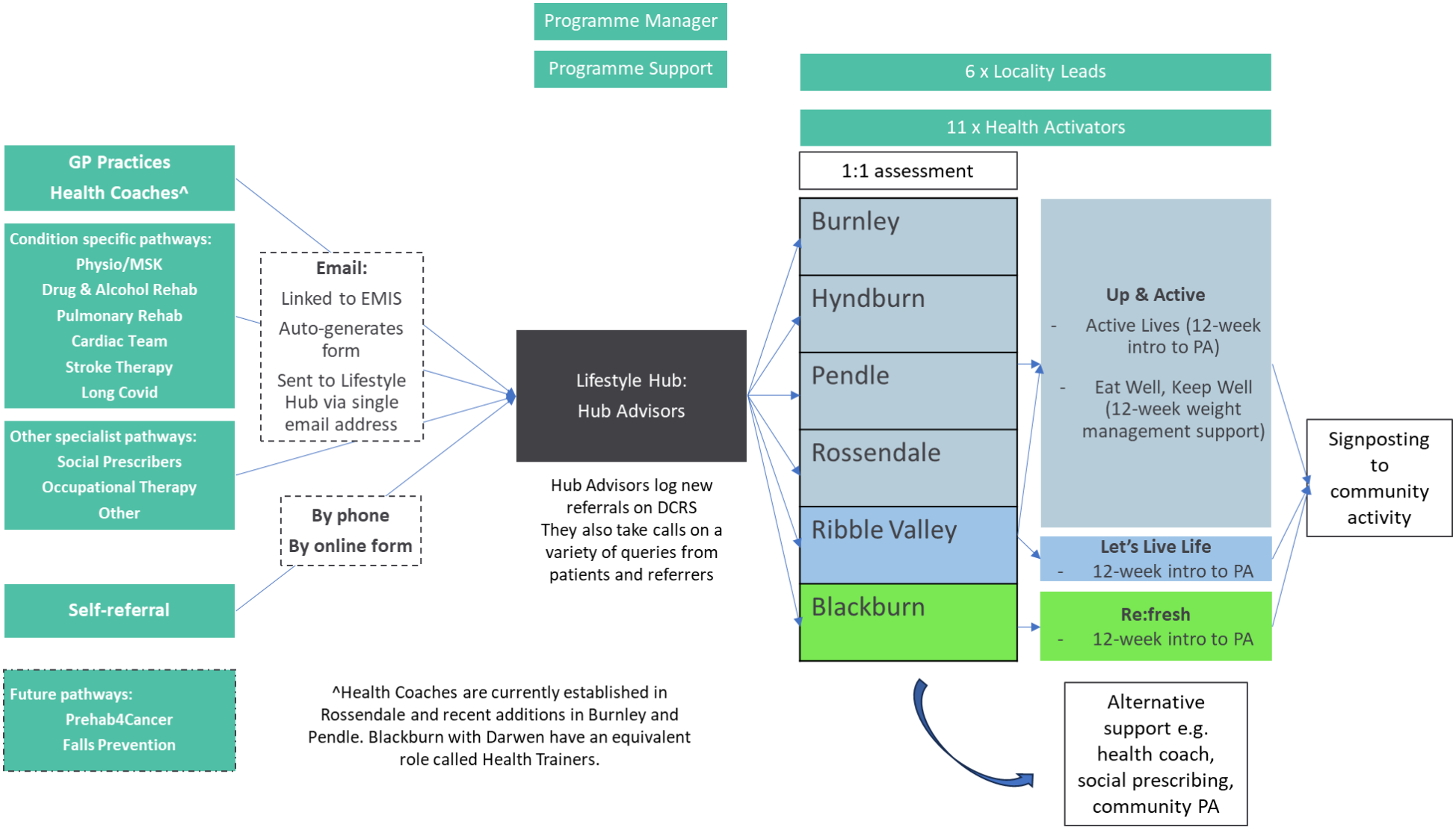
Health Activators arrange a 1:1 assessment with each patient to understand their background, the details behind their referral, and their needs and priorities. They will then create an action plan with each patient, which includes connecting them to suitable support. This is usually for physical activity, but on occasion this can be to wider support such as a Health Coach. The primary route for patients is a 12-week introduction to physical activity in leisure-based settings, with ongoing support from the Health Activator. In the majority of localities this is known as Up & Active and has 2 strands:

- Active Lives – 12-week introduction to physical activity
- Eat Well, Keep Well – 12 week weight management programme

In Ribble Valley, weight management is run by the council under the Up & Active banner, whilst their 12-week introduction to physical activity is run by Health Activators and is known as Let's Live Life. In Blackburn with Darwen they have a slightly different model called Re:fresh which encompasses similar 12-week options, however, self-referral is not currently available.

Activators undertake 6-week and 12-week assessments with individuals and, as the end of the 12-weeks approaches, they discuss with participants other community activity options that they might enjoy to continue being active. Most localities offer some kind of continued subsidised leisure membership, however, what is on offer is not consistent in each locality.

Figure 3: Lifestyle Hub Referral Model - Current



N.B. Data quoted in remainder of this report refers to East Lancashire (Burnley, Hyndburn, Pendle, Rossendale & Ribble Valley), unless otherwise stated.

4.2 Referrals

Across the UK, exact processes of physical activity referral vary in different schemes and there seems to be a degree of fitting with local processes in most cases. An audit of schemes in Scotland, for example, found that 53% schemes still used a paper referral form (NHS, 2018). Where digital referrals were employed, a range of different systems were used.

Most schemes identified operated over smaller geographic footprints than the Lifestyle Hub, commonly covering a particular PCN or LA area. The most similar set-up to the Lifestyle Hub we observed was a scheme located in one London borough. This incorporated 3 different PARS programmes, a variety of referral routes, and "included a central administrative hub that organised the referrals from health professionals" (Downey *et al*, 2021).

Referrals from primary and secondary care are common, however, there is no consistent model. Self-referral is also on the rise.

4.2.1 Who refers?

Referrals were most common from GPs, with almost all schemes taking GP referrals. Referrals also frequently came from other healthcare professionals based in primary care settings, such as practice nurses and mental health nurses. A review of schemes in the National ReferAll Database (NRD)[1], covering schemes in England, found that 61% referrals were from GP Surgeries, with a further 17% from Medical Centres (Steele *et al*, 2021). In Wales, the National Exercise Referral Scheme (NERS) was shown to receive 58% referrals from GPs, with a further 31% from physios (Morgan *et al*, 2020).

A high number of schemes also took referrals from secondary care, including patients from pathways in stroke, cardiac, pulmonary, falls rehabilitation, cancer, pain management, dietics and physiotherapy. Self-referral is a growing feature, for example in West Lancashire, one scheme took a mix of referrals from primary and secondary care, however, 56% referrals had come through self-referral (Portman *et al*, 2023). For social prescribing, referral through GPs is still the most common referral route, according to latest guidance from The Kings Fund[2]. Although here too self-referral is becoming more common.

In Pennine Lancashire, as well as the Lifestyle Hub being open to all GP surgeries, there are established referral pathways with physiotherapy/MSK, Drug & Alcohol rehab, Long Covid, pulmonary rehab, stroke therapy, social prescribing, and Get Set for Surgery. Some of these pathways are still relatively new, hence have only had small numbers of referrals to date. New pathways are also being explored for Prehab4Cancer and Falls Prevention.

DCRS data highlights the make-up of recent referrers (Table 2) and by far the three main sources of referrals to date are GPs, Health Coaches, and self-referral. Self-referral has been highlighted as a key pathway for the Lifestyle Hub as it can remove an extra barrier

> "Enabling self-referral may widen scheme participation opportunities among those reluctant to seek referral from a healthcare provider and reduce the administrative burden for healthcare providers themselves."
>
> **Portman *et al.* 2023**

[1] National ReferAll Database (NRD) is a project to collate data from PARS schemes across England to enable broader analysis of scheme characteristics and outcomes. ukactive and ReferAll publish new data from UK's first open access database for exercise referral schemes | ukactive

[2] Kings Fund: What is social prescribing? https://www.kingsfund.org.uk/publications/social-prescribing?gclid=EAIaIQobChMI8b269uCK5AIVR_hRCh3AowOCEAAYASAAEgIVHPD_BwE

> **[When patients self-refer] "that's the 1st step done and that's them taking a bit of control of their own health" Interviewee, Lifestyle Hub Team**

to entry for those less likely to visit their doctor surgery. It also prevents GPs from acting as gatekeepers to the service. Where a patient does self-refer and medical issues or risks in being active are identified, they can be directed back to the GP for further treatment or advice prior to engaging in exercise. Notably, in Rossendale, where Health Coaches are fully established, referrals from Health Coaches have all but replaced referrals from GPs.

Table 2: Referrals to Lifestyle Hub by Referrer (May 2022-23)[3]

	NHS - GP	Self referral /attendance at event	Health Coach	NHS - MSK/Community Physiotherapy	Inspire East Lancashire (Drug & Alcohol Rehab)	Online Assessment /Referral Form	NHS - Pulmonary Rehab Team	NHS - Cardiac Team	Social Prescribing Link Worker	ELHT - Stroke Therapy Team	NHS - Other Health Professional	Total
Burnley	561	413	124	43	90	59	11	27	14	4	34	1380
Hyndburn	262	117	7	101	20	10	11	1	4		31	564
Pendle	85	151	102	17	35	10	13	3	2	7	19	444
Ribble Valley	49	50	8	12	4	61	3	2	3		30	222
Rossendale	90	270	586	27	5	4	2	4		1	55	1044
Total	1047	1001	827	200	154	144	40	37	23	12	169	3654
Total %	28.65%	27.39%	22.63%	5.47%	4.21%	3.94%	1.09%	1.01%	0.63%	0.33%	4.63%	100%

Oliver et al (2021) found in a review of 14 schemes that successful schemes had a range of entry pathways in addition to GPs (e.g. charities, private physios, social prescribers, local support groups). Schemes also had a range of local relationships and participated in local networks to connect with local services and identify new referral routes. As is the case with the Lifestyle Hub, dedicated resource was made available for this purpose; however, notably, the Lifestyle Hub have recently taken on additional resource to extend strategic capacity, due to the extent of operational programme management needs.

4.2.2 Who is being referred?

Our review found that there is no standardised set of criteria for referral into different schemes and most set their own criteria locally. It is most common to see schemes open to people with or at risk of one or more LTHCs, with some schemes targeting specific conditions (Birtwistle *et al*, 2019) and some aligned with recovery from serious illness (e.g., Cancer, cardiovascular disease; see section 4.4 for more).

> **Most schemes target those with LTHCs. Women and older people are more likely to be referred than men or young people.**

LTHCs which are commonly eligible are mental health conditions, cancer, cardiovascular, obesity, respiratory issues and MSK issues. Whilst conditions varied between schemes, MSK, cardiovascular, and mental health were frequently observed.

Accepting only patients with a BMI above a certain threshold is also common, for example in Wales, NERS required a BMI >28 (Morgan et al, 2020). Portman *et al* (2023) noted that, whilst obesity wasn't often the cited reason for referral, it was common for patients to have high BMIs, including in self-referral. Many schemes target patients who are physically inactive (e.g. Albert *et al*, 2020; NHS, 2018), although this is typically coupled with a requirement to be living with or at risk of a LTHC.

[3] Note that Long Covid patients are directed to the self-referral form so are not counted separately.

The majority of schemes see more referrals for women than men (uptake can also be poorer for men once referred; see Section 5.2). Many studies also noted more older people being referred, for example, a review of the National ReferAll Database (NRD) saw an average age of 52 (Steele *et al*, 2021).

Across UK schemes, Steele also provides data on relative deprivation which suggests a reasonable split of participants across all income deciles. Although you could argue that, whilst it is positive that those from the most deprived backgrounds appear not to be excluded, you might hope to see higher referrals from areas of greatest socioeconomic disadvantage in the bid to tackle health inequalities. In NERS, Morgan *et al* (2020) observed declines in both referral and uptake of lower socioeconomic groups over time, which correlated with introduction of and then increases in charges for physical activity sessions.

