Health and Social Care Research: Pathway to Portfolio funded project - Cwm Taf Morgannwg University Health Board

Creating sustainable community assets/social capital within the context of social prescribing: Findings from the workshop held 17/07/19

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Creating sustainable community assets/social capital within the context of social prescribing

Summary of findings

45 participants from across the Cwm Taf Morgannwg University Health Board (Rhondda Cynon Taf, Merthyr Tydfil and Bridgend) attended a workshop held on 17th July 2019 at a local community venue (Rhydyfelin Community Centre, Rhydyfelin, Pontypridd) to consider the role community assets plays within the context of social prescribing. Participants identified 135 research questions/comments, which were collapsed down to 6 ranked research priority areas through consensus methodology based upon a points system (top priority 6 points, second choice 5 points, third choice, 4 points and so on):

1. **Educating and communication (154.5 points)**
   It was important that a clear and consistent message was communicated to GPs, other health care professionals and community leaders about the existence and key benefits of social prescribing. Citizens needed to know that there were alternative community-based activities available in the community to support them rather than relying on a medical intervention. There needed to be a better understanding. There needed to be improved communication mechanisms between organisations and sectors across Cwm Taf Morgannwg University Health Board, with training in social prescribing available and a programme of public education.

2. **Dissemination and information sharing (143.5)**
   The Information, Advice and Assistance offer needs to be up to date and widely shared and available to citizens, but how that happens is variable. The public information on Social prescribing needs to be freely available; how to access and what to expect.

3. **Pre and post implementation infrastructure (127.5 points)**
   There was a need to establish a mechanism for the planning and commissioning of social prescribing and create a workable infrastructure to support this. This is reliant on having robust systems in place and the full involvement of people benefiting from Social prescribing and those providing a service.

4. **Quality (126 points)**
   Quality was articulated at several levels and that quality assurance should be proportionate, but that safeguarding the individual was paramount. Therefore, voluntary organisations and community activities needed to ensure that services were safe, consistent and reliable, and were clear as to how the well-being needs of people were being addressed based upon the 'what matters' conversation. Agreed tools to measure and evaluate was central to understanding what works for people accessing a social prescription.

5. Evidencing sustainability (123 point)

Crucial to the success of social prescribing was to have varied, vibrant and sustainable assets. However, community assets are vulnerable due to public sector funding arrangements and competition from within the voluntary/community sector for funding. The test for voluntary and community organisation is how they can provide and present robust evidence to sustain their assets when funders have more of a focus on quantitative than qualitative data. Sustaining community assets/social capital requires sustainable funding, while at the same time sustaining social prescribing through re-current funding.

6. Systems (121.5 points)

Systemic barriers existed, which were challenging and had the potential to hinder the growth of social prescribing, but also grow and sustain the community assets people could be referred to. Commissioning and procurement processes need to be transparent, compassionate and responsive for both social prescribing and the commissioning of community activities. A simpler and proportionate commissioning process would allow smaller community-based organisations and groups fairer and equitable access to funding alongside larger not-for-profit organisations.

7. Other factors

The public and professionals need to know about social prescribing to improve involvement and uptake. There are access issues which needs to be addressed such as activities close to home and transport infrastructure, especially in Valleys communities. Volunteers play an important part in delivery and supporting people to access local community assets. The social aspect of volunteering as a social prescription choice, builds confidence, skills and gets people engaged in the community, having a dual role in improving well-being.

1. Introduction

It is acknowledged that social prescribing as a concept, is becoming more widely proposed as non-clinical alternative for people with complex psycho-social needs. However, there is need to build the critical evidence base (Bickerdicke et al., 2017), on the effectiveness of social prescribing against a backdrop of different models. Presently, social prescribing is largely facilitated by County Voluntary Councils and other voluntary sector organisations and in primary care in Wales. While no universal definition of social prescribing exists, essentially an individual can be referred through several pathways to a social prescriber, link worker or similarly titled worker, through their:

- GP or other health professional,
- a social worker, for example, or
- in some cases, by self-referring to a voluntary sector organisation or community asset for care and support services and activities to better manage their health, social care and well-being needs.

