HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM CHEST HEART & STROKE 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?

Whilst we are not aware of any evidence available about the direct impact of social prescribing on long-term participation levels, it will undoubtedly play a key role in supporting people who are living with long-term conditions to sustain their ongoing rehabilitation.

Physical activity is vital in preventing disease, but is equally important for the health and wellbeing of people living with long-term health conditions. Being physically active is key to the secondary prevention of stroke, heart disease, and exacerbations of lung disease. It also helps people self-manage their conditions, live independently, and prevent isolation.

Physical activity is a core component of NHS rehabilitation programmes for people living with chest, heart and stroke conditions. But there is limited capacity and investment in rehab programmes, particularly for people living with chest conditions and needing access to pulmonary rehabilitation.

The benefits of rehabilitation programmes can be lost within months if exercise isn’t sustained, and so ongoing access to community-based exercise opportunities is critical to helping people maintain their activity levels. There need to be robust pathways in place which ensure that people are signposted to those local and accessible opportunities to be active. Social prescribing can therefore be an important component of those pathways.

Social prescribing can also incorporate the main success factors which support people living with our long-term health conditions to be active, through providing opportunities to:

- Highlight the benefits of physical activity at the earliest point, and reinforcing that message at key points;
- Avoid breaks between different stages of someone’s rehabilitation journey, for example the transition from formal rehabilitation programmes to community based exercise;
- Provide a ‘safety net’ to allow for follow up of patients who disengage with services;
- Provide a self-referral system for those who do not follow the rigid rehabilitation pathway;
- Improve awareness of exercise maintenance opportunities which are available.
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)

For social prescribing to be normalised as a component of individualised support it should be available as an option for all health professionals and Community Link Workers. The risk of inactivity to someone’s health or recovery is often far greater than being active, and health professionals need to provide reassurance and advice accordingly.

People should also be able (and encouraged) to self-refer to activities, facilitated by third sector organisations such as Chest Heart & Stroke Scotland providing support and signposting. Rehabilitation programmes help allay people’s concerns about being active after a diagnosis or event, but not everyone is able to access these.

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

The Scottish Household Survey highlights that ill health and disability has the biggest impact on rates of participation in physical activity. People living with long-term conditions are far less likely to be physically active – just 40% compared with 89% of people with no condition.

Prevalence rates of long-term conditions such as chest and heart disease or stroke are also higher amongst areas of greater deprivation. Many people living with these conditions are experiencing significant inequalities which impact on their ability to access opportunities to be physically active. These include the cost involved, transport, availability of local options, as well as barriers such as isolation, or poor mental health.

Many people do not have a history of being physically active prior to a diagnosis or event such as a stroke or heart attack, and for them beginning activity afterwards can be particularly challenging. Traditional venues such as gyms can be unfamiliar and particularly intimidating, and not only do people have to overcome their concerns about being active, but change their long-standing behaviours.

Peer-based support within communities which is easily accessible can help overcome these barriers. Chest Heart & Stroke Scotland has a network of 150 such groups across Scotland which are run by members, and provide support in whatever form members’ require. Many

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offer physical exercise led either by volunteers or instructors; all offer the crucial social support which is key to sustaining participation. Volunteers can play a similar role outwith group settings, building motivation and individuals’ confidence to participate.

To ensure that social prescribing best directs people to these opportunities, there needs to be collaboration and partnership working across NHS, third sector, local authorities and other agencies. This can be resource-intensive, but helps ensure that there is a recognised pathway into such groups. In Drumchapel, Chest Heart & Stroke Scotland has built a partnership with the local GP practice and Community Link Workers which sees people being signposted to our Community Hub and the projects it supports, and to our Health Defence team who offer free health checks, support and advice.

Barriers to that pathway operating smoothly include health professionals’ reluctance to signpost people to activities outwith formal clinical pathways, disproportionate requirements for highly-qualified training instructors, and easy access to information about what opportunities are available in a community. Whereas there are information systems such as the Scottish Government’s ALISS database\(^2\), there are challenges in ensuring information is up to date and remains viable.

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

At a population level, if social prescribing was fully normalised in the future, we could expect to see an increase in the physical participation levels of people living with long-term conditions.

At individual level we would expect people’s self-reported wellbeing and quality of life to improve. Where communities now have Link Workers in place measures such as numbers of GP visits, and membership of local groups could be monitored.

\(^2\) [https://www.aliss.org/](https://www.aliss.org/)