A further bias is noted (Hanson *et* al, 2021; Oliver *et al*, 2021, Rowley *et al*, 2020) in referring those who have previously been active and those with greatest perceived motivation, suggesting that PARS is not always being used to serve those least likely to become active. Steele *et al* (2021) found that, where starting levels of physical activity are collected (and this is far from a given – see section 5.1), only 61% participants in PARS included in the NRD were categorised as *insufficiently* active (taking part in <3 days physical activity/week). Where the Sport England Single Item Measure was used, only 35% PARS participants were previously doing 0 days physical activity per week with a further 18% doing 1 day. Rowley *et al* (2020) pointed out that, whilst modest increases in activity levels are observed for participants who are *minimally* active, these are often not enough to move the IPAQ category.[4]

BOX 1: TANDRIDGE WELLBEING SERVICE

PRE-PANDEMIC THE SERVICE MAINLY SAW REFERRALS TO WELLBEING ADVISORS FOR LIFESTYLE SUPPORT (E.G. WEIGHT MANAGEMENT, INCREASING PHYSICAL ACTIVITY). POST PANDEMIC THIS CHANGED DRAMATICALLY WITH FAR MORE PATIENTS WITH COMPLEX NON-MEDICAL NEEDS INCLUDING EMOTIONAL AND PSYCHOLOGICAL (E.G. ANXIETY, SOCIAL ISOLATION, CONFIDENCE TO MEET NEW PEOPLE) AND PRACTICAL (HELP WITH IDENTIFYING CARER SUPPORT, DEBT MANAGEMENT, HOUSING). THIS HAS FUNDAMENTALLY CHANGED THE NATURE OF THE SERVICE, WITH A MUCH WIDER RANGE OF SUPPORT OPTIONS NOW AVAILABLE (TANDRIDGE DISTRICT COUNCIL, 2021)

Oliver *et al* also observed that broad eligibility can exacerbate bias in referrals from healthcare professionals, as almost anyone can be seen as eligible, hence who gets referred comes down more to professional judgement. In the Lifestyle Hub, one referrer did note that some patients just didn't see being active as for them and that they would never refer them as they didn't think they would stick to it anyway. Self-referral can be particularly important here, as it allows access without relying on gatekeepers.

In terms of referrals into social prescribing, these services have a broader wellbeing scope than just physical activity. Interestingly, some studies noted a significant increase in referrals for emotional, mental health and practical support since the pandemic (Conservation Volunteers, 2021; Tandridge District Council, 2021 – see Box 1). Nonetheless, referrals from those seeking physical activity is common and there are many parallels to PARS, particularly around gender and age.

[4] International Physical Activity Questionnaire (IPAQ) https://sites.google.com/view/ipaq/faq

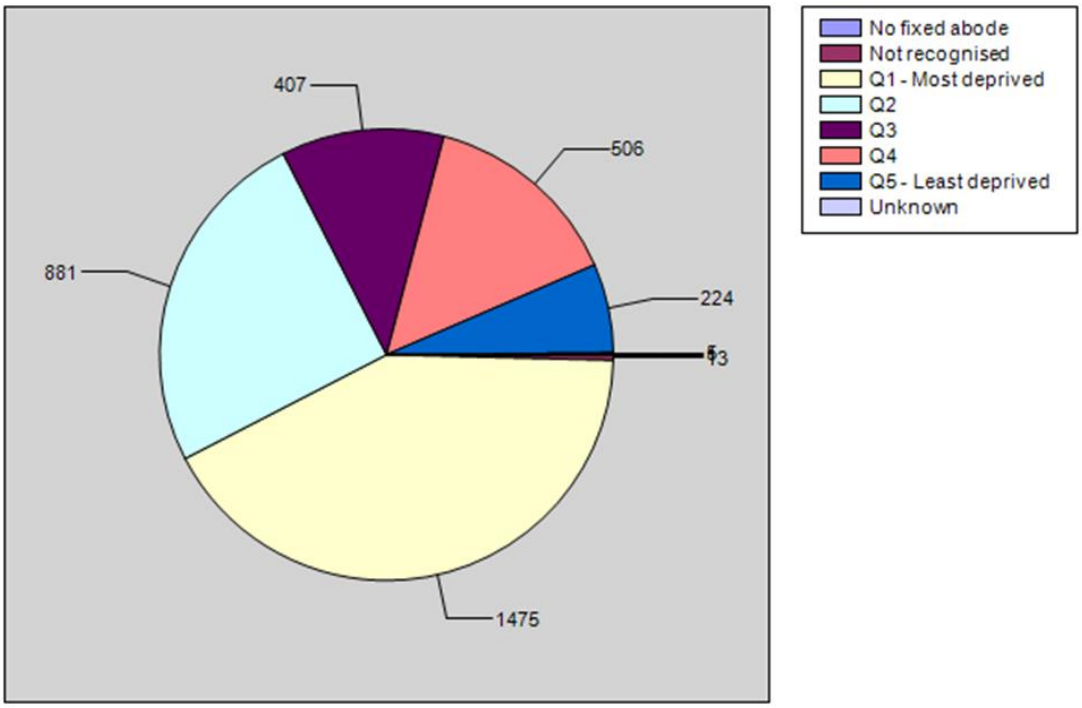
There are increasingly efforts to broaden access to social prescribing for young people, for example, Street Games have been leading on the Youth Social Prescribing Network since 2020, including pilots in four locations in England[5]. Street Games also conducted research for Sport Wales (2021) to understand provision of youth social prescribing across England and Wales. Physical activity is a valued referral route in youth social prescribing, both for the direct health benefits and linked to wider practical and emotional support for wellbeing.

In the Lifestyle Hub, eligibility criteria for the physical activity programme are to be inactive and have one or more LTHC; for the weight management programme participants should have a BMI over 30 (25 for ethnically diverse populations). Historically, data on who was referred was not systematically collected however with the introduction of DCRS, this data gap is slowly being filled. For 2022-23, where data is available, MSK referrals are most common, followed by anxiety, depression and hypertension (See Appendix 3). Two-thirds of referrals come from the 40% most deprived areas (Figure 4).

> **"It's a wide range of people, it couldn't be more varied if we tried" Interviewee, Lifestyle Hub Team**

Interestingly, interviewees mentioned a wide range of client types and did not feel particular conditions or characteristics were prevalent.

Figure 4: Deprivation Quintile of those referred to Lifestyle Hub



4.3 1:1 Assessment

Where exactly 1:1 assessment of patient needs sits can vary significantly in different schemes. Within the Lifestyle Hub, the formal 1:1 assessment, is undertaken by Health Activators, and it is not uncommon in PARS, that assessment is done by a physical activity professional within a leisure setting. Activators then work with participants to develop an exercise programme bespoke to their needs.

[5] Street Games Youth Social Prescribing Network: https://www.streetgames.org/what-we-do/areas-of-work/health-and-wellbeing/youth-social-prescribing/ [Accessed 16th July 2023]

Within the Hub model, however, there can also be assessment of needs undertaken at other points, for example by Health Coaches and Hub Advisors, as well as by Health Activators. Social prescribers also undertake 1:1 assessment and, whilst each role is different, it can be argued that there is a degree of overlap between the aims and methods of Health Coaches, Social Prescribers, and Health Activators.

> **"[Health Coach] conversations are simply coaching, and [they] have 30 mins as oppose to a GPs 10 mins…[they] have the benefit of scratching more than that top level, just the surface…getting a good understanding of that individual and their needs"**
> **Interviewee, Referrer**

All are focused on being patient-centred, seek to understand what matters to the person, and work with them to collaboratively devise a plan of action. Although note that action plans for Health Activators focus on physical activity, whilst others may take a broader view of non-medical health and wellbeing needs.

BOX 2: AMOUNT OF SUPPORT TO PATIENTS BY LINK WORKERS

THIS CAN BE CATEGORISED INTO:

- LIGHT - MORE A ONE OFF OR EVEN SIGNPOSTING
- MEDIUM - SPECIFIC NUMBER OF MEETINGS (E.G. 4-6)
- HOLISTIC - AS MUCH TIME AS PERSON NEEDS

The wider literature also highlights the importance of Link Workers being patient-centred, and understanding what matters to people (University of Westminster, 2017; Healthy London Partnership, 2019).

They go on to underscore the value in Link Workers having more time to spend with patients than is typically available to GPs or other HCPs. This was also raised in our interviews as an important aspect of the Pennine Lancashire Health Coach role, allowing them to get under the skin of what a patient might be facing.

Caution should be exhibited before viewing coaching roles as a catch-all solution to lack of GP capacity though. In their review of physical activity referral in social prescribing, SHU (2022a) highlighted that high referral targets could also be a challenge to Link Workers in providing effective, holistic support.

University of Westminster (2017) highlighted that support offered by Link Workers varies in different schemes, but typically would align with one of 3 levels (see Box 2). This variation clearly has a major influence on the number of patients a link worker is able to support at any given time. A case can clearly be made, however, that for complex cases, holistic, long-term support is more likely to lead to long-term behaviour change.

> **"in our area we're inundated with referrals so we're always busy trying to catch up with ourselves…it's hard getting everybody done"**
> **Interviewee, Lifestyle Hub Team**

This aligns with what was observed in interviews with Up & Active Delivery Teams. The majority of people made reference to heavy caseloads and the constant need to keep on top of new referrals. This could present a risk to patient outcomes, if team members don't have time to provide the additional resource needed for complex cases.

SHU (2022a) went on to discuss a lack of regular training and CPD as a barrier for link workers. This included technical areas, such as safeguarding and data protection, and softer skills such as how to support complex cases, supporting the wider determinants of health, motivational interviewing (MI), and supporting specific LTHCs.

Several articles also highlighted the skills required to be an effective link worker. These naturally included practical skills, such as project, data and workload management; but also highlighted softer skills, like good interpersonal skills, being non-judgemental, being able to support complex needs, and being an active listener (University of Westminster, 2017; NASP, 2022; SHU, 2022a).

Elsewhere, we identified examples where assessment is undertaken in alternative settings. For example, in the Bromley-by-Bow Centre, assessment is undertaken in their community hub and people can be referred to a range of community support and activities which takes place within the same hub (both physical activity and non-physical activity; Bromley-by-Bow Centre, 2019). There are also examples of specialist schemes, such as the award winning Prehab4Cancer scheme, where assessment is completed by a programme officer who supports someone throughout their treatment journey (GM Cancer, 2022).

4.4 Community physical activity referred into

Historically, the model for PARS has been referral by a GP into a leisure setting, typically for gym-based exercise or, in some cases, fitness classes. This is still the basic model of PARS and many schemes still adopt this. For example schemes in West Lancashire develop exercise programmes exclusively consisting of "cardiovascular endurance or resistance-based machines typically found within gyms, such as treadmills, cross-trainers, and fixed weight machines" (Portman et al, 2021, 2023). Rowley et al (2018) looked at 13 PARS in the UK focused on cardiovascular, mental health, and MSK disorders. They found the majority of schemes referred to gym-based exercise, with some using aerobic groups, swimming, or studio classes.

Most common activities referred into are gym and leisure-based classes. But this is broadening to community settings & activities.

There is evidence to suggest, however, that the scope of PARS is expanding to a broader range of referral routes. In a review of schemes in Scotland (NHS, 2018), whilst schemes had previously focused on leisure centre, gym or pool based activities, many now included a range of community-based activities, such as tai-chi, cycling, led-walks, green-gyms, and conservation work. 85% delivery was still in leisure centres, but with a growing set of alternatives (e.g. community centres, parks). Interestingly, 2 schemes referred to sports clubs, which could be a potentially untapped avenue for PARS, if the right conditions can be met for potentially vulnerable audiences.

Another scheme in North-West England (Birtwistle, 2019) offered subsidised sessions in leisure centres, including activities in sports halls, as well as a range of community settings (e.g. scout huts). All schemes appear to have some level of subsidy (e.g., Hanson, 2019; Downey et al, 2021), however, 54% schemes in Scotland were free of charge (NHS, 2018), as was the scheme in West Lancashire (Portman et al, 2021).

Oliver *et al* (2021) affirmed the importance of a wider range of settings, as leisure centres aren't inclusive for everyone (practically OR psychologically). Effective schemes included community settings and creative options like delivery in supported living facilities. Hanson *et al* (2021) also emphasised the risk of *scheme dependency* where participants are not encouraged to engage in activity beyond the core facility.

Within the Lifestyle Hub, as has been earlier noted, referrals are mainly passed through to Up & Active, or the equivalent 12-week physical activity or weight management programme for that locality. These are exclusively leisure-based and include gym and other leisure centre-based options. What is actually offered in each locality, however, is set at a local level and varies from place to place.

Various Hub team members spoke confidently about the range of options on offer within Up & Active in their area, noting it wasn't just the gym and classes, but included other options within the leisure setting and, in some cases, some community-based options. Some spoke about sessions in both peak and off-peak slots to accommodate different user groups (although getting space in peak slots was challenging so some localities offered off-peak only). In Burnley and Rossendale, community-based sessions are also run which are particularly popular with certain groups (e.g., older people who don't want to come into town; ladies who prefer a female only environment). Some areas also refer into community activities due to having fewer leisure facilities in their area. Activators also mentioned that, on occasion, they do refer out to free community activities, instead of Up & Active, but this did not appear to be typical.