In Cwm Taf Morgannwg (Rhondda, Cynon Taf, Merthyr Tydfil and Bridgend Local Authority areas), the variety of models replicates the Wales-wide experience of social prescribing activity, all of which require the NHS, Local Authorities and the voluntary and community sector to work together for the benefit of the public in delivering social prescribing. Currently, based upon more recent literature (Husk et al., 2019; Bickerdicke et al., 2017; Lovell et al., 2017) and the findings from the Wales Social Prescribing Research Network's (WSPRN) inaugural consensus event (May, 2018), there is a need to understand how, when, why and in what circumstances social prescribing works and what community assets/social capital are helpful, available, need developing or sustained to ensure there are improved outcomes for people.

2. Health and Care Research Wales - Pathway to Portfolio Development funded project

Pathway to Portfolio (Health and Care Research Wales) Development Fund was awarded (April-September 2019 - £20,000) to develop a research project/activity within the context of Social prescribing and was based upon the research priorities and themes identified by the WSPRN and across Cwm Taf Morgannwg. The project funding was awarded to Dr Carolyn Wallace (Associate Professor, University of South Wales) at Cwm Taf Morgannwg University Health Board through her honorary contract, with Dr Sally Rees (WCVA) who provided the researcher input. The project is lead within Cwm Taf Morgannwg University Health Board by Sara Thomas (Consultant Public Health, Local Public Health Team). The aim was to explore social prescribing across Cwm Taf Morgannwg and to develop in partnership at least one large grant application and 1-2 smaller grant submissions based upon the outcomes of the project findings.

The WSPRN consensus event (May 2018), through a process of discussion, defining and voting identified eight top research priorities, the top voted priority being ***What systems might sustain community assets? How can we make it (social prescribing) sustainable?*** On

that basis, a consensus event, in the form of a workshop was organised to consider the key aspects and questions to agree in ***Creating sustainable social capital/community asset exchange in social prescribing?*** across Cwm Taf Morgannwg University Health Board.

3. Methodology

The consensus event consisted of a workshop based upon the Nominal Group Technique (Delbecq and Van de Ven, 1971) and further developed by Kenkre et al. (2015) brought together an invited participatory group of practitioners, commissioner, social prescribers and individuals interested in social prescribing; representing the public, private, voluntary and community sectors and academics to share their experiences to generate their top research priority areas. Participants received the agenda for the event (Appendix 1) and a study information sheet (Appendix 2) prior to attending and upon arrival were asked to complete a consent form (Appendix 3). This method provided the opportunity to generate a number of varied ideas, gave everyone the opportunity to participate using co-productive principles and created the conditions to be constructive and problem solve through a democratic process to prioritise. In this case, it was the research questions and grant submissions to be taken forward in Cwm Taf Morgannwg with respect to social prescribing. This was achieved through active discussion and democratic negotiation using a four-phased approach led by Dr Carolyn Wallace, who acted as the moderator. Prior to proceedings Sara Thomas presented the context to social prescribing in Cwm Taf Morgannwg, with Dr Sally Rees providing the background and details of the research project.

3.1 The four phases

Phase One: Participants were asked to consider their individual 3 research question, discuss and share based upon the research question posed.

Phase 2: Series of Round Robins to record the research questions through increasing the size of the groups incrementally as the rounds progressed. Each round was recorded on colour coded paper.

Phase 3: Discussion on the research questions and collapse down to a manageable and realistic number based upon the number of people participating who contributed their three research questions.

Phase 4: Each participant ranked the top three research questions or focus to progress one large grant proposal and to develop 1-2 smaller scale applications for research funding. The priorities were ranked using points system (top priority 6 points, second priority 5 points and so on).



3.2 Ethical approval (Appendix 4)

This study received ethical approval from the Schools of Health, Sport and Professional Practice and Care Sciences Research Ethics Sub Group, University of South Wales on 12/07/19 (Reference number: 19CW0702LR). The approval is valid for two years from date of issue and a report upon completion of the project will be submitted to the Sub Group.

4. Results

The workshop took place on 17th July 2019 at a local venue (Rhydyfelin Community Centre, Rhydyfelin, Pontypridd) recently transferred to the community. **45** participants took part from across Cwm Taf Morgannwg University Health Board, representing both public, voluntary, community and private sectors, across health and social care disciplines or related fields. The findings, hand analysed and colour coded per priority area, are based upon the four-phased approach, which initially identified **135** individual research questions/comments (Appendix 5, Table 1.) and concluded with a discussion in the large group (final phase) to agree the top 3 ranked priorities. However, there was consensus that the 6 priorities agreed at the previous round (Appendix 5, Table 5, 'White paper': 2 large groups) should be taken forward to the next stage and voted anonymously in order of priority. There was a view that the final six did not fully relate or reflect earlier conversations about sustainable funding as a priority and that year on year funding needs to be replaced with funding that gives project or service longevity. All the recorded information across the series of round robins at Phase Two were analysed alongside the individual responses (3 research questions/comments) collected from Phase One to mitigate against any loss of information and interpretation and to identify themes within and without the top six research priority areas.

