**cardiff and vale – social prescribing**

Development Matrix [FINAL – March 2023]

**PURPOSE OF THE MATRIX**

This Development Matrix (DM) provides a framework for a qualitative assessment to be made of progress. The DM is designed so that services/projects can determine which of the descriptors in the cells in the matrix best describes their progress to date against different dimensions within six domains. It has been designed after conversations with different social prescribing services/projects working in Cardiff and the Vale. Accordingly it is important to note that not every single indicator of the 21 contained herein will be relevant to everyone (hence the ‘N/A’ option).

It is intended that the DM helps services to compare their progress over time, and also to potentially facilitate a conversation between services in Wales working in a multi-professional context. One of the benefits of the DM is that services can use it to assess their progress in relatively short order – services do not need to engage in a detailed data collection exercise before they make a determination of progress against the matrix.

It is also important to note that it is a tool designed to support the development of social prescribing services/projects – it is not a performance management tool, and there is no mandate to have to share information within it with anyone else. However, it will only be useful if people are honest about where they feel their service is when an assessment is made. It is not just about getting to ‘Statement 5’ without thinking carefully about the stages before, and equally there is no problem in recognising that you may be at ‘Statement 1’. We are concerned to reflect on the importance of ‘development’ in the matrix – where you start the journey is just an honest reflection on where things are.

Our aspiration in developing a matrix was to produce a tool that stakeholders – whether leaders, managers, practitioners and others – would find helpful. It was designed to:

* Describe what is happening with ‘face validity’ for the key stakeholders;
* Facilitate a description of what is happening in a way that enables discussion between stakeholders;
* Illustrate what ‘good’ looks like, with steps to suggest and/or demonstrate development; and
* Enable stakeholders to discuss *amongst and for themselves* how they perceive their current circumstances and agree on the next steps to be taken, as this is how such tools work best.

**HOW TO USE THE MATRIX**

It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental – moving along the boxes from Statement 1 (S1) to Statement 5 (S5) presupposes that forms of practice under the previous statement are largely included in the next one. However, it was clear that due to variations in service models, not every indicator within each line is present in every setting. On some occasions it is not required, in others it is not currently an option. Therefore, there is an opportunity to provide context around the statements in the box underneath the matrix. There is also an ‘N/A’ option which can be used if the domain/indicator is determined to be outside of the current remit of the service model, is not required in that locality or if there is capacity elsewhere in the system that can be drawn upon.

Different levels of ‘development’ have been determined through the production of the DM. It is now possible for those completing the matrix to use darker shading against statements where there is greater evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a ‘work in progress’.

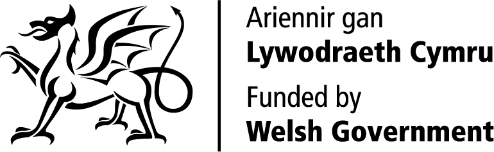
Whilst not wishing to be overly prescriptive about the way in which the matrix should be used, it is important to note that it can be deployed variously within different contexts. There should, of course, be one ‘composite’ matrix that is completed at service/project level, but this single matrix can be an amalgamation of a number of different matrices that have been completed by operational teams, managers, stakeholders and others either in combination or completing it alone. This is how such a matrix is designed to work.

It is crucial though that having established a local approach, the same method is repeated the next time the matrix comes to be completed to ensure comparability over time. It is useful also to reflect on the purpose for completing the matrix – whether it is for reporting, for evaluation, or for learning. These are not mutually exclusive of course, but it is worth being clear for those completing the matrix as to why they are doing so. Crucially, the matrix is about development of the service and should not be used for performance management and validation of activities. However, it should be used longitudinally, with assessments typically made in cycles of 6 to 12 months to determine distance travelled over time.

Along the top of the five statements across each domain are suggested data that relate to how the domain might be measured or improved. These data items have been identified as the top 25 most important and/or easy to collect by social prescribing professionals of various roles across Wales as part of a Group Concept Mapping study[[1]](#footnote-1) tied to this project. Data items are only suggestions and the full rankings of these are available in Appendices 1 (for the most important) and 2 (for the most important *and* easiest to collect) should further suggestions for data wish to be identified. However, the lists presented are hierarchical and so the farther down data items appear the less important, or the harder to collect, professionals have ranked them and so it will be more useful in practice to focus on items presented earlier.

