CORE MINIMUM DATASET FOR SOCIAL PRESCRIBING

GROUP CONCEPT MAPPING

Report

for Cardiff & Vale RIIC Hub

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CONTENTS

1. INTRODUCTION AND CONTEXT

The University of South Wales (USW) has been working with the Cardiff & Vale Research Innovation and Improvement Coordination (RIIC) hub seeking to develop an evaluation framework for social prescribing services in the area. The RIIC hub, working with USW, have engaged a number of local social prescribing services in production of the evaluation framework and, in the case of this part of the project, have sought some opinion from All Wales. The next step will be the establishment of a Community of Practice to embed the framework into service functioning.

The project has involved several components to date including a scoping review (Randall & Wallace, 2022[1]) and development of a qualitative evaluation matrix (Llewellyn & Randall, 2022)[2] in addition to the Group Concept Mapping (GCM) study detailed in this technical report. This work is due to be taken into practice and trialled in the early stages of next year.

The GCM component of this project was implemented to explore the views of professionals working in social prescribing regarding the data they feel should be included in the evaluation framework's core minimum dataset. The data gathered here will be used to support other parts of the project i.e. by providing quantitative data to underpin the qualitative matrix. In addition it provides insight into the views of the professional community who will be engaging with the Community of Practice going forward. .

In particular, this study gathers information across two specific domains, these being:

- What do professionals think is most important?
- What data do professionals consider easy to collect?

GCM is a form of consensus building, and so the aim is to understand the professional consensus in answer to these questions. Key themes are generated from this work in addition to specific data items ranked across both domains. In understanding these, professionals can then be presented with meaningful items and suggestions to aid the development or maintenance of social prescribing services.

This is combined with the other aforementioned parts of the programme to provide a meaningful framework rooted within a strong evidence base that reflects the views of the professionals that it applies to.

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[1] Randall S and Wallace C (2022) Patient Experience of Social Prescribing: A Scoping Review. Wales School for Social Prescribing Research. Welsh Institute for Health and Social Care. PRIME Centre Wales. University of South Wales.

[2] Llewellyn M and Randall S (2022) Cardiff and Vale Social Prescribing Development Matrix. Wales School for Social Prescribing Research. Welsh Institute for Health and Social Care. PRIME Centre Wales. University of South Wales.

2. METHOD AND APPROACH

This study was carried out between 19th July 2022 and 25th November 2022. Ethical approval was sought and given by the University of South Wales, Faculty of Life Science and Education low-risk ethics panel (220405LR). NHS Permission to engage with NHS staff was sought from CVUHB and given on 27th June 2022.

This study used an online form of GCM to explore opinions of professionals working in social prescribing services to understand what data relating to social prescribing they feel is important and easy to collect. The process of GCM is summarised below in Figure 1.
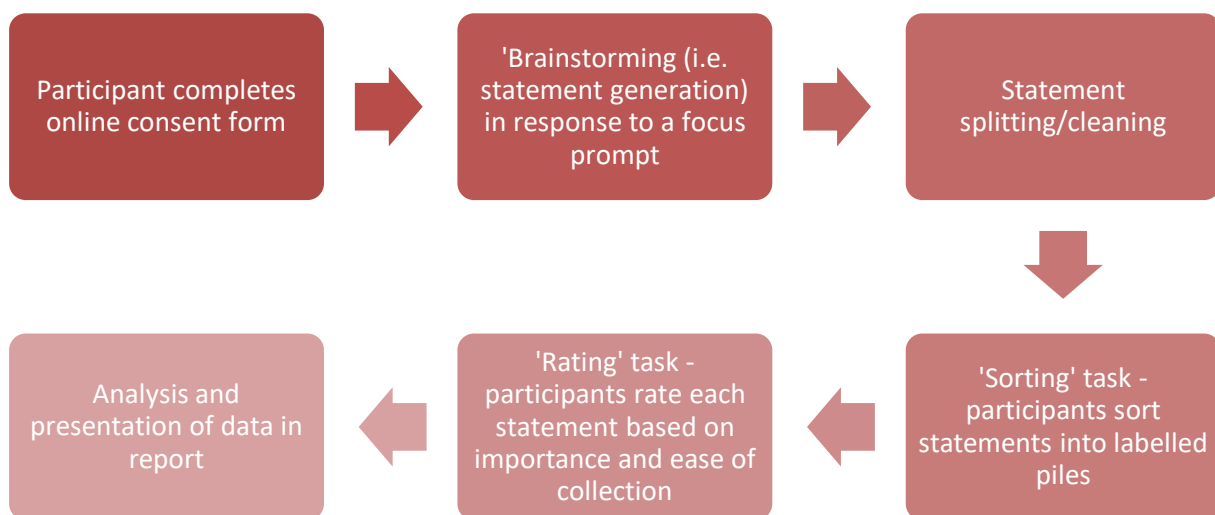

Figure 1: The process of Group Concept Mapping

The views of professionals were explored using the three activities of the GCM method: statement generation, sifting and sorting statements into themes with labels, rating each statement for importance and ease of collection. GCM offered an opportunity for virtual groups of geographically dispersed participants to participate using online software to help them individually organise and present their ideas supported by a trained facilitator. Participants answered five demographic questions:

- In which stakeholder group do you identify?
- In which regional partnership board (RPB) area do you currently work?
- Under which category does your current social prescribing role mainly fall?
- How long have you been working in/with social prescribing services?
- How would you rate your knowledge for evaluating social prescribing services?

The GCM facilitator-led methodology used Group Wisdom™ software for data collection, data integration and analysis.

Data analysis used the online software to conduct four steps of data analysis following data review, cleaning and acceptance processes:

- Step 1 – Participant demographic responses were analysed using descriptive statistics.

- Step 2 – A similarity matrix was created from the participant sorted statements. This demonstrates the number of participants who sorted the statements together.

- Step 3 – Multidimensional scaling analysis of the similarity matrix which produced a point map. Each participant statement is allocated a point on a two-dimension (XY) axis (Figure 7).

- Step 4 – Ward's algorithm used in hierarchical cluster analysis of statement clusters to produce a cluster map with cluster labels (see Figure 8), cluster rating (Figures 9, and 10) go-zone analysis (Figures 12 and 13) to identify the top ten items that professionals should consider when adopting and developing multi-professional working in the community.

3. FINDINGS

## 3.1   WHO WERE THE PARTICIPANTS?

Thirty four participants were recruited using purposive sampling and enrolled onto the Group Wisdom™ software. They were recruited through the existing PRIME and WSSPR networks of the researchers and contacts of the RIIC hub. For sorting/rating, additional participants were recruited as part of a workshop held for the project. Participants completed the following:

- Participant questions: n = 34
- Brainstorming activity: n = 10
- Finished sorting activity: n = 16
- Finished importance rating activity: n = 19
- Finished ease of collection rating activity: n = 16

Data from a previous study to establish a core minimum dataset in Cwm Taf Morgannwg (CTM) was merged with this data due to the similarity of the project (i.e. those participants had rated many of the same statements). After merging, the following were completed:

- Participant questions: n = 44
- Finished importance rating activity: n = 33
- Finished ease of collection rating activity: n = 26

The majority of participants identified their stakeholder group as Third Sector (39%) however there were also some participants that identified as Other (27%), University Health Board (16%), Cardiff Local Authority (LA) (9%), Vale LA (2%) or Cardiff and Vale LA (2%), and as Independent Sector (5%). See Figure 2
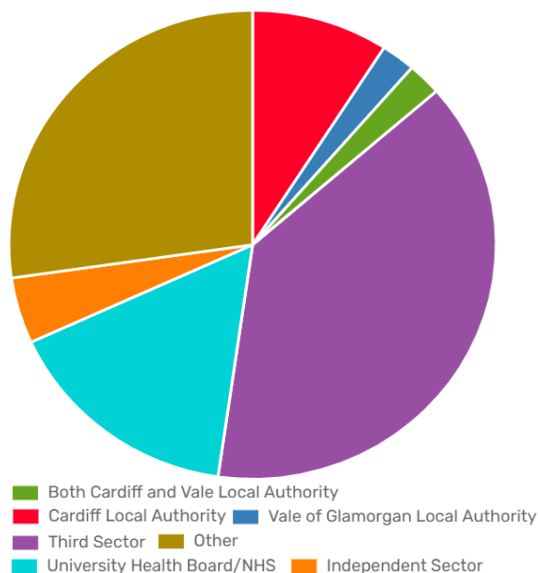
OPTION	FREQUENCY	%
Third Sector	17	39%
Other	12	27%
University Health Board/NHS	7	16%
Cardiff LA	4	9%
Vale of Glamorgan LA	1	2%
Both Cardiff and Vale LA	1	2%
Independent Sector	2	5%
Total	**44**	**100%**

Figure 2: Defining the stakeholder group of participants

Participants worked across a few different RPB areas (Figure 3). Most worked in Cardiff and Vale (60%) though there were participants who answered 'other' (17%) in addition to participants working in Cwm Taf Morgannwg (10%), Powys (3%), West Glamorgan (3%), West Wales (3%) and North Wales (3%).