"that's what we say [to GPs] always refer in because there's something for everybody"
Interviewee, Lifestyle Hub Team

"The gym isn't for everyone, especially the older ones. It would be good to have alternatives like gardening, walking groups, and dancing"
Interviewee, Referrer

Referrers, however, noted that they would like to see a wider range of activities available, particularly in the community, as Up & Active isn't suitable for everyone. In part this was down to individual preferences on the activities people enjoyed. In other cases, it was down to the difficulty level. Referrers highlighted the importance of exercise at a suitable pace for patients, not only from a medical point of view, but to build confidence and support perseverance. One referrer noted that, if they weren't confident Up & Active was right for a patient, they'd probably refer to Social Prescribing.

Where physical activity is referred through social prescribing, there tends to be more connections to a range of community deliverers and referral to a wider range of physical activity opportunities. Healthy London Partnerships (2019) highlighted the presence of high-quality community assets and opportunities as central. Having up-to-date information about what activities are available in the community was a key enabler for effective link workers and something they see as a key part of their role. This can include walking groups, running networks, gardening, general sport and leisure-based activities, and activities in outdoor green spaces. Many activities are outdoors and many are free. (SHU, 2022a). In Pennine Lancashire, one social prescriber highlighted feeling fortunate about the wide range of local options available in their area.

Patients needed to feel confident taking part in the sessions, they can be quite self-conscious...just being overstimulated and not being able to manage...it's not to do with U&A as such but more their self-consciousness"
Interviewee, Referrer

It is important to note, however, that physical activity is only one of many options available to social prescribers. As well as practical options such as financial support, examples include volunteering, arts activities, group learning, gardening, befriending, cookery, and healthy eating advice.[6] The extent to which physical activity is prescribed may therefore depend on patient needs and also Link Worker values and belief in physical activity as a tool in supporting wider health outcomes.

[6] Kings Fund: What is social prescribing https://www.kingsfund.org.uk/publications/social-prescribing

4.5 Alternative Models of Promoting Physical Activity for Health

4.5.1 Embedded in recovery pathways

Outside the above, a number of specialist schemes were identified which are embedded in treatment pathways for specific conditions, such as cancer, stroke, or cardiac rehabilitation. These are generally in secondary care and align to wider treatment pathways. They can be part of a broad healthy living approach, and are based on evidence that lifestyle changes can improve patient outcomes. For example, the Prehab4Cancer programme, a programme of physical activity ahead of cancer treatment, reduced hospital stays and increased 1-year survival rates (GM Cancer, 2022). There are also schemes such as Macmillan Social Prescribing for cancer patients (Macmillan, 2019), where half of referrals come from teams undertaking outreach in cancer wards and clinics, a third direct from HCPs and the remainder through self-referral. Onward referrals are to a wide range of services, with physical activity second only to financial support.

BOX 3: SCOTTISH NATURAL HERITAGE: GREEN HEALTH PARTNERSHIPS (GHP)

FOUR GHP PILOT AREAS BRING TOGETHER A RANGE OF PARTNERS ACROSS SECTORS. THEY ENCOURAGE USE OF THE NATURAL ENVIRONMENT AND ESTABLISH PATHWAYS WHERE GREEN HEALTH INTERVENTIONS CAN CONTRIBUTE TO HEALTH IMPROVEMENT. A NUMBER OF NEW REFERRAL PATHWAYS HAVE BEEN ESTABLISHED AND EXISTING ONES EXPANDED. SOME PATHWAYS WERE ALIGNED TO EXISTING SOCIAL PRESCRIBING OR PARS SERVICES AND, IN ONE AREA, AN OPTION FOR WALKING/ OUTDOOR ACTIVITY WAS ADDED DIRECTLY TO GP REFERRAL FORMS.

These types of pathways are also in operation in Pennine Lancashire, with Cardiac, Stroke and Pulmonary Rehab all running their own entry-level exercise programmes. This ensures vulnerable patients get the level of medical, physical, and emotional support required in early recovery. Up & Active can be a follow-on option for some patients however, it is not seen by referrers as a suitable option for patients with high support needs.

4.5.2 Community models

Beyond the more conventional model of referral described so far, it is worth noting that there are a number of other models emerging. These are often still through promotion by healthcare professionals, or in healthcare settings, commonly building on the concept of Brief Advice. For example in work by parkrun (Fleming *et al*, 2019; Quirk & Haake, 2019), through development of Active Practices[7], or in specific activity schemes, such as Dance to Health for older people (AESOP, 2020), or the Brightstar Counterpunch Programme, which combines boxing training with talking therapy to support young people and adults in Shropshire, Telford and Wrekin (MIND, 2022).

A further example in Scotland is the Natural Health Service Programme (McHale et al, 2020; See Box 3). Physical activity is also a key component of weight management programmes, either individual, as in the BeeWell Specialist Weight Management Service (SWMS) in Wigan[8], or family support, such as Be Your Best in Surrey.[9] Similar weight management schemes are run across Pennine Lancashire, as noted earlier, with Eat Well, Keep Well embedded in the Lifestyle Hub.

[7] Physical Activity Hub: Active Practice Charter (rcgp.org.uk)

[8] BeWell Specialist Weight Management Service https://www.wigan.gov.uk/BeWell/Active-health/Weight-management/Specialist-Weight-Management-Service.aspx

[9] Be Your Best Family Weight Management Support https://www.bybsurrey.org/about-be-your-best

5. What makes an Effective Referral Service

5.1 Evaluation of Physical Activity Referral Services

As noted, the evidence base for the effectiveness of PARS is patchy, due to a combination of factors:

- inconsistent data collection and evaluation methods which limit comparability;
- Inconsistent definitions of terms such as uptake and completion;
- studies of homogenous groups which do not consider either the characteristics of the individuals taking part or variations in how schemes are delivered;
- lack of consistent measurement (or no measurement) of broader wellbeing measures.

In 2014, NICE guidelines highlighted that, despite the strong evidence base for the benefits of physical activity for health, the evidence for long-term behaviour change was weak and did not warrant the cost of physical activity referral schemes (PARS) to the public purse. They instead recommended that healthcare professionals offer brief advice[10] on physical activity to patients, as this was shown to be almost as effective as PARS in changing physical activity behaviour, at a fraction of the cost (NICE, 2014).

> Policy makers should NOT commission PARS for the sole purpose of getting people to be more active. The only exception is for schemes that collect a minimum data set and make it available for analysis, monitoring & research to inform future practice.
> **NICE Guidelines, 2014**

Since 2014, a plethora of critical analysis has suggested that past studies were too general, focusing on broad, general population samples, rather than people with specific health conditions or characteristics (Portman *et al*, 2021; Hanson *et al*, 2019). Schemes studied also fail to incorporate suitable behaviour change techniques or measure long-term behaviour change (Downey *et al* , 2021; Buckley *et al*, 2018). This suggested that further research was needed to understand what works, for who, in what context.

Despite this, there remains considerable variability in what is collected and when, with many schemes only undertaking short-term measures. In Scotland, for example, an audit of PARS showed that not all schemes even collected physical activity data at baseline and completion, often due to staff capacity and skills (NHS, 2018). Only 23% schemes collected follow-up data at 12 months.

Portman *et al* (2021) noted an increasing amount of qualitative data on what influences uptake and completion but a lack of evidence on how to improve these. Morgan *et al* (2020) highlighted that uptake is often defined as attending the first appointment, meaning that numbers who actually engage in any physical activity are unknown. They also flagged a lack of research on uptake by socioeconomic status.

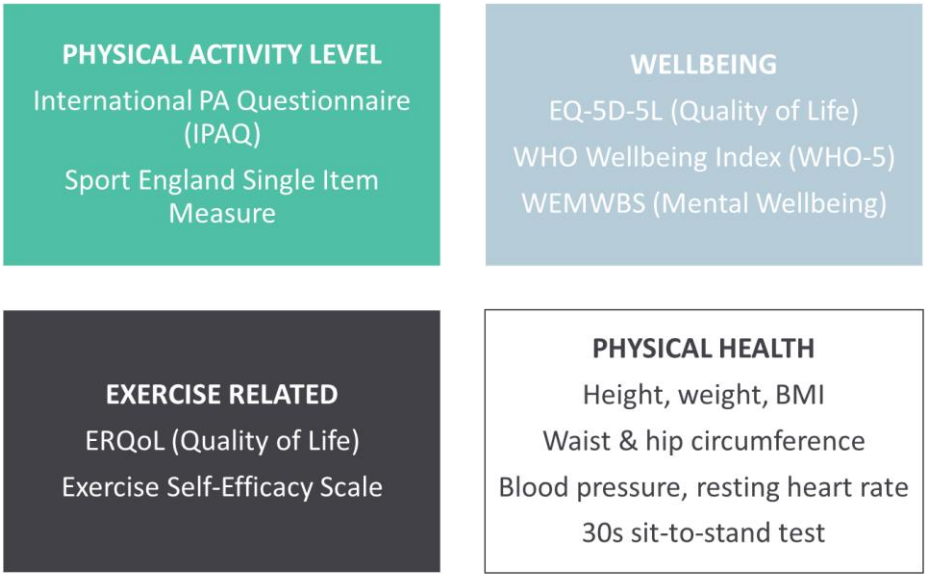
In terms of who is taking part, many schemes are failing to collect even basic demographic data. In Scotland, for example, it was common to collect data on gender and age but not ethnicity, disability or socio-economic status (NHS, 2018). Oliver *et al* (2021) similarly found that, in a review of 14 PARS in England, only 17.5% participants had a recorded disability status.

[10] Brief Advice on Physical Activity means verbal advice, discussion, negotiation or encouragement from a health and social care professional, with or without written or other support or follow-up. It can vary from basic advice to a more extended, individually focused discussion (NICE Guidelines, 2014).

In the Lifestyle Hub, basic demographic is routinely collected at the start of the programme, including address, age, gender and contact information. Data is also collected on existing medical conditions.

In terms of broader health and wellbeing measures, collected across different PARS schemes, these range hugely. The most commonly collected, based on analysis of the NRD (Steele *et al*, 2021), are highlighted in Figure 5.

Figure 5: Most common health and wellbeing measures collected by PARS identified in the NRD



In the Lifestyle Hub, baseline physical activity level (SPAQ), as well as WEMWBS[11] and the General Health Questionnaire (GHQ; a clinical measure of mental health)[12] are administered at week 1 and week 12, although data collection rates are currently lower than might be hoped[13]. Other health measures may be recorded in specific location but this is not consistent across localities.

Oliver *et al* (2021) discussed how heterogeneity between schemes and a lack of consistent measurement make it difficult to make best practice recommendations for scheme commissioners and deliverers. With this in mind, the Lifestyle Hub provides an excellent platform to add to the evidence for PARS.

To attempt to address some of the above concerns, Hanson *et al* (2019, 2020) developed a classification taxonomy for PARS, which considers both scheme and participants characteristics (see Figure 6). Since the Lifestyle Hub brings together multiple schemes under one umbrella, this could be a useful tool for design and evaluation.

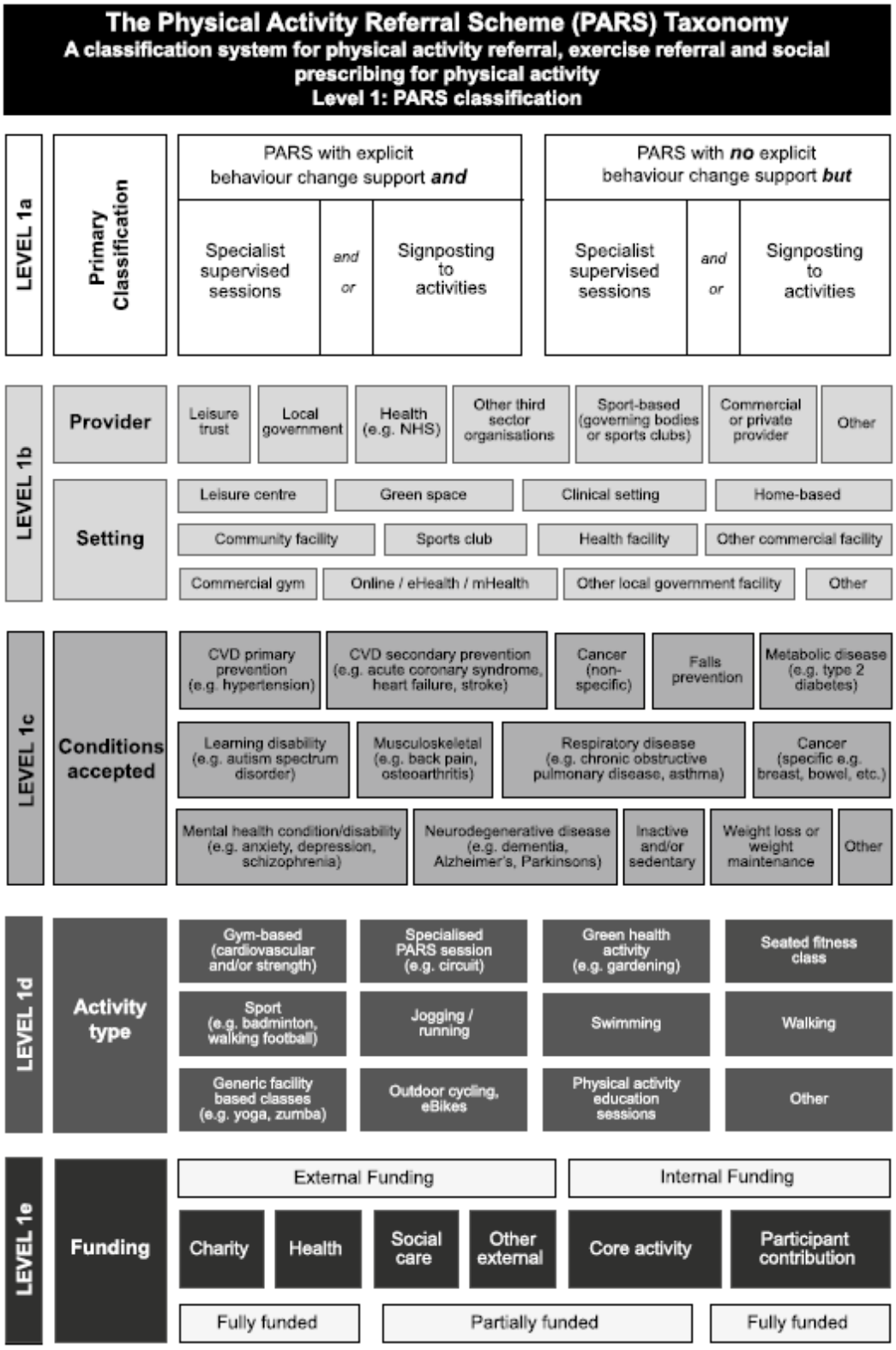
5.2 Recent data on effectiveness of Physical Activity Referral Services

