HEALTH AND SPORT COMMITTEE

SOCIAL PRESCRIBING OF PHYSICAL ACTIVITY AND SPORT

SUBMISSION FROM: A JOINT SUBMISSION FROM NHS HEALTH SCOTLAND AND THE SCOTTISH DIRECTORS OF PUBLIC HEALTH

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

a. Limited but growing evidence

Whilst there is limited robust evidence available on the impact and or cost effectiveness of social prescribing programmes per se\(^1\), there is evidence of social prescribing as an early intervention approach used to achieve population health and wellbeing outcomes by tackling social and health inequalities\(^2\). Evaluations show that social prescribing can have a positive impact on physical and mental health and wellbeing and thereby reducing the demand on healthcare services\(^3\)\(^4\)\(^5\)\(^6\)\(^7\).

b. Evidence Based Physical Activity Interventions

With respect to social prescribing as a means of achieving sustained participation in physical activity for health and wellbeing, there are currently two inter-related evidence based approaches applicable to this context. NICE have produced public health guidance for both; Physical activity: brief advice for adults in primary care (PH44), (NICE; 2013)\(^8\) and Physical activity: exercise referral schemes (PH54), (NICE; 2014)\(^9\). Both approaches are person centred and include elements of health behaviour change, signposting and or formal referral and align with the principles of social prescribing.

c. NHS Health Scotland National Physical Activity Pathway

The NHS Health Scotland National Physical Activity Pathway (NPAP)\(^10\) is underpinned by NICE public health guidance PH44, as a clinical and cost effective intervention\(^8\). The NPAP is designed to enable health care professionals to integrate physical activity into existing practice. This is achieved by taking a person centred approach and utilising health behaviour change techniques, such as motivational interviewing. Using these approaches health care professionals are able to appropriately; raise the issue of physical activity with those within their care; assess a person’s physical activity levels; deliver physical activity brief advice; signpost on to local physical activity opportunities; or where further support is required, refer onto those able to provide further structured support in the form of a brief intervention, such as an Exercise Referral programme, Lifestyle Advisor or Link Worker (where such opportunities exist, as they are not universally available across Scotland).

It is estimated that one in four people would be more active if advised to do so by a health care professional\(^11\). Therefore, there is significant potential to increase physical activity levels of those in contact with health care professionals by incorporating physical activity into routine practice as advocated by the NHS Health Scotland NPAP.

d. Exercise Referral
Exercise referral is one of the most popular interventions used by health care professionals to encourage inactive individuals who are at risk of developing, or living with, a long-term condition to become more physically active. Whilst a National Exercise Referral Scheme exists in Wales\(^{12}\), none of the other home countries have adopted a national approach.

Exercise referral schemes operate in various ways; typically schemes involve a partnership between multiple agencies such as local NHS health boards, general practices, community health partnerships, local authorities and leisure service providers.

A recent audit defined exercise referral as “any physical activity intervention that includes a referral by a health care professional to either a physical activity specialist or third-party physical activity/exercise service provider; to conduct an initial, individualised assessment to determine what type of physical activity to recommend for the individual’s specific needs and an opportunity to participate in a tailored programme of physical activity, exercise or sport\(^{21}\).

A number of factors influence the effectiveness of exercise referral schemes, including the intensity, duration and frequency of the exercise sessions, the experience and skills of those delivering the sessions\(^9\) and the proportion of those referred who initially participate in an exercise referral scheme (‘uptake’) and of these individuals how many continue to participate (‘adherence’)\(^{13}\). The uptake and adherence rates can be affected by the referral methods, the number of exercise sessions offered\(^9\) and the type of disease the person being referred has and the follow-up period\(^{14}\).

An economic analyses undertaken by NICE\(^9\) found that exercise referral schemes are less cost effective than physical activity brief advice. This was primarily due to the cost intensive nature of exercise referral compared to physical activity brief advice.

A Health Technology Assessment found that exercise referral schemes showed a small improvement in the number of people who increased their levels of physical activity\(^{15}\). A recent preliminary systematic review found that exercise referral schemes increased physical activity levels for people with cardiovascular, mental health and musculoskeletal disorders\(^{16}\). Similarly, the evaluation of the national exercise referral scheme in Wales\(^{12}\) concluded that exercise referral schemes can promote physical activity in the short term but only in certain populations and may be ineffective in sustaining long term outcomes. A study in Northumberland\(^{17}\) found that physical activity levels increased but remained below the national recommendations. A systematic review examined the effect of social prescribing on physical activity and other outcomes and found evidence of a short-term increase in physical activity when exercise referral schemes were compared with usual care, but there were no statistically significant differences\(^{18}\).