**STATUS OF THE MATRIX**

Now the matrix is finalised, the WSSPR/USW team will be working to help implement this DM during Phase 2 which will run between January and March 2023. Details of this are to follow – please contact Prof. Mark Llewellyn ([mark.llewellyn@southwales.ac.uk](mailto:mark.llewellyn@southwales.ac.uk)) if you want to find out more about what this is likely to entail.



| **Domain** | **Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position?**  *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental –* ***moving along the boxes presupposes that forms of practice under the previous statement are included in the next one****.*  *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a ‘work in progress’.* | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| *S1* | *S2* | *S3* | *S4* | *S5* | *N/A* |
| **1. RELATIONSHIPS** | | | | | | |
| **Most important data items**: is the person more confident in finding support in the future if needed?; number of people reporting a positive experience; the persons experience of taking part; how accessible is the project?; stakeholder engagement | | | | | | |
| **1.1** | **With senior leaders** | Senior leaders are not aware of or understand the service | Senior leaders and may be aware of the service, but lack understanding of service needs | Senior leaders have enough communication with the service to develop a basic understanding of need | Senior leaders communicate regularly with the service, have a good understanding of service needs, and support its work | Established feedback mechanisms for bi-directional communication between senior leaders becoming ‘champions’ for the service, fostering comprehensive understanding |  |
| **1.2** | **With GP surgeries and staff** | Initial contact made with GP surgery via practice manager, however GPs and surgery staff may not be aware of the service or of the SP professional | Initial contact made with wider surgery staff – they are given basic information about the service | SP professional has some regular contact with surgery staff and explains the service, so they are aware of the service offer – increasing reciprocity in the relationship | GPs and surgery staff have a good, up-to-date knowledge of the service and of the referral pathway due to regular ‘two-way’ contact between surgery and SP professional | Full integration of the SP professional with the surgery – GPs and wider staff have a comprehensive understanding of the service and have streamlined referral pathways – complete reciprocity in relationship |  |
| **1.3** | **With clients in the service** | Lack of alliance between client-SP professional means clients do not engage with the service leading to high dropout rates | SP professionals are supported to form alliances, though these may be inconsistent across the service | Clients are generally satisfied with the service and alliances with professionals are mostly positive leading to reduced dropout | Good client-SP professional alliances that encourage clients to remain engaged in the service and foster good client satisfaction | Clients feel well supported and at ease leading to high satisfaction, appropriate ‘repeat business’, word of mouth referrals and high service engagement |  |
| **1.4** | **With the general public** | The general public are unaware of the service and would not be able to access it unless signposted. Unrealistic expectations are held when people are signposted | Basic communications (i.e. posters in GP surgeries) to raise rudimentary awareness of the service  Access points may be unclear | Increased communications to raise service awareness, but many people still require signposting  Promotion of service access points | Good public awareness of the service with clear access points for self-referral  Most people have realistic expectations of the remit of the service | General public have a good knowledge of the service, how to access it, and what to expect from their involvement |  |

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| --- | --- | --- | --- | --- | --- | --- |
| *S1* | *S2* | *S3* | *S4* | *S5* | *N/A* |
| **2. COMMUNITY INSIGHT AND INVOLVEMENT** | | | | | | |
| **Most important data items:** lived experience case studies; identifying areas where there are lower levels of take up (i.e. due to gaps in opportunity/provision/link workers); does the person require a holistic service; the difference the person thinks they make | | | | | | |
| **2.1** | **Knowledge of the local context** | Limited knowledge of local context and the needs of the population | Basic understanding of the local context and population needs (i.e. demographic information, socio-economic needs) | Consideration given to the needs of the local population but not yet integrated into the service offer | Good understanding of local context and population and use of this information to inform the service offer | Comprehensive knowledge of local context, population and the specific needs of the locality, which is fully integrated into the service offer |  |
| **2.2** | **Knowledge of local services and groups** | Basic awareness of services in the area is provided, but this may be outdated and/or limited (i.e. a list of groups) | SP professionals have access to a common resource to inform their knowledge of local services | SP professionals initiate contact with services to gain better knowledge and inform their practice | SP professionals have a good awareness of local services and have formed a relationship with key contacts | SP professionals are proactive in identifying/communicating with local services and have bi-directional relationships with key contacts within |  |
| **2.3** | **Community presence** | SP professionals have limited local presence and local services are typically unaware of their work | Some local services recognise the service, however would not recognise specific SP professionals | SP professionals build basic local presence however there is variation in this presence across the community | SP professionals build name/face recognition within their local context which fosters their presence | SP professionals have a distinct local presence and are recognised and trusted across their community |  |
| **2.4** | **Contribution into the community** | The service signposts to others without due consideration of giving back into the community | Some consideration of community needs undertaken, with limited contribution made | The service considers sufficiency of existing community ‘resource’ (financial, human or other) when signposting and makes an ‘offer’ when asked (i.e. to pause referrals) | The service is sensitive to the resource and needs of the community and actively ‘puts back’ (including through the service itself) a limited amount (i.e. funding contributions, volunteering) | The service is sensitive to the resource and needs of the community and actively ‘puts back’ (including through the service itself) a significant amount |  |