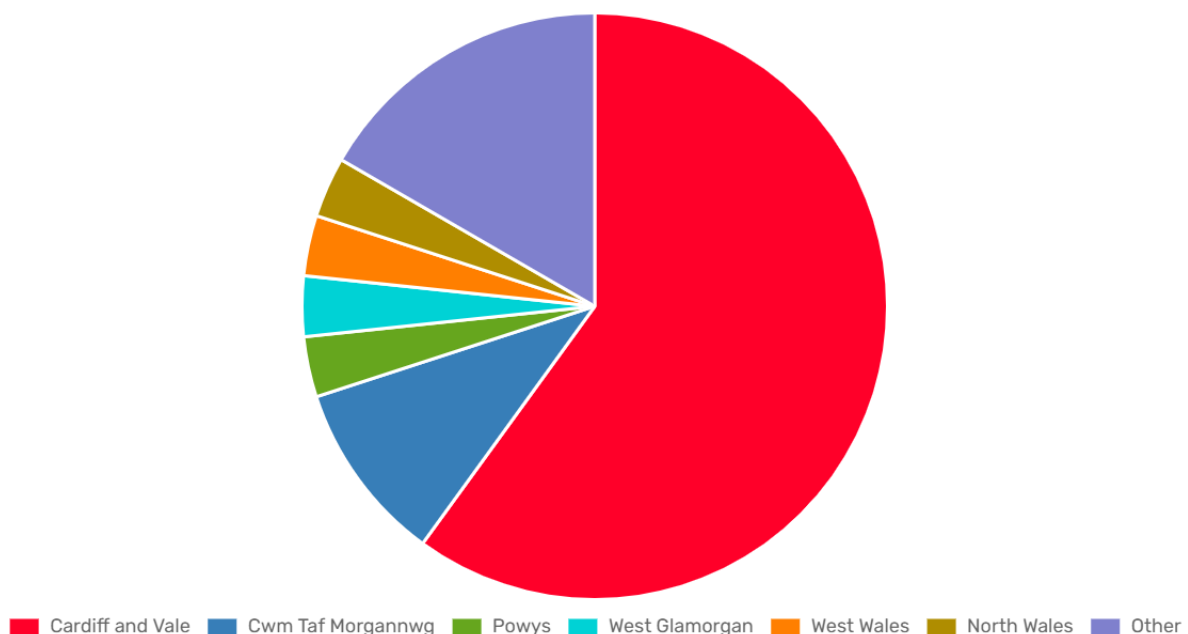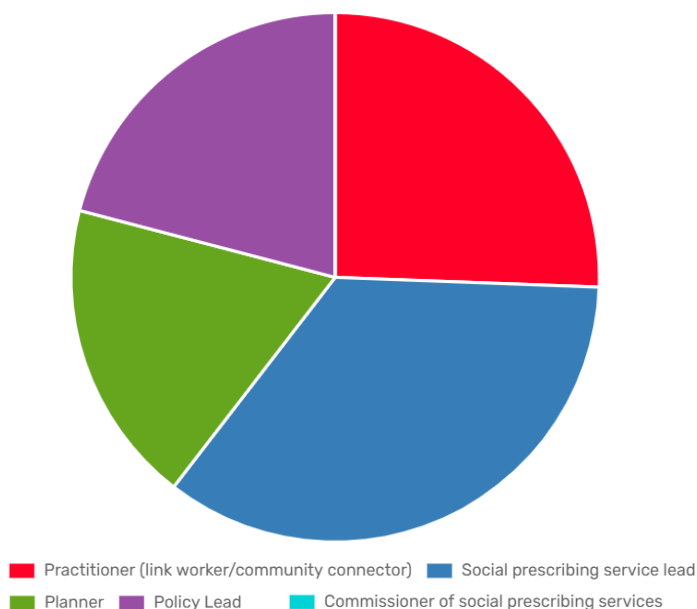| OPTION	FREQUENCY	%
Cardiff and Vale	18	60%
Cwm Taf Morgannwg	3	10%
Powys	1	3%
West Glamorgan	1	3%
West Wales	1	3%
North Wales	1	3%
Other	5	17%
Total	**30**	**100%**

**Figure 3**: Current RPB area of participants

The majority of participants were social prescribing service leads (35%) however there were also social prescribing practitioners (26%), planners (18%) and policy leads (21%). No participants indicated that they were involved in commissioning (Figure 4, overleaf).

OPTION	FREQUENCY	%
Practitioner	11	26%
Social prescribing service lead	15	35%
Planner	8	18%
Policy lead	9	21%
Total	**43**	**100%**

Figure 4: Participants' category of social prescribing role

Participants ranged in their length of service in/with social prescribing. The majority had been working in services for between 1 – 3 years (34%), however there were participants who had been working for between 4 – 6 years (22%) and over 6 years (12%) as well as participants who had been working for less than 12 months (12%) or that had Start-up/no experience (20%). See Figure 5.
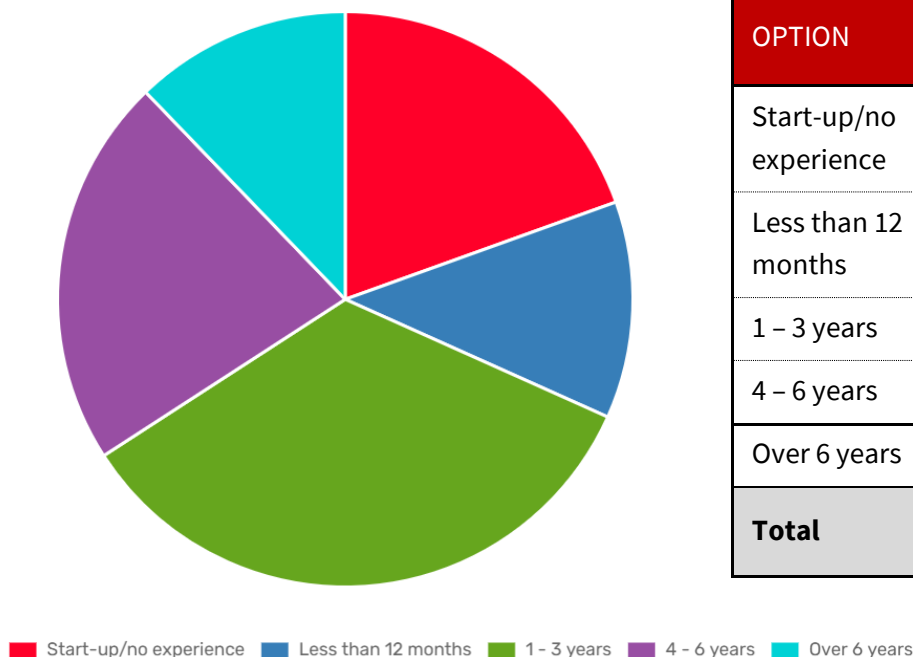
OPTION	FREQUENCY	%
Start-up/no experience	8	20%
Less than 12 months	5	12%
1 – 3 years	14	34%
4 – 6 years	9	22%
Over 6 years	5	12%
Total	**41**	**100%**

Figure 5: Participants length of time working in/with social prescribing services

Finally, when asked to rate their knowledge for evaluating social prescribing (Figure 6), participants had a range of responses. Most rated their knowledge as 'quite good' (44%) with some answering 'very good' (12%) and 'extremely good' (9%). However, there were also participants who rated their knowledge as 'poor' (26%) or 'very poor' (9%).

