HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM : NHS Grampian Public Health Directorate.

1. To what extent does social prescribing for physical activity and sport increase sustained participation in physical activity and sport for health and wellbeing?
   - I think that social prescribing, when done with link workers, can make a big difference. Sometimes all people need is a bit of confidence to start something new e.g. exercise, and link workers can provide this. The issue is long term follow up, systems need to be in place, which monitor this. There may be sustained pressure on link workers to maintain contact with patients who have been referred, therefore adequate resources need to be provided.
   - Although there is less focus on measuring the sustained participation in physical activity and sport for health and wellbeing, there is increased focus and awareness among professionals and members of the society. Participation may have been increased and sustained where access and support was greater and people had wider choices of a range of social prescription activities.

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, self-referral)
   - This can come from a variety of health and social professionals, community workers, or anyone who is in contact with target groups and feels that someone would benefit from social prescribing. I don’t think it has to be the domain of GP’s. It could be anyone who is cognisant of a person’s say mental health or weight issues, and recognises the benefits of physical activity on mental health and a healthy weight. But any referral should be linked up with the patients current care pathway, IT systems need to “talk” to each other.
   - The acute care professionals could also be in a unique position to promote social prescribing because evidence suggests behaviour change interventions works when people going through life changing events and as hospitalization in many situations could be a life changing events. So to bring behavioural changes acute care settings and clinicians should decide who will gain advantage from social prescriptions.

3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?
   - Lack of training, staff need to be adequately trained and have the confidence to prescribe exercise rather than drugs. It is perhaps difficult sometimes to have these conversations, to patients who want a “quick fix”, when long term health behaviour change is the real answer.
   - Perception that physical activity means joining a gym or is expensive, when it is small changes such as walking and active travel, and starting according to your own ability.
• Confidence to try new things and understanding that e.g. weight loss takes time to be done in a safe and sustainable way, with exercise, and that “quick fixes” are not always the right way.

• Low income, poverty, deprivation (access, social isolation, exclusion, range of vulnerabilities etc) links to self esteem, low confidence, lack of control, belief system could all be the barriers.

• Referrals alone may not help, people need supportive conditions, an environment which does not stigmatise, discriminate especially those with low confidence.

• People struggling with drugs and alcohol, living with a long-term condition or mental health problem are often victim of stigmatisation or in many case self-stigma.

• Some of these barriers can be overcome through a culture change and in an ideal world every single professional should be trained around ‘inequality sensitive practice’ and very much aware of the nine protected factors/equality act and how it is practiced. Access can be denied through non-verbal communication by showing negative attitudes towards vulnerable groups for example how we treat a homeless person or a drug/alcohol user as compared to a more affluent person at a service delivery point is highlighted in the evidence.

• We should not generalize services for everyone as it could further increase the ‘health gap’. A new methodology will be required to support the most vulnerable rather than targeting everyone.

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

• Greater communication between different professionals, and IT systems which support this, with access to notes etc. Any social prescription should be coded appropriately and consistently as with any other morbidity and treatment. IT systems have tendency to operate in silos, often not “talking” to other systems, this needs to be more open, to allow easier cross-referencing and monitoring.

• Acute care should also include social prescription indicators - this requires senior level commitment.

• IT systems could include quantitative monitoring to observe the numbers/epidemiology, judge the success in terms of numbers engaging and where, when and why they are engaging. We should not only observe the ‘program effect’, but observe and record what is happening around in the social system. This type of monitoring could help us to observe the causal links in an explicit way to will allow replication of the programs in other contexts/settings with a degree of confidence.