| **Domain** | **Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position?**  *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental –* ***moving along the boxes presupposes that forms of practice under the previous statement are included in the next one****.*  *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a ‘work in progress’.* | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| *S1* | *S2* | *S3* | *S4* | *S5* | *N/A* |
| **3. STAFF** | | | | | | |
| **Most important data items:** right knowledge and skills for project delivery | | | | | | |
| **3.1** | **Well-being of the staff team – managing capacity** | There is a negative impact on most staff wellbeing after a short time working in the service as their workload is mismatched to their capacity | Some staff experience negative impacts on their wellbeing due to workload, but consideration is given to prevention | Staff may experience a negative impact on their wellbeing due to their workload following a long period working in the service | Few staff experience negative impacts on wellbeing due to workload, however support is established to address concerns to prevent this | Staff wellbeing is well managed as support is easily accessible and workload is consistently matched to their capacity |  |
| **3.2** | **Well-being of the staff team – emotional load** | There is a negative impact on most staff wellbeing after a short time working in the service due to unmanageable emotional load of their role | Some staff experience negative impacts on their wellbeing due to emotional load, but consideration is given to prevention | Staff may experience a negative impact on their wellbeing due to the emotional load of their role following a long period working in the service | Few staff experience negative impacts on wellbeing due to emotional load, however support is established to address concerns to prevent this | Staff wellbeing is well managed as support is easily accessible to prevent negative impact due to emotional load of the role |  |
| **3.3** | **Staff supervision** | Very limited (if any) supervision is offered to staff, and they may be unable to access this even on request | Staff can access supervision on request only, and the provider of supervision may vary | Access to supervision with a consistent and appropriate member of staff is established, but not given regularly | Staff supervision is offered with a consistent and appropriate member of staff on a regular basis | Staff are given regular supervision and are able to access this on request. Their supervisor is consistent and appropriate to their level. |  |
| **3.4** | **Staff development** | Staff are expected to ‘learn on the job’ and are not supported in development | Staff learn through passive techniques such as low quality shadowing | Staff are offered training at commencement of the service, but are not supported in further development | Training packages are offered to staff throughout their time in the service, high quality shadowing undertaken | Staff have access to established training pathways and are actively encouraged in further development |  |