OPTION	FREQUENCY	%
Very poor	3	9%
Poor	9	26%
Quite good	15	44%
Very good	4	12%
Extremely good	3	9%
Total	**34**	**100%**

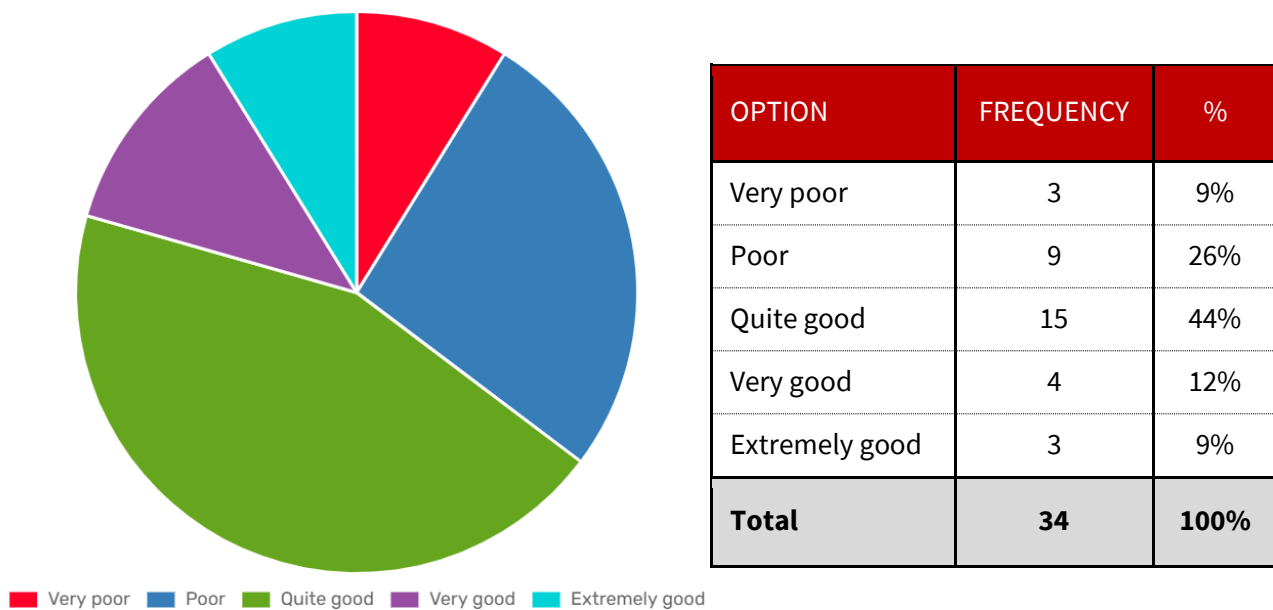■ Very poor ■ Poor ■ Quite good ■ Very good ■ Extremely good

Figure 6: Participants self-rated knowledge for evaluation social prescribing

3.2 IDENTIFYING AND ANALYSING THE 118 DATA ITEMS FOR SOCIAL PRESCRIBING

Activity 1 – Brainstorming

During this activity n = 10 participants together provided 47 statements to complete the single online focus prompt '*When developing a core minimum data set for our evaluation framework, I think the data that needs to be included is…*' Examples of statements can be seen in Table 2[3].

Statement no	Statement
88	Outcomes and benefits in the persons own words
91	Preferences for indoor or outdoor activities
92	Barriers to participation
94	Whether social prescribing was filling a gap in statutory services

Table 2: Four statements kept in their entirety provided by participants

Many statements comprised more than one key message and so these were split into separate statements, following this there were 91 statements generated by participants. Additionally, 41 statements were taken from the content of a previous study (Wallace & Randall, 2022[4]) and added by the researcher, and 6 more were added by the researcher from the scoping review attached to the project (Randall & Wallace, 2022[5]).

This left a total of 138 statements before statements were 'cleaned' (i.e. duplicates removed, wording altered for clarity in sorting/rating). Following statement cleaning 118 statements were included for sorting and rating, of which 71 were generated by participants and others were added by the researcher as above.

Activity 2 – Grouping/sorting

In this activity participants were asked to sort and group all the statements into piles and provide each pile with an individual label. The software at first generated a point map showing all the 118 statements (Figure 7).

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[3] The full list of statements is available in Appendix 1

[4] Wallace, C., Randall, S., (2022) Evaluation Framework Development and Reporting. Cwm Taf Morgannwg Regional Partnership Board. University of South Wales. Welsh Institute for Health and Social Care (WIHSC). Wales School for Social Prescribing Research (WSSPR),p36.

[5] Randall S and Wallace C (2022) Patient Experience of Social Prescribing: A Scoping Review. Wales School for Social Prescribing Research. Welsh Institute for Health and Social Care. PRIME Centre Wales. University of South Wales.
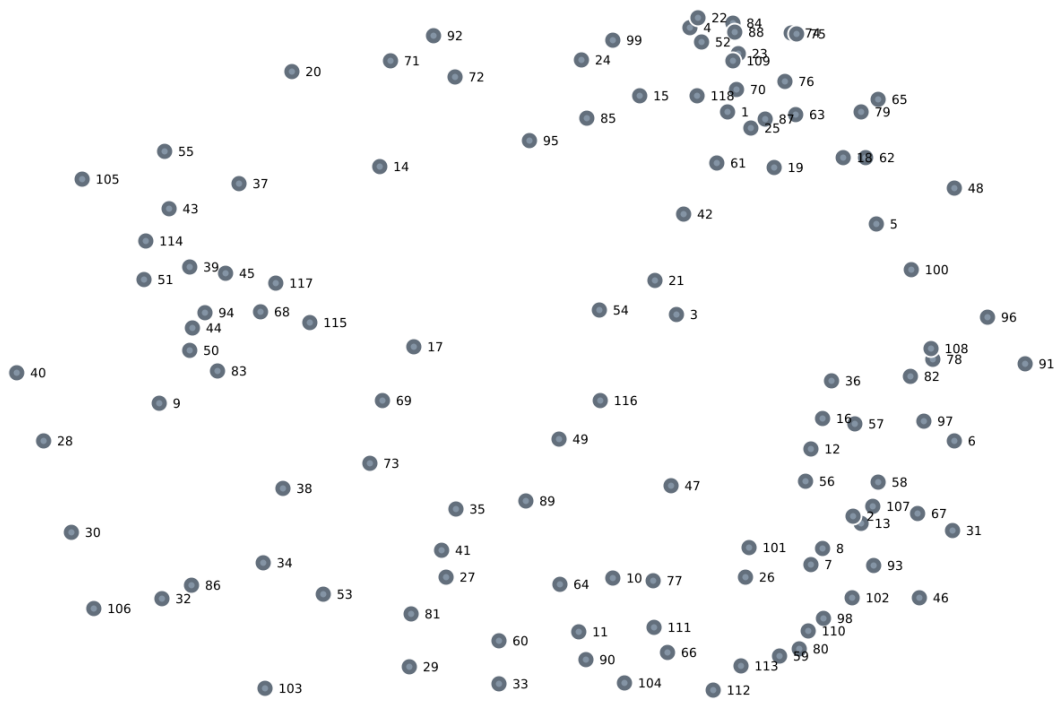
Figure 7: Computer generated point map of 118 statements

The dataset had a final stress value of 0.2841 – the acceptable range is 0.205-0.365, and therefore this is considered to be similar to reliability (Kane and Trochim, 2007).[6] The stress value is situated towards the middle of the range and so is considered to be a good fit. The closer the statements (represented by a point) to one another the more frequently they were sorted together by participants. For example statements 108 ("did the person attend the activity or service") and 78 ("how long did the person attend the activity or service for?") are close together and so have been sorted together most frequently. Whilst statement 84 ("the difference the person thinks they make") and 103 ("information on housing") are on opposite ends of the map and were either not sorted together often or not at all.

The software then provided a cluster map where the statements had been distributed across five clusters: service user perspective, service activity data, referral pathway, sharing learning and referral agencies and stakeholders (Figure 8). Statement placement in a cluster originates from participants' grouping and rating of each statement. For example statement 52 ("the persons experience of taking part") is positioned in the 'service user perspective' cluster because that is where the majority of participants placed the statement. The conceptual relationship between clusters is shown by the distance between them. Therefore the cluster called 'referral pathway' is closer to 'service activity data' and 'referral agencies and stakeholders' than it is to the other two clusters.

