HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM SCOTTISH SPORTS ASSOCIATION

The Scottish Sports Association (SSA) thanks the Health and Sport Committee for the invitation to submit to this call for views.

The Scottish Sports Association (SSA) exists to represent and support Scottish Governing Bodies (SGBs) of Sport as the independent and collective voice for SGBs. We represent their interests and currently have ~50 full members and ~18 associate members. SGBs are responsible for the governance, development and delivery of their individual sports and provide a formal structure for the over 900,000 individuals in Scotland who are members of one of Scotland’s 13,000 sports clubs. Most of these organisations are run on a not-for-profit basis and are managed by volunteers. They provide coaching, competition and participation development opportunities for their local communities and most of the 195,000 people who volunteer in sport do so within the club structure.

The SSA has, as usual, compiled this submission in consultation with our members.

Summary

- Through performing their core role, sports clubs make an invaluable contribution to public health
- Through 13,000 sports clubs with 900,000 members, sports clubs are the largest setting through which an opportunity exists to promote health through the conduit of sport
- One key barrier is the lack of awareness of the benefits of sport and physical activity and of the CMO guidelines within the healthcare profession
- Public Health England states that a quarter of the population would be more active if they were advised to do so by a health care professional
- A strong understanding and application of the principles of health behaviour change will be required by those developing and delivering activities if they are to be of benefit to those previously inactive
- To be successful a more strategic and whole system approach is required – that sport and physical activity organisations (and the comparatively small budget associated with the sector) require support from not just the healthcare sector, but also professionals in social care, education, transport, justice, planning etc
- Access to a broader range of sporting and physical activities, through a supported pathway, could encourage the retention of participants with a variety of backgrounds, experiences and motivations to continue to reap the health, wellbeing and social benefits of being active
- Fully understanding an individual’s interests and motivations could help to identify the most appropriate and appealing sporting/active opportunity for an individual, which is likely to increase the participation rates in such schemes
- The services which people are referred to in social prescribing are nearly always provided by the voluntary and community sector but social prescribing initiatives rarely offer any resource to help with their capacity to deliver what is required
- A key factor in the success of any intervention relies upon the quality of the offering; the provision of sport/physical activities opportunities are no different. Providing such quality and diversity of opportunities requires resources
The ‘Sport Clubs for Health’ proposal be reviewed in relation to its applicability for Scotland and for additional resources to be released to enable this

The resourcing of social prescriptions should be considered in parallel with those for medical prescriptions – i.e. that they are provided free of charge through the NHS for as long as they are required.

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

*Sport and physical activity evidence*

The evidence which supports the contribution of sport and physical activity to improving health and wellbeing is both extensive and compelling (and is summarised in our WhySportMatters resources).

The contribution of sport and physical activity to health and wellbeing is particularly important in considering the World Health Organisation’s (WHO) definition of health:

“A state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity”.

Our members would like to highlight the following evidence which may be most relevant to this call for evidence in highlighting why sport, in addition to other forms of physical activity, plays such an important role:

- Vigorous-intensity physical activity may produce greater health benefits than moderate-intensity physical activity
- High intensity levels characterise many sports disciplines
- The UK Chief Medical Officers’ physical activity guidelines contain three components. While the 150 minutes of moderate intensity activity each week is the most commonly quoted, the requirement to also undertake two sessions to improve muscle strength per week is less commonly cited (the third aspect is minimising sedentary time) – and is most frequently undertaken through sporting activities
- Through performing their core role, sports clubs make an invaluable contribution to public health
- People who participate in sport through a club environment participate more often and for longer than those that participate within other environments
- Through 13,000 sports clubs with 900,000 members, sports clubs are the largest setting through which an opportunity exists to promote health through the conduit of sport
- Social prescribing to a sport through a club environment appropriate to the needs of the individual brings significant additional benefits in alignment with the WHO definition of health, as summarised in the diagram below (Kokko & Vuori 2007, from Sports Club for Health 2017):
Social prescribing evidence

Evidence supports the general premise of social prescribing as a form of early intervention for social and health inequalities in improving health and wellbeing outcomes through a positive impact on physical and mental health and wellbeing, thus resulting in a reduced reliance on NHS services.

