Health and Sport Committee
Social Prescribing of Physical Activity and Sport
Submission from: The Observatory for Sport in Scotland
26th August 2019

Introduction

The Observatory for Sport in Scotland (OSS) welcomes the opportunity to provide a response to the Health and Sport Committee consultation on ‘Social Prescribing for Physical Activity and Sport’.

As Scotland’s dedicated ‘Sports Think Tank’ with its focused objective of empowering sport in the community through evidence and engagement, this is an issue that has been discussed widely by stakeholders at OSS and other events. OSS supports Scotland’s community sport sector with strategic insight and expertise, independent research, knowledge exchange, policy/practice recommendations and international benchmarking. We believe a strong community sport sector makes a vital contribution to a thriving Scotland centred on wellbeing and belonging for all. However, recent analysis of Scottish Government research shows that Scotland faces an uncertain future for community sport with an increasingly divided nation of ‘sporting haves’ and ‘sporting have nots’, where access relies increasingly on wealth, and a generation of young people disengaged from sport with widening and longer term health impact.

OSS has been established as an independent charity led by a committed board and passionate, experienced volunteers to increase collective understanding to champion a movement of support for sport and the wellbeing and belonging it can bring to all. Uniting people from across communities, business, universities and the wider sports sector OSS encourages cross disciplinary working with an intelligent, innovative, evidence-led approach through forums and partnerships.

Partnering with Europe’s most active nations we look to adapt ‘what works’ to a Scottish context to create a movement of passionate people working together to grow participation in communities across Scotland.

Review questions

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

OSS understands social prescribing as a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Our
understanding in this context, and experience of successful programmes, is that ‘social
prescribing’ would involve a designated ‘Community Link Worker’ (CLW) signposting and
supporting ‘patients’ referred from primary healthcare settings to engage in sport, exercise
and other forms of recreational activity in the community.

Our research shows that to effect change requires long-term persistence and collaboration
and an understanding that no single intervention or organisation solves the challenge alone.
OSS believes that social prescribing (properly evaluated) has a role to play in this system
particularly in its ability to target socially and economically (and inactive) deprived groups in
the population. We would however, emphasise the following:

a) OSS makes an important distinction between ‘sport’ in its widest sense with its
organisational elements, social engagement and connections and psychological
attributes, and ‘exercise’ with its focus on physical fitness, health and informal
everyday activities such as walking and cycling for transport, DIY and gardening. Sports participation comes in many forms from the highly organised and competitive
to the less formally organised and recreational, all with wider physical and mental
health benefits. We would like to take this opportunity to emphasise the arguments
for placing sport as a central element in this programme.

b) We are concerned that historically the social psychological benefits of engaging in
sport have been undervalued in the overall model and justification for interventions of
this type, due to a lack of understanding of the wide variety of sport, away from the
traditional view. Participation in sport in an ‘organised social setting’ has many
benefits that extend beyond the more limited field of vision often found in the ‘health
world’ that focuses extensively, if not exclusively, on the physiological outcomes
associated with frequency, intensity and duration of physical activity. Sport provides
additional opportunity to overcome social isolation, build self-esteem and self-
confidence, facilitate self-expression and provide enjoyment and fun in life.

c) The crucial word in the question we have been asked to address is ‘sustained’. Research shows it is relatively easy to motivate people to sign up to and attend an
‘exercise class’, particularly when it comes with the authority of a health professional
and is motivated by health concerns, but is extremely challenging to sustain levels of
engagement over a sufficient period of time to provide the health outcomes
associated with an active lifestyle. There is extensive evidence that for most, initial
attendance is soon followed by attrition and drop out. Although engaging previously
inactive people in sport has considerable challenges these can be turned into
positives if the right approach is taken to addressing the quality of experience in a
way that is appropriately tailored to the motivations, needs and capabilities of the
individual. When appropriately delivered sport can provide the social and
psychological glue that effects longer term sustained participation with all the
physical, mental and social benefits that flow from this.

d) A concern is that to ‘medicalise’ sport takes it into a domain that can potentially
undermine these intrinsic qualities and have negative impacts on sustainability. This
is where the initial ‘first contact’ with GPs and health professionals is crucial – and
has significant implications for training and developing the skillsets required. This is
not just about understanding, for example, the cardiovascular benefits of exercise but
also the complexities of motivation and behaviour change, and people’s life
circumstances.
e) Finally, our understanding is that although there is a long history of ‘exercise prescription’ in the UK the evaluative evidence of sustained impact is at best contentious. We would assume that the same would apply to a wider approach that incorporates a ‘social prescription model’. We have provided our outline views on this later in our response regarding monitoring and evaluation, the OSS having been launched to provide the kind support service in this area common in more active European countries, and would be happy to elaborate.

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)

OSS recommends a ‘logic model theory of change’ approach to designing social prescription programme(s) for sport and recreation. This would identify key players in the system, their roles and responsibilities and relationships to each other, the points and contexts in which they have contact with the ‘patient’, and the referral processes, pathways and destinations available. In most cases we would anticipate that the initial ‘prescription’ coming from a GP or qualified health professional, but this does not always have to be the case. The principal requirement is for appropriate training and ‘skill alignment’ in the system to ensure that the right assessment is made, and the referral an appropriate one. This training is as much about understanding behaviour change and motivation, and having the right personal skills to engage and motivate, as it is about clinical and technical knowledge.