5.2.1 Uptake and adherence

In light of what has been described about inconsistent definitions and measurement, we cannot make between scheme, or between study comparisons of uptake and completion rates. We can note, however, that even where completion rates are high, there is limited evidence of long-term behaviour change at 12-months or beyond (sometimes through lack of measurement).

[11] The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) [Accessed 21st July 2023]
[12] The General Health Questionnaire (GHQ) [Accessed 21st July 2023]
[13] For recorded Up & Active completers, GHQ is available for 70% and WEMWBS for 85%.

Figure 6: Taxonomy of PARS to support improved scheme design and evaluation



We can also comment on characteristics within schemes which appear to influence better uptake and adherence and these are summarised in Table 3.

Notably, those referred for mental health reasons do not see good uptake and adherence and this feels like a missed opportunity for PARS, particularly given evidence for the clinical effectiveness of PA for anxiety and depression (Glowacki *et al* 2019, Schuh *et al*, 2019). Whilst we might speculate at the reasons for this, details were conspicuously absent in our review.

Table 3: Patient characteristics influencing increased uptake and adherence in PARS

UPTAKE	ADHERENCE/COMPLETION
Female	Male
Older	Older
From less deprived locality	From less deprived locality
Physical health referral	Physical health referral (esp. Cardiovascular)
Higher initial physical activity level	

Glowacki *et al* (2017, 2019) discuss barriers to exercise adherence for those with depression more broadly and identify low mood, lack of energy, and fatigue as key disablers. Lack of motivation was also highlighted, whilst social influences, including social support and encouragement from others were major facilitators. Further exploration of these factors, and how a patient-centred approach might support these patients, could be of interest for the Hub, given they had >900 referrals of patients for anxiety or depression in 2022-23.

For the Lifestyle Hub, we know from DCRS that 3654 people were referred in Pennine Lancashire between May 2022 and May 2023. Of those, 63% were put forward by a Health Activator as eligible to proceed onto Up & Active or equivalent. Exact number of physical activity sessions attended is not monitored, as participants may go to a range of sessions, including outside the leisure setting, e.g. walking groups. Continued participation in the scheme can be tracked through attendance at 6-week and 12-week follow-ups; however, 6-week appointments are not always completed. This is something the Hub team are actively seeking to improve.

Nonetheless, the data suggests that around 55% of those who start go on to complete the 12-week programme (participating on at least 10/12 weeks). A further 8% partially complete (8/12 weeks).

5.2.2 Health Outcomes

Methodological challenges aside, numerous recent studies have shown improvements to a variety of health outcomes over and above increased physical activity levels following PARS completion (Table 4).

Table 4: Health Improvements recorded following physical activity referral

PHYSICAL HEALTH	MENTAL HEALTH
Functional Fitness	Happiness & positive outlook
BMI	Self-confidence
Blood Pressure	PA Self-efficacy
Healthy Behaviours	Decreased feelings of anxiety and depression

Several studies show improvements in physical health outcomes, especially with cardiovascular patients, including increased functional fitness, and lower blood pressure. Of particular interest though is that most studies report improvements in mental health (including two studies specifically with mental health patients; Albert *et al*, 2020; Wade *et al*, 2019), in spite of challenges discussed above in achieving strong uptake and adherence amongst this audience.

Examples of mental health and wellbeing improvements included increased self-esteem, happiness, and positive thinking, increased confidence and greater self-efficacy being physically active. Hanson *et al* (2021) observed that wellbeing improvements were greater in women.

Albert *et al* (2020) identified physical and mental health improvement across almost all audiences in a 27 study international meta-analysis (half of studies UK-based), although note a lack of health gains for patients referred to stop smoking or for MSK issues.

Importantly, Rowley *et al* (2018, 2020) reported greater adherence and improvements to health outcomes for longer schemes (>20 weeks). Wade *et al* (2019) found "a general lack of meaningful change over time in participants undergoing ERSs lasting between six weeks to three months in length."

Greatest health improvements observed for participants in schemes >20 weeks.

Hanson *et al* (2019) also found that PARS worked best for those with existing enablers (e.g. previous good experience of PA, enjoyment, social support); it worked in the short-term for some who were actively motivated to improve health even in the absence of wider enablers, although they were less likely to continue post-scheme, perhaps feeling their aim had been achieved or seeing physical activity as more of a chore.

Where physical activity was referred through social prescribing, significant physical and mental health benefits were also observed. An evidence review (NASP, 2022) found indications of improved:

- Physical health: BMI, blood pressure, healthy behaviours
- Mental health: Lower anxiety and depression, improved wellbeing and quality of life
- Empowerment: Skill, beliefs & confidence to manage health

Evaluation of the Tandridge Wellbeing Prescription Service (2021) also found modest increases in activity levels for those referred to physical activity, but major improvements in mental wellbeing.

In areas of deprivation, health improvements were more likely when patients saw a link worker a minimum of three times (NASP, 2022). This speaks to the importance of social support and a person-centred approach for those who are most vulnerable. It shows the potential for health coaches in the Lifestyle Hub as well as improved links with social prescribing.

In the Lifestyle Hub, where data is available, GHQ scores are seen to improve by around 32% and WEMWBS improve by around 22% for those completing U&A.

5.3 Enablers and disablers of an effective referral service for patient engagement

A wide range of enablers and disablers from a patient point of view were discussed in the literature and a summary of these is presented in Figure 7. (Albert *et al*, 2020; Birtwistle *et* al, 2018, Hanson *et al* 2019a; Hanson *et al* , 2021, NASP, 2022; Oliver *et al*¸ 2021; SHU, 2022a) Whilst not an exact science, we have set these out as a spectrum from the more psychological to the more practical.

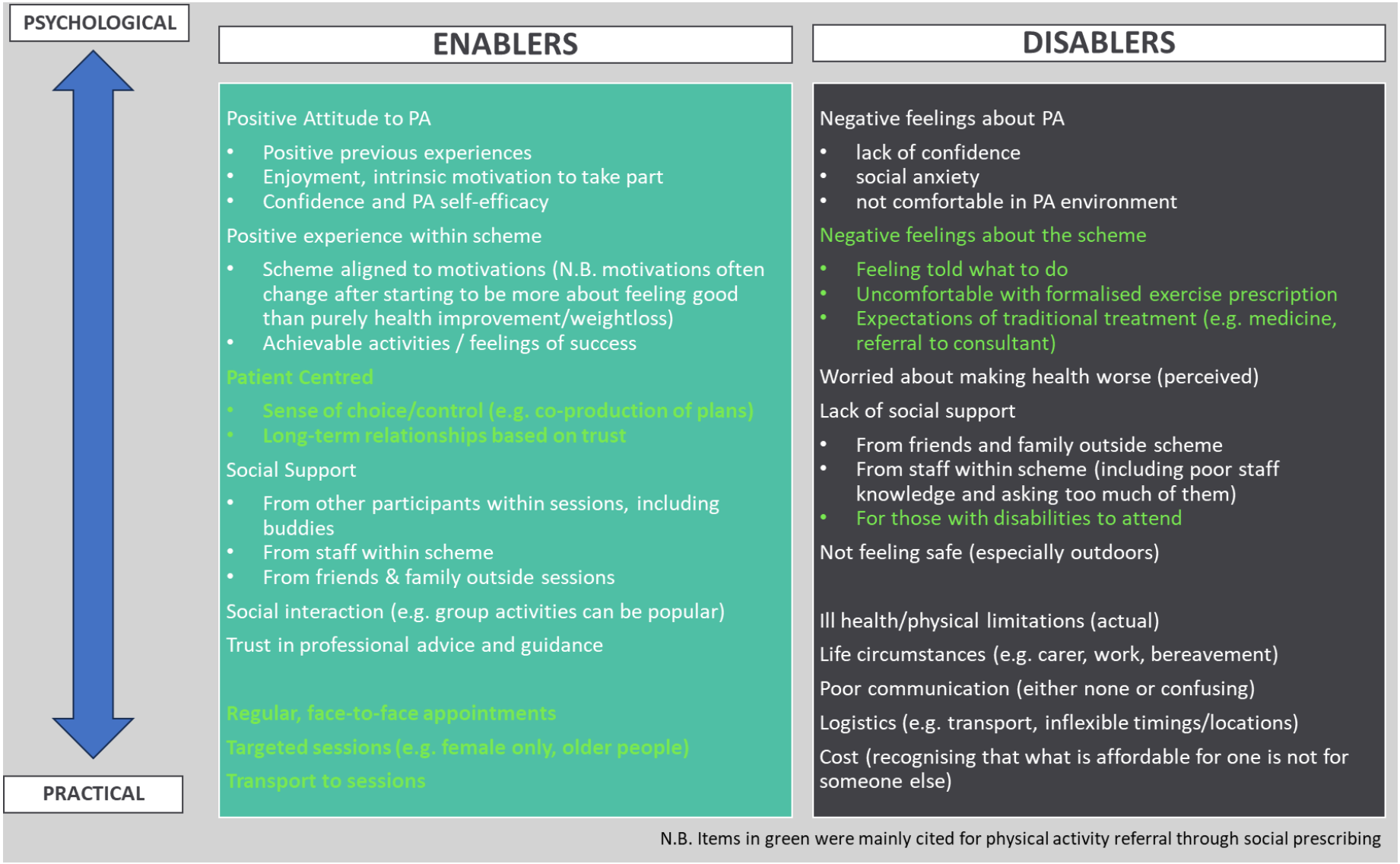
It is interesting to note the extent to which enablers tend to be more psychological, whereas disablers are more of a combination. Also worthy of comment is that psychological disablers are commonly the absence of enablers (e.g. social support); however, the same is not always true in reverse.

This underscores the fact that, whilst the removal of practical barriers remains important, in particular for those experiencing the greatest levels of disadvantage, their removal alone is rarely enough to promote behaviour change. This is supported by the fact that practical enablers were referenced more for physical activity referral through social prescribing than PARS and, as has been mentioned earlier, social prescribers are often working with particularly vulnerable patients.

Whilst patient-centredness was not always explicitly identified as an enabler in studies of PARs, it is generally implicit in the narrative. Hanson (2019) emphasised that a universal referral model to a generic programme is potentially setting up PARS to fail, with measures of success generally focused on uptake and adherence as opposed to long-term behaviour change and, importantly, what works for who. In an analysis of inequalities and inclusion across 14 schemes, Oliver *et al* (2021) found that successful schemes were more targeted in recruiting people from priority groups and localities. They also discussed tailoring support to participants at every stage, including in following up non-attenders.

Being patient-centred was also frequently mentioned in interviews as a key element of the Lifestyle Hub, including the range of routes to be referred into the service, the flexible and accommodating approach of team members, and the expertise of Activators in supporting different conditions.

Figure 7: Enablers & disablers of success for patients referred for exercise



N.B. Items in green were mainly cited for physical activity referral through social prescribing

Whilst dealing with a wide range of complex needs can be challenging at times, Activators appeared committed to understanding participant needs and giving them the best possible support.

