HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM SCOTTISH FA & HAMPDEN SPORTS CLINIC

INTRODUCTION

The Scottish FA & Hampden Sports Clinic welcome the Health and Sport Committee’s consultation on social prescribing of physical activity and sport. As the National Governing Body of the most popular sport in the country, we believe that Social Prescribing should play an integral part in communities across Scotland to help contribute to make the country ‘more active, more often’.

It has long been understood that many of the health issues in our communities can’t be ‘solved’ by traditional medical models particularly prescribing of medicines. It is acknowledged that the health of the population is determined by a range of factors including financial position, employment status, social class, family/networks and factors in the local and national environment such as access to recreational facilities, Social Index of Multiple Deprivation (SIMD), rates of crime and so on.

Social prescribing schemes have been well established within mental health agencies, both statutory and voluntary, with support staff on hand and a range of projects to engage participants including activity sessions, gardening, away days etc. as well as more sedentary opportunities such as cooking and arts based sessions.

Traditionally, General Practice (GPs) has involved a degree of advice and counselling together with signposting to other areas within and external to the National Health Service. However, increasing time pressure on GPs has reduced this community referral route. In addition, there is a lack of information or coordination of these services locally, making referral a ‘postcode lottery’ or haphazard at best.

The ability of football clubs and wider sporting organisations to attract and retain individuals cannot be underestimated, they play a fundamental role for the lives of individuals and communities across Scotland.

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

The key to social prescribing is a link/key worker who has the local knowledge and contacts for activities and the experience to “place” the individual in an activities that maximises adherence. No one is unsuitable for social prescribing – indeed the most isolated and vulnerable are likely to enjoy greatest benefit.

Appropriate activity based sessions can produce sustainable results. Indeed, referral based projects have demonstrated success. For example, an early adopter project in Renfrewshire gave free access to the local authority leisure facility with an initial and ongoing fitness consultation – these sessions were “prescribed” by the patient/clients GP.
Benefits were seen in **physical** (weight loss lower blood pressure), **mental health** (improved mood and reduced anxiety) and **social** (better integration with friends and family, less time spent alone) aspects. While all such projects will have an immediate and later fall-off adherence, when formally measured, the outcomes were excellent.

We also feel that football and its flexible game formats offer the opportunity for sustained engagement. The Scottish FA One National Plan - [https://www.scottishfa.co.uk/media/2386/scottish-fa-one-national-plan-2017-20.pdf](https://www.scottishfa.co.uk/media/2386/scottish-fa-one-national-plan-2017-20.pdf) illustrates that ‘Football for Life’ is a key pillar of the sports strategic direction. The opportunities for social prescribing in football is truly lifelong. Both on and off the pitch, from our early years programme, our small sided and full size player pathway through to programmes such as over 35’s, Walking Football to Football Memories. Football and its clubs can make a significant contribution to the health and wellbeing of communities across Scotland.

The recent project implemented by Dundee Green Health Partnership, with its multi-agency approach which included Dundee United Community Trust, is a model which could be replicated nationally and we would welcome the opportunity to roll out further projects using this method.

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. GP practices are now practice teams with practice nurses, community nurses and health visitors as part of the extended team. Many have links with mental health services and local voluntary agencies. The key is having the correct person with the right skill set, experience and personality to facilitate the action and the correct network around them to effectively support both individuals and communities.

In addition we feel that the current location of GP practices could be extended to include sports stadiums. For example, the links created with the GP and associated staff within the confines of a football stadium could lead to some natural wins both from a patient and stakeholder perspective. There are numerous examples nationally, of football club and ground based initiatives which demonstrate an increased uptake versus those in a ‘typical’ health setting.

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

Perception; football (and other sport) clubs are often viewed by those out with the sector as only providing playing opportunities for a select few in the community. However, in the past 10 – 15 years, an increasing number of these clubs offer both ‘on and off pitch’ activity for the benefit of the local community. Clubs are often the focal point of their community with a unique reach. The power of the badge cannot be underestimated in attracting those who choose not to engage through more traditional routes.
The Football Fans in Training (FFIT), delivered by the SPFL Trust [https://spfltrust.org.uk/ffit/](https://spfltrust.org.uk/ffit/) is one such highly successful programme which uses football clubs to attract a section of the community where 'normal' health care interventions have had limited impact.

Other key barriers to exercise include cost, need for equipment, insufficient time and family responsibilities. In addition low mood and/or anxiety can influence a person’s ability to engage. These can be overcome by free provision, a good range of attractive activity options and the enthusiasm of the key worker. For example, a study carried out by staff in Hampden looked at adherence to PE in adolescent girls in school. Levels in some schools were less than one third. By introducing dance as an option and providing better changing facilities (including hairdryers) this rose to 75% - and this was maintained when extended to boys.

We believe that many of these barriers can be removed by placing a greater emphasis on incentivising sport and physical activity for the population, both as part of primary and secondary care. Successful programmes in Nordic countries and Central Europe have created a system that recognises the role that sport and physical activity can play in preventing and treating illness and crucially increasing subjective wellbeing.

We would welcome the opportunity to demonstrate best practice from other UEFA nations on both the programme and infrastructure changes that have led to success in this field.

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

While the case studies and anecdotal stories are rich, the challenge we as a sector face is demonstrating both the quantitative and qualitative value of sport and physical activity.

Evaluation is key and the programme has to be seen to be working and be cost-effective. This should be a combination of quantitative research with a formal undertaking with both participants and staff and qualitative which is “softer” and should include personal experience, focus groups etc.

The role of football and other sports in both primary and secondary care is being increasingly explored. A recently published journal from Denmark titled “Football is medicine: it is time for patients to play!” stated that “More than 150 peer-reviewed articles published in 35 international scientific journals tell us that football is a joyful, social and popular sporting activity that is effective and versatile; a multipurpose type of training with marked positive effects for almost all types of people and across their lifespan”. Krstrup P, et al (2018) - [https://bjsm.bmj.com/content/bjsports/52/22/1412.full.pdf](https://bjsm.bmj.com/content/bjsports/52/22/1412.full.pdf)

The Social Return on Investment (SROI) is a key indicator on the success of such an initiative. The Scottish FA & UEFA recently undertook a piece of work to demonstrate the value of football participation to Scotland - [https://www.scottishfa.co.uk/media/4460/scottish-fa-uefa-sroi-digital-version-2.pdf](https://www.scottishfa.co.uk/media/4460/scottish-fa-uefa-sroi-digital-version-2.pdf). The report found that registered football activity is worth over £500 million, while if you include all non-registered activity and recreational players the figure is over £1.35 billion. Crucially,
the report demonstrated that football activity prevents 5,000 mental health cases and is worth approximately £700 million in terms of subjective wellbeing.