The final voted order of research priorities:

1. **Educating and communicating (154.5 points)**
2. **Dissemination and sharing information (143.5 points)**
3. **Infrastructure pre and post implementation (127.5 points)**
4. **Quality (126 points)**
5. **Evidencing sustainability (123 points)**
6. **Systems (121.5 points)**

4.1 Educating and communicating

Communicating to GPs, other health care professionals and community leaders about the existence and key benefits of social prescribing was important part of ensuring citizens had an awareness of an alternative to a medical or social care intervention and that the awareness translated into referrals to social prescribing. Crucial to increasing referral rates was the need to:

- Have a better understanding of what kind of information needs to be communicated to the public; what is available, what the public should expect.
- Once a person is referred that feedback mechanisms were in place for organisations to report the individual experience through case studies, identify good practice and the challenges and issues.
- Training in social prescribing should be available and a programme of public education in place, with
- better communication mechanisms established between organisations and sectors across the region.

4.2 Dissemination and sharing information

A key driver of the Social Services and Well-being (Wales) Act, 2014 is that local authorities and partners have a duty to develop an Information, Advice and Assistance (IAA) offer of what is available to citizens in their local community to meet their care, support and well-being needs. How well that offer materialises and is communicated is variable, with barriers in the system inhibiting improvements in the way the IAA offer is communicated to the public.

Good communication is at the centre of disseminating and sharing information in educating the public about social prescribing. It was felt that there needed to be:

- A shared language across sectors.
- Improved data sharing across sectors about what is working well/not working well and what needs to change to ensure community assets are sustainable; taking the learning from, for example, community hubs.
- GPs having an up to date data base they can access for patients for social prescribing.
- More active use of technology to disseminate information and raise awareness of Social prescribing in the community.

4.3 Pre/post implementation Infrastructure

There was a need to establish a mechanism for the planning and commissioning of social prescribing and create a workable infrastructure to support this. This is reliant on having robust systems in place and the full involvement of people benefiting from social prescribing and those providing a service. This means working co-productively to scrutinise, investigate and challenge the infrastructure, but there needs to be more of a focus on *'non-deficit models, drawing from organic development of groups'* balanced against the *'notions of "need" and the complexities of a strong structure'.*

4.4 Quality

It was notable throughout the round robins that co-production should be encouraged to be at the heart of social prescribing; supporting people and organisations to identify the right assets, provide support at the right time and level, incorporating an agreed standard of support and quality assurance. The notion of quality was articulated at several levels and that quality assurance should be proportionate, but that safeguarding the individual was paramount. Therefore, voluntary organisations and community activities needed to ensure that services were safe, consistent and reliable, and were clear as to how the well-being needs of people were being addressed based upon the 'what matters' conversation to achieve their personal outcomes. From a quality perspective there needs to be a duty of care of people; that safeguarding and having transparency policies which promote good governance, training, development and support awareness need to be in place, but that can be problematic for more informal community activities. The provision of a range of quality activities that suit everyone, providing *'enough choice to satisfy the interests of the many'*, while having the ability to provide bespoke support or packages that are tailored to the individual need, is challenging for smaller voluntary and community organisations. However, such organisations can respond to localised need and often have a better understanding of what is needed for their communities, but the resources to do so inhibit development. The delivery of quality-based services, which become household names and involving people; the service users, in the design and development should be the aim.

A baseline position of what needs to be offered to meet the social prescribing agenda needs to be agreed to ensure that the client gets the best possible journey without frequent or re-current signposting to activities, which are not meeting their specific needs. For GPs, to 'buy-in' to social prescribing they need to have confidence that when they refer a patient to an activity or voluntary or community organisation that there was a guarantee that quality of provision was assured, which is safe and ethical.

Evaluating the impact and quality of social prescribing needs an agreed and robust methodology. Participants articulated that it should include, for example:

- Evaluating the impact of the individual's experience of social prescribing and the community assets they have accessed, and the system itself.
- The individual's contact with the social prescriber; how they have been supported.
- The experience of social prescribers; their skills, knowledge and training needs.
- The role and experience of voluntary and community organisation supporting people through a social prescribing referral.