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| --- | --- | --- | --- | --- | --- | --- |
| *S1* | *S2* | *S3* | *S4* | *S5* | *N/A* |
| **4. PERSON-CENTRED APPROACH** | | | | | | |
| **Most important data**: what matters to the person; if people are empowered to look after themselves; outcomes and benefits in the persons own words; did the person achieve their goals?; does the person think that the service has helped them with their problem?; patient reported experience measures; how accessible is the project; barriers to taking part in activities; being participant centred and led; how inclusive is the project | | | | | | |
| **4.1** | **Inclusivity and responsivity of the service ‘offer’** | ‘Tick box’ service is delivered without sufficient holistic consideration of the client | Client needs are considered on commencement of the service, but service offer may be insufficiently inclusive or responsive | Service inclusivity and responsivity is provided in some, but not all, areas (e.g. number / length of appointments) | Service is mostly inclusive and responsive however some clients may still feel this does not meet their goal | Full inclusivity and responsivity for the service to be adapted, within established parameters, to a person’s well-being goal |  |
| **4.2** | **Flexibility and person-centredness of the SP professional** | SP professional works only within rigid guidelines and is not confident enough to provide flexibility | SP professionals consider how they can start to provide flexible and person-centred practice | SP professionals provide flexibility and person-centredness in some, but not all, areas (i.e. in the groups they signpost) | SP professionals are considerate of and responsive to client needs and adjust the service offer within the bounds of their knowledge | SP professionals are confident and knowledgeable enough to be able to provide fully flexible and person-centred practice |  |
| **4.3** | **Removing barriers to service access** | Service delivery is rigid (e.g. only accessible in one way, or in one place), and can only be accessed through a GP | The service can only be accessed through a range of healthcare professionals, including those who work in a GP surgery and across primary care | In addition to healthcare professionals, self-referral is available but may not be well established  Some hybrid appointment offers may be in place (e.g. online, phone call or face to face) | Self-referral is promoted and can be done in a multitude of ways  Clients are given choice in the format of their appointment | Self-referral is partnered with proactive outreach to establish contact with ‘hard to reach’ groups  Appointments are offered in a variety of ways to suit all client needs |  |
| **4.4** | **Client feedback into the service** | Clients are given limited opportunity to give their feedback to the service | Clients have an opportunity to give feedback however they often do not  Feedback is not usually implemented or acted upon | Clients are usually asked to provide service feedback and there is moderate uptake  Feedback is easy to give, sometimes implemented, but there is variation in this | Clients are always asked to provide service feedback, there is good uptake  Feedback is easy to give, usually implemented and acted upon | Clients are actively encouraged, and want, to provide feedback to the service  Feedback is easy to give, always implemented and acted upon |  |

| **Domain** | **Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position?**  *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental –* ***moving along the boxes presupposes that forms of practice under the previous statement are included in the next one****.*  *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a ‘work in progress’.* | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| *S1* | *S2* | *S3* | *S4* | *S5* | *N/A* |
| **5. SERVICE DEVELOPMENT** | | | | | | |
| **Most important data items:** patient reported outcome measures; number of people reporting a positive experience; mental wellbeing scores; using examples of patient/client journeys to illustrate the financial gain of SP to health and social care; social wellbeing scores; being participant centred and led | | | | | | |
| **5.1** | **Monitoring of outcome measures or performance indicators, utilisation and feedback** | Outcome measures/performance indicators are inconsistent and are gathered irregularly | Basic outcome measures/ performance indicators are agreed upon, often as part of contract monitoring arrangements with funders, however are not always used for service development | Outcome measures/performance indicators have been chosen and are usually collected, but are limited in their range and scope | Outcome measures/performance indicators are always collected and there is an established feedback loop within the service, although it has limited impact | A variety of meaningful outcomes/performance indicators are always collected and are used for reporting, auditing and research |  |
| **5.2** | **Opportunities for co-producing the service with clients** | There are limited opportunities for co-production within the service | Basic co-production which is limited in scope occurs, but it is not further utilised | Co-production is undertaken at some service levels but there is variation in whether this is acted upon | Opportunities for co-production are embedded in several service levels and the contribution is utilised | Co-production is embedded and encouraged at every service level and its contribution is valued and utilised |  |
| **5.3** | **Funding and longevity** | Time limited and insecure funding that is insufficient for long term service delivery exists | Funding may be time limited but is secure for that time | Funding is secured and diversification/future funding streams are considered | Funding is secure for sufficient time for service development, and future funding is identified | Secure, sufficient, long term funding that guarantees service longevity and development is realised |  |
| **5.4** | **Supply and demand** | There is insufficient supply or demand for the service to function well | Supply and demand vary significantly leading to either ‘wasted’ SP professional time, or burden on SP professionals | Supply and demand are sufficiently matched for service functioning, however this may add burden (e.g. waiting lists) | Supply and demand are generally matched and any imbalance is quickly addressed | Supply and demand are well balanced so that SP professional time is well utilised, but they are not over-burdened |  |