With this in mind, NICE\(^9\) err on the side of caution and only endorse the delivery of exercise referral for people who are sedentary or inactive and have existing health conditions or factors that put them at increased risk of ill health. In doing so, schemes are required to incorporate recommendations 7–10 of ‘Behaviour change: individual approaches’ NICE public health guidance \(^{49}\). Therefore, exercise referral schemes
should only be implemented in accordance to evidence of effectiveness as stated by NICE.

e. Other forms of physical activity social prescribing

Whilst the NPAP and exercise referral models primarily focus on increasing physical activity levels to prevent, manage or alleviate multiple health conditions. Models also exist with a specific focus on single issues such as mental health, cancer, falls, pain management, stroke, diabetes or healthy weight.

In addition, other forms of physical activity social prescribing exist where physical activity is the vehicle through which co-benefits for mental health and wellbeing are achieved. These activities include health walks, modified sports such as walking football, netball or rugby and green health initiatives which, reduce social isolation, provide mechanisms of social support, reconnect people with nature, create community cohesion, develop life skills, reduce stress, and quite simply enable people to have fun. For instance, Paths for All support the development of health walks in communities across Scotland by trained leaders targeting inactive individuals or individuals living with a LTC. These have been extensively evaluated as having positive outcomes as well as having a strong social return with every £1 invested generating around £8 of benefits²⁰.

f. How to achieve sustained change

The act of social prescribing alone will not lead to sustained physical activity levels, unless the systems, culture and environment in which the programme exists are also conducive to physical activity. It is therefore important to consider aspects such as the social prescribing and physical activity knowledge of health care professionals, the process by which and the nature of the services to which someone is referred⁹ ¹⁰ ²¹.

Findings from the NPAP Feasibility Study²² and more recent evidence from Public Health England’s Moving Health Professional Programme²³ provide mechanisms to upskill health professionals and enhance their ability to integrate physical activity into routine patient care, which in turn would lead to more people being appropriately signposted or referred to local services.

Evidence suggests that to achieve sustained participation in physical activity someone will require long term health behaviour change support. e.g. frequent follow up over a 12 month period²⁴ ²⁵ ¹⁰ ²⁶ that develops motivation, confidence, physical competence, knowledge and understanding to value and take responsibility for engagement in physical activities for life²⁷ and also that the environment in which they live is supportive of an active lifestyle⁸.

This reflects the need to consider social prescribing as part of a whole system approach and to utilise evidence based approaches such as the NPAP; consider the workforce development needs of health care professionals to raise the issue of physical activity; the existence of support roles such as a Link Workers or Physical Activity Counsellor to provide long term health behaviour change support and access to appropriate local community based services such as Exercise Referral, Health Walks, Green Health initiatives. As well as seeking to effect behaviour change it is important to create
‘supportive’ environments and these include access to green space, cycle and walking pathways, as well as affordable, appropriate community facilities.

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. Person centred**

   Social prescribing encompasses prevention and early intervention as well as supporting the management and promotion of self-care for people with long term conditions, all of which can help to reduce future demand on primary care services.

   Adopting a person-centred approach focuses on the needs, preferences and interests of the individual. It involves a conversation shift from asking ‘what's the matter with you’ to ‘what matters to you’ and aims to support individuals to take greater control of their own health in line with the psychological principles of autonomy, motivation and self-efficacy. Those referring people onto a social prescribing scheme should be discussing it with them and deciding together if and which type of social prescribing scheme is the most appropriate to meet their needs. Therefore, physical activity may not be discussed, if not relevant to the individuals needs at the time of consultation with the link worker or equivalent support worker. Providers of social prescribing should be able to ‘co-design’ solutions for people that consider the wider determinants of their health and help people to choose activities that address these needs.²⁸

   Recognising the constraints on health and social care services, Community Link Workers (CLWs) can use evidence-based behaviour change techniques to support the individual to consider their own wellbeing and to identify interventions appropriate to their own needs. CLWS can invest time with the individual to understand their personal circumstance in a holistic manner to address any barriers. At times, it may be necessary for a GP or health professional to provide advice where an underlying medical condition is concerned. Need to know information should be included in any referral pathways between the health professional and the community link worker with the individual’s consent.