It was felt that training of social prescribers needs to be of a high quality; that social prescribing projects were able to:

- Attract the right people with the right skills into the role,
- were to sustain those roles, and that

- the social prescribers had a good understanding of the community assets available to refer to, but also were able to identify gaps and work in partnership to address those gaps in community provision.

4.5 Evidencing sustainability

Key to the success of social prescribing is having vibrant, accessible and sustainable community assets. Nonetheless, while there is a richness and variety of community assets/social capital they are vulnerable due to public sector funding arrangements and competition from within the voluntary/community sector for funding, including from grant making bodies and trusts. The challenge is how voluntary and community organisations can provide and present the robust evidence to sustain their assets when funders have more of a focus on quantitative than qualitative data. Monitoring should not solely be statistically driven, but a have a focus on quality, what people have experienced and their collective outcomes. Commissioners need to re-consider requesting qualitative data rather than quantitative monitoring information to understand the *'barriers related to 'human' issues, disabilities and poverty'* and use the information to create the conditions to ameliorate through access to social prescribing as an option to address such issues as loneliness, social isolation and mental health.

To create sustainable community assets/social capital requires sustainable funding, while at the same time sustaining social prescribing through re-current funding. It is difficult to secure long-term funding in the context of short-term funding pots (1-3 years), which does not support longevity of what works or provide the opportunity to plan effectively, develop, refine or change. This is set against a backdrop of cuts in public funding and austerity which continues to have an impact on how and if community assets/social capital are funded in the short or long term. There is a lack of equitable opportunity to access funding and a lack of co-productive endeavour to develop and design care and support services to meet need. Investing in the community will encourage use and improve individual and community resilience. However, there needs to be a change in the way the voluntary and community sector is funded as well as social prescribing. Models of social prescribing are mainly project based and time limited and smaller voluntary organisation and more informal groups *'generally do not have the resources to continue to run a project and are at risk while waiting funding confirmation'*.

Agreement on tools to measure the experience of individuals and a sustainable system in place to evaluate consistently were all identified. Current social prescribing projects to gain a baseline but recognising that there are 'competing notions of "what matters" and there are many different types of community assets' and *'different roads/journeys to sustainability'*.

4.6 Systems

It was felt that there were systemic barriers to not only sustain social prescribing, but also the community assets people are referred to and the asset transfer processes (e.g. transfer of local authority building to the community). Obstacles existed, with barriers around the

commissioning process, which was complex and bureaucratic. A simpler system was called for so that smaller voluntary organisations and local community groups would not be disadvantaged. This was due to capacity issues and skill gaps to respond to public sector funding calls. However, the continuity of funding that enables long-term planning and reliability comes at a time when local authorities and health boards are experiencing reduced funding because of austerity which makes it challenging to address the prevailing short-term funding conditions. Smaller voluntary organisations or informal community groups were unaware of how to propose alternative sustainable models without knowing who to approach or the systems to do so. Many smaller community/neighbourhood groups have informal systems which often led them to being more ad hoc and 'pop up' and unsustainable. At the second-round robin (the 'pink paper') it was felt that there was a need to understand how to ensure that there is a sense of balance in terms of system responsibilities to safeguard people versus giving smaller more informal groups a foot in the door to funding, by not constraining them by imposing formal processes which inhibit their development.

Commissioning and procurement processes need to be fair, transparent, compassionate, proportionate and responsive for both social prescribing and the commissioning of community activities and services which provide social value to individuals and communities. However, the relations between individuals, organisations and sectors needed to embrace and understand that the power in having a voice in a relationship needs to be equal and reciprocal through commissioning processes. Likewise, that through co-production, the culture change required to produce innovative ideas and practice, needs to allow for the evolution of social prescribing with citizens as active co-producers. There needs to be flexibility, fluidity and support across the voluntary and community sectors, with a prerequisite to:

- Audit good practice to *'ensure confidence in the system'*,
- map community assets, including identifying community venues to keep up to date with the *'diverse, dynamic nature of the community and third sector'* and to address duplication of provision,
- identify the gaps and how those gaps could be addressed through proactive and supportive commissioning,
- have a shared vision of what good partnerships look like;
- a single vision for a co-production system which currently is fragmented and difficult to develop, manage and assess. It was felt this needed to be a directive from an authoritative body (Welsh Government or Local Health Boards) to make it effective and to ensure that everyone worked in the same direction, with
- more of a focus on *'non-deficit models, drawing from organic development of groups' balanced against the 'notions of need and the complexities of a strong structure'*.