| **Domain** | **Descriptors: For each of the dimensions below, which statement below (S1-S5) best describes your current position?**  *It is important to note that there is an underlying logic in how the statements build on one another across the matrix. The statements are incremental –* ***moving along the boxes presupposes that forms of practice under the previous statement are included in the next one****.*  *Darker shading against statements indicates that there is evidence that the statement has been fully achieved. Lighter shading is an indication that some progress has been made in this domain, but that it remains a ‘work in progress’.* | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| *S1* | *S2* | *S3* | *S4* | *S5* | *N/A* |
| **6. INFORMATION GOVERNANCE** | | | | | | |
| **Most important *and* easy to collect data items:** safeguarding – DBS checks | | | | | | |
| **6.1**| **Confidentiality and consent** | Defined consent and confidentiality procedures are in place, however clients may not be aware of these | Clients are made aware of all basic consent and confidentiality procedures on service commencement | SP professionals are familiar with procedures and have some awareness of safeguarding policy, though may be unsure of how to implement  Consent is usually recorded, but not always | SP professionals have a good understanding of the service consent, confidentiality and safeguarding policies and explain these to clients (e.g. GDPR requirements)  Consent is consistently recorded | SP professionals are confident in explaining consent and confidentiality, and deploy safeguarding procedures effectively  Established and protected records of consent are kept |  |
| **6.2** | **IT systems** | Lack of access to relevant information, and IT systems act entirely in isolation | Relevant systems are identified, and access is requested by the service  GDPR compliance in utilised IT systems is present | Service has access to necessary information and systems, but duplication occurs as that access is restricted  Limited communication between IT systems | Communication established between IT systems but may be cumbersome to navigate  Ability to access all necessary information and systems | IT systems are able to communicate so all relevant information can be seen or added to by SP professionals with ease  All required systems access granted in full, and systems work inter-operably |  |