Social Support in a variety of forms is also cited as a key enabler across virtually all studies. In one interesting example, the use of volunteer peer supporters in a formalised capacity was explored. This was found to enhance participant experience, but the extra help to meet everyone's individual needs was also was appreciated by PARS delivery officers (Portman *et al*, 2021).

> "The existing model of universal referral to a common programme is potentially setting such schemes up to fail… Regardless of suitability, providers may feel obliged to 'shoehorn' referrals into schemes if the continuation of funding is reliant on achievement of such KPIs. This type of approach fails to consider the complex health and social circumstances of ERS participants, leading to an inadequate focus on what works and for whom."
>
> **Hanson *et al*, 2019**

On the disabler side, cost was also mentioned frequently in interviews, with some differing perspectives emerging. The Lifestyle Hub Team largely felt that Up & Active offered good value for money (although there seemed to be some differences in pricing models and what was included in different localities). Referrers, however, raised concerns about affordability for clients on low incomes, emphasising that what was affordable for one person was not for someone else. Having pay as you go options and free community alternatives was therefore key.

BOX 4: KATHLEEN - BURNLEY

KATHLEEN WAS REFERRED TO UP & ACTIVE BY HER GP AFTER BEING DIAGNOSED AS PRE-DIABETIC. SHE ALSO HAD HIGH BP AND ARTHRITIS OF THE KNEES.

DURING THE 12-WEEK PROGRAMME KATHLEEN LOST 5KG BUT MORE IMPORTANTLY SHE FELT MORE ENERGETIC AND HER OVERALL HEALTH HAD IMPROVED.

SHE ENJOYED THE CLASSES AND MADE NEW FRIENDS AND SHE NOW FEELS REALLY MOTIVATED TO KEEP EXERCISING.

"I would most definitely recommend the Programme to others as the Instructors give you the confidence to exercise at a level you are comfortable with without feeling self-conscious."

BOX 5: STEPHEN - PENDLE

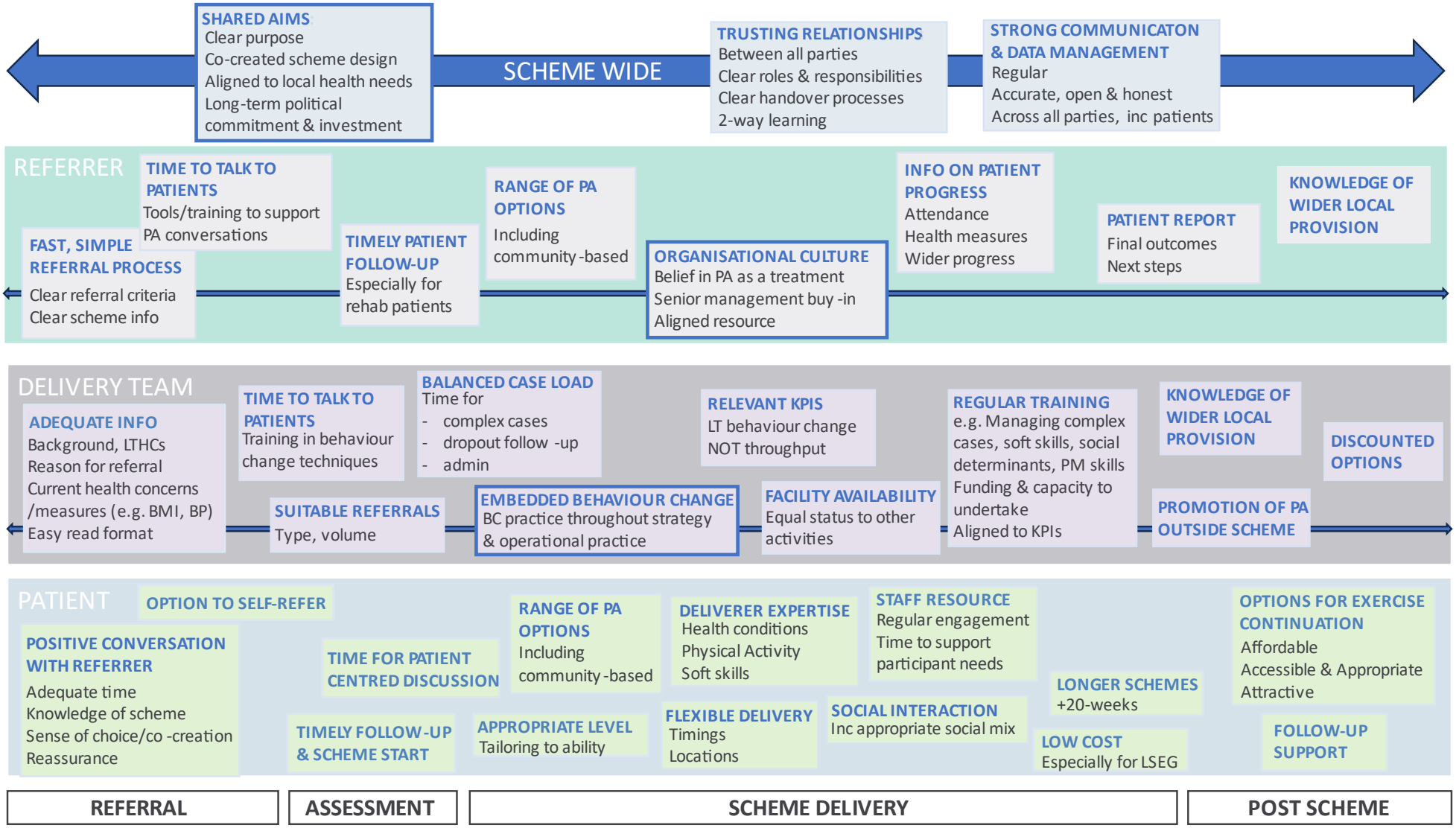
STEPHEN TOOK PART IN THE CARDIAC REHAB PROGRAMME FOLLOWING A HEART ATTACK IN APRIL 2022.

STEPHEN FOUND TAKING PART WITH OTHER PEOPLE IN THE 'SAME BOAT' HUGELY REASSURING AND COULDN'T BELIEVE HOW MUCH HIS HEALTH AND FITNESS IMPROVED OVER THE 12-WEEK PROGRAMME. HE IS GRATEFUL FOR THE HARD WORK AND PROFESSIONALISM OF HIS MENTOR, EMMA.

"I could never have anticipated the improvement in my physical health over a twelve week period as has been the case. I know that this sentiment is echoed by all of my class mates – many of whom have become friends as we continue to attend local gyms.."

Interestingly, some of the major enablers and disablers to patient engagement identified in the literature did not come up in interviews, for example, feelings towards being active, and social support. This is likely a feature of the fact we have not to date engaged directly with patients about their experiences, rather than that these factors hold no importance. In Up & Active case studies, provided by locality teams, participants often highlight areas such as social support as important. Examples can be found in Box 4 and 5 and more details in Appendix 4.

Figure 8: Practical enablers of an effective physical activity referral service



5.4 Enablers and disablers of an effective referral service process

Whilst direct enablers for patients are key to an effective service, there are many factors in how a service runs which sit behind the scenes and contribute to creating optimum conditions for change. We have identified the most common ones from the literature and interviews and these are summarised in Figure 8. From a patient perspective, this includes practical steps which could support the required conditions for change described in the previous section.

5.4.1 Broad conditions for change

At an overarching level there are a number of things that are fundamental to a successful scheme. The first is a sense of shared purpose, which is bought into by all stakeholders and has strong political support. SHU (2022) identified that programmes should be designed collaboratively between all partners with strong emphasis on behaviour change. Those who have been involved in design are found to have a strong commitment to making it work. Oliver *et al* (2021) found that in successful schemes, there wasn't heavy handed oversight, and this enabled shared learning and local ownership.

In line with this, trusted relationships and partnerships were highlighted as essential in almost every paper. To support this there needed to be clear consensus on roles and responsibilities, including clear understanding of what happens in other parts of the patient journey, and clear handover protocols with built-in flexibility to accommodate patient needs. The relationship between the referrer and the PARS practitioner was particularly emphasised (SHU, 2022) with appropriate training in place for all parties.

Regular, open & accurate communications between all parties are natural precursors to trusted relationships. A strong system of data management can help to support this, as it helps practitioners to effectively gather and share patient progress information. For example, team members can see where participants are due to be contacted, where they have missed appointments, or where they have specific support needs.

In the Lifestyle Hub, many of the relationships with referrers are relatively new and building these relationships is a priority for the core team. To date, this has focused at a more strategic level, however, there are aspirations for further work with individual referrers at both a buy-in and process level.

Additionally, relationships with wider community providers are key; not only in terms of understanding what is available, but also to build confidence for all sides that what is delivered can meet the needs of vulnerable patients.

5.4.2 Enablers and disablers for referrers

Culture is also essential within the referral environment. In the context of social prescribing, a positive physical activity culture in the workplace where the benefits are widely accepted and promoted was a major enabler for both Link Workers and referrers (NASP, 2022). Increasing awareness of the benefits and of available local physical activity provision would be beneficial, as this knowledge can often be lacking (SHU, 2022b). For example, the Consensus Statement on the risk of physical activity for people with LTHCs states that in the majority of cases, the benefits outweigh the risks (Reid *et al,* 2021), however, this knowledge is still not yet widely shared and accepted amongst HCPs.

The referrers we spoke to within the Lifestyle Hub were all generally bought into the idea of physical activity as a positive treatment option; however, they acknowledged that this may not be the case for all colleagues. There is an opportunity here to build on the advocacy of those who are already behind the scheme and bring more ambassadors on board.

A study by Buckley *et al* (2020) looks at barriers and facilitators to referring exercise for GPs in Liverpool. Although 80% GPs in the study made at least 1 referral every month, only 20% always asked patients about physical activity in consultations. The biggest barrier was lack of time (61%), and in qualitative interviews some GPs suggested other HCPs might be better placed to have conversations about physical activity as they had more time with patients. 39% also noted a lack of motivation to discuss the topic.

68% GPs in one study wanted a simple, electronic referral process into physical activity

A 2009 study found that, in Australia, 98% of GPs identified "discussing ways to increase PA" with patients as part of their role, with 53% discussing PA with >10 patients per week (Buffart *et al*, 2009). In England, however, in 2017 only 20% GPs were broadly or very familiar with the national physical activity guidelines and 55% had undertaken no training with respect to encouraging patients to be more active (Chatterjee *et al*, 2017). Significant work has been ongoing to rectify this situation in the intervening time (e.g., Sport England (2022) have been leading on Moving Healthcare Professionals); however, it is important to acknowledge that we were starting from a very low baseline.

In Liverpool, the biggest GP enablers were a simple, electronic referral process (68%), clear information about what's involved (46%), and clear information on eligibility (45%). A third also mentioned they'd prefer options to refer outside of leisure facilities and 27% wanted more feedback on patient outcomes.

A review of physical activity referral in social prescribing (SHU, 2022a) also highlighted lack of time, lack of knowledge about the benefits of physical activity, lack of knowledge about where to refer, and lack of confidence as major barriers for referrers. They noted beliefs such as social prescribing being short-term, about the competence of community physical activity deliverers to support vulnerable patients, and a lack of support for physical activity as a solution within their practice.

On the enabling side, referrers wanted tools and resources to support conversations with patients, including information about local opportunities. They were open to further training for staff at their practice and found it helpful having a third party expert or 'physical activity champion' who they could pass patients on to for further discussions.

5.4.3 Enabler and disablers for delivery teams

Culture & Capacity

Culture was a major enabler within the delivery environment too, with much discussion on ensuring a patient centred approach is at the heart of schemes. Downey *et al* (2021) identified the need to have behaviour change practice embedded in operational structures, for example, written into operational manuals, training, CPD, mentoring, and performance management They observed that, where services focus on throughput as their key measures, practitioner are less likely to employ behaviour change tactics as they prioritise meeting targets.

Within the Lifestyle Hub, the core team have emphasised the focus on a person-centred approach and long-term behaviour change and that no one has a throughput target.

"There was consensus among policy-makers, practitioners and patients that the ERS should have a person-centred approach, with a focus on improving whole person wellbeing…yet this emphasis on lifestyle PA behaviour change was not reflected in the current ERS culture, built around fitness centres and fixed-term exercise prescriptions."

Buckley *et al*, 2018

Nonetheless, there is a sense that this aspiration is not felt equally by all staff as yet.

Linked to the earlier point, that delivery teams can feel under pressure to keep on top of referrals (Section 4.3), there is a sense that often they would like to be more patient-centred, but capacity doesn't always allow. It was also noted by some that they might not feel comfortable to refer outside of Up & Active as it wouldn't 'count towards targets'. This may be a hangover from the previous scheme administration, but suggests work to reassure and align teams is still needed; particularly if the scope of the Lifestyle Hub is to be widened.

