HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM [Christopher Wilkins, Co-founder, The Sporting Memories Foundation Scotland]

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

The Sporting Memories Foundation Scotland is a charity working with particularly hard to reach isolated older people including older men living with long-term conditions like dementia, Parkinson’s disease and depression. In our weekly Clubs we include inclusive physical activities. Eighteen months ago, in a survey of 120 Club members across North and South Lanarkshire who were taking part in such activities, 84% of them had not been taking part in any regular physical activity. Eighteen months later, those same members are still talking part in those weekly physical activities.

My first comment is that it is the provision of Clubs and activities such as ours that can increase sustained participation in physical activities rather than social prescribing itself. I do find that the narrative always sounds as if social prescribing itself is the cure that requires support without mention of support for the right kind of services themselves. There would be no positive outcomes without properly supported activities that can be sustained in the long term.

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

To date, referrals to our Clubs are through family members directly or occupational therapists, community link workers, dementia link workers suggesting our services to individuals or family members. Very occasionally we have referrals from GPs and yet we have received letters of support for our work from the likes of NHS Lothians at Director level. Social prescribing could certainly help referrals as it is always difficult for a small charity to make itself known to the wider community, especially when our target audience are often extremely isolated. While GPs, health professionals and paid community link workers could really help, we would not want to exclude self-referrals or referrals direct from families. The first step to services like ours is always the most difficult one, especially as often our new members have very low confidence, low self-esteem, and may have been socially isolated for some time. A social prescription from a GP or health professional might give the impetus that some individuals need to make that first step. It is then still up to the service provider to come up with the right solution that engages and delivers impact.
What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?

A vital aspect that we feel so many physical activity provisions miss or underestimate, and that social prescribers could also miss, are the huge social and emotional issues that can create the barrier between inactivity and starting that journey back to sustained physical activity.

We strongly believe that the depth of our engagement and success in getting the inactive, active (84% of our members surveyed) is that our initial offering or call to action isn’t overtly about physical activities at all. We use the hook of sport, of an interest in sport and a desire to share stories about watching or playing sport to bring isolated older people together. Crucially, because our Clubs are weekly and ongoing we provide a welcoming environment and specific non-physical activities, that engage everybody (regardless of cognitive or physical conditions) that help to build confidence, raise self-esteem and help to foster friendships. As a group of friends, we then find their common interest in sport means that they are open to taking part in games and physical activities, with peer support overcoming any initial reluctance and fear of failure. This works with older men and women, people living with dementia, Parkinson’s disease, depression and other long-term conditions and multiple conditions. This is also just the start. We have gone on to re-introduce our members who have self-excluded themselves from sports they used to play; introduced new sports to people, and we are now weaving strength and balance exercises into all our activities to help prevent falls and help older people live independent lives for longer.

Fundamentally our experience tells us that the ‘social’ aspect of social prescribing is equally important when it comes to sustained physical activities, especially when it comes to those difficult early steps.

For someone who is inactive, socially isolated, experiencing low confidence and low self-esteem a social prescription directing them straight to a physical activity in a sporting environment that they may have avoided for years could encounter the same barriers that 12-week physical activity programmes have historically faced in the past, with high dropout rates. Fundamentally, for our target groups we believe there is a need for proper stepping-stones that help bridge the gap from inactivity to activity built into services that first improve confidence, self-esteem and encourages meaningful peer support.

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

Monitoring and evaluation is crucially important. ‘Social’ prescribing shouldn’t be confused with activities that just offer a nice, social thing to do. We see all around currently once a month activities provided for people living with dementia which simply by dint of being just once a month will have almost zero impact outside of the activity itself – and yet they are heralded and referred by health professionals because there is little else on offer.
Organisations and activities that are socially prescribed should have strong ‘theories of change’ and evidence of impact – otherwise there is a real danger that the wrong kind of services are supported and given further legitimacy through those very prescriptions.

Monitoring and evaluation also needs to be designed with service users in mind and take into account their cognitive and physical abilities such that their direct feedback can be gathered wherever possible. A careful balance also needs to be made between the sometimes onerous demands that academic institutions might make for more robust evaluations that can alienate users (and volunteers) during the monitoring phase, and not gathering sufficient evidence to demonstrate real impact.

I would also suggest that some existing measures used by sporting bodies do not reflect some vitally important impact that physical activities can have on particular groups of people. For example, Sport Scotland currently has a threshold of inactive people as being those who spend less than half an hour a week undertaking physical activity. The next meaningful threshold after becoming ‘active’ is then those who undertake more than 150 minutes per week. I would suggest that while we are proud of getting our members ‘active’ in our weekly sessions to then, through our work, encourage our members to undertake one or two more physical activities between sessions would be remarkable and potentially have huge health benefits while still not meeting the next Sport Scotland 150 minutes per week threshold. A deeper understanding of what impact smaller steps in a set of sustained physical activities can make to groups like older people is required and an appropriate monitoring and evaluation framework designed to reflect it.