**APPENDIX 1: ALL DATA ITEMS RANKED BY IMPORTANCE**

| **Rank** | **Statement** | **Avg. importance rating (out of 5)** |
| --- | --- | --- |
| 1 | What matters to the person | 4.7222 |
| 2 | Is the person more confident in finding support in the future if needed? | 4.6111 |
| 3 | If people are empowered to look after themselves | 4.5882 |
| 4 | Outcomes and benefits in the persons own words | 4.5862 |
| 5 | Did the person achieve their goals? | 4.5862 |
| 6 | Does the person think that the service has helped them with their problem? | 4.5789 |
| 7 | Number of people reporting a positive experience | 4.5357 |
| 8 | Is the person more confident in looking after their wellbeing? | 4.5263 |
| 9 | The persons experience of taking part | 4.5 |
| 10 | Lived experience case studies | 4.4444 |
| 11 | Patient reported outcome measures | 4.4286 |
| 12 | Patient reported experience measures | 4.4286 |
| 13 | Mental wellbeing scores | 4.3889 |
| 14 | How accessible is the project | 4.3684 |
| 15 | Barriers to taking part in activities | 4.3684 |
| 16 | Being participant centred and led | 4.3158 |
| 17 | Identifying areas where there are lower levels of take up i.e. due to gaps in opportunity/provision/link workers | 4.2963 |
| 18 | Using examples of patient/client journeys to illustrate the financial gain of SP to health and social care | 4.2857 |
| 19 | How inclusive is the project | 4.2632 |
| 20 | 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)? | 4.25 |
| 21 | Right knowledge and skills for project delivery | 4.2333 |
| 22 | Social wellbeing scores | 4.2222 |
| 23 | The difference the person thinks they make | 4.2222 |
| 24 | Stakeholder engagement | 4.2143 |
| 25 | Barriers to participation | 4.2105 |
| 26 | Quotations from service users | 4.2 |
| 27 | Level of uptake | 4.2 |
| 28 | Using examples of patient/client journeys to illustrate patient/client responses | 4.1786 |
| 29 | Is there a difference in outcome amongst those who report barriers? | 4.1667 |
| 30 | Outcomes for referral | 4.1579 |
| 31 | Physical wellbeing scores | 4.1579 |
| 32 | Did the person attend the activity or service | 4.15 |
| 33 | Reasons that individuals take up a referral offer to a socially prescribed activity | 4.15 |
| 34 | Reasons that people do not take up a social prescription | 4.15 |
| 35 | Have social isolation scores decreased? | 4.1111 |
| 36 | Data to determine whether the project addresses social inequality | 4.1053 |
| 37 | Workforce training | 4.069 |
| 38 | Reason for referral | 4 |
| 39 | The impact of the programme they were prescribed in relation to the reason for their referral | 4 |
| 40 | Capture learning and sharing across Wales from project evaluations | 4 |
| 41 | Added third sector value | 4 |
| 42 | Completion of programmes | 3.9655 |
| 43 | Longitudinal follow up to ascertain long term impact | 3.963 |
| 44 | Whether social prescribing was filling a gap in statutory services | 3.9474 |
| 45 | Where can lessons be learnt and learning shared? | 3.9412 |
| 46 | Exit pathways | 3.8966 |
| 47 | Length of waiting time | 3.8929 |
| 48 | The perceived outcome from the staff delivering service | 3.8929 |
| 49 | Awareness of similar projects elsewhere (avoiding duplication) | 3.8929 |
| 50 | Return on investment | 3.8929 |
| 51 | Number of referrals | 3.8667 |
| 52 | Understanding sub groups where support is needed | 3.8421 |
| 53 | Withdrawals from programmes | 3.7895 |
| 54 | Safeguarding - DBS checks | 3.7857 |
| 55 | Geographical uptake of social prescribing | 3.75 |
| 56 | Systems outcomes e.g. health care system | 3.7333 |
| 57 | Referral agencies social prescribing use | 3.6667 |
| 58 | What is social prescribing work aiming to help with? | 3.6667 |
| 59 | Services signposted/referred on to | 3.6429 |
| 60 | Individual project measures e.g. WEMWBS | 3.6429 |
| 61 | Quotes from services social prescribing use | 3.6316 |
| 62 | Referrals presenting health and wellbeing issues | 3.6316 |
| 63 | Core outcomes agreed nationally | 3.6316 |
| 64 | Referrals to which sector | 3.6071 |
| 65 | Experience of link workers | 3.6071 |
| 66 | How long did the person attend the activity or service for? | 3.6 |
| 67 | Having physical activity levels increased? | 3.6 |
| 68 | Number of compliments and complaints | 3.5926 |
| 69 | Local outcomes | 3.5882 |
| 70 | Referral source | 3.5862 |
| 71 | Number of carers receiving support | 3.5862 |
| 72 | 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) | 3.5789 |
| 73 | Demographics of referrals | 3.5769 |
| 74 | Follow ups | 3.5263 |
| 75 | Details of participant protected characteristics | 3.5185 |
| 76 | Evaluation of how projects influence other bids | 3.5 |
| 77 | Outcome for the referrer | 3.4643 |
| 78 | A specific category for learning (including upskilling and qualifications) | 3.4483 |
| 79 | GP surgery of referrals | 3.4211 |
| 80 | Number of non-attenders DNA's | 3.3846 |
| 81 | Number of carers involved in activities | 3.3704 |
| 82 | RBA card - results based accountability - every quarter | 3.3571 |
| 83 | Number of volunteers supporting delivery | 3.3214 |
| 84 | Route of referral | 3.3158 |
| 85 | Length of intervention | 3.2963 |
| 86 | Details of any other agencies involved | 3.2778 |
| 87 | How headline data is captured | 3.2778 |
| 88 | Organisation data i.e. those delivering social prescriptions | 3.25 |
| 89 | Public service data | 3.25 |
| 90 | Number of evaluation forms collected | 3.2414 |
| 91 | Number of contacts with the social prescriber | 3.2143 |
| 92 | Postcode of referral | 3.2105 |
| 93 | National datasets available | 3.1786 |
| 94 | Customer service type data | 3.1667 |
| 95 | Information on housing | 3.1579 |
| 96 | Number of professional enquiries received | 3.1111 |
| 97 | How headline data is presented | 3.1111 |
| 98 | Number of sessions offered | 3.069 |
| 99 | Has the individual started to volunteer as a result of SP? | 3.0556 |
| 100 | Patterns of activity use, particularly in unstaffed areas | 3.0556 |
| 101 | Location of activity | 3 |
| 102 | Who is facilitating any activity | 3 |
| 103 | Perceived extra benefits to outdoor activity | 3 |
| 104 | Online or in-person referral | 2.9655 |
| 105 | Number of employed staff in project | 2.9643 |
| 106 | Covid impacts to projects | 2.963 |
| 107 | Preferences for indoor or outdoor activities | 2.95 |
| 108 | Type of outdoor setting prescribed (i.e. park, coast, woodland etc.) | 2.9444 |
| 109 | Has the individual begun their own project? | 2.8889 |
| 110 | Did the person need a fitness referral | 2.8824 |
| 111 | Covid - use of alternate ways of working | 2.8519 |
| 112 | Information on medical help | 2.7895 |
| 113 | How headline data is given to third party facilitators who might have used their spaces for wellbeing/socially prescribed activity | 2.7647 |
| 114 | Did the person need blue prescribing? | 2.75 |
| 115 | Did the person need green prescribing? | 2.7059 |
| 116 | Clinical diagnosis of referral | 2.5882 |
| 117 | Any actions taken with space provider down the line (e.g. taking out membership) | 2.5625 |
| 118 | Outsourcing to another provider | 2.4286 |