   **b. Inclusion and exclusion criteria**

   A recent audit of exercise referral schemes in Scotland²¹ collated data on inclusion and exclusion criteria, which differed from scheme to scheme. Generally, inclusion criteria included the following; being physically ‘inactive’; having one or more long term condition; having a risk factor that could lead to a long term condition; being motivated to increase physical activity levels (stage of change). While the exclusion criteria generally consisted of; client having had a ‘recent’ acute event; presence of an unstable health condition; already regularly physically active; previous participation in the scheme and not living in the designated area for the scheme.

   A similar inclusion and exclusion criteria was developed for the NPAP. Inclusion primarily focuses on those who are inactive or sedentary, have one or more stable long term condition or other factors which put them at increased risk of ill health. The exclusion criteria is minimal and restricted to those with unstable conditions and recent acute events²⁹. This criteria was based on evidence from similar approaches.³⁰
Evidence shows that individuals living in the most deprived communities are 30% less likely to meet the minimum physical activity guidelines compared to those living in more affluent communities\(^3\). There is a need to ensure that interventions are targeted and remove barriers to participation. The inclusion and exclusion criteria for a social prescribing activity will depend on the nature of the activity, the target audience and the referral model applied (formal or self-referral). Referral to exercise referral should also consider the individuals needs and motivations, and it may be more applicable to ensure that the individual is able to access a more community based resource such as a local sports club or exercise class.

c. Referral model

Social prescribing is more than simply a process of referral or as a method of signposting individuals to community provision. At its best, social prescribing is a unique ‘pathway’ in which individuals meaningfully participate in the selection of the support they are offered. It involves building relationships and supporting people throughout their participation\(^2\). Effective referral is crucial to ensure both a smooth process and improved outcomes for individuals\(^2\). This requires a workforce that is equipped with the necessary knowledge, skills, competencies and time to effectively support people making changes in their lives which result in improved health and wellbeing.

It is recognised that due to funding restrictions, some projects may have explicit referral criteria and therefore there may be some variable factors e.g. age, employment status. Where possible referral guidelines should be designed to fit the target population for the social prescribing scheme, as clear guidelines will ensure that individuals receive the most appropriate support dependent on their circumstances\(^2\).

d. Referrers

A review\(^7\) found that GPs and practice nurses were the main sources of referral onto a social prescribing scheme. However, there is growing evidence of more health professions engaging in the promotion of physical activity and social prescribing\(^5\),\(^3\)\(^1\),\(^8\). The recent audit of exercise referral in Scotland found that GP referrals are still prominent in most schemes but since the initial development of exercise referral schemes the range of healthcare practitioners referring into schemes has grown. Most schemes are now accepting referrals from many different healthcare professionals such as physiotherapists, practice nurses, mental health professionals, specialist nurses, occupational therapists, community nurses/health visitors/midwives and dietitians\(^2\)\(^1\). With this in mind the NPAP is targeted at and appropriate for delivery by a range of health care professionals\(^3\)\(^2\).

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

a. Physical activity knowledge of health care professionals

One of the main barriers to physical activity social prescribing is a lack of awareness of the importance of physical activity amongst health care professionals. Studies show that as little as 20% of GPs\(^3\)\(^3\), 59% nurses\(^3\)\(^4\) and 16% of physiotherapists\(^3\)\(^5\) are aware of the
current UK CMO Physical Activity Guidelines\textsuperscript{36} for adults and as many as 72\% of GPs do not discuss the benefits of physical activity with patients\textsuperscript{33}. Therefore actions are required to increase the physical activity knowledge of health care professionals. Public Health England’s Moving Health Professional Programme\textsuperscript{23}, provides an approach and mechanisms to upskill health professionals and enhance their ability to integrate physical activity into routine patient care, which in turn would lead to more people being appropriately signposted or referred to local services. This approach is reinforced in guidance on physical activity\textsuperscript{37} developed to accompany the All Our Health Framework\textsuperscript{38}. However further resources are required to upscale this approach in Scotland.

b. Uptake and adherence

Barriers to joining and participating in the social prescribing schemes include fear of stigma of people knowing they have a particular problem because they are participating in the scheme, patient expectations and the short-term nature of the interventions\textsuperscript{39}. The Pesheny qualitative study\textsuperscript{39} also found that people were likely to uptake and adhere to the social prescribing scheme if they trusted their GP, they had supportive link workers and service providers, free services and if they could see the need and benefit of the programme i.e. improved benefits in physical and mental health\textsuperscript{39,31}.