> "The system will be much better once it falls into place…its quite challenging at the moment for the team…it's a new system for them"
> **Interviewee, Lifestyle Hub Team**

> "[the new system] is a real stress for the team at the moment, as everyone seems to be spending more time on the admin than on any other job"
> **Interviewee, Lifestyle Hub Team**

Capacity management also emerged as a challenge for PARS teams in the literature. This was particularly critical to ensuring that practitioners could provide the time needed to support complex cases, whilst also having time for other aspects of their role, such as following up on non-attenders, admin, and CPD. Buckley *et al* (2018) observed tension between what is ideal and what is practical in the available resource.

Practicalities

At a practical level, delivery teams need adequate information from referrers in an appropriate format with enough information to prepare for their first meeting with those being referred. This makes it easier for them to ask the right questions in 1:1 assessment and put patients at ease from the start. In the Lifestyle Hub, delivery teams felt this information wasn't always provided and there was some confusion about what information was meant to be provided by who at what stage in the referral process. Delivery teams also noted that the structure of DCRS didn't always allow for capturing everything they felt was needed (e.g. other health behaviours), meaning these had to be added as general notes, where they are difficult to find.

Ensuring the suitability of referrals is another area that can help with demand management. Voluntary sector organisations active in the London social prescribing space report high levels of inappropriate referrals (Healthy London Partnerships, 2019). Similarly, Lifestyle Hub team members (both Advisors and Activators) mentioned a lot of unsuitable referrals, including many who have been referred after GPs told them it is a 'cheap gym membership' (this was also observed by Buckley *et al*, 2018).

Prioritising support and training for referrers is a key way to tackle this and may include more specific referral criteria. For the Hub, there is also appetite from Hub Advisors to be empowered to take on more of the early triage stage. Where referrals come through by phone, Advisors do try to pass on only appropriate referrals, however, when referrals are received digitally this is more difficult.

Another practical challenge to navigate can be facility availability for PARS activities. Oliver *et al* (2021) discussed facility constraints, as there is huge demand on existing facilities, including schools and community venues. This often stems from competition with other community activities, as well as other physical activity offers.

This was also raised as an issue by Up & Active delivery teams and can it can feel like physical activity referral sessions are seen as lower priority and therefore pushed towards off-peak times. This obviously goes against the need to be patient-centred and flexible, and links back to culture and the need for shared aims and embedded behaviour change practice.

Training & CPD

The literature identified high quality workforce learning and development as a major challenge across PARS schemes. In Scotland, most schemes did offer some CPD for PARS practitioners but there was considerable variability in what was on offer (NHS, 2018). SHU (2022) suggested that CPD, personal reflection and an annual review should be embedded into practice for all professionals in the PARS process. NASP (2022) also advocated for varied learning methods, including shadowing, peer support and 1:1 supervision.

Soft skills were also important, and Buckley *et al* (2018) observed that some practitioners, including personal trainers, did not have the self-awareness, self-compassion or motives to effectively use behaviour change techniques.

The knowledge and expertise of team members within the Lifestyle Hub was commended with delivery staff confident in supporting complex cases. They referenced having undertaken qualifications for working with specific patients groups (e.g. stroke) and undertaking regular CPD. Activators highlighted the importance of having the right expertise to reassure patients. This is already a relative strength for the Lifestyle Hub, although some team members noted that more training is always welcome to keep skills up to date. A minimum skills and qualifications framework is currently in development which will enhance consistency of offer across localities.

> "[our expertise] puts them [clients] at ease and they trust us, they believe in what we're saying"
> **Interviewee, Lifestyle Hub Team**

Aligning with community provision

We have already discussed the importance of having a variety of physical activity and links with the community. It provides patient choice, ensures achievable opportunities for different patient needs, and can prevent scheme dependency at the end of schemes. Healthy London Partnership (2019) spoke about the importance of a thriving community sector to support referrals from social prescribing, including those into physical activity.

From our interviews with Lifestyle Hub team members, the knowledge of local community provision appeared variable across teams, with some seeing it more as a priority than others.

Hub Advisors articulated frustration in this area, explaining that they have good knowledge of wider provision in Blackburn with Darwen (where they are geographically based and where the Hub approach has been longer established); but limited knowledge of other localities. They talked about a number of scenarios where patients called up and could benefit from this type of information (e.g. unsuitable referrals; not comfortable with Up & Active; previously undertaken Up & Active and now looking for alternatives).

Up & Active delivery teams expressed that, whilst they rarely refer outside of Up & Active at present, they do try to signpost people after the scheme, but don't necessarily know everything that is available.

In line with the Hub's aspirations to become a true 'one-stop shop' for all physical activity referral across Pennine Lancashire, it will be key to grow this knowledge and also work with community partners so they can meet the needs of complex patients and the wider scheme processes. As the scheme grows, embedding this local knowledge could be invaluable for long-term behaviour change.

6. Strengths & Unique Characteristics of the Lifestyle Hub

The Lifestyle Hub has brought together PARS for 6 localities across Pennine Lancashire under a single referral pathway. The service has undergone significant redesign over the last 12 months, and significant progress has been made. Some key strengths are emerging around the new Hub Model, however, challenges naturally remain. Here we bring together the key strengths and opportunities of the Hub.

6.1 USPs

The Lifestyle Hub brings many benefits, however, beyond that, there are number of things about it that appear unique to Pennine Lancashire.

6.1.1 Simplicity of referral processes

As we saw earlier, there are many barriers to referrals into physical activity by health professionals, however, the most common appear to be practical, with referrers calling for fast and simple processes with clear criteria. The manner in which the Hub brings together all Pennine Lancashire referrals into a single, online form, integrated into EMIS, a system that healthcare providers are familiar with and use everyday, is game changing for many.

> " I know how difficult it is [for referrers] so for them to have one collective place to go into is definitely, moving forward, something that has to happen."
> **Interviewee, Lifestyle Hub Team**

Both referrers and Hub team commented on the simplicity of the EMIS referrals. The process already has the Hub being described as a “One-Stop Shop” for physical activity referral, and this only has the potential to grow, as the system matures.

> "Within EMIS we can literally generate a form within a second which is self-populated…we just have to take a couple of things…it’s minutes of a job."
> **Interviewee, Referrer**

The addition of self-referral is also highly regarded, being seen as a way to remove a barrier to entry for those who may not feel comfortable visiting their GP, or who may see their own health issue as too trivial to bother a doctor when the NHS is under considerable strain.

6.1.2 Central data collection

The power of the DCRS system as a central data repository for the region is increasingly recognised. Most of those interviewed were aware of the need to make the case for continued funding beyond 2025 and saw DCRS as a key tool in achieving that. The ability to track and monitor patient outcomes at scale was valued and understood and the central team realise that this data could have huge implications, not just for the future of PARS in Pennine Lancashire, but for the future of PARS everywhere.

> “We have to have our evidence that its working, and if we're not all doing it [inputting data to DCRS], we're not all on board and following the same process, it’s not going to happen is it."
> **Interviewee, Lifestyle Hub Team**

6.1.3 The opportunities

The Hub is already proving itself as a fantastic asset for the area, however, what is particularly compelling is the potential to develop a truly game changing, future-proofed offer. Prevention is a key

target for the NHS and other health and social care services, with non-medical interventions to improve health and wellbeing a core part of the strategy.

At present, the landscape for healthy lifestyle interventions is fragmented and complex for both referrers and patients, and the offer is inconsistent in different places. This creates a postcode lottery for what support is available. The long-term vision for the Lifestyle Hub as a genuine One-Stop Shop for healthy lifestyle support could revolutionise this picture and make a significant difference in reducing health and social care costs to the public purse.

And as has been noted, success in Pennine Lancashire would not only benefit local people, it would also provide a platform to advance all PARS delivery and evaluation.

6.2 Other Strengths

There are other key strengths to the Hub model which, whilst they are also observed in other schemes, are still key to success and worthy of highlighting.

6.2.1 Quality and dedication of Lifestyle Hub Team

> "We were just, we're not going to get through these [referrals]…they're going to be waiting months, so the hub jumped on board, started picking up the text messages, we did group inductions"
> **Interviewee, Lifestyle Hub Team**

Throughout the interviews, references were made to the level of support and commitment from team members, both within teams (e.g., Health Activators) and between teams. Various examples were given of teams working together to ensure the best possible service, including Health Coaches working with the central team to design the EMIS referral process, and Hub Advisors stepping in to support one locality who experienced staff shortages at a time when they had a surge in new referrals.

> ""I know that if I sent out an email today saying 'Oh my god, I'm struggling' people would help out, they'd be on it"
> **Interviewee, Lifestyle Hub Team**

Further to the above, referrers and delivery team members commented on the commitment to being patient-centred and seeking to work flexibly with participant needs and preferences.

> "Up & Active have been very good…if we've had a patient that we've had any concerns about, they've allowed us to take patients to try [sessions] before they've signed up for the 12-weeks….they do handover sessions, they ask us for further information, we've met with activators to get a bit of a feel for the service."
> **Interviewee, Referrer**

It was clear that every member of the Lifestyle Hub team that I spoke to, from the central team to the localities, was committed to making the service work and were willing to go the extra mile to ensure that it does. This strongly links to the importance of culture, highlighted as a key enabler of an effective referral system in chapter 5, and is a marker that the team can achieve its lofty ambitions.

6.2.2 Health Coaches

Whilst a relatively new addition to some areas of Pennine Lancashire, the potential of these roles being aligned with the Lifestyle Hub is already becoming apparent. In chapter 4, we discussed how factors such as past experience of physical activity and readiness to change can have a big impact on patient adherence and long-term behaviour change.

Health coaches can play a critical future role in breaking down biases in who PARS can be successful for, and helping those at greatest disadvantage to engage in the programme fully. This will be further assisted by the planned broadening of available ways to be active within the scheme.

6.3 Challenges – what is tricky?

On the flip side, there are naturally still challenges within the scheme, which is aiming to strengthen and streamline a highly complex, multi-stakeholder environment. Pleasingly, the majority of these issues are already in the sights of the core team. Effectively addressing them will make a huge difference to the Hub's long-term success.

6.3.1 Confusion around processes

There has been significant change within the service over the last 12 months and there is still confusion amongst stakeholders about many of the new processes and ways of working. This is entirely expected, given they are undertaking alignment of a whole region, and good progress is being made, but this is still a work in progress.

Some examples include:

- **Branding and terminology:** Stakeholders expressed that confusion is caused by the different services in different localities (Up & Active, re:fresh, and Let's Live Life), by what different teams are called, and some even pointed out that they weren't sure which bit 'the Hub' is. Some thought it was the Hub Advisor team, some saw it as everything prior to starting a programme of exercise and some felt it was the whole service.
- **Offer in each locality:** Uncertainty exists around exactly what is available in each locality, with differences apparent in which conditions can be supported where, and uncertainty about what community activities are available, either within the Up & Active or equivalent service, or through other community organisations.

> "We're seen as [locality] health programmes, community wellbeing team, U&A, it's so confusing, and that's just in [locality]. So how would someone in [another locality] know that we're the same…if its confusing for us its confusing for everyone…it just needs to be the same"
> **Interviewee, Lifestyle Hub Team**

- **Team roles:** There was considerable variability in understanding of the roles and responsibilities of different teams, including where opportunities could be being missed to support each other when capacity is stretched. This was particularly the case with Hub Advisors, who felt they could play a bigger role in helping other teams if they had greater visibility.
- **Data management:** despite the central data system being a key strength, its implementation is still presenting challenges at this early stage. Many team members are confused about who inputs what data, at what stage, or what data is used by who for what purpose. There is variability in how challenging people find it to extract relevant information from DCRS and the accuracy and completeness of data is still a work in progress. Vigilance in enforcing new processes is inconsistent, with some always reinforcing, whilst others still allow referrals straight from referrer to Activator when they are stretched and it feels easier.

> "there's things on there that are totally missing, like are they drinkers, how much do they drink, how much do they smoke"
> **Interviewee, Lifestyle Hub Team**

> "the system will be much better once it falls into place…its quite challenging at the moment for the team…it's a new system for them"
> **Interviewee, Lifestyle Hub Team**

6.3.2 Supporting long-term behaviour change

As discussed in Chapter 5, evidence of long-term behaviour change and health impacts is something which is sorely lacking in many PARS and this limits the ability to understand the true impact. This is an area the Lifestyle Hub central team are keen to address, but is another work in progress.

The issue is two-fold, and in both cases, requires effective measurement to know if what we're doing is working. DCRS is starting to show its potential in tracking outcomes, but there is plenty of scope to grow this further.