**APPENDIX 2: ALL DATA ITEMS RANKED BY IMPORTANCE AND EASE OF COLLECTION**

| **Rank** | **Statement** | **Avg. combined importance & ease of collection (out of 10)** |
| --- | --- | --- |
| 1 | What matters to the person | 8.7889 |
| 2 | Does the person think that the service has helped them with their problem? | 8.7789 |
| 3 | Outcomes and benefits in the persons own words | 8.5427 |
| 4 | Number of people reporting a positive experience | 8.5357 |
| 5 | Number of referrals | 8.3867 |
| 6 | The persons experience of taking part | 8.3667 |
| 7 | Patient reported outcome measures | 8.3453 |
| 8 | Quotations from service users | 8.3333 |
| 9 | Social wellbeing scores | 8.0889 |
| 10 | Mental wellbeing scores | 8.0764 |
| 11 | Is the person more confident in looking after their wellbeing? | 8.0596 |
| 12 | Patient reported experience measures | 8.0536 |
| 13 | Lived experience case studies | 8.0444 |
| 14 | Outcomes for referral | 8.0246 |
| 15 | Is the person more confident in finding support in the future if needed? | 7.9444 |
| 16 | Physical wellbeing scores | 7.8912 |
| 17 | Referral source | 7.8362 |
| 18 | Geographical uptake of social prescribing | 7.8214 |
| 19 | If people are empowered to look after themselves | 7.7882 |
| 20 | Safeguarding - DBS checks | 7.7857 |
| 21 | Quotes from services social prescribing use | 7.7649 |
| 22 | Reason for referral | 7.76 |
| 23 | The difference the person thinks they make | 7.7555 |
| 24 | Level of uptake | 7.7333 |
| 25 | Length of waiting time | 7.7262 |
| 26 | Did the person attend the activity or service | 7.7125 |
| 27 | Did the person achieve their goals? | 7.7112 |
| 28 | Completion of programmes | 7.6055 |
| 29 | Services signposted/referred on to | 7.6012 |
| 30 | Using examples of patient/client journeys to illustrate patient/client responses | 7.5536 |
| 31 | Number of evaluation forms collected | 7.5331 |
| 32 | Route of referral | 7.5158 |
| 33 | Postcode of referral | 7.4772 |
| 34 | Demographics of referrals | 7.4465 |
| 35 | Referrals presenting health and wellbeing issues | 7.4316 |
| 36 | Referrals to which sector | 7.3988 |
| 37 | Workforce training | 7.3733 |
| 38 | Reasons that individuals take up a referral offer to a socially prescribed activity | 7.35 |
| 39 | How long did the person attend the activity or service for? | 7.35 |
| 40 | How accessible is the project | 7.3017 |
| 41 | GP surgery of referrals | 7.2878 |
| 42 | The perceived outcome from the staff delivering service | 7.2679 |
| 43 | Referral agencies social prescribing use | 7.2667 |
| 44 | Number of compliments and complaints | 7.2593 |
| 45 | Online or in-person referral | 7.2572 |
| 46 | Number of contacts with the social prescriber | 7.256 |
| 47 | Being participant centred and led | 7.2491 |
| 48 | Individual project measures e.g WEMWBS | 7.2262 |
| 49 | Barriers to taking part in activities | 7.2255 |
| 50 | Exit pathways | 7.1883 |
| 51 | Have social isolation scores decreased? | 7.1778 |
| 52 | Number of employed staff in project | 7.1726 |
| 53 | Withdrawals from programmes | 7.1228 |
| 54 | 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)? | 7.1071 |
| 55 | Barriers to participation | 7.0772 |
| 56 | What is social prescribing work aiming to help with? | 7.0667 |
| 57 | Using examples of patient/client journeys to illustrate the financial gain of SP to health and social care | 6.994 |
| 58 | Number of non-attenders DNA's | 6.9679 |
| 59 | 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) | 6.936 |
| 60 | Follow ups | 6.9263 |
| 61 | Length of intervention | 6.8796 |
| 62 | Where can lessons be learnt and learning shared? | 6.8745 |
| 63 | Location of activity | 6.8667 |
| 64 | Number of sessions offered | 6.8607 |
| 65 | Local outcomes | 6.8549 |