With reference to exercise referral, the reasons for not joining the intervention include; limited choice of activities and sessions not being subsidised after the initial intervention has finished\textsuperscript{5}. Poor referral practices and staff training can affect the effectiveness of exercise referral schemes\textsuperscript{9}.

Offering a variety of exercise and/or physical activity options including alternatives to gym-based activities and having flexible session times might overcome some of the above barriers\textsuperscript{31}. Schemes may be less effective because they do not fully account for participants’ motivation and ability\textsuperscript{9}. Having tailored exercise programmes to meet individual needs will help with adherence to scheme and therefore make them more effective\textsuperscript{31,9,13}.

NICE suggest in their guidelines for exercise referral schemes\textsuperscript{9} that ‘Behaviour change individual approaches’ (NICE public health guidance 49)\textsuperscript{19} should be included in the schemes. These individual approaches include recognising when people may or may not be open to change; agreeing goals to help change behaviour; tailoring interventions to individual need and monitoring progress and providing feedback. If the activities take place in accessible locations with good transport links this might also help to facilitate adherence to exercise referral schemes\textsuperscript{13,31}.

c. Awareness of social prescribing benefits, opportunities and processes

NHS Dumfries and Galloway Social Prescribing Framework\textsuperscript{2} emphasises that social prescribing works best where those involved have a good understanding of what it is, what it can offer and who it can benefit. Staff training, support and engagement can all help to make social prescribing feel part of everyday practice and not an additional area of work. It can also ensure that staff have a sense of ownership and a clear understanding of how they can contribute to social prescribing\textsuperscript{2}.
Studies show that health care staff may be unfamiliar with local social prescribing services and referral processes\(^4\)\(^ {40}\). Communication and partnership working between health care professionals such as GPs, and link workers and community organisations and participants is important if social prescribing is to be effective\(^4\).

Those referring need to explain to possible participants about social prescribing and what to expect from the scheme\(^4\)\(^ {41}\). Delivering feedback on participants’ progress encourages health care professionals to refer people on to social prescribing schemes\(^4\). In a small qualitative study on social prescribing in Scotland they found that health care professionals did not always trust unknown community/voluntary organisations and were concerned whether they would be accountable for referrals, which were not successful or positive for the patient. The authors of the study suggested building trust and connections between the different partners\(^4\)\(^ {42}\). A Physical Activity Signposting Consultation, conducted with health care professionals in Scotland made similar findings\(^4\)\(^ {40}\).

Evidence suggests that initiatives such as social prescribing cannot be seen as ‘magic bullets’. In the context of economic austerity, such approaches may not achieve their potential unless funding is available for community organisations to continue to provide services and make and maintain their links with primary care. BJGP, 2018\(^4\)\(^ {43}\)\(^ {47}\)\(^ {43}\).

The need for a clear and easy referral process is identified repeatedly by NHS Health Scotland\(^ {22}\)\(^ {44}\)\(^ {46}\) and NHS England\(^4\)\(^ {45}\). Health care professionals expressed that multiple referral processes bespoke to each service were too time consuming and confusing. NHS England\(^4\)\(^ {45}\) also suggest that social prescribing is more effective when there is an easy referral process to follow. Existing NHS referral systems such as SCI-Gateway could present a potential solution to this issue. However, it is recognised that not all practitioners have access to these systems and that there needs to be some flexibility with the referral system. Another route is through an email referral process into a specific secure mailbox\(^2\).

Recognising the range of projects that embed social prescribing, it is important that referral processes and pathways are made as easy as possible for both the referring person and the individual who is being referred\(^2\).