1. **Changes in physical activity behaviour:** the premise of PARS is grounded in being more active to have long-term benefits for wider health and wellbeing. The first step obviously therefore needs to be an increase in levels of physical activity. This is easier to support and monitor within a 12-week scheme, and DCRS is helping with this tracking as the system becomes more established. What feels less visible is what happens at the end of the 12-weeks.
   Activators spoke about how they always try to sign-post people into continued activity; however, the scheme simply isn't set-up to do significant work to help participants integrate into wider activity. For those who want to continue in the leisure setting, discounted membership options are available in all localities, however, affordability varies, and there is no capacity built into the scheme at present to support people into community activities.
   Long-term measurement of physical activity behaviour post-scheme is not yet built in.
2. **Improved health & wellbeing outcomes:**
   Improvements in WEMWBS and GHQ scores over the course of the 12-week exercise programmes (Chapter 4) is a good indicator of short-term wellbeing improvements, We do not, however, have wider data on other health indicators. Nor do we have significant data to understand what is leading to improvements, for who in what context. Looking to the future, one referrer noted that understanding this was the priority going forward. Several interviewees also commented on this, with a general appetite observed to understand more about long-term patient outcomes.

> "We do you know need some case studies here, that's the real meat on the bones isn't it, how they're feeling, what differences it's made to their lives. In the past there's been too much emphasis on have you lost 2lbs."
> **Interviewee, Referrer**

6.3.3 Aligning referrers to the value of the service

Currently it feels like the relationships with some referrers is excellent, with them strongly advocating for physical activity as a treatment and backing the service locally. Others refer much less frequently, if at all. The referrers we spoke to are all advocates of physical activity but, in spite of this, only had limited knowledge of the wider Lifestyle Hub offer. There has also been limited opportunity to hear from those who aren't referring. Anecdotally, for those who don't refer, there appears to be a lack of understanding of what the service is, they don't know how to refer, they don't see the clinical benefits of physical activity, or they don't believe patients will adhere.

As well as limiting the opportunity to be referred for patients in some services/localities, this has a knock on effect on quality of referrals. This includes people being referred who don't meet referral criteria; and people being referred who Up & Active isn't suitable for (e.g. because the level of exercise is too hard, because they aren't confident exercising in a leisure environment, or because they simply don't like the gym or fitness environments).

There have also been some teething issues with the referral process for a small number of referrers. Whilst feedback suggests these have been resolved and managed well, it is remarkable the extent of reach things these have. For example, one referrer mentioned not using the correct Hub referral process, due to having heard anecdotally that someone else had issues; instead preferring to go direct to a

trusted Activator. This kind of myth persistence is reputationally important and highlights the value of not only swiftly dealing with issues, but also continuing to support and reassure referrers.

Expanding and improving the relationships with referrers is a key priority for the core team. It is seen as a key enabler to grow the service and also build support and advocacy for long-term investment.

6.3.4 Capacity

Challenges around capacity and capacity management came through as a common theme in all interviews and all aspects of this work; everything from referrer capacity to spend time talking to patients about physical activity, to activator capacity to spend additional time with complex cases.

There does not appear to be any lack of willing or caring about delivering the best service possible, however, the impression was that lots of people are juggling lots of priorities. It felt like there was a real desire to spend time on some of the bigger strategic issues, but that the reality saw people getting caught up in the day-to-day 'urgent' activities, leaving limited time for the strategically 'important'.

In Blackburn, where the service has been established longer, interestingly they implemented a two-week service shut down to create space to step out of the day-to-day and immerse the team in a wider strategic review. In addition to examining the service itself, it was a great opportunity for additional training and team building. The team spoke about the value they took from this opportunity.[14]

> "It's probably not top priority to think about 2025 right now...but I know we're going to lose something in [locality] that's absolutely key to our patients if we don't"
> **Interviewee, Lifestyle Hub Team**

More broadly, those we spoke to in the Hub Team were aware of the need to make a compelling case for long-term investment by 2025. There were differing levels of how concerned people are at this stage. Some still have the attitude that 'it will work out in the end' because it has in the past. Some team members spoke about being aware of the importance, but not feeling like they had the capacity to make it their focus right now. Others are really starting to recognise the significance of the moment and the part they can play.

> "It was the first time [when LCC withdrew funding] we all went into a little bit of panic mode, we've always been at this situation, but we've always been refunded and the money's come from somewhere...there's a mindset now that we really need to keep promoting the service, promoting what we do, we need to keep having those conversations with the right people who can influence those who make decisions "
> **Interviewee, Lifestyle Hub Team**

That empowered view was more common for Locality Leads, who had recently had opportunities to come together as a team and discuss that hurdle on the horizon. It is important to reiterate though that there was no one who didn't care about this service and want it to succeed. There is nonetheless a risk that not everyone gets behind the mission proactively due to feeling disconnected, like someone else is taking care of that, or like they don't really know how they would contribute.

6.4 Is the Lifestyle Hub helping to tackle inequalities?

Whilst it is our view that this is possible, the data currently available does not yet provide a conclusive picture on tackling inequalities. We know that patient wellbeing measures are seeing improvement over

[14] Re-fresh team members discuss benefits of a service shutdown https://www.youtube.com/watch?v=h1d_oj4ul6g

the course of the programme, and data to date on IMD suggests high levels of referral from more deprived areas. We do not yet have a complete enough picture to know to what extent those from the lowest IMD areas are succeeding through the scheme.

This is in part because building a comprehensive dataset is still a work in progress, and full analysis of what is available has not yet been possible. It is also down to a lack of data tracking long-term behaviour change, which is not yet routinely collected.

Nonetheless, early signs are good and this should be a continued area of focus over the coming period.

7. Conclusions and Recommendations

7.1 General conclusions/key observations

In spite of its small scale, a lot has been uncovered in this short review. Firstly, in spite of having been around for more than a decade now, PARS still feels like a messy topic with an evidence base in its infancy. Inconsistent political support, contradictory evidence, and a lack of central leadership in building the evidence base on best practice have all contributed to this circumstance, leaving a major gap in understanding, almost 10 years after it was called out by NICE (2014).

Against this backdrop, the Lifestyle Hub offers a pretty unique opportunity if the aspirations can be achieved. Firstly for Pennine Lancashire, to grow this service into something pretty special with demonstrable health and wellbeing benefits for the local health service and local people. Secondly it can make a major contribution to what works, for who, in what context, and set the direction for both future delivery and evaluation. Achieving these two things also positions it as a mentor for other localities who want to do similar.

7.2 Future ambitions

As noted in Chapter 6, the most unique selling point of the Lifestyle Hub is the huge opportunities it presents, given the work already underway and the progress to date. The ambitions of the core team should rightly be bold and include:

- Establish new referral pathways and strengthening existing.
- Grow a detailed understanding of local physical activity offer which can support LTHCs in each locality; identify gaps and work with the VCSFE sector to build the offer further.
- Become the genuine 1-stop shop for PA for health opportunities across the region.
- Build out DCRS data to include long-term health and wellbeing measures.
- Use data already collected, refine what is collected further, and supplement with further qualitative work to make a compelling case for LT investment in the Hub that can't be refused.
- Grow evidence base for PARS and become a Centre of Excellence for what works for PARS.
- Expand into other healthy lifestyle support, e.g., stop smoking, mental health, healthy eating.

7.3 Key recommendations

Whilst the findings of this report should be reflected on in full, we suggest some key recommendations for TaAF's consideration.

First and foremost – keep going. There is fantastic momentum in the Lifestyle Hub right now and a lot of great stuff happening, but this work is happening in a complex system and the progress made to date is part of a longer journey. Whilst there are a lot of challenges and a lot still to do, there is nothing insurmountable. To make it happen though, capacity to do work that matters is crucial, and managing workloads and creating space is essential.

7.3.1 Do now

- **Take the findings to the team** – Interviewees were keen to see what emerged and want to be part of taking learning forward. Celebrate progress and what has been achieved to date before delving into what happens on the next stage of the journey.
- **Do some process workshops** – Bring people from different parts of the team together to explore how things work. This will:
    1. Build understanding of roles and responsibilities, and how the whole service works.
    2. Build team alignment on aims of the Hub, growing the offer, and doing your bit in making the case for 2025
    3. Clear up areas of confusion and allow more sharing of info between teams.
    4. Enable co-creation of actions and solutions.

Could a service shutdown similar to the one undertake in Blackburn be feasible in East Lancs?

- **Raise the profile of the long-term vision for the Hub in the team** - Give everyone the chance to discuss their part in the 2025 mission. Review and re-establish team targets focused on long-term behaviour change. Remember - what gets measured gets done.
- **Reaffirm the commitment to working with communities** – Make sure the whole team is aware of the option to refer out to other services where this is right for the patient. Consider appropriate ways to record and reward.
- **Stay vigilant on the small stuff** – We know that the small stuff (e.g., glitches in the referral process) can make a big difference to people's confidence so make sure there are easy ways for people to raise concerns and stay vigilant on resolving issues and reassuring.

7.3.2 Do next

- **Create an action plan** - Using findings from process workshops to prioritise what next. These will emerge further through team discussion but might include:
    - **Maximise capacity** - Identify short-term process fixes that can create space for strategic thinking, e.g., best use of Hub Advisors, improving quality of referrals in.
    - **Set out clear priorities for the core team** – not everything can get done at once so decide what needs doing first and what you'll do later; make sure to share with the team.
    - **Identify ways to increase interaction and sharing between teams** – For example, you could align a Hub Advisor to each locality.
    - **Strengthen community referral options** – Understand the current offer in each locality and establish processes to bring appropriate community activities under the Lifestyle Hub umbrella.
    - **Understand and improve signposting post 12-weeks -** Work with service delivery team to understand the current process for signposting and what might need to evolve.
    - **Aligning branding** – establish the steps that would need to happen to allow alignment of service terminology and branding.
- **Undertake further mapping/analysis work** – use available data to understand what is already known about what is working for who in what context (see research recommendations).
- **Set-up data reporting templates** – Based on work above, create data reporting templates in DCRS to enable access to key reports in a few clicks.
- **More work with referrers** – help them understand purpose of the Hub, the process, referral criteria; understand what type of patient outcome data they want, in what format, how often; what can they share with the Hub (with patient consent) about long-term health outcomes?
- **Maximise the value of Health Coaches** - Work with Health Coaches and those they interact with to understand current working practices and opportunities to develop the role.

7.3.3 Do later

- **Expand community physical activity options for health** – Understand what makes a good offer and support new opportunities to come online.
    - Co-create support and QA processes with referrers, community providers and patients.
    - Focus on free/low-cost and those embedded in localities.
    - Prioritise underserved communities.
    - Ensure QA give confidence for all parties, particularly where new provision will support vulnerable audiences.
- **Develop a plan for a post-scheme sustainability in patient journeys** - Starting early to integrate patients with wider community opportunities and support structures to sustain activity. Consider options for extending scheme beyond 12-weeks where beneficial to patient.
- **Introduce LT patient follow-ups** – At 6- and 12-months post-scheme. Consider extra support to restart activity where lapsed.
- **Audit on Lifestyle Hub team learning & development** - What has been done by who? What expertise/qualifications are held in which localities? Where do gaps or opportunities exist?
- **Grow the team** - where funding allows to meet demand.
    - More central resource to support both strategic and operational work

    - Dedicated data management and evaluation capacity;
    - Increase Health Activator capacity; free up Locality Leads for more strategic work.
- **Expand into other healthy lifestyle options** - Once physical activity elements are operating smoothly, bring online a test case; use learning from weight management service.

7.3.4 Do in partnership with Sport England

- **Develop best practice resources** – Tools to share learning, advice and guidance with other areas on how to set up your own service (including what did not work).
- **Test the approach somewhere new** - Identify a suitable test and learn site and establish a similar service whilst testing support and resources.

7.4 Recommendations for further research

To support the above objectives, we know that data and evidence is essential, and so we are also recommending a number of areas for further research.

- **Undertake further mapping and analysis of DCRS data** – Including cross-referencing of data streams. E.g., Are certain localities or surgeries referring more or less, or certain types of patients? Are certain types of people more likely to complete? Are people doing certain activities more likely to complete?
    - Referrals
        - Who referring in (location/service/person)
        - How referring (by service/org/referrer)
        - Primary conditions referred
            - Co-morbidities
        - Types of people referred (demographics, other characteristics)
    - Analysis of outcomes/behaviour change
        - Uptake/retention/completion rates
        - Activity levels
        - Health outcomes (e.g. BP, BMI, wellbeing, condition specific measures) – What is being recorded in each locality?
        - Wellbeing measures (i.e. WEMBWS or GHQ)
        - Wider wellbeing outcomes – What is being recorded in each locality?
    - Activities being undertaken (link to community sector piece below)
        - What is offered in each locality?
        - Follow-on support/onward referrals/signposting being offered

  Consider linking to Hanson (2020) taxonomy.
    - **Understand how terms are being used** (e.g. Uptake, completion) - How are measures understood and used by teams.
    - **Check for biases** - Are biases in referrals seen in the literature apparent in DCRS data?
- **Qualitative research with participants/patients** – whole patient experience, holistic care.
- **Research with GPs and more research with other referrers** – to support further work with this audience highlighted above.
- **Research with Social Prescribers** – understand how can this relationship be built to support patients with complex needs. Align with Health Coaches for complementarity.