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[6] Kane, M., and Trochim, W. M. K. (2007). *Concept Mapping for Planning and Evaluation.* Thousand Oaks, CA: Sage
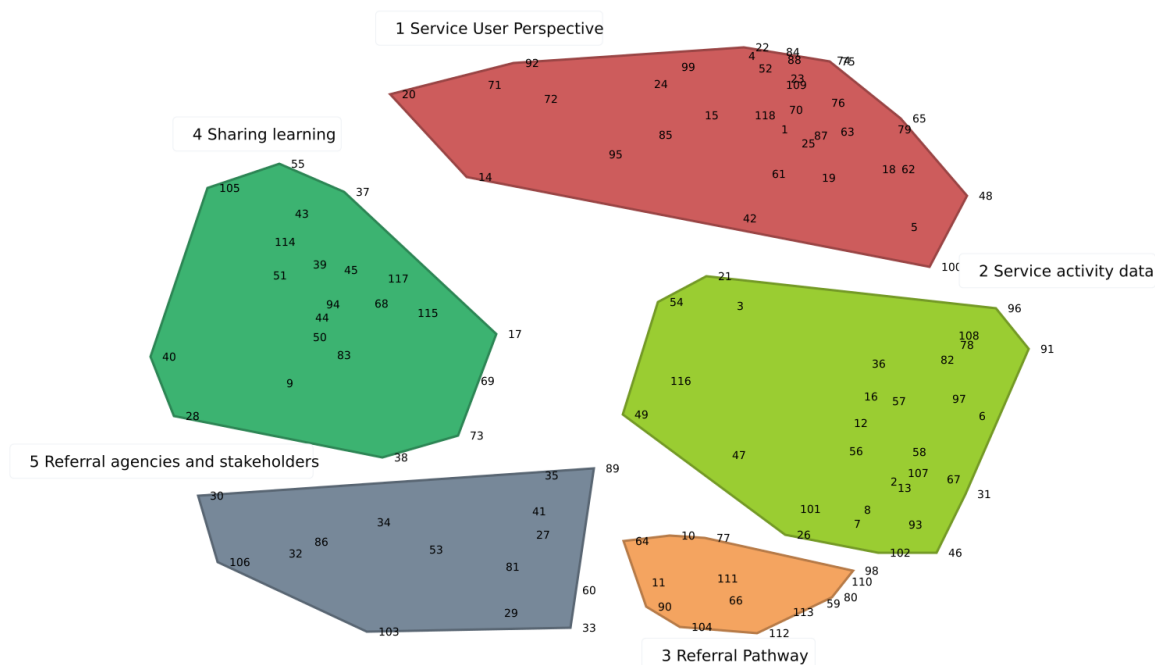
Figure 8: Cluster map with labels from the participant grouping exercise

The service user perspective cluster had most statements (n = 36) with service activity data following closely (n = 31); whilst the referral pathway (n = 14) and referral agencies and stakeholders clusters had least statements (n = 15), with sharing learning having only a few more (n = 22). Table 3 shows the number of statements per cluster and Table 4 (overleaf) provides three statements examples per cluster.[5]

Construct	Service user perspective	Service activity data	Referral pathway	Sharing learning	Referral agencies and stakeholders
Number of statements	36	31	14	22	15
Average rating of importance of statement	4.09	3.51	3.31	3.68	3.45
Ave rating of ease of collection of statement	3.36	3.42	3.60	2.62	3.06

Table 3: Cluster characteristics

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[5] The full list of statements by cluster is available from: Appendix 2

Activity 3 – rating for importance and ease of collection

In this activity participants were asked to rate all 118 statements using importance on Likert type scales. The cluster-rating maps in Figure 9 (and Table 3 above) demonstrates that the cluster called 'service user perspective' is considered the most important of all five clusters, when considering the most important data to be included in a core minimum dataset (4.09).
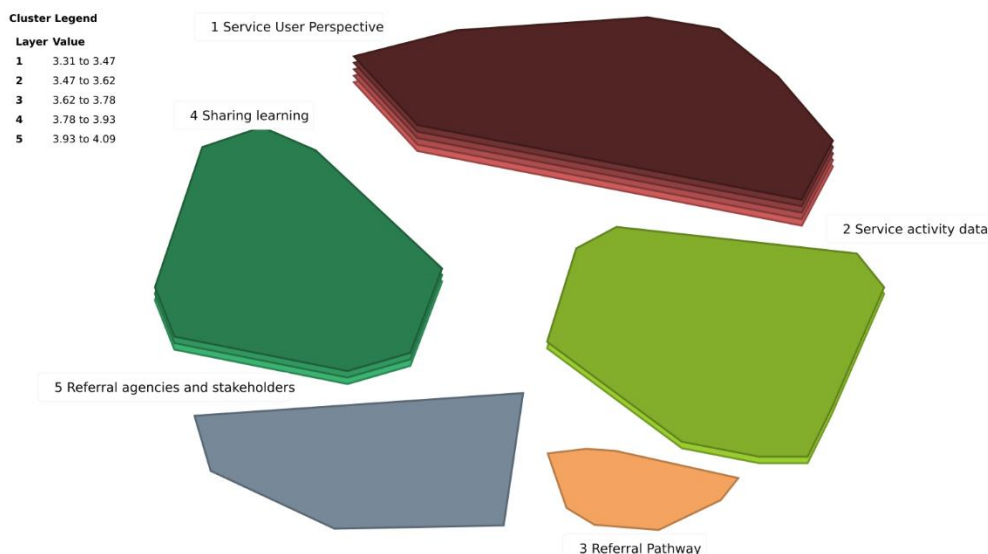

Figure 9: Cluster rating map – importance of data to be included in a core minimum dataset

No.	Wording
SERVICE USER PERSPECTIVE	
23	Patient reported experience measures
24	Lived experience case studies
25	Number of people reporting a positive experience
SERVICE ACTIVITY DATA	
3	Reasons that people do not take up a social prescription
7	Details of participant protected characteristics
8	Number of professional enquiries received
REFERRAL PATHWAY	
10	Referrals to which sector
11	Outsourcing to another provider
59	Online or in-person referral
SHARING LEARNING	
52	How headline data is presented
55	Core outcomes agreed nationally
68	Where can lessons be learnt and learning shared?
REFERRAL AGENCIES AND STAKEHOLDERS	
33	Awareness of similar projects elsewhere (avoiding duplication)
35	Covid impacts to projects
60	Referral agencies social prescribing use

Table 4: Examples statements in each of the five clusters

In addition, to understand whether the opinions of those with highly self-rated knowledge of evaluating social prescribing services differed from those with a lower self-rated knowledge, data was analysed in the form of point maps for all participants, for participants who answered 'extremely good', 'very good' and 'quite good' in response to the demographic question asking them about their knowledge, and for participants who answered 'poor' or 'very poor'. A summary of these results presenting the top 10 rated statements for each of these three groups is presented in Table 5.

RANK	All participants		Participants with extremely, very or quite good knowledge		Participants with poor or very poor knowledge	
	STATEMENT	RATING	STATEMENT	RATING	STATEMENT	RATING
1	What matters to the person (118)	4.72	What matters to the person (118)	4.91	Does the person think that the service has helped with their problem? (109)	4.88
2	Is the person more confident in finding support in the future if needed? (74)	4.61	Is the person more confident in looking after their wellbeing? (75)	4.75	Patient reported outcome measures (22)	4.75
3	If people are empowered to look after themselves (79)	4.59	Number of people reporting a positive experience (25)	4.70	Is the person more confident in finding support in the future if needed? (74)	4.75
4	Did the person achieve their goals? (76)	4.59	Did the person achieve their goals? (76)	4.64	The persons experience of taking part (52)	4.57
5	Outcomes and benefits in the persons own words (88)	4.59	If people are empowered to look after themselves (79)	4.60	If people are empowered to look after themselves (79)	4.57
6	Does the person think that the service has helped them with their problem? (109)	4.58	Outcomes and benefits in the persons own words (88)	4.55	The difference the person thinks they make (84)	4.57
7	Number of people reporting a positive experience (25)	4.54	How inclusive is the project (116)	4.55	Did the person achieve their goals? (76)	4.56
8	Is the person more confident in looking after their	4.53	Using examples of patient/client journeys to	4.50	Did the person attend the activity or service	4.56

	wellbeing? (75)		illustrate patient/client responses (15)		(108)	
9	The persons experience of taking part (52)	4.50	Lived experience case studies (24)	4.50	Mental wellbeing scores (63)	4.50
10	Lived experience case studies (24)	4.44	Identifying where there are lower levels of take up i.e. due to gaps in opportunity / provision / link workers (69)	4.50	Physical wellbeing scores (65)	4.50