Health care professionals also identified not knowing what or how to signpost or refer people to local services as a barrier to social prescribing. Potential local solutions have been developed such as local activity directories or by utilising information systems such as ALISS\(^\) a local information system for Scotland managed by the Health and Social Care Alliance (The Alliance) or the NHS24, Scottish Services Directory available online through NHS Inform, the public facing health interface for NHSScotland.

d. Quality assurance

Concerns relating to the variability of delivery or quality of social prescribing service could be addressed by applying the principles laid out in the Quality Assurance Framework for Social Prescribing recently published by the National Social Prescribing Network in England\(^4\)\(^ {46}\). Or by following frameworks such as that developed by NHS Dumfries and Galloway\(^2\).
Further to this, NHS Health Scotland have convened an Exercise Referral Development Group, the purpose of which is to identify the core components of a quality assurance framework for exercise referral in Scotland, as a means of enhancing quality and consistency across exercise referral programmes in Scotland. The first phase of this work will be completed by March 2020.

e. Wider contextual factors

In order to maximise the uptake of non-medical solutions such as physical activity interventions, cultural expectations of patients in regards to medical interventions need to be addressed. Public awareness of self-management would be one supporting action to ensure that the public embrace the use of non-medical interventions.

Individual barriers such as confidence, self-esteem and poor mental wellbeing can all have an impact on motivation to participation. CLWs can work with individuals to address any barriers that an individual may face.

Rurality can bring further barriers in terms of the ability to access opportunities, as transport availability can be problematic. Poverty and the cost of interventions can also have an impact, as personal financial circumstances may limit accessibility to services where payment is required or where there is a real or perceived need to purchase appropriate clothing or equipment.

There is a need to acknowledge the importance of ‘place’ in respect of accessing physical activity interventions as well as addressing social isolation and loneliness\(^47\). Working with communities to create the conditions that engender a sense of belonging and foster greater social connectivity is essential. Pathways should promote a range of opportunities from a simple walk through to specific sporting activities where possible. Alternative interventions, such as the use of technology e.g. apps and schemes that use pedometers to improve physical activity levels can be used within peoples own communities. The active promotion of physical activity within green space would be beneficial, as green space is easily accessible to most adults in Scotland and helps improve mental and physical health whilst promoting social connectedness and community resilience\(^48\)\(^49\).

In the current financial climate, funding and resourcing is a concern that may present barriers to implementation and sustainability of social prescribing. The current shift from health and social care delivery to communities needs to be mindful not to overburden the third sector. Health and Social Care Partnerships should consider opportunities to support community organisations and groups to ensure that resources and quality of physical activity interventions are maximised. Consideration should be given to building and growing assets within local communities, such as local sustainable solutions with low cost access and the use of volunteering. Support should be provided to local groups and clubs to allow them to access a range of training opportunities that include qualifications, as well as those that promote inclusivity (e.g. equality and diversity, mental health awareness, dementia awareness, loneliness) and health behaviour change. Reporting should be mindful of quality of outcomes rather than quantity of access, especially within delivery in rural areas.

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

Participation in physical activity and sport initiatives can improve the quality of life of individuals and communities, promote social inclusion, improve health, raise individual self-esteem, confidence, and widen horizons. Evaluation should include a range of measures that acknowledge the wider benefits to individuals that participation in physical activity can induce and not just increased physical activity levels. This will allow individuals to make the connections and value to their own needs in line with the principles of behaviour change.

The Quality Assurance Framework for Social Prescribing recently published by the National Social Prescribing Network in England lists a number of recommended measures of quality assurance, covering the following; data protection, safeguarding, insurance, health and safety, financial, equality, governance, pathways and procedures, skills and experience, first aid (incl. mental health first aid) and user experience.

The NHS Dumfries and Galloway Social Prescribing Framework highlights that, integral to any social prescribing project is the need is to ensure that it meets the objectives and outcomes that it is intended, most specifically in relation to addressing health inequalities and improving health and wellbeing outcomes. In this context the following measures are proposed:

Process measures:
- No and % of individuals referred to social prescribing practice
- No and % of service users who are referred to support services and types of support services
- Key demographic information
- No of organisations that are supported and able to receive referrals
- Capacity of third sector organisations to support a social prescribing scheme including giving feedback to referrers

Output or outcome measures:
- % of individuals who successfully engage with a social prescribing practice
- % increase self-efficacy
- % increase – loneliness
- % increased physical activity levels
- % increased wellbeing
- Quality of life scores
- Response to health questionnaires
- Qualitative feedback from stakeholders on perceived impact of service on users
- Self-reported improvements in health condition and well being
- Clinical improvements to health
- Reduction in contact/usage of health care services e.g. GP appointments
- Reduction in medication
- Case studies

Context and service measures:
• Qualitative feedback regarding service quality (GPs, Practice Nurse, Health professionals, Patients, Referral partners, SP deliverers
• Impact on prescribing rates
• Impact on frequent attendances

b. Evaluation of existing schemes such as exercise referral

A recent audit of exercise referral in Scotland\(^{21}\) found that while most schemes in Scotland are collecting data on age and gender of participants, other demographic data on ethnicity, disability and socio-economic status are less frequently collected. Therefore it is still unknown if or how widely schemes achieve equitable reach, or the extent to which they impact on reducing health inequalities. The audit report therefore recommended that further consideration is given to how schemes could be supported to capture this important demographic data, to determine whether they are reaching those in most need.

