HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM Active Aberdeen Partnership

Active Aberdeen Partnership (AAP) is a strategic partnership within the City of Aberdeen encompassing third sector; academic sector and public sector agencies who each have an interest in the provision of sport, leisure and physical activity.

The AAP Strategy for an Active Aberdeen 2016-2026 sets who the partners are and their commitment to:

1. Increasing opportunities for people to participate in sport and physical activity.
2. Investing in the infrastructure of people and place within Aberdeen.
3. Being inclusive so that everyone has, the opportunity to be and stay active.

This contribution to the Scottish Parliament Health and Sport Committee has been compiled and informed by responses received from AAP Partners.

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

The Active Aberdeen Partnership (AAP) notes that the above question does not clarify if “sustained” participation refers to increased participation throughout the lifetime of a prescription or if the term “sustained” refers to sustained life-long behaviour change as a direct result of social prescribing.

There are member organisations of AAP that can show that (social prescribing) referral into physical activity programmes/interventions which act as supported pathways back in to physical activity/regular exercise have led to people increasing and sustaining their participation in physical activity beyond the lifetime of a referral through bespoke, structured and supportive practice.

Outcomes experienced and reported by people include increased confidence to engage in physical activities; people experience an increase in and sustain their own peer support networks; establishing positive connections (new friendships) within their own communities; improved physical mobility; improved physical and mental wellbeing; reduced social isolation; and increased participation in active citizenship across age groups.

Social prescribing of sport and physical activity should extend across all age groups including babies; children; young people; adults and older adults.

The reach of social prescribing should also extend to preventing physical, wellbeing or mental health decline and where there is a risk that a lack of physical activity will or is resulting in dependency. An example provided included the following (in relation to ageing well)
“If an individual is referred to a podiatrist because they can no longer reach far enough to cut their own toenails, why not refer them to a soft exercise programme or yoga classes to improve their flexibility instead of building dependency upon podiatry? In terms of physical fitness “if you don’t use it, you lose it”. All of us need to be a bit more creative, a bit more proactive in challenging perceptions of what the prescribing sport and physical activity can achieve with people.” (AAP Partner)

Social prescribing has the potential and (as stated above) is, enabling people to sustain sport and physical activity to improve, self-manage and enhance their own health and wellbeing.

**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.)**

AAP would promote co-design of referral criteria and any development (if there is a national; regional or local approach to referral design) seeks to actively engage with organisations who are improving people’s health and wellbeing through provision of sport and physical activity; from the very beginning.

Understanding of what exists within the sport, physical activity and leisure sector as it relates to primary health care and the full potential of physical activity interventions is not (from this sector’s perspective) universal:

“All involvement in discussions is important to allow those less familiar to better understand the variety of what is available, and to help design things that may not YET be available.” (AAP Partner)

And that:

“Social prescribing decisions should be placed as far down the decision-making pyramid as possible/safe.” (AAP Partner)

To support active participation the person who is being referred to a sport or physical activity should be enabled to play an active role in the decision-making process; and where possible the design of referral criteria.

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

**AAP members have stated that barriers include:**

Lack of knowledge and understanding of what initiatives exist locally and the different ways in which these are delivered; co-designing social prescribing and referral pathways (as stated above) may provide a foundation for shared learning. Local, regional and national
organisations should be invited to contribute; particularly organisations that are already engaging with communities (of place and interest).

Potential for reluctance to prescribe, and a continued reliance on more familiar exercise referral schemes only, due to a lack of understanding of the full potential and breadth of outcomes that can be achieved through sport and physical activity social prescribing. This can be overcome through shared learning, meaningful collaborative approaches to referral; investment in training across sectors and improved use of communication systems/hubs.

Attitudes to sport and physical activity as not being considered a suitable or more “clinical response”.

Generic resistance to change in relation to adopting social prescribing as a primary health care response to physical and mental health/wellbeing issues, or closed mindsets that are focussed only upon respective specialist areas – again collaborative approaches, meaningful co-design and co-production approaches may assist in overcoming these barriers.

An approach to learning and a commitment to shared learning across sectors through practice about the impact of social prescribing would perhaps be beneficial in overcoming barriers associated with: the recognised lack of empirical evidence; lack of dialogue across specialisms; understanding of challenges (try and fail) that may or do exist have been suggested during this consultation.

There may be a legislative requirement to enable the change required to integrate the practice of the social prescribing of sport and physical activity has also been suggested by an AAP Partner.

Cost of participation in a social prescribing referral will also be a factor, particularly if appropriate clothing, travel and/or additional equipment is needed.

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

Aspects to mental wellbeing can be perceived to outweigh the immediate physical benefits of sport and physical activity.

A shared approach to setting and agreeing outcomes (national, regional, local, community and personal) and indicators is required.

Monitoring and evaluation should include quantitative and qualitative data.

There should be a commitment to embedding monitoring and evaluation throughout the design and practice of social prescribing; and that this is met throughout whilst ensuring that the process is not burdensome to the individual, or the organisations referring or delivering sport and physical activity.
Close partnership working as a requirement by organisations, agencies, groups, communities and trusts engaged in the social prescribing of sport and physical activity has been recommended to help ensure that any monitoring and evaluation planning/practice will align across respective agency evaluation practice.

End.