All of the above will help build the evidence base needed to make the case for 2025. It may also identify gaps in data collection, which can be filled, or gaps in service provision. This then presents opportunities to undertake co-design of service developments.

Another quick win to strengthen the case for 2025, would be to collect testimonials from referrers who are already advocates of the scheme. This could be undertaken as part of the above research.

Finally, the team might consider applying for a research grant to commission an in-depth evaluation of the Lifestyle Hub service. This could make a compelling proposal due to the potential to add significantly to the evidence base around PARS.

References

1. AESOP_2020_Dance_to_Health_Phase_1_Overall_evaluation
2. Albert_etal_2020_Functionality of PA Referral Schemes - Systematic Review
3. Birtwistle_etal_2019_Factors influencing patient uptake of an ERS
4. Bromley-by-bow Centre_2019_ Social Prescribing Annual Report
5. Buckley_etal_2018_Codevelopment of a physical activity referral scheme
6. Buckley_etal_2020_Investigation of PA Counselling & Referral in GPs
7. Buffart_et al_2009_ General practitioners' perceptions and practices of physical activity counselling
8. Chatterjee_etal_2017_GP knowledge use and confidence in national PA guidelines and tools
9. Downey_etal_2021_Behaviour change practices in exercise referral schemes - developing realist programme theory of implementation
10. Fleming_etal_2019_Engagement with and the delivery of the parkrun practice initiatives by GPs
11. Glowacki_etal_2017_Barriers and facilitators to PA among adults with depression.
12. Glowacki_etal_2019_Its more than just a referral - Development of an evidence informed exercise and depression toolkit
13. GM Cancer_2022_Prehab4Cancer_Evaluation_Report
14. Hanson_etal_2019_We are failing to improve the evidence base for ERS - how a PARS taxonomy can help
15. Hanson_etal_2019a_How participant experience and characteristics influence engagement in ERS - Qual Longitudinal
16. Hanson_etal_2020_A modified Delphi study to gain consensus for a taxonomy to report and classify PARS
17. Hanson_etal_2021_Gender Differences in ERS uptakes, adherence, experience in Scotland
18. Healthy London Partnership_2019_VCSE Sector Engagement and Social Prescribing
19. Macmillan_2019_Bromley By Bow Centre Social Prescribing Evaluation Report
20. McHale_etal_2020_Pathways for Green SP and PA Referral in Scotland
21. MIND_2022_Case Study - Bright Star Boxing Counterpunch
22. Morgan_etal_2020_Patterning in Patient Referral to and uptake of National ERS in Wales
23. Muhl_etal_2022_Establishing Internationally Accepted Conceptual and Operational Definitions of Social Prescribing
24. NASP_2022_Evidence Briefing_Physical Activity
25. NHS_2018_Audit of Exercise Referral Schemes in Scotland
26. NICE_2014_Exercise Referral Schemes to promote physical activity
27. Oliver_etal_2021_Inequalities and Inclusion in ERS
28. Portman_etal_2021_Acceptability of a peer support intervention for ERS
29. Portman_etal_2023_ERS Participant Characteristics Referral Mode and Completion Status - West Lancs
30. Quirk&Haake_2019_How to get more people with LTHCs involved in parkrun - Qual evaluation of the PROVE project
31. Reid_etal_2021_Consensus statement on the risks of PA for people living with LTHCs
32. Richmond Group_2019_Social Prescribing – Learning from Doing the Right Thing
33. Rowley_et_al_2018_Effects of ERS in UK for CV MH and musculoskeletal disorders - systematic review
34. Rowley_etal_2020_Are Exercise Referral Schemes Associated With an Increase in Physical Activity

35. Schuh_etal_2019_Physical activity protects from incident anxiety: A meta-analysis of prospective cohort studies
36. SHU_2022_How Can Exercise Referral Schemes increase PA - developing initial programme theory
37. SHU_2022a_rapid-scoping-review-social-prescribing-physical-activity
38. SHU_2022b_Social Prescribing and PA - Scoping an agenda for policy practice and research
39. Sport England_2022_Moving Healthcare Professionals Programme Final Evaluation Report
40. Sport Wales_2021_Youth social prescribing of physical activity – a rapid evidence review
41. Steele_etal_2021_National ReferAll Database - Open Dataset of ERS in UK
42. Tandridge District Council_2021_Evaluation of the Wellbeing Prescription Service
43. University of Westminster_2017_Making-sense-of-social-prescribing
44. Wade_etal_2019_Effect of ERS on health and wellbeing - analysis of National Referral Database

Appendix 1: Abbreviations

Abbreviation	Meaning
CPD	Continuous Professional Development
BMI	Body Mass Index
DCRS	Data Collection and Reporting Service
ERS	Exercise Referral Scheme
GP	General Practitioner
HCPs	Health & Social Care Professionals
IPAQ	International Physical Activity Questionnaire
KPIs	Key Performance Indicators
LA	Local Authority
LTHC	Long-Term Health Condition
MI	Motivational Interviewing
MSK	Musculoskeletal
NERS	National Exercise Referral Scheme (Wales)
NICE	National Institute for Health & Care Excellence
NRD	National ReferralAll Database
PA	Physical Activity
PCN	Primary Care Network
PARS	Physical Activity Referral Scheme
SHU	Sheffield Hallam University
TaAF	Together an Active Future

Appendix 2 - Definitions of Exercise Referral & Social Prescribing

10.1 Exercise Referral

Portman et al 2023
Exercise referral schemes (ERSs) are physical activity (PA) interventions for adults (18+ years) with long-term physical and/or psychological health condition(s) who do not engage in ⩾ 150 minutes per week of moderate-to-vigorous PA (National Institute for Health and Care Excellence (NICE), 2014). ERSs provide approximately 12 weeks of free or discounted access to a community-based PA environment (Rowley, 2019), where participants adhere to bespoke PA programmes under the supervision of a qualified exercise professional (Rowley et al., 2018).

SHU 2022
An exercise referral scheme (ERS) is a formal partnership between a leisure provider and primary care to identify and refer people with mild chronic diseases to a time-limed person-centred programme. The aim of ERS is to support PA behaviour change.

Hanson et al 2019
As traditionally defined, ERS contain four essential components: (i) an assessment involving a healthcare professional to determine that someone with a LTHC or other factors that put them at risk of ill-health, is sedentary or inactive, (ii) referral by this professional to a PA specialist or service, (iii) a personal needs assessment by the specialist or service, (iv) an opportunity to participate in a PA programme.

This definition now fails to represent a myriad of innovations in both evidence-informed models, and contemporary practices, which support PA uptake. We suggest that 'physical activity referral scheme' more appropriately describes the range of interventions offered. Specific examples include entry routes via self-referral or from other professionals (e.g., health trainers) and group-based needs assessments. Our taxonomy therefore encompasses all PA schemes that:

(a) have the primary aim of increasing physical activity,

(b) have a formalised referral process,

(c) are provided for individuals who are inactive/sedentary, and/or have or are at risk of a health condition.

NHS, 2018
For the purpose of this audit an exercise referral scheme was defined as "any physical activity and exercise intervention which included 1) a referral by a healthcare professional to either a physical activity specialist or third-party physical activity/exercise service provider; 2) an initial, individualised assessment to determine what type of physical activity to recommend for the individual's specific needs and 3) an opportunity to participate in a tailored programme of physical activity, exercise or sport"

NICE, 2014 (Last reviewed in 2018)
In this guideline, exercise referral schemes consist of: ·

- an assessment involving a primary care or allied health professional to determine that someone is 'inactive', that is, they are not meeting the current UK physical activity guidelines (Department of Health 2011) ·
- a referral by a primary care or allied health professional to a physical activity specialist or service .

- an assessment involving a physical activity specialist or service to determine what programme of physical activity to recommend ·
- an opportunity to participate in a physical activity programme.

This guideline does not consider exercise referral schemes designed for, or that include, management of, or rehabilitation for, specific diseases. This includes cardiac or pulmonary rehabilitation programmes

10.2 Social Prescribing

What is social prescribing? | The King's Fund (kingsfund.org.uk) Social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses.
Recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

Making sense of Social Prescribing (westminster.ac.uk)
Based on the original descriptions of social prescribing, a social prescribing scheme can have three key components – i) a referral from a healthcare professional, ii) a consultation with a link worker and iii) an agreed referral to a local voluntary, community and social enterprise organisation

Richmond Group (2019)
'Social prescribing' (as described by the NHS and others) links people into personal networks as well as practical and emotional support within communities and the voluntary sector. This is often via their GP, nurse or other primary care professional. The aim of social prescribing is to help people live their lives as well as possible, with a focus on supporting them to take control of and to improve their health, wellbeing and social welfare.
Services are normally time-limited (but with some flexibility).

Muhl etal (2022)
Operational Definition
Social prescribing is "a holistic, person-centred, and community-based approach to health and wellbeing that satisfies Condition 1 and either Condition 2 or Conditions 3 and 4:
• Condition 1: Identifier identifies that person has non-medical, health-related social needs (e.g., issues with housing, food, employment, income, social support)
• Condition 2: Identifier connects person to non-clinical supports and services within the community by co-producing a non-medical prescription
• Condition 3: Identifier refers person to connector
• Condition 4: Connector connects person to non-clinical supports and services within
Conceptual Definition
LONG VERSION: Social prescribing is "a holistic, person-centred, and community-based approach to health and wellbeing that bridges the gap between clinical and non-clinical supports and services. By drawing on the central tenets of health promotion and disease prevention, it offers a way to mitigate the impacts of adverse social determinants of health and health inequities by addressing non-medical, health-related social needs (e.g., issues with housing, food, employment, income, social support). While it looks different across the globe, it is recognized as being a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections. It requires collective action and collaboration among multiple sectors and stakeholders. It begins with an identifier, usually a clinical professional, who identifies that a person has non-medical, health-related social needs. Typically, they refer the person to a connector, but they may act as the connecting agent themselves by connecting the person to non-clinical supports and services within the community. Hence, either party may co-produce the social prescription with the person. The

connector, who is usually a non-clinical professional, provides personalized support and focuses on what matters to the person. They co-produce a personalized action plan with the person by supporting them to assess their needs, strengths, and interests, and they subsequently connect the person to non-clinical supports and services within the community, support them to access those community resources by addressing any barriers that may exist, and follow up with them. Through a feedback loop, they report back to the identifier. They conduct motivational interviewing to promote behaviour change, spend time with the person to build trust, and
empower them to take greater control of their own health and wellbeing. Finally, monitoring and evaluation are conducted to measure outcomes through the collection of qualitative and quantitative data and the completion of pre and post assessments to understand the impact on the person (e.g., non-medical, health-related social needs, health and wellbeing [physical, mental, social], satisfaction), clinical and non-clinical supports and services (e.g., demand, costs), and the community."

SHORT VERSION: Social prescribing is "a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community by co-producing a social prescription – a non-medical prescription, to improve health and wellbeing and to strengthen community connections."

Appendix 3: Lifestyle Hub Referrals by Health Condition (May 2022-2023)

	Recorded LTC by district					
	Burnley	Hyndburn	Pendle	Ribble Valley	Rossendale	Total
Not recorded	458	118	117	23	307	1023
Anxiety	148	120	84	66	73	491
Arthritis	135	58	54	66	45	358
Asthma	61	40	26	27	49	203
CKD	1	1		2	3	7
Depression	141	96	88	39	75	439
Diabetes	78	36	52	19	43	228
High Cholesterol	95	71	37	50	63	316
Hypertension	163	86	84	64	90	487
Long COVID	6	5	3	11	2	27
Mobility	12	17	12	42	50	133
Musculoskeletal	167	186	95	115	130	693
Obesity	53	11	52	46	159	321
Osteoporosis	19	4	10	11	13	57
Other (add to notes)	299	212	183	74	165	933
Pre-Diabetes	35	11	14	10	7	77
Stroke	23	4	11	7	11	56
Total	1894	1076	922	672	1285	5849

N.B. Some patients have more than one condition

Appendix 4: Up & Active Participant Case Studies

Burnley

Burnley Case Study_Stephen.docx Burnley Case Study_Kathleen.docx Burnley Case Study_Danielle.docx

Hyndburn

Quotes from participants available on Hyndburn Leisure website [Up & Active – Hyndburn Leisure]

Pendle

UP&ACTIVE CARDIO REHAB - STEPHEN BRENNAN [Up&Active Cardio Rehab - Stephen Brennan - Pendle Leisure Trust]

Further Case Studies can be found in individual posts on Pendle's Up & Active Facebook page https://www.facebook.com/UpAndActiveUK/

Rossendale

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