The audit\(^{21}\) also identified some common monitoring tools in use across schemes such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), Scottish Physical Activity Screening Questionnaire (Scot-PASQ), Physical Activity Readiness Questionnaire (PARQ), Physical Activity and Lifestyle Questionnaires, Quality of Life Scales (i.e. EQ-5D/EQ-5D-3L), General Self-Efficacy Questionnaires. As well as outcome measures for physical activity, body mass index, body composition, physical fitness, waist circumference, weight and blood pressure.

In addition exercise referral scheme also reported using the following performance indicators\(^{21}\):  
- Number referred to the scheme  
- Number taking up the referral  
- Number completing the programme  
- Number of activity sessions attended  
- Number dropping out of the scheme  
- Number active at specific time points  
- Number taking out memberships after the programme  
- Number follow-up contact appointments attended  
- Number and range of healthcare professionals referring into the scheme

Lack of staff capacity and training in evaluation is often cited as one of the challenges to undertaking high quality evaluation of exercise referral schemes

The audit therefore recommended that exercise referral professionals responsible for scheme evaluation are offered support and/or training on how to undertake high quality and robust evaluation of an exercise referral scheme\(^{21}\).

Evaluation support and the development of a minimum dataset for exercise referral have been identified by the NHS Health Scotland, Exercise Referral Development Group, as core components of a quality assurance framework for exercise referral and will draw on learning from the Welsh NERS scheme\(^{50}\) which has established a national standardised approaches to measuring physical activity and wider wellbeing benefits. A partnership approach that includes a range of stakeholders such as academia, national bodies as
well as regional public health specialists could provide effective evaluation expertise to support this going forward, aligned to local delivery actions related to Public Health Priority 6.  

NICE public health guidelines (PH54) on Exercise Referral recommend that exercise referral programmes should be monitored and evaluated in line with the Standard Evaluation for Physical Activity Interventions specifically programme description, evaluation details, demographics of individual participants, baseline data, follow-up data (also known as impact evaluation) and process evaluation.

c. Research

Given the limited amount of high quality robust systematic studies in this area, further research should be undertaken to investigate the effectiveness and cost effectiveness of social prescribing schemes. These studies should use controls to show that it is the intervention which is causing the effect. Follow up with participants should be sustained over a longer period of time than in previous studies and go beyond the end of the intervention. As identified within the Audit of Exercise Referral in Scotland, outcomes other than physical activity should be considered such as quality of life, behaviour change, physiological changes, the impact on health inequalities and health service and medication usage. It is also recommended that key outcomes are measured using objective measures rather than subjective outcome measures, where feasible. The outcome measure selected will vary depending on the reasons for referral, type of social prescription, the needs of the people participating and the resources available for evaluation.

One study suggested that it is preferable to gather different type of evidence rather than using a single method to assess outcomes using quantitative and qualitative methods and that evaluation should include feedback from all key stakeholders such as referrers, providers and participants.

The need to differentiate between people who adhere to the programme and how it has increased their physical activity levels was also highlighted i.e. measuring both outputs and outcomes. Recording baseline data which can then be monitored at regular intervals for comparison with baseline data is recommended. Going a stage further, NHS England also suggest that the evaluation of social prescribing schemes should include measuring the impact on people, community groups and the health and care system.

Whilst more research is required, implementation should continue in such a way that it adds to the evidence base. The introduction of a standardised approach to monitoring and evaluation as part of a quality assurance framework would greatly enhance the design and quality of delivery of physical activity social prescribing programmes and enable comparison of effectiveness across programmes.

References:


NHS Health Scotland.(2014). NHS Primary Care Physical Activity Pathway Feasibility Study.


NHS Health Scotland. (2016). Analysis of physical activity actions reported within NHS Board: Annual Health Promoting Health Service Reports.


Department Health. (2011). Start Active, Stay Active: A report on physical activity for health from the four home countries’ Chief Medical Officers.


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