In line with the response from our partners at SCVO: the ‘Connecting communities and healthcare: Making social prescribing work for everyone’ research on social prescribing published in July 2019 by The National Lottery Community Fund suggests that resources have largely gone into supporting the link worker role common in most social prescribing initiatives, but the National Lottery Community Fund’s view is that that is not enough. The services which people are referred to in social prescribing are nearly always provided by the voluntary and community sector but social prescribing initiatives rarely offer any resource to help with their capacity to deliver what is required.

Social prescribing is effective if it does more than simply signposting. Other research papers suggest there is a need for better evidence to show the strength and impact of social prescribing if it is to become embedded within health services.

More specifically relating to the social prescribing of sport and physical activity, The National Institute of Health and Clinical Excellence (NICE) has produced two sets of guidance:

- Physical activity: brief advice for adults in primary care
- Physical activity: exercise referral schemes

Further, Public Health England states that a quarter of the population would be more active if they were advised to do so by a health care professional.

In supporting the response of our partners at the Scottish Volunteering Forum: traditional medical prescriptions are often viewed as essential and patients are likely to follow them without question. A different approach would be required for social prescribing as activities which can benefit health and wellbeing, such as volunteering, are only likely to be beneficial if those participating in at are doing so of their own volition.
Participation in any form of volunteering, or activity supported by volunteers, has the potential to increase confidence, forge social connections and lead to sustained behaviour change regarding physical activity. As a result it has strong links with the health and social care agenda, and is reflected in both local and national wellbeing outcomes.

In addition to the more common exercise referral programmes, there are an increasing number of sport/physical activity social prescribing options which have shown benefits for both physical and mental health while also aiding community cohesion, developing new and life skills, reducing stress and providing opportunities for social interaction and having fun. Examples of such activities include walking (including though the supported health walks offered through Paths for All, amongst others), golf, adapted or modified sports including walking football and ongoing initiatives provided for people with a disability through Scottish Disability Sport (SDS).

SDS has been working in partnership with a wide range of health professionals for many years (including ~150 referrals in the past 2 years) to support sport and physical activity referrals for individuals with a disability, demonstrating the profound health, wellbeing and social benefits which can be accessed through participating in sport and physical activity.

Sustaining participation in sport and physical activity
Research has shown that a limited choice of activities can reduce the uptake of exercise referral schemes. While popular, anecdotal evidence suggests that walking health/referral groups, which are not necessarily set up to support social prescribing, often become full and unable to support further referrals due to individuals wishing to remain within the group rather than being supported towards other activities; ongoing support and exit strategies are required to help to overcome this issue. Such opportunities, in line with research on golf referrals suggests that as well as being beneficial activities in their own right, these activities may also provide a gateway to other activities should such a pathway exist.

Access to a broader range of sporting and physical activities, through a supported pathway, could encourage the retention of participants with a variety of backgrounds, experiences and motivations to continue to reap the health, wellbeing and social benefits of being active. However a strong understanding and application of the principles of health behaviour change will be required by those developing and delivering such activities, if they are to be of benefit to those previously inactive.

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)

Our members assume that the most successful approach to any process relating to behaviour change of any kind would be taken in consideration of and discussion with the individual/patient concerned (through a process of ‘co-designing’). Adopting a person-centred approach allows the interests, preferences, motivations, experiences and needs of the individual to be married with the expertise of health professionals to find the option which the individual is most likely to: initially attend, benefit from, enjoy, complete any specific programme/scheme/timeframe and then maintain/progress their participation either in the same activity and/or through a pathway to exploring a new activity.
Where they exist, it may prove beneficial if Community Link Workers could assist in this co-design through behaviour change processes and taking the time to fully explore and understand individual interests and motivations as well as having access to a network of diverse, welcoming, accessible, affordable and inclusive local opportunities. Fully understanding an individual’s interests and motivations could help to identify the most appropriate and appealing sporting/active opportunity for an individual, which is likely to increase the participation rates in such schemes.