Table 5. Rankings of importance of statements across participants with different knowledge

Analysis was also undertaken on the cluster of statements which were seen as easy to collect in relation to multi-professional working (Figure 10). The highest rated, and therefore viewed as easiest to collect, was 'referral pathway' (3.60) followed by 'service activity data' (3.42), with 'sharing learning' being see as the most difficult to collect (2.62)
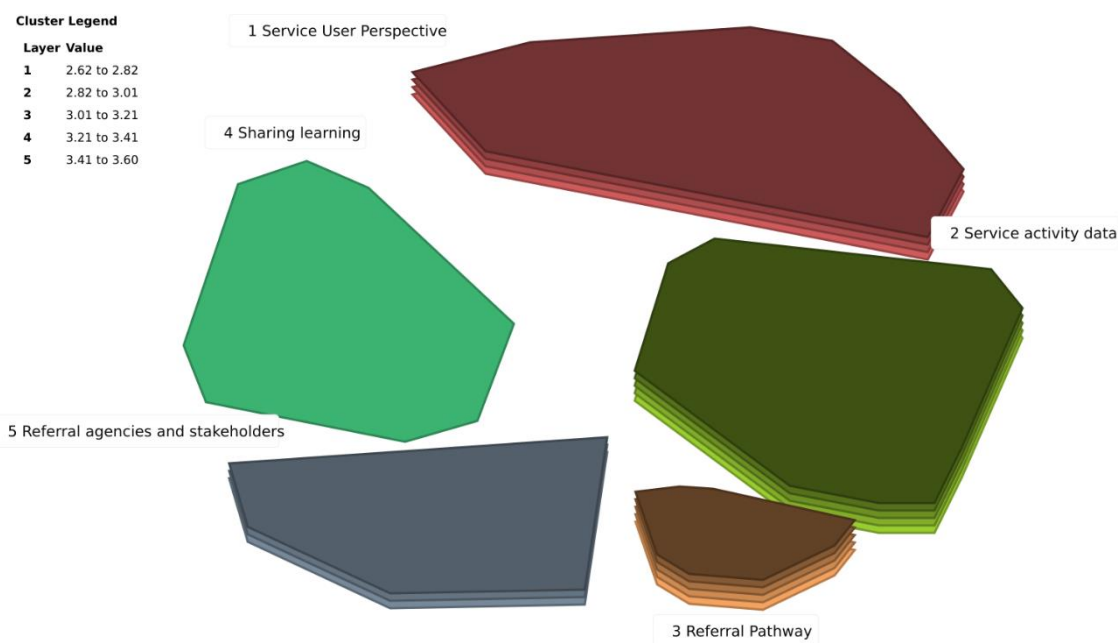

Figure 10: Cluster rating map – ease of collection of data items

As above, point rating maps were generated for all participants, for those with 'extremely good', 'very good' or 'quite' good' self-rated knowledge of evaluating social prescribing services, and for those with 'poor' or 'very poor' knowledge. A summary of results is presented in Table 6.

RANK	All participants		Participants with extremely, very or quite good knowledge		Participants with poor or very poor knowledge	
	STATEMENT	RATING	STATEMENT	RATING	STATEMENT	RATING
1	Number of referrals (93)	4.52	Number of referrals (93)	4.73	Number of people reporting a positive experience (25)	4.80
2	Number of evaluation forms collected (36)	4.29	Number of evaluation forms collected (36)	4.50	Number of evaluation forms collected (36)	4.80
3	Online or in-person referral (59)	4.29	Quotes from services social prescribing use (95)	4.40	Online or in-person referral (59)	4.80
4	Postcode of referral (111)	4.27	Postcode of referral (111)	4.40	Who is facilitating any activity (81)	4.75
5	Referral source (113)	4.25	Referral source (113)	4.40	Number of referrals (93)	4.60
6	Number of employed staff in project (29)	4.21	Number of people reporting a positive experience (25)	4.30	Outcomes and benefits in the persons own words (88)	4.60
7	Does the person think that the service has helped them with their problem? (109)	4.20	Length of waiting time (26)	4.30	Withdrawals from programmes (56)	4.40
8	Route of referral (112)	4.20	Number of employed staff in project (29)	4.30	Completion of programmes (57)	4.40
9	Quotes from services social prescribing use (95)	4.13	Quotations from service users (99)	4.30	Mental wellbeing scores (63)	4.40
10	Quotations from service users (99)	4.13	Number of contacts with the social prescriber (107)	4.30	Physical wellbeing scores (65)	4.40

Table 6. Ratings of ease of collection of statements across participants with different knowledge of multi-professional working

We then used both the cluster map and the rating scales to develop a Go-Zone. This looked at the interaction of importance and ease of collection (Figure 11).
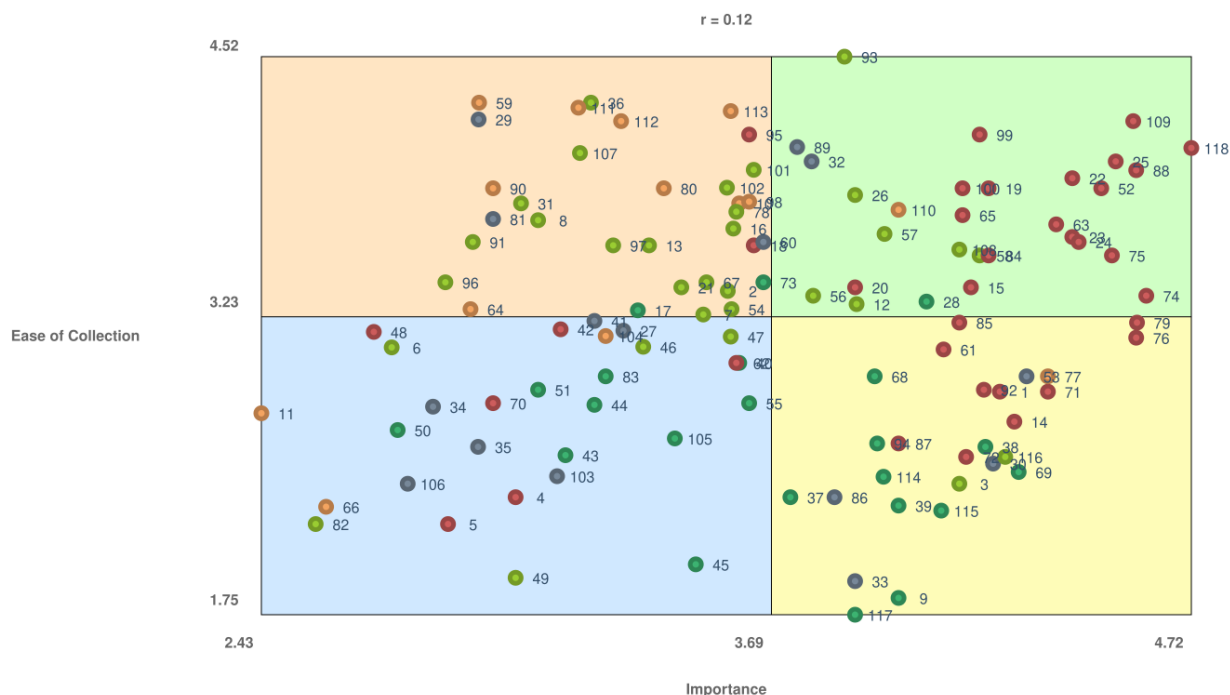

Figure 11: Go-Zone report displaying how each statement is rated in relation to importance and ease of collection

This shows which statements were above or below the mean (average) across the two rating criteria of 'importance' and 'easy to collect'. Statements above the ease of collection mean (3.23) were easiest to collect and are in the orange and green zones. Statements above the importance mean (3.69) are the statements which have most importance i.e. the green and yellow zones. Figure 11 shows that the statements presented in the green zone are most important and easiest to collect, and those in the orange zone are easiest to collect but least important. Statements in the yellow zone are least easy to collect but have most importance, and those in the blue zone are statements of least importance and are least easy to collect. Example statements from each quadrant can be seen in Table 7. These zones may be of interest to commissioners, providing an indication of those statements which they may wish to consider in the commissioning and decommissioning processes.