Evidence of social prescribing clearly shows that one size does not fit all. There are a number of behaviour change models and theories that may be applied to decision making in this area. In the context of sport, OSS would recommend that the Committee considers the model of ‘sporting capital’ that would tailor the intervention to the profile of physical competency, psychological confidence and social connections of the individuals concerned. In a systematic ‘programme theory approach’ all players in the system would be trained and familiar with the principles of sporting capital and its application, including the potential to use it as a profiling device, to ensure appropriate interventions and enhance sustainability.

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

The principal barriers or challenges to the effectiveness of social prescribing lie with the psycho-social barriers to participation in sport and physical activity amongst the target sedentary population. These are often habitualised and resistant to change. Overcoming them systematically is not just a question of providing improved opportunities (although good quality and accessible opportunities are important) but requires more fundamental insight and approaches to behaviour change that understands motivation and its social and cultural context. We have referred above to the theory of sporting capital which addresses as its key concern the motivational dynamics of participation and what sustains it.
OSS believes the quality of the ‘destination environment’ (places) and the skills and abilities of staff (people) are crucial to the effectiveness of any social prescribing model. The people at the ‘delivery end’ need to understand, empathise and adapt their offer to the levels of sporting capital of those who are referred. Sport historically has not been good at this – a key contributor to the high levels of drop out. Destinations will be in the business of building sporting capital of people who will in the main come with very low levels or at least with levels that have declined significantly with many years of inactivity and lack of engagement.

OSS’s own commissioned research\(^1\), analysing Scottish Government data, raised concerns about Scotland becoming a ‘divided sporting nation’. This programme needs targeted investment in the total system and infrastructure of socially and economically deprived areas to help to address this. Resources spread too thinly and omitting crucial parts of the jigsaw (e.g. the quality of the destination environment) will be ineffective.

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

Any interventions need to be systematically evaluated using a combination of qualitative and quantitative techniques. Randomised control trials are a possibility – but we recognise the challenge involved in such designs (in a complex social system) and the potential costs. OSS would support and recommend a process oriented ‘realistic evaluation’ approach that is informed by a theory of change (see above) to provide evidence of what works, why, for whom and in what context. This would engage practitioners in the research process and would examine intermediate outputs and outcomes in the context of probabilities of success and value for money.

Ideally, any research approach would involve a prospective design that would follow the same individuals over an extended period from initial recruitment and engagement to impact post the programme intervention to explore more sustained behaviour change and associated social and health outcomes. A wide definition of value and metrics to incorporate social, psychological as well as physiological benefit should be applied.

Within the overall programme different area-based approaches could be explored, for example, to examine the comparative effectiveness of ‘sport-based referrals’ and ‘exercise-based referrals’, and of different referral processes and training regimes.

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\(^1\) See: Rowe, N. F., Sport Participation in Scotland: Trends and Future Prospects, OSS, June 2019

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\(^1\) See: Rowe, N. F. (2018). ‘Sporting Capital: Transforming Sports Development Policy and Practice’. London, Routledge. Sporting capital is defined as: “The stock of physiological, social and psychological attributes and competencies that support and motivate an individual to participate in sport and to sustain that participation over time.”
Sporting Capital

What is it?

- A response to the theoretical void that is holding back sports development and to the frustration with unchanging participation rates and intractable inequities.

- Definition: “The stock of physiological, social and psychological attributes and competencies that support and motivate an individual to participate in sport and to sustain that participation over time.”

- Analogous to Human Capital

- Three C's competence, confidence and connections

- Three main components or 'domains': Physical (health and basic movement skills); psychological (self esteem, self confidence, self efficacy and identity); social (friends, family, workmates play sport)

- Someone with high levels of sporting capital is physically competent, confident in their abilities, comfortable in the settings where sport takes place, usually has sporty parents and siblings and mixes with people who are positive about sport.

- Someone with low levels of sporting capital is physically awkward, lacks confidence, often has poor body image finds sport and its settings intimidating and unpleasant and gravitates to social circles that don't participate or place high value on sport.

Important characteristics of sporting capital:

- The higher levels of sporting capital the higher the probability of participating in sport - and sustaining participation through the life course.

- It can appreciate or depreciate. Good experiences increase it. Bad experiences decrease it.

- People with high levels of sporting capital are less affected by external barriers such as time limitations, cost and access - they are more resilient to things that might get in the way of their participation in sport.

- It is more durable than participation - people with high levels of sporting capital are more likely to come back to sport after a break than those with low levels and to
transition to other sports as they get older.

- Through the 'transferability of capitals' it impacts on other 'capitals', social, human, cultural. Increased sporting capital contributes towards employability, health, wellbeing, quality of life.

- It is socially structured, men have higher levels than women, older people less than young people, upper social class groups more than lower social class groups.

- PUBLIC POLICY can change it!

**How can public policy intervene to change sporting capital?**

- building understanding and empathy of what it is like to have low levels of sporting capital
- training staff
- profiling participants
- tailoring approaches
- thinking differently
- joining up approaches
- looking for ways to transfer capitals - from sporting capital to social, cultural and human capital
- measuring impact - judged by increasing sporting capital not by participation/attendance alone

**Outcomes**

- A more confident, competent and socially connected participant base
- Sustained increases in participation
- Reduced social inequity
- Empowered individuals - self motivated and able to get the most enjoyment from sport.
- **Improved wellbeing and quality of life**