HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

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

This very much depends on how the social prescribing is delivered. The typical model of a GP prescribing X number of sessions at a local gym to improve health is almost always doomed to failure for a number of reasons; People with health related issues are generally not the type who have maintained physical activity since childhood and will generally lack the understanding or the motivation to attend any exercise on prescription programmes, particularly in gyms and other settings which many will perceive as intimidating or even frightening environments where they feel they don’t belong or fit in. The introduction of community link workers may help to personalise social prescription and signpost to appropriate community assets but it does little to actually develop and link a diverse range of assets into a comprehensive network of resources able to meet the personalised and individual needs of the whole population. The model developed by Lorn and Oban Healthy Options (LOHO) fulfils the role of community link worker and so much more, allowing supported access to a range of health and wellbeing services – any modelling for the community link worker role should look at how the staff at LOHO currently delivers this service in Oban and how they are able to support and influence other community assets to ensure that social prescriptions can be personalised, accessible and diverse.

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)

All of the above would seem to be the most appropriate approach. Sometimes it may be necessary to check suitability for certain activities with a GP or other health professional but why create additional barriers to access by creating more gatekeepers to access.

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

There are some significant cultural barriers to social prescribing; part of the problem is that during 70 years of the NHS we have promoted a medical/medication dominated service which relies on waiting for an illness to strike or condition to deteriorate before offering medication to fix the symptoms. This approach has not only built a society conditioned to think that medicine is the only answer to health problems but that the NHS as the gatekeepers to this model hold the responsibility for people’s health or ill health. Personal responsibility for one’s own health has never been promoted apart from isolated campaigns relating to the significant harms of cigarettes and alcohol. Even the emerging message of ‘exercise as medicine’ misses the point and reverts back to a reactive medical model – exercise will help you get better after you are unwell. This misses the point that exercise throughout life can actually prevent ill health and protect against many common medical conditions – very few medications can offer this sort of health protection, particularly with an
absence of side effects. As a result we need to change the message from 'exercise is the remedy' to 'inactivity is the problem', a subtle but important change in our message.

Another cultural barrier to the social prescribing particularly around exercise is our approach to our elderly relatives. We accept poor health and function as a natural part of aging and we live in an era where it has never been easier to do nothing; internet shopping, supermarket delivery services, stair lifts and riser recliner chairs. We consider these as excellent innovations for our elderly friends and relatives as their health and function deteriorate rather than recognising them as excellent methods to actually speed up that decline. Sarcopenia, the age related loss of muscle bulk which leads to reduced mobility and falls starts at the age of 30. It is inactivity in the elderly that allows sarcopenia to start impacting on mobility and safety rather than age itself yet most people will consider buying Granny a riser recliner chair rather than a gym membership when she starts to struggle. Until we articulate the greater importance of activity and exercise for our older population we will struggle to convince many people of the value of exercise by social prescription.

Even if we do start to get the message right, we do start to educate people and return the responsibility for health to the individual we still need to support them to make changes – we have seen from numerous 'signposting' models of exercise referral schemes that pointing people in the direction of a gym or leisure centre simply does not work and a collaboration between health and third sector leisure services that supports people to seamlessly move from health services to leisure services is the only way to achieve any meaningful engagement. LOHO services have a completion rate approaching 65% for their exercise programmes compared to reported data showing completion rates as low as12% for some traditional GP exercise prescription services.

Until we get the message right we can develop a reactive social prescription service which will support engagement and use social prescription to limit or reverse the impact of many common medical conditions. Building on models such as LOHO, who have clearly demonstrated a model to reduce barriers to engagement, will improve the effectiveness of social prescription services but that in itself is self limiting. Hopefully the ultimate aim should be to place social prescription front and centre in health and social care services acknowledging that exercise can be a preventative ‘vaccination’ programme safeguarding against ill health rather than just another medicine to help when ill health has already set in. Until we are clear in our message that inactivity is not benign we will not use social prescription to its full benefit. Social prescribing of activity cannot be viewed as just a slightly quirky new way to support health services, it needs to be embedded as our first line of defence against health problems.

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

Since we already have a wealth of evidence that exercise improves health and we have a range of evidence based physical intervention approaches we do not need to spend time evaluating the specific impact of each individual intervention rather we should use numbers of people engaging and maintaining physical activity as a measure of success. Evaluation of changes in the number of GP attendances and medication changes can provide evidence of both health improvement and financial savings as well as comparisons of the performance of different approaches to social prescribing adopted in different areas. Subjective data can provide powerful stories around the wide ranging impact of improving
activity levels on wellbeing as well as health and since those in the lower socio-economic bandings are less likely to proactively seek out social prescribing opportunities specific measures to address health inequalities should be evaluated. Health education questionnaires can help to highlight changes in public understanding of the link between poor health and sedentary behaviours and a key role LOHO have adopted is its involvement in health education for adults. Key performance indicators such as falls may be influenced by social prescription services but trying to evaluate one single element of a wider approach to falls prevention may prove difficult. In areas that have a more comprehensive pathway for community services such as the Oban Living Well initiative evaluation of the impact on falls is attributed to all services across the whole pathway from primary care services through AHP rehab/reablement services and third sector services delivered by LOHO rather than just one particular part of the overall pathway.

Arbitrary targets should be avoided at least until such time as a wide range of approaches can be independently evaluated and compared to try and get a clear understanding of what works and what works less well.