No.	Wording
GREEN QUADRANT [n = 29]	
15	Using examples of patient/client journeys to illustrate patient/client responses
19	Social wellbeing scores
20	The perceived outcome from the staff delivering the service
ORANGE QUADRANT [n = 33]	
29	Number of employed staff in project

No.	Wording
31	Number of sessions offered
36	Number of evaluation forms collected
BLUE QUADRANT [n = 29]	
104	Details of other agencies involved
105	A specific category for learning (including upskilling and qualifications)
106	Information on medical help
YELLOW QUADRANT [n = 27]	
85	Reasons that individuals take up a referral offer to a socially prescribed activity
86	Understanding sub groups where support is needed
87	The impact of the programme they were prescribed in relation to the reason for their referral

Table 7: Example and total number of statements from each quadrant.

By examining the twenty-nine statements from the green quadrant (the most important and easiest to collect) we can identify the top five statements and their respective clusters. The top statement is number 118 'What matters to the person' which had a mean average of 4.39 and can be found in the 'service user perspective' cluster, other top statements were either in the same cluster or in the 'service activity data' cluster (Table 8).

Cluster	Statement	Importance	Ease of Collection	Mean
Service user perspective	What matters to the person	4.72	4.07	4.39
Service user perspective	Does the person think that the service has helped them with their problem?	4.58	4.20	4.38
Service user perspective	Outcomes and benefits in the persons own words	4.59	3.96	4.27
Service user perspective	Number of people reporting a positive experience	4.54	4.0	4.26
Service activity data	Number of referrals	3.87	4.52	4.19

Table 8: The top five most important and easiest to collect data for our social prescribing evaluation framework

Finally, in order to gain some further comparisons in the data utilising the demographic information gathered, pattern matches using ladders graphs were generated to visualise comparative data. The importance of statements amongst professionals of different roles and between different RPB's was felt to be of particular interest and has therefore been visualised. Figure 13 provides relative pattern matches showing the differences in importance ratings between participants who are practitioners within social prescribing, and those that do not have a practitioner role. Relative as opposed to absolute pattern matches are presented because n = 8 participants were practitioners and n = 22 participants had other roles (i.e. service lead, planner or policy lead)

The ladder graph in Figure 12 shows relative consensus in the way they rated the importance variable of four of the clusters with a difference of opinion in the 'referral pathway' cluster.
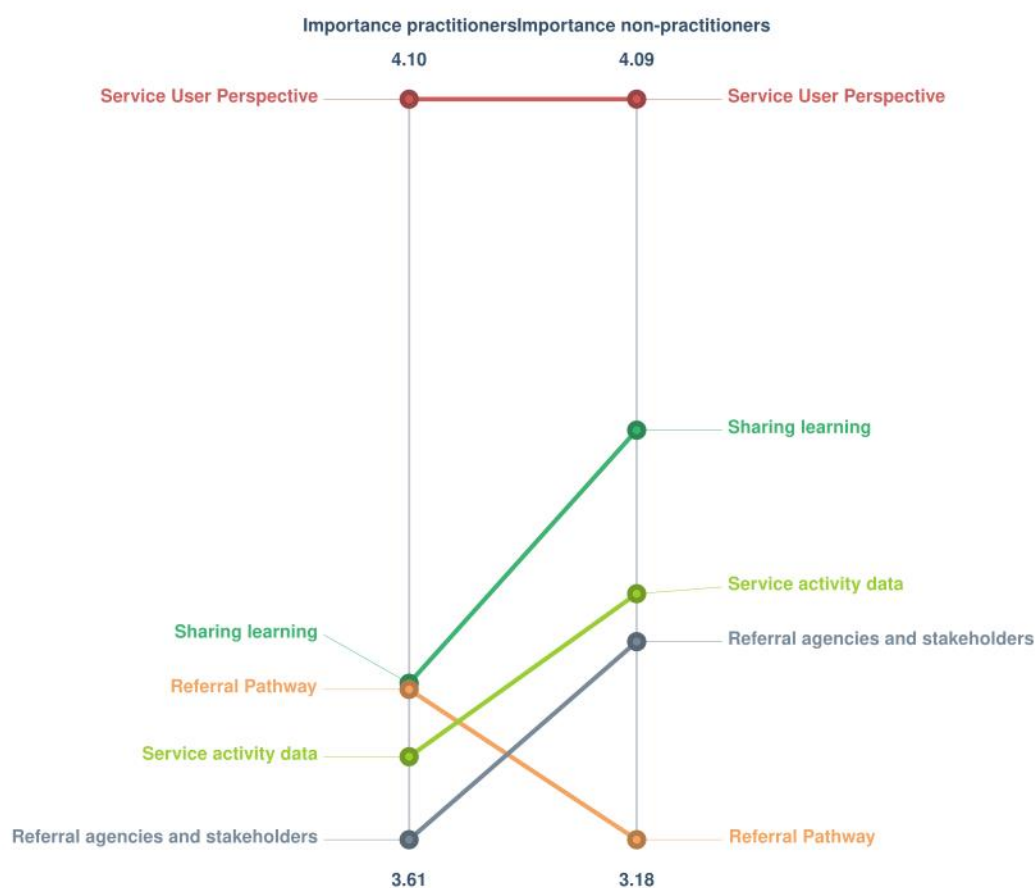
Figure 12: Ladder graph comparing importance variable between practitioners and non-practitioners of social prescribing

This process was repeated for the importance rating comparing those working in Cardiff and Vale RPB, and those who work in other RPB's. In this cases the consensus of these groups differs on four of the clusters (sharing learning, service activity data, referral agencies and stakeholders and referral pathway), though service user perspective is rated as the most important across both. Results can be seen in Figure 13 (overleaf).

Figure 13: Ladder graph comparing importance between UHB participants and all others

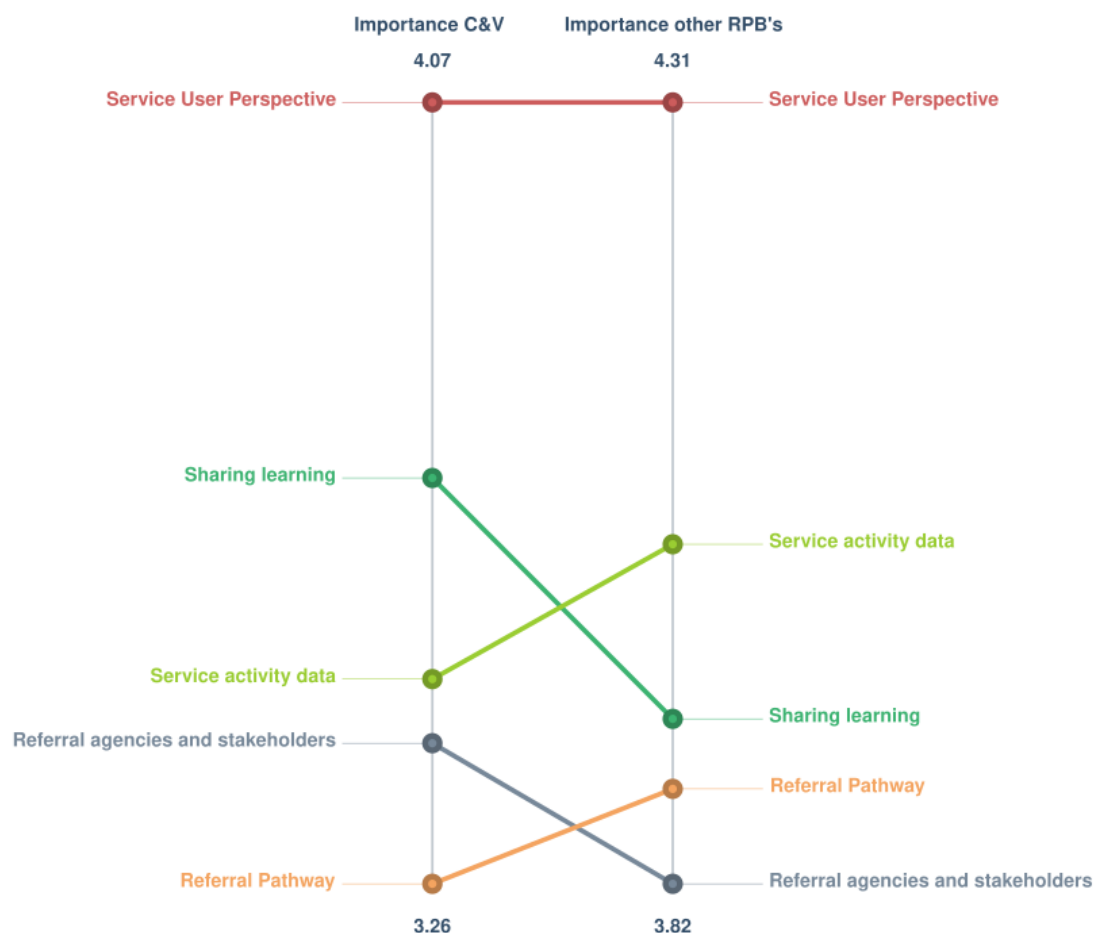## WHAT SHOULD WE DO WITH IT?