| 66 | Outcome for the referrer | 6.8393 |
| 67 | Number of professional enquiries received | 6.8194 |
| 68 | Stakeholder engagement | 6.7976 |
| 69 | How inclusive is the project | 6.7965 |
| 70 | Details of participant protected characteristics | 6.7585 |
| 71 | Identifying areas where there are lower levels of take up i.e. due to gaps in opportunity/provision/link workers | 6.7546 |
| 72 | Right knowledge and skills for project delivery | 6.7333 |
| 73 | Number of carers receiving support | 6.7166 |
| 74 | Who is facilitating any activity | 6.7143 |
| 75 | Is there a difference in outcome amongst those who report barriers? | 6.7 |
| 76 | RBA card - results based accountability - every quarter | 6.618 |
| 77 | Experience of link workers | 6.6071 |
| 78 | The impact of the programme they were prescribed in relation to the reason for their referral | 6.6 |
| 79 | Having physical activity levels increased? | 6.6 |
| 80 | Reasons that people do not take up a social prescription | 6.55 |
| 81 | Preferences for indoor or outdoor activities | 6.55 |
| 82 | Whether social prescribing was filling a gap in statutory services | 6.5474 |
| 83 | Number of volunteers supporting delivery | 6.4814 |
| 84 | Organisation data i.e. those delivering social prescriptions | 6.4583 |
| 85 | Number of carers involved in activities | 6.4504 |
| 86 | Core outcomes agreed nationally | 6.4316 |
| 87 | Details of any other agencies involved | 6.4111 |
| 88 | Longitudinal follow up to ascertain long term impact | 6.3978 |
| 89 | Data to determine whether the project addresses social inequality | 6.372 |
| 90 | Customer service type data | 6.3334 |
| 91 | Capture learning and sharing across Wales from project evaluations | 6.2917 |
| 92 | Did the person need a fitness referral | 6.2824 |
| 93 | How headline data is captured | 6.2111 |
| 94 | Type of outdoor setting prescribed (i.e. park, coast, woodland etc.) | 6.2111 |
| 95 | Understanding sub groups where support is needed | 6.1754 |
| 96 | A specific category for learning (including upskilling and qualifications) | 6.0733 |
| 97 | Systems outcomes e.g. health care system | 6.0666 |
| 98 | Public service data | 6.0417 |
| 99 | How headline data is presented | 5.9778 |
| 100 | Did the person need green prescribing? | 5.8597 |
| 101 | Added third sector value | 5.8333 |
| 102 | Did the person need blue prescribing? | 5.8269 |
| 103 | Awareness of similar projects elsewhere (avoiding duplication) | 5.8096 |
| 104 | Perceived extra benefits to outdoor activity | 5.8 |
| 105 | National datasets available | 5.7203 |
| 106 | Return on investment | 5.6429 |
| 107 | Covid - use of alternate ways of working | 5.6345 |
| 108 | Information on housing | 5.5954 |
| 109 | Covid impacts to projects | 5.5463 |
| 110 | Evaluation of how projects influence other bids | 5.5 |
| 111 | How headline data is given to third party facilitators who might have used their spaces for wellbeing/socially prescribed activity | 5.4314 |
| 112 | Has the individual started to volunteer as a result of SP? | 5.3889 |
| 113 | Information on medical help | 5.1895 |
| 114 | Outsourcing to another provider | 5.1786 |
| 115 | Has the individual begun their own project? | 5.0889 |
| 116 | Patterns of activity use, particularly in unstaffed areas | 4.9889 |
| 117 | Clinical diagnosis of referral | 4.8739 |
| 118 | Any actions taken with space provider down the line (e.g. taking out membership) | 4.7625 |

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1. Randall, S., Wallace, C. (2022). *Core Minimum Dataset for Social Prescribing – Group Concept Mapping*. Wales School for Social Prescribing Research. Welsh Institute for Health and Social Care. PRIME Centre Wales. University of South Wales. Available on request. [↑](#footnote-ref-1)