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

There are a number of examples in Ayrshire and Arran where physical activity is a key consideration within clinical consultations and through which social prescribing/exercise referral may result.

The Scot-PASQ has been integrated into routine consultation across a range of staff groups such as Allied Health Professionals (AHPs), mental health and occupational health. Examples of programmes which have an element of exercise referral include: our adult weight management programme (Weigh to Go); the Healthy Active Rehabilitation Programme (HARP); Invigor8 (falls prevention), Mind and Be Active; and McMillan Move More in which participants who may be living with a health condition can self refer or be referred by a clinician to a range of physical activity opportunities delivered by local leisure services.

In Ayrshire we are also leading two demonstration projects as part of the Our Natural Health Service programme to support people to engage more with nature. An element of this involves green health referral/prescription by clinicians into nature based activities such as Green Gyms, community gardening, walking programmes and conservation activities.

It is our understanding that data on sustained engagement resulting from social prescribing is not routinely collected in Ayrshire and Arran. However, key ingredients which appear to be important in securing longer term lifestyle change are: ensuring there is a social element to the activity; that activities are embedded within and enable people to become more involved in their local communities; and that participation is open ended and flexible rather than time limited. There is also evidence to suggest that success is increased if the referral process is mediated by a ‘dedicated person’ and if support/buddying is available. This might come from ‘the dedicated person’ and/or from natural support within communities (which might include intergenerational support).

Our Community Links Practitioners (CLP)/Community Connectors (CC) are central to local social prescribing within Primary Care and provide the role of the ‘dedicated person’ mediating the referral process. An evaluation of the service in one of our HSCP areas highlighted issues which may be of interest to this review which include: the need for operational guidelines and procedures for referral; clarity around the role of CLW/CC and clear communication of the role of the service to other providers; the need to invest in training and skills development in CLP/CC; and the need for investment in befriending to support social prescribing.
It is also worth noting that a range of social prescribing takes place – not all of which is physical activity or sport focused but much of which will have health and wellbeing benefits. Conversely, there are wider benefits to health and wellbeing of sport and physical activity prescribing. This may also be of interest to this review.

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)

A wide range of health and social care professionals (in addition to staff within other services such as housing and emergency services) are well placed to participate in social prescribing if they have the knowledge, skills and confidence to do so.

Within this there is a need to: assess a person’s readiness and ability to take part (particularly during recovery from illness); have knowledge of the availability, accessibility, suitability and benefits of activities, and have confidence in the skills and knowledge of those delivering them.

Self referral is also important, however, ensuring that people who are able to make the decision themselves of whether or not to participate are encouraged to do so with the support of professionals if needed.

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

A wide range of referral routes are required from a range of practitioners and services to enable throughput to community services; however this needs to be balanced by ensuring that community based services are adequately supported and have capacity to deliver. There is a risk of shifting the emphasis to community providers without this being accompanied by adequate investment and support.

Maintaining a live list of community providers that have capacity to receive referrals is always challenging and, as a result, clinicians sometimes build up a local knowledge of activities they know and are comfortable to refer to, perhaps at the expense of others.

Practitioners involved in social prescribing need to have the knowledge, skills and confidence to refer; and need to feel confident about participant follow-up mechanisms and the overall sustainability, accessibility and suitability of community based activities before they will make referrals. Referral processes needs to be kept simple and information exchanged based on a need to know basis and appropriately protected in line with GDPR requirements. Therefore, standards and quality assurance are important but can create barriers to delivery if they are too prescriptive and are not proportionate to the size and capacity of the provider. Quality assurance in social prescribing has recently been explored by The Conservation Volunteers (TCV) on behalf of The Social Prescribing Network in England.

There is a also a need to ensure that wider infrastructure and planning decisions support social prescribing e.g. that there is sufficient and equitable quality, accessible greenspace,
active travel infrastructure and leisure provision in local communities. Therefore policies across Community Planning partners require to be complementary, have shared outcomes and maximise their impact on health and on addressing health inequality.

There are also financial barriers to social prescribing which may affect longer term participation in physical activity or sport. These include costs of activities, equipment such as footwear, and transport costs to access activities. Locally, this is being addressed in part by some of our programmes e.g. by providing families with leisure passes as part of the child healthy weight programme; however it is unclear at this point whether this is enough to support behaviour change in the longer term.

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

Evaluation requires to be proportionate to investment and should build on sufficient, transferable evidence generated elsewhere.

Although it may be of interest to gain a sense of output and to understand the volume of throughput from referrers to providers it is more important to understand: how systems and processes work; what the key elements of success are; what barriers were experienced and how this has impacted on the lives of participant and how services operate.