Whilst the findings are open to interpretation the intended use for the data is to be integrated with other parts of the evaluation framework commissioned by the Cardiff & Vale RIIC hub to provide a quantitative underpinning throughout the project. The data could be used alongside the qualitative matrix to provide the professionals utilising this with meaningful guidance to improvement.

The first task in the GCM was to respond to the prompt: "*When developing a core minimum data set for our evaluation framework, I think the data that needs to be included is…*" and so all statements generated in response to this prompt by participants identifies data that they feel should be included in the core minimum dataset for the evaluation framework, regardless of subsequent sorting/rating.

The data speaks to the importance of considering context when making suggestions as the relative pattern matches in Figures 12 and 13 suggest that there may be some differences in opinion between different roles in social prescribing, and between different RPB's.

WHAT SHOULD HAPPEN NEXT?

The top ten most important and easiest to collect statements could be considered as hierarchical priority statements in regard to the data that social prescribing services should be collecting, and data that needs to be included in our evaluation framework. These statements allow for focus on data that can be collected with ease, but that also has high importance in practice for services. The majority of these statements are related to service user perspective:

1. What matters to the person
2. Does the person think that the service has helped them with their problem?
3. Outcomes and benefits in the persons own words
4. Number of people reporting a positive experience
5. Number of referrals
6. The persons experience of taking part
7. Patient reported outcome measures
8. Quotations from service users
9. Social wellbeing scores
10. Mental wellbeing scores

Of course, if a service feels that they are already performing well in these areas and are not concerned about the ease of data collection, they may instead choose to focus on the statements rated as only the most important. These would be:

1. What matters to the person
2. Is the person more confident in finding support in the future if needed?
3. If people are empowered to look after themselves
4. Outcomes and benefits in the persons own words
5. Did the person achieve their goals?

Similarly, if a service is relatively new or has not been collecting data thus far and feels that they would like to begin with data that they can capture easily, then they may be interested in only the statements that are easiest to collect. These would be:

1. Number of referrals
2. Number of evaluation forms collected
3. Online or in-person referral
4. Postcode of referral
5. Referral source

4. DISCUSSION AND CONCLUSION

The data gathered, analysed and presented in this report forms an interesting basis for discussion, and for priority areas moving forwards when developing an evaluation framework for social prescribing. Key results include the findings that:

- Responses to the focus prompt: "When developing a core minimum data set for our evaluation framework, I think the data that needs to be included is…" were varied and considered a wide range of data to be included, spanning several domains
- Service user perspective was identified as the most important cluster of statements. This was still true when data was separated by role type and by RPB area.
- Referral pathway was identified as the cluster of statements that was the easiest to collect, however none of the statements from this cluster are included in the top ten statements for ease of collection and importance.
- There was some disparity in the ratings of importance of clusters between those holding different roles in social prescribing, and between different RPB areas.
- It appears based on the rankings of the top ten statements for importance and ease of collection, that self-rated experience of evaluating social prescribing services may somewhat change opinion in these domains.

Additionally, top ten statements across both rating scales, and the top five across importance and ease of collection are identified above, and provide a useful basis for future focus and suggestion.

When considering the results, the background of the data is important to hold in mind. In this GCM study, data comes from two key sources: from participants of the current Cardiff & Vale project which recruited across All Wales, and from participants of a similar project conducted in CTM. Therefore, some data is primary and has been collected specifically for this piece of work, and some is secondary and has been merged with the primary data. There are two main influences to consider as a result of this. The first is that, as sorting data could not be merged, there are fewer responses to the sorting activity than the rating. The second is that because the CTM project originally contained fewer statements, the merged data does not include a rating for every statement and so some statements have a higher number of ratings than others. Although this should not significantly impact the findings presented, it is an important piece of context to consider.

The reason for the data merging relates to a key limitation of the present study: lack of engagement with the GCM. Despite continued efforts from USW and the RIIC hub, the GCM received fewer responses than desired which impacts the extent to which it can be considered representative of the opinions of other professionals. This could be due both to a lack of communication to services that we are not aware of but also due to the existing time

commitments of professionals working in the services that do want to take part. As is reflected in other parts of this project, via the scoping review and evaluation matrix, social prescribing staff are often time poor and may be more focussed on tasks such as community outreach or service promotion, and therefore feel that engaging with this project was not the most valuable use of their time, speaking to the need for a culture of improvement and better communication within the sector.

Of particular interest in this study was the finding that the top ten statements for ease of collection and for importance differed between those with good knowledge for evaluating social prescribing services, and those with poor knowledge (presented in Tables 5 and 6). As opinions may change with experience, it is important to keep this in mind when presenting suggestions and data to different groups. The need for continued workforce training is also implicated in these differences, to ensure that opinions and practice as a result are well informed. However, despite differences in the exact order of statements, there was agreement between these groups that 'service user perspective' was the most important data to be included in an evaluation framework.

Additionally, there were further differences between practitioners and non-practitioners in the importance of clusters, particularly regarding 'referral pathways'. This difference appears to allude to differences in experience, in which practitioners may be more keenly aware of the importance of data regarding referral pathways as this is something they may be more likely to experience directly. This highlights the need to gather the perspective of a range of professionals when producing an evaluation framework such as this as they may have distinct viewpoints based on their experiences. Furthermore, there were differences in the ratings of importance of every cluster aside from 'service user perspective' between the Cardiff & Vale RPB and all other RPB's (represented in Figure 13). This may be due to the higher number of participants within the Cardiff & Vale RPB, or it may be due to the difference in geographical region as the populations may have differing needs and priorities which is then reflected in the perspective of professionals. This is of particular important in social prescribing and emphasizes the need to tailor the offer of services in line with the population and location that they are targeting to ensure that the priorities of the population are met.

In conclusion, this study provides many interesting insights into the consensus of the professional community in regards to the data to be included in the core minimum data set for our social prescribing evaluation framework. There are several statements to be taken from this which can form 'jumping off' points for development, and other areas which have highlighted both their importance, and their need for increased focus in the future.

APPENDIX 1: ALL INCLUDED STATEMENTS

No	Statement
1	Does the person require holistic service (A service that aims to treat the whole person in a holistic manner over a longer period of time, aided by a link worker who helps the client navigate and access suitable services.)?
2	Is the individual signposted only to a community activity? (A light-touch form of social prescribing whereby an individual is provided with information and choice through the process of highlighting services in the community.)
3	Reasons that people do not take up a social prescription
4	Has the individual started to volunteer as a result of SP?
5	Has the individual begun their own project?
6	Did the person need blue prescribing
7	Details of participant protected characteristics
8	Number of professional enquiries received
9	Added third sector value
10	Referrals to which sector
11	Outsourcing to another provider
12	Exit pathways
13	Number of non-attenders DNA's
14	Using example of patient/client journeys to illustrate the financial gain of SP to health and social care
15	Using examples of patient/client journeys to illustrate patient/client responses
16	Number of compliments and complaints
17	RBA card - results based accountability - every quarter
18	Individual project measures e.g. WEMWBS
19	Social wellbeing scores
20	The perceived outcome from the staff delivering service
21	Outcome for the referrer
22	Patient reported outcome measures
23	Patient reported experience measures
24	Lived experience case studies
25	Number of people reporting a positive experience
26	Length of waiting time
27	Number of volunteers supporting delivery
28	Workforce training
29	Number of employed staff in project
30	Right knowledge and skills for project delivery
31	Number of sessions offered
32	Safeguarding - DBS checks
33	Awareness of similar project elsewhere (avoiding duplication)
34	COVID - use of alternate ways of working
35	Covid impacts to projects
36	Number of evaluation forms collected
37	Systems outcomes e.g. health care system
38	Stakeholder engagement
39	Capture learning and sharing across Wales from project evaluations
40	Experience of link workers
41	Organisation data i.e. those delivering social prescriptions
42	Customer service type data
43	National datasets available
44	Public service data
45	Evaluation of how projects influence other bids