Another key factor to be explored in such discussions is the nature of the individual’s challenges, the local services available and the positive impacts of different types of sports/physical activities. A useful starting point for such discussions would be the following assessment of the positive impacts of different types of sports on key health outcomes (from Sport Clubs for Health 2017).

![Expected health outcomes table]

There are 13,000 sports clubs across Scotland – ensuring that provision is both diverse and local in communities throughout Scotland. The forthcoming connection between ALISS (A Local Information System for Scotland) and the National Services Directory via NHS Inform should provide a mechanism for more local and community activities to register on the site and for their activities to be searchable by a wide range of health practitioners and the general public.

Research by SDS in 2018 showed that 42% of respondents felt that access to more opportunities would make it easier to get involved in sport or other physical activity. However those delivering such opportunities need to have to appropriate knowledge and skills in health behaviour change to appropriately motivate and support individuals to achieve long term health behaviour change.
3. What are the barriers to effective social prescribing to sport and physical activity and how are they being overcome?

Access for the least active
Those who would reap the greatest benefits of being active, are often those that are not currently active. For the least active in society, participation in sport and physical activity may not be considered a top priority nor be seen as their most significant challenge. In such instances, an integrated approach to providing support, which may involve an appropriate aspect of sport/physical activity which may help to alleviate challenges may prove a useful starting point.

Individuals who are least active in society include those who are in long term care, have significant and often long term health issues and often who may have complex and inter-related challenges and/or dependencies. While these individuals have the most to gain from being active, they also highlight the reliance of and the role for non-sporting organisations to support and guide individuals to consider sport and physical activity and to facilitate and support an appropriate introduction to activity. Supporting the least active to become active is an excellent example of where a whole system approach is required – that sport and physical activity organisations (and the comparatively small budget associated with the sector) require support from not just the healthcare sector, but also professionals in social care, education, transport, justice, planning etc.

Knowledge and awareness of healthcare professionals
One key barrier highlighted by our members is the lack of awareness of the benefits of sport and physical activity and of the CMO guidelines within the healthcare profession; research shows the following levels of awareness of the CMO guidelines:

- GPs = 20%
- Nurses = 59%
- Physiotherapists = 16%.

Further, 72% of GPs do not discuss the benefits of sport and physical activity with their patients. This is further exacerbated by the fact that only 4% of the population are, themselves, aware of the CMO’s guidelines.

Increased support and training for healthcare professionals may prove beneficial in helping to upskill individuals in raising sport and physical activity with their patients. Further, a requirement for all GP consultations to ask patients about their physical activity habits (in the same way they do about smoking and alcohol habits) may also prove revolutionary in enhancing awareness in both professionals and patients as well as facilitating an opening dialogue about being active.

While some feedback to date has highlighted the important role of the Community Link Workers and the opportunity they provide in this facilitation, the fact that the role is not universally available in all local areas presents a challenge to ensuring access to this support across Scotland.

It is also understood that healthcare professionals themselves have reported a key barrier to social prescribing referrals is a lack of knowledge about where or how to signpost patients to local services.
A mechanism for healthcare professionals and sport/physical activity professionals to shape and share expertise, guidance and practice would be welcomed to optimise existing knowledge and expertise.

**Access to appropriate opportunities**
It is assumed that the most commonly cited barriers to sport and physical activity are also relevant to the social prescribing of sport and physical activity. As such, the following factors need to be considered:

- Access to local facilities and clubs (including access to transport as required)
- Affordable access to activities
- Inclusive sporting/activity opportunities
- Access to a diverse range of sporting/activity opportunities
- Provision of a welcoming environment
- Provision of supported pathways to enable people to easily engage and continue to develop within an activity/activities
- Provision of flexible opportunities at a range of times
- Awareness of a range of opportunities for various levels of participants, abilities, ages and motivations.

