HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM [PAIN ASSOCIATION SCOTLAND]

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

I would say that there is little evidence around how much the social prescribing of this results in sustained participation. However, one must ask the question as to why everything needs to be around “evidence based” arguments? Surely the fact that a patient is being given some lifeline to help manage their long-term condition and lead a better quality of life is significant in itself?

The other factor to consider when social prescribing to encourage sustained is how the prescribing is done in the first place. Is it through mere signposting or recommendation or is it through direct referral (if available)? The reason I pose this question is that in order to encourage sustainability, you need to have the right message of engagement in the first place. Our experience has found that if you merely give someone a leaflet, they are less likely to take the opportunity of the initial uptake as they often feel “fobbed off” and question why they are not being kept locked in a medical model. However, if they are actually referred and correct language is used, for example, we are referring you to……as it is a recommended next step in your pathway of care and you have reached the limits of what medicine can do for you and it will help you lead an improved quality of life. By having a referral, people are more likely to be engaged from the onset and if they are engaged and see it as a joined up model within their care pathway, then they are more likely to embrace the benefits of this.

For many years we have created a very dependent society and it will therefore take time for people to embrace a very different way of taking responsibility for their own self-management and care.

2. Who should decide whether a social prescription for physical activity is the most appropriate intervention, based on what criteria? (e.g. GP, other health professional, direct referral from Community Link Worker or self-referral)

I would challenge as to why it needs to come down to the question of “most appropriate intervention”? Why does any social prescribing need to come down to it being an alternative? One must remember social prescribing for physical activity can also be done at the same time that the patient may be waiting for an intervention or further treatment.
At the end of the day, they then might be in a better place for their next step of treatment/investigation etc.

Again, from experience what I would say is that in order to get the engagement of GP’s or any other healthcare professional to refer to your service, you have to make the process as simple as possible for them. At the end of the day, they do not have the time to go into detail about the nature of the social prescribing, how they do it, how they register, what will happen, what they should expect and what the next steps are. Therefore, and again to support my point from earlier, a direct referral would be much more appropriate.

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

There a quite a few barriers to effective social prescribing:

- **Time** - it is far easier and takes less time to write a prescription than it does to explain to a patient why you are not writing a prescription for medication. It takes 30 seconds to prescribe medication and 30 minutes to explain how a patient can look at alternative ways of managing their condition.

- **Knowledge** – how can prescribers know all the options that are available to the patient and how do they pick the ones which would be most appropriate?

- **Trust** – for healthcare professionals to refer to a service they need to be able to trust the service to which they are referring. If they have either none or little knowledge of the service then they are less likely to refer due to the blame culture in which we operate.

- **Patient knowledge and engagement** – as mentioned earlier, the difficulty we have in helping to change perceptions that we need to take responsibility for our own health and well-being.

- **Stages of change** – we also have to remember that many patients are just not at that right time mentally when it comes to self-management – it’s easy to say but hard to do. Someone with a recent diagnosis who has been round in circles, locked in a medical model for many years is going to have to come to terms with this and would at this stage quite often be going through the grief stage. Therefore getting them to commit to in effect “going alone” would not be the right time for them.

With all of the above I would say that we are not at that stage yet in these barriers being overcome. There is certainly a lot of work to be done and it is hoped that with the introduction of community link workers and the work of various Health and Social Care Partnerships and digital platforms that we can move forward on this.
4. How should social prescribing for physical activity and sport initiatives be monitored and evaluated?

Cognisance should be taken of outcomes as opposed to outputs. It is about how a person is coping better in managing their long-term condition and if they are leading a better quality of life as a result. I would be inclined to stay away from some of the methods currently used to assess patients pre and post activity levels as these methods of measurement do not factor in that a patient could be having a set-back or flare-up on the day of assessment and therefore their performance on that day would not be a true reflection of the overall stages of change they have gone through.

In terms of key data on the ground, I would say that one could look at the number of GP visits as to whether these have reduced. The amount of medication and dosage could also be factored into this.