No	Statement
46	Number of carers involved in activities
47	Number of carers receiving support
48	Did the person need green prescribing
49	Patterns of activity use, particularly in unstaffed areas
50	How headline data is given to third party facilitators who might have used their spaces for wellbeing/socially prescribed activity
51	How headline data is presented
52	The persons experience of taking part
53	Being participant centred and led
54	Local outcomes
55	Core outcomes agreed nationally
56	Withdrawals from programmes
57	Completion of programmes
58	Level of uptake
59	Online or in-person referral
60	Referral agencies social prescribing use
61	Have social isolation scores decreased?
62	Have physical activity levels increased?
63	Mental wellbeing scores
64	Type of outdoor setting prescribed (i.e. park, coast, woodland etc.)
65	Physical wellbeing scores
66	Clinical diagnosis of referral
67	Follow ups
68	Where can lessons can be learnt and learning shared?
69	Identify areas where there are lower levels of take up i.e. due to gaps in opportunity/provision/link workers
70	Perceived extra benefits to outdoor activity
71	Barriers to taking part in activities
72	Is there a difference in outcome amongst those who report barriers?
73	What is social prescribing work aiming to help with?
74	Is the person more confident in finding support in the future if needed?
75	Is the person more confident in looking after their wellbeing?
76	Did the person achieve their goals?
77	How accessible is the project
78	How long did the person attend the activity or service for?
79	If people are empowered to look after themselves
80	GP surgery of referrals
81	Who is facilitating any activity
82	Any actions taken with space provider down the line (e.g. taking out membership)
83	How headline data is captured
84	The difference the person thinks they make
85	Reasons that individuals take up a referral offer to a socially prescribed activity
86	Understanding sub groups where support is needed
87	The impact of the programme they were prescribed in relation to the reason for their referral
88	Outcomes and benefits in the persons own words
89	Geographical uptake of social prescribing
90	Location of activity
91	Preferences for indoor or outdoor activities
92	Barriers to participation
93	Number of referrals
94	Whether social prescribing was filling a gap in statutory services
95	Quotes from services social prescribing use

No	Statement
96	Did the person need a fitness referral
97	Length of intervention
98	Referrals presenting health and wellbeing issues
99	Quotations from service users
100	Outcomes for referral
101	Services signposted/referred on to
102	Demographics of referrals
103	Information on housing
104	Details of any other agencies involved
105	A specific category for learning (including upskilling and qualifications)
106	Information on medical help
107	Number of contacts with the social prescriber
108	Did the person attend the activity or service
109	Does the person think that the service has helped them with their problem?
110	Reason for referral
111	Postcode of referral
112	Route of referral
113	Referral source
114	Longitudinal follow up to ascertain long term impact
115	Data to determine whether the project addresses social inequality
116	How inclusive is the project
117	Return on investment
118	What matters to the person

APPENDIX 2: ALL STATEMENTS GROUPED BY CLUSTER

No.	Statement
Service user perspective	
1	Does the person require holistic service (A service that aims to treat the whole person in a holistic manner over a longer period of time, aided by a link working who helps the client navigate and access suitable services)?
4	Has the individual started to volunteer as a result of SP?
5	Has the individual begun their own project?
14	Using examples of patient/client journeys to illustrate the financial gain of SP to health and social care
15	Using examples of patient/client journeys to illustrate patient/client responses
18	Individual project measures e.g. WEMWBS
19	Social wellbeing scores
20	The perceived outcome from the staff delivering service
22	Patient reported outcome measures
23	Patient reported experience measures
24	Lived experience case studies
25	Number of people reporting a positive experience
42	Customer service type data
48	Did the person need green prescribing?
52	The persons experience of taking part
61	Have social isolation scores decreased?
62	Have physical activity levels increased?
63	Mental wellbeing scores
65	Physical wellbeing scores
70	Perceived extra benefits to outdoor activity
71	Barriers to taking part in activities
72	Is there a difference in outcome amongst those who report barriers?
74	Is the person more confident in finding support in the future if needed?
75	Is the person more confident in looking after their wellbeing?
76	Did the person achieve their goals?
79	If people are empowered to look after themselves
84	The difference the person thinks they make
85	Reasons that individuals take up a referral offer to a socially prescribed activity
87	The impact of the programme they were prescribed in relation to the reason for their referral
88	Outcomes and benefits in the persons own words
92	Barriers to participation
95	Quotes from services social prescribing use
99	Quotations from service users
100	Outcomes for referral
109	Does the person think that the service has helped them with their problem?
118	What matters to the person
Service activity data	
2	Is the individual signposted only to a community activity (A light-touch form of social prescribing whereby an individual is provided with information and choice through the process of highlighting services in the community)
3	Reasons that people do not take up a social prescription

No.	Statement
6	Did the person need blue prescribing?
7	Details of participant protected characteristics
8	Number of professional enquiries received
12	Exit pathways
13	Number of non-attenders DNA's
16	Number of compliments and complaints
21	Outcome for the referrer
26	Length of waiting time
31	Number of sessions offered
36	Number of evaluation forms collected
46	Number of carers involved in activities
47	Number of carers receiving support
49	Patterns of activity use, particularly in unstaffed areas
54	Local outcomes
56	Withdrawals from programmes
57	Completion of programmes
58	Level of uptake
67	Follow ups
78	How long did the person attend the activity or service for?
82	Any actions taken with space provider down the line (e.g. taking out membership)
91	Preferences for indoor or outdoor activities
93	Number of referrals
96	Did the person need a fitness referral
97	Length of intervention
101	Services signposted/referred on to
102	Demographics of referral
107	Number of contacts with the social prescriber
108	Did the person attend the activity or service
116	How inclusive is the project

Referral pathway	
No.	**Statement**
10	Referrals to which sector
11	Outsourcing to another provider
59	Online or in-person referral
64	Type of outdoor setting prescribed (i.e. park, coast, woodland etc.)
66	Clinical diagnosis of referral
77	How accessible is the project
80	GP surgery of referrals
90	Location of activity
98	Referrals presenting health and wellbeing issues
104	Details of any other agencies involved
110	Reason for referral
111	Postcode of referral
112	Route of referral
113	Referral source

Sharing learning	
No.	**Statement**
9	Added third sector value
17	RBA card - results based accountability - every quarter

No.	Statement
28	Workforce training
37	Systems outcomes e.g. health care system
38	Stakeholder engagement
39	Capture learning and sharing across Wales from project evaluations
40	Experience of link workers
43	National datasets available
44	Public service data
45	Evaluation of how projects influence other bids
50	How headline data is given to third party facilitators who might have used their spaces for wellbeing/socially prescribed activity
51	How headline data is presented
55	Core outcomes agreed nationally
68	Where can lessons be learnt and learning shared?
69	Identifying areas where there are lower levels of take up i.e. due to gaps in opportunity/provision/link workers
73	What is social prescribing work aiming to help with?
83	How headline data is captured
94	Whether social prescribing was filling a gap in statutory services
105	A specific category for learning (including upskilling and qualifications)
114	Longitudinal follow up to ascertain long term impact
115	Data to determine whether the project addresses social inequality
117	Return on investment

Referral agencies and stakeholders	
No.	**Statement**
27	Number of volunteers supporting delivery
29	Number of employed staff in project
30	Right knowledge and skills for project delivery
32	Safeguarding - DBS checks
33	Awareness of similar projects elsewhere (avoiding duplication)
34	Covid - use of alternate ways of working
35	Covid impacts to projects
41	Organisation data i.e. those delivering social prescriptions
53	Being participant centred and led
60	Referral agencies social prescribing use
81	Who is facilitating any activity
86	Understanding sub groups where support is needed
89	Geographical uptake of social prescribing
103	Information on housing
106	Information on medical help