The diversity and local nature of Scotland’s 13,000 sports clubs present a significantly underutilised asset to help to improve Scotland’s health and wellbeing. ‘Sports Clubs for Health’ (2017) identifies a wide range of ways that sports clubs can further enhance the nation’s health through both:

- The direct provision of sporting/physical activities
- Promoting the benefits of taking part in sport and being active.

In optimising the uptake and retention of individuals in social prescribing schemes, and as participants in sport and physical activity more generally, a diverse menu of different opportunities and a pathway promoting transitions between different activities needs to be available.

In addition to the direct provision of sporting/physical activities – the provision of environments where people can enjoy being active is also vital – including access to, and promotion of, parks/green spaces and paths for walking and cycling.

**Ambiguity around referral qualifications**
Some of our members have reported a barrier around information they have been provided with which states that in order for a sports club/programme to have patients referred to it, the programme leader/coach requires to have undertaken a Level 3 Referral qualification. Without this qualification, they have been informed that the sports programme/club is not recognised as suitable to accept direct referrals by healthcare professionals. We understand that NHS Health Scotland is currently taking work forward to identify the core components of an exercise referral quality assurance framework and we look forward to being engaged in such discussions as this work progresses.

The vast majority of sports clubs and sporting opportunities are run by volunteers. To expect volunteers to undertake such training could prove a significant additional barrier. Clarification is sought urgently in relation to this advice.
A strategic approach

Our members would prioritise the need for a more strategic approach to be taken to both embed the social prescribing for sport and physical activity model and to ensuring the provision of a suitably diverse range of quality opportunities.

Feedback from our members to date shows that often the current approach relies upon trusted relationships between individuals, as opposed to a holistic and systematic approach. Embedding such an approach will also require suitable resources to support the delivery, as well as appropriate publicity, monitoring and evaluation.

A good example where a holistic approach and suitable publicity are required relates to the findings of the Activity Alliance, who reported that 47% of people with a disability fear losing their benefits if they are seen to be physically active.

It is vital to accept that social prescribing as a stand-alone mechanism will not result in increased and sustained participation in sport and physical activity; the supporting environment, culture and systems must all work together to ensure a holistic approach is taken.

Resourcing

A key factor in the success of any intervention relies upon the quality of the offering; the provision of sport/physical activities opportunities are no different. Providing such quality and diversity of opportunities requires resources. It is also vital to understand that often supporting those that are currently inactive or who face greatest disadvantage may require a specific focus, a specialised approach and, therefore further additional resource. Many sports clubs are run by or supported by volunteers – this does not mean this resource is free, and resources will be required to enable the delivery, training, promotion and general support for clubs to engage with such opportunities.

Our members would also suggest that the ‘Sport Clubs for Health’ proposal be reviewed in relation to its applicability for Scotland and for additional resources to be released to enable this.

Our members would propose that the resourcing of social prescriptions should be considered in parallel with those for medical prescriptions – i.e. that they are provided free of charge through the NHS for as long as they are required. This is contrary to feedback received from some current social prescribing approaches, whereby the patient is expected to pay all or part of the costs of the activity.

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

Our members support monitoring and evaluation encapsulating the wide range of benefits of participation in sport and physical activity – including physical, mental and social health and wellbeing – and considering quality of life and perhaps the wider impact on the health and social care system.

In support of the response from our partners at SCVO: the monitoring and evaluation of social prescribing needs to be facilitated by those who are making the prescription, but it is vital that this is not overly formalised. It should be based on self-reported and qualitative
evidence based on personal outcomes agreed with the individual. Therefore it is vital that a baseline measure is established to adequately ascertain progress made, and we would suggest that progress is self-reported at follow up medical appointments or appointments with the Community Link Worker.

Any monitoring tool needs to be proportionate, simple, effective and allow enough consistency for local and national monitoring. The availability of training and support may also be beneficial in this regard.