

Health and Sport Committee, Scottish Government

Preventative Agenda Inquiry - Call for Views



Faculty of Sport and Exercise Medicine UK Response

Below is detailed the role of physical activity in population health and the impact a more active nation would have on the health of a nation. In responding to the call for views on prevention strategies, the Faculty of Sport and Exercise Medicine (FSEM) UK is able to provide clear guidance and support for prevention strategies focussed on the role of physical activity in a community, the known benefits and the role that a structured Sport and Exercise Medicine Consultant (SEM) would bring to the wider clinical and social structure in the Scottish Healthboards.

Essential Reading

- **Sport and Exercise Medicine A Fresh Approach 2011**
http://www.fsem.ac.uk/media/4165/sport_and_exercise_medicine_a_fresh_approach.pdf
- **Sport and Exercise Medicine A Fresh Approach in Practice 2015**
<http://www.fsem.ac.uk/media/33484/a-fresh-approach-in-practice-full-pages.pdf>
- **Scottish Physical Activity Pathway**
<http://www.healthscotland.scot/health-topics/physical-activity>
- **Everybody Active Everyday – Public Health England report**
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/374914/Framework_13.pdf

Which areas are most useful to investigate?

It is well known that leading a more active lifestyle has health benefits and these are well researched and studied the world over. The benefit is not just for prevention but also maintenance of health in situations where an illness is present (eg: diabetes, mental health, osteoarthritis). On average, an inactive person spends 38% more days in hospital than an active person, and utilizes 5.5% more GP visits, 13% more specialist services and 12% more nurse visits than an active individual.

Where impact will come from is creating a healthcare / community / social interface where the benefits of active lifestyles (eg: active commuting, active schools, active leaders) become second nature to a community. Healthcare teams are no longer a traditional medic and nurse led structure but include wider allied health professionals such as physiotherapists, orthotists, podiatrists, psychologists and exercise physiologists. These teams are now starting to integrate with social and community based structures such as city councils, council sport departments, regional authorities and central government departments.

It would be encouraging to have in each Healthboard of Scotland a “Physical Activity Champion”, a Sports & Exercise Medicine Consultant who understands the impact of inactivity on disease and population health, who can lead the wider integrated team eluded to above and influence local and national governmental bodies. That Consultant would also provide a service to colleagues across the medical specialties, advising on prevention strategies that are researched and impactful (eg: ischaemic heart disease, stroke, certain cancers, diabetes, mental health), providing clinical support for complex rehabilitation cases or areas such as concussion where supervision of return to work / return to play is becoming increasingly important. There are the additional skills that can be utilised in the musculoskeletal pathway, reducing referrals to secondary care, reducing radiology burdens, improving patient outcomes and access to the right person at the right time.

Such roles already exist in NHS England. There are currently 56 NHS SEM Consultant posts in England, working over 16 NHS Trusts. There are 44 National Training Numbers with 12 new trainees per year. There are three National Centres for Sport and Exercise Medicine where NHS care, research and care of the performance athlete are delivered. These integrate with local authorities to look at the wider population health and inactivity endemic. Scotland had 4 training numbers for a few years, stopped in 2013. No substantive posts in the NHS for this cohort has meant that all 4 are now working outside Scotland, in the NHS under another role (GP or A&E) or in professional sport. Trained in NSH SEM, currently inactive in NHS SEM.

NHS Tayside has had an intermediate care MSK clinic for 12yrs, instigated in 2005 and led by a Sport & Exercise Medicine Practitioner which replicates the data noted in England and in some instances, provides greater patient care evidence. There are no other such services in NHS Scotland although there are developments for better integrated MSK care in Scotland utilising Allied Health Professionals.

There is an opportunity to link NHS Scotland with local authorities alongside sportscotland (as national agency for sport) to create centres for health and wellbeing, where living an active lifestyle is promoted, health and sport interventions can occur (eg: community activity classes), specialist clinical care can be delivered and NHS staff can learn and improve their own wellbeing through access to education and physical activity. These centres can also act as research hubs with key links to university departments. Using specialist knowledge in sport and physical activity alongside local community planning knowledge would create a service that brings health and community care closer.

NHS England, following the London 2012 Games, created the legacy of the National Centres for Sport and Exercise Medicine where SEM services are blended with research and community care. These are situated in Sheffield, Loughborough and London and have close links with respective universities. These deliver all that is noted above.

Spend

Spending shift from reactive/acute services to primary or preventative services must be backed with evidence.

Musculoskeletal (MSK) Service

Setting up an MSK service to offload traditional Orthopaedic referrals is already known to save £62 - £85 per consultation. NHS Tayside MSK clinic, over a 10 year period, seeing approximately 800 patients per year in one session per week has created a £500k - £650k saving. The evidence from England reflects this economic benefit too.

Physical Activity and population health

The question about incentivising or speeding up the shift of monies from reactive to prevention work has to lie in the presentation of evidence. A good point in case is diabetes. Taking UK as a whole, there is an estimated £10bn spent on the care of patients with diabetes. Within Scotland, there are 275000 people with diabetes and an estimated 600000 at risk of diabetes. By working on preventing diabetes in the 600000 at risk, there are longer term savings to be made. The research evidence is available (Journal of Public Health March 2012) where NICE guidelines on cost effectiveness of intervention are applied. Physical activity interventions are cost effective and we know that leading a more active life reduces your overall risk of diabetes by 30%. Applying this to 600000 Scots at risk of diabetes, 180000 would be spared the illness by a simple intervention.

The evidence for a whole host of clinical areas is compelling and researched. With risk reductions ranging from 24% to 50% in common conditions such as breast cancer to hypertension, applying resource to prevention strategies will bring return clinically (which is the most important patient-centred aspect) and financially. There are trained health care clinicians, SEM Consultants, who can assist with and deliver this to the NHS in Scotland.

Further Communication / Correspondence

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