HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM Glasgow Health and Social Care Partnership

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

Social prescribing is a widely used term generally aimed at addressing the social determinants of ill health, supporting patients with non-clinical root causes of poor health or preventing disease. In this respect there should be a cautionary association between referral and support pathways for physical activity and social prescribing. Firstly because social prescribing approaches within Glasgow (and Scotland in general) will not have the coverage required for an effective physical activity referral scheme in primary care, thus potentially aggravating efforts to reduce inequalities.

Secondly there is clear and consistent evidence of the impact of being active on the management of long term conditions, clinical risk factors, treatment and recovery, captured through NICE guidelines. Referral for participation in physical activity should form part of the treatment plan for a range of physical and psychological conditions, hence the outcomes are of a clinical rather than social nature.

To avoid any confusion it is assumed that the committee are seeking to understand views on the effectiveness of prescribing by NHS staff (primary care and otherwise) to increasing sustained participation in physical activity. In this context there is a history of prescribing for behaviour change e.g. around smoking, weight, alcohol brief interventions and physical activity, as well as broader tests of prescribing around employability, financial advice, and other forms of social support. In many cases these demonstrate that doctors (and in some cases other primary care staff) are able to improve engagement rates, and in some cases this has shown improvements in outcomes compared to general population initiatives. Commonly the trusted relationship with the health care professional is seen as a critical success factor. When someone you trust, who is there to support you, offers something that may help you, you are more likely to listen and respond. What happens then depends on a plethora of other factors in your life and the nature of the interventions on offer.

We already understand that having a sense of control over your life, a regard for yourself, and the means (financial and social) to act, are all fundamental to initiating and sustaining changes like being active. This sits alongside systematic changes which make it easier for all of us to be active. Locally we use the Toronto Physical Activity Charter as a proxy for public health action as this offers an internationally recognised evidence base. Referral pathways through primary care to physical activity is one of the population measures recommended in the Charter.
Evidencing sustained change in physical activity is hampered by a lack of easy ways to assess activity levels in individuals that are robustly able to track real change over time. Fitbit technology is opening new avenues for researchers and in terms of self-reporting (survey options) more recently we have been thoughtful of measuring change in terms of the reported time spent being sedate (while awake) as a better way of reflecting activity levels and changes.

To this end evidencing sustained improvements in being active are challenging, however prescribing does improve engagement, and particularly (from local data) with groups less likely to engage by other means. This is a pre-requisite to sustainable change and should be part of Scotland’s strategy to improve physical activity, alongside other aspects of the Charter.

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)

A combination of health care teams (primary care, acute, rehabilitation etc) and public health professionals should work together to devise the most workable prescribing processes for physical activity for their patient group. The business reality for the NHS is that a single ‘scheme’ is unlikely to be equally workable across the differing business areas. As an example NHS staff delivering on smoking cessation services are in a good place to refer and sustain patients during the six week quit interventions, such connectivity would need designed into any local scheme.

Any referral scheme does require the ‘referrers’ to have the knowledge and skill to access readiness for change and connect to the most appropriate resource. Building the capacity of the referring workforce is a fundamental component of any workable scheme.

All HSCP’s in Scotland have developed their infrastructure to work with general practice and primary care as a result of the new GP contract and primary care improvement planning requirements. With health improvement support, these may offer the best vehicle for future considerations of how to develop and/or adjust referral schemes that are to focus on primary care.

However supporting people (and patients) to be more active is not an exclusive role to the NHS, for most of us getting more active is a good thing and not something we need an NHS referral to do.

3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?
A key challenge is the demand on health care services and action that might drive further business through primary and acute services where that is not necessary. In a survey of over 4,300 adult residents in Glasgow City last year, 41% indicated that they were currently receiving treatment from the NHS [https://www.stor.scot.nhs.uk/handle/11289/579884](https://www.stor.scot.nhs.uk/handle/11289/579884). This scale of demand for health care services is exceptional. Even where staff are absolutely committed to working more preventatively, the daily challenges can exhaust any ability for this to happen. Systems need to be integrated, and be easy and effective for NHS staff to engage with and designed to fit with their existing delivery models, hence the need for local flexibility.

The other key barrier from our existing experience is the costs to patients. Community Link Workers and others are trying to find inventive ways of enabling patients to be active without incurring costs as this is a very real limitation. The impact of poverty on the ability (means and motivation) to exercise is significant in Glasgow.

The Primary Care Improvement Plan investments could, over time, assist in aspects of primary care engagement, if planned into future allocations. There are also opportunities from having a wider primary care team and further expansion of the more generalist community link worker role.

Given their increased time with patients and their holistic generalist social approach, Community Link Workers are well placed to ‘prescribe’ physical activity for their patients. However caution should be applied in directing CLW to respond to specific population health requirements as this may risk diluting their respected role as generalist social practitioners within the Multi-disciplinary Primary Care teams.

Ideally having a package of local funding to invest in enabling the Toronto Charter requirements to be met, inclusive of referrals through health settings, would enable local systems to generate an investment programme to meet current weaknesses. Such investment plans couldn’t just be directed to primary care, and would more appropriately be tracked through integration authorities to plan within their Community Planning Partnership governance arrangements.

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

Within public health a mixed methods approach inclusive of population impact measurement’s (potentially through the Scottish Health Survey, school census, Growing Up in Scotland longitudinal study) and specific research programmes are both required. This mix of benefits, beneficiaries and population changes is needed in the round and developing a research and outcomes framework would support this.
Greater Glasgow and Clyde NHS tried to develop an outcomes assessment tool to measure progress against the Toronto Charter a couple of years ago. Taking and refining this early work would also enable any NHS schemes to sit within a wider physical activity context and enable local Community Planning Partnerships to focus their efforts.

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