HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM: Allied Health Professions Directors Group Scotland

The report is provided on behalf of the AHP Directors Scotland Group who represent the AHP Directors and Associate Directors or equivalent from all Boards across Scotland.

- **Who should decide whether a social prescription is the most appropriate intervention, based on what criteria? (GP, other health professional, direct referral from community link worker, self referral)**

There is strong evidence that physical activity can improve health and well being and prevent disease. As such it is everyone’s responsibility to explore activity levels in routine conversations in any health social care or education setting. Health promoting conversations and advice should be offered to promote behaviour change.

We consider Social Prescribing to be a key component of prevention which seeks to address the social determinants of health and shift the focus from medical intervention to one of empowerment of the individual to take control of their own life and health. As such it can reduce the impact of health inequalities and also the effect of living with a long term condition. AHPs work across the whole life course and in a wide variety of roles and we therefore see ourselves ideally placed to support social prescribing.

In order to ensure the individual has timely access to any support that may be identified as likely to offer benefit we believe that the social prescribing routes should be as wide as possible including all health and social care professionals and community link workers. Community link workers/navigators are valuable within the community to embed physical activity and community participation.

The AHPs in NHS England have undertaken a review of social prescribing and their role within this and have considered three levels of social prescribing:

- Active signposting
- Referral to a link worker
- AHPs as a social prescriber


Concern was expressed related to the concept of criteria with this being thought to evoke a clinical problem and a subsequent referral to a service. As senior AHPs across Scotland we considered that a request for assistance to achieve the individual’s personal outcomes would be our preferred model. As an approach, this helps to move the public and services away from the traditional medical model of healthcare towards a wider public health and wellbeing model with prevention and early intervention at the heart.
We explored the concept of self referral within a social prescribing construct and what would be different for example from someone simply deciding to join a club or attend an exercise class. In this context we considered it to be as a result of signposting and so again were supportive of the person being able to exert their own informed choice. It was thought that a person taking the initiative to refer themselves may in turn impact upon engagement and sustained participation. Social prescribing should be considered in the context of shared decision making with the person as an equal partner and ideally the person should be able to self-refer to the programme or activity rather than it being a formal prescription/referral process.

Below are examples where social prescribing was considered helpful:
- Supporting independence
- Development of skills to support employment opportunities
- Improvement of mental health and wellbeing, including addictions
- Physical activity and falls particularly for people who’s current level of activity does not mean the minimum recommended level for their age group
- Social isolation
- Healthy weight
- Best start/ reduction in impact of Adverse Childhood Experiences
- Long term health conditions (such as chronic pain, Fibromyalgia, Diabetes Mellitus, Inflammatory arthritis, Osteoarthritis, stable respiratory conditions, stable cardiovascular conditions, obesity, certain neurological conditions, etc).

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

This is not known as that information it is connected to local facilities/ opportunities and is not universally available at the moment. Anecdotally it is suggested that social prescribing results in an increase in sustained participation in physical activity for some people. This is more likely to be effective if:

a. Supported through education, guidance and follow up, and
b. The correct prescription is provided in terms of logistics, cost, engagement, different options, physical and social level.

The importance of any activity being meaningful to the individual cannot be underestimated and this will impact on the sustainability in participation. AHPs are very skilled at working with individuals to help them identify goals and ways to support these that are meaningful to them.

There is good evidence around the impact of having personalised exercise programmes to address specific goals around muscle strength for example being more impactful than
generic physical activity messages therefore it is important to consider this on an individual needs basis for maximum impact and long term benefit

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

  Taking the first step is often the hardest barrier to overcome and need to recognise an individual’s readiness for change – those who enter into social prescribing need to have knowledge and skills in behaviour change to be able to recognise where people are along the change curve to then be able to offer meaningful choices that can be paced and adapted based on the individual need

  Barriers include:

  o Lack of knowledge, skills and confidence on behalf of potential prescribers, including knowledge of available offerings locally

  o Choice: A variety of activities needs to be available – physical activity takes many forms – gardening groups, dancing, walking etc as well as traditional gym type based. In order for it to be valuable and effective it needs to be meaningful to the individual

  o Lack of confidence on behalf of potential beneficiaries

  o Perception of specialist equipment requirement on behalf of providers. Introduction of initiatives such as Green Gyms mean no specialist equipment required

  o Costs to both the individual and the provider. Exercise referral systems in some areas are provided at no/low costs initially and an introductory offer following this initial period. Exercise prescription could assist in reducing health inequalities

  o Short term funding meaning that this is an ever changing environment and opportunities for access change.

  o Complex/exclusive referral processes

  o Body image concerns for some individuals

  o Transport costs in rural areas

  o Not embedded as part of pathways of care

  o Cultural – where the person’s family and peers do not exercise and do not see any issue with this. Overcome through repeated education, positive messages and support networks (such as online groups, social workers, key workers, the referrer etc)

  o Social reasons – no time to attend due to family or work commitments. They can be overcome through engaging whole families (e.g. kids park run or family events), and through employer engagement - asking workplaces to dedicate time to physical activity / making allowances for this (flexible working, 15 minute longer lunchtimes to allow for a walk / circuit class etc).

  o Health – people very often cite ill health as a reason not to be physically active. This is harder to overcome, and takes education, reassurance and referral from
an informed source (GP / AHP etc) as well as prescribing the right level of activity.

- There is a need for a political and strategic approach to embrace a change in how we deliver our services and the public perception of what to expect from our services. Key messages of social prescribing often perceived as budget cutting and not to improve longer term health benefits. This can be overcome by:
  - Good conversations starting at the very first point of contact.
  - Improved communication around services available.
  - Greater Community partnership working – embedding the principles at all levels - AHP staff in third sector and community partnerships

- Prescribing something that then is not available or accessible in a timely way can be de motivating and potentially lose momentum and the window of opportunity for behaviour change

- Inadequate conversations and poor therapeutic relationships may hinder participation particularly if people feel they are being ‘told’ to be more active

**How should, social prescribing initiatives be monitored and evaluated?**

- Uptake
- Retention
- User’s experience/impact upon wellbeing
- Self-reported surveys of physical activity could be used. use digital tracking solutions
- Attendance of an individual or group of individuals at a GP could be monitored
- Usage of analgesia or medication could be monitored
- Impact on primary care visits to GP; A&E etc
- Link workers role evaluation
- Resource costs/cost effectiveness
- Sharing stories encourages others. Outcome focused stories linked to improved levels of functional ability health and wellbeing. A really good example is use of the Lifecurve™ App to support how function is impacted on and improved with increased levels of activity.

- 15 key functional daily living tasks are assessed to monitor where a person is sitting on the Lifecurve. The visual representation can have real impact and can give greater motivation to support people to achieve goals of increased independence. The App supports and can monitor outcomes.

- The evidence for the future tells us there will be more disability if our lifestyles don’t change.