The individual and anyone subscribing such as a GP needs to know how the system works from a social prescribing perspective; how to navigate it, what to expect, and once signposted they follow through with an activity. Several participants felt that there was a need to have an easier system to access, for example, physical activity opportunities, e.g. a

simple referral to schemes such at the National Exercise Referral Scheme and a more sustained approach to communication and improve the Information, Advice and Assistance offer which could happen at different levels.

4.7 Key themes

4.7.1 Public engagement

A consistent message to the public, but also to professionals about the role and benefits of social prescribing is an essential requirement; promoting social prescribing in a way that stimulates the involvement of people who do not engage with health and social care service.

4.7.2 Access to and uptake of social prescribing

The public needs; to know firstly about social prescribing, secondly understand the benefits and the role local community assets can play in improving well-being outcomes and thirdly, agree to be referred or self-refer and take up a social prescribing offer. Where individuals have self-referred, they need to understand why and this, in turn, will help to encourage others to access social prescribing. More support for people with complex needs and protected characteristics is required and to *'hand hold'* when appropriate.

There are access issues which are likely to contribute to the uptake of social prescribing:

- Isolated communities across the Cwm Taf Morgannwg region due to poor or a lack of connecting public transport across and down the Valleys.
- Financial poverty a barrier.
- Time issue, both for the individual who has competing pressure of home and work, and the time when activities are available which may not be conducive to taking part, including green spaces or availability locally.

It was suggested that the development of a trusted cohort of 'community champions' to work in local communities whose role would be to encourage self-referral to social prescribing; modelling by example of the key benefits and encourage the community, including young people to engage and being involved.

4.7.3 Volunteers

Central to the deliver and success of social prescribing is the availably of community assets which many depend on volunteers to support and deliver. While there should not be an over reliance on volunteers, they have a role to play in driving change and supporting sustainability. The social aspect of volunteering as social prescription choice, builds confidence, skills and gets people engaged in the community and have a dual role in improving well-being.

4.8 Underpinning principles

Social prescribing works on the premise that certain conditions need to exist. Consistently, throughout the round robin phase, the following key principles help towards developing thriving models and the means to develop an evaluation framework based upon those principles:

Key principles:

Communication	**Co-ordination**	**Collaboration**	**Cohesion**	**Consistency**
Co-production	**Connecting**	**Confidence**	**Continuity**	**Community Development**

5. Conclusion

The co-productive methodology used to produce consensus on the top priority areas worked well and gave all participants the opportunity to share their experiences. While the priority areas were ranked, they are interlinked and are dependent upon one another. Consensually, participants articulated similar experiences and suggestions from varying perspectives. They saw the importance of establishing relationships between and across different sectors and at different levels so not to exclude the more informal local provision in Social prescribing activity for members of their community. Importantly, that community assets are suitable and appropriate, right for the community as recognised and decided by the community, rather than those assets being imposed due to lack of involvement community. However, support for individuals is required for those who find it difficult to engage and access the services in the first place. GPs, for example, are a vital access point for people who are unlikely to self-refer. While, it was highlighted that a database GPs can use for patients for social prescribing would be helpful, DEWIS and Infoengine already exist to find services in the community, but health care professionals may not be aware of those search engines that could help their patients access non-medical interventions.

The sustainability and development of social prescribing universally should be led by the voice of those who are or are likely to benefit in a co-productive relationship across all the relevant stakeholder groups; that sustaining social prescribing means:

Evidencing sustainability + Ensuring sustainability = Commissioning + Long-term funding = Sustainable Social prescribing and community assets

Co-production should be the value base, and the principles of co-production and involvement should run through social prescribing, including how it is evaluated through an agreed set of quality standards. This will provide a credible platform for the sustainability and social value of social prescribing.

5.1 Next steps

The output of the Pathway to Portfolio is to identify potential grant funders to develop one large and at least one smaller research proposal using the finding from the workshop. It is the intention to establish a Task and Finish Group to progress the proposals. At the workshop, and subsequently individuals have already identified themselves as wishing to contribute.

6. Acknowledgements

Cwm Taf Morgannwg University Health Board would like to thank all those who attended the workshop on 17th July 2019. Your contributions will be valuable in progressing social prescribing across the Cwm Taf Morgannwg region. We would also like to thank our funders Health and Care Research Wales for supporting this project through the Pathway to Portfolio Development Fund.

7. References

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8. Appendices

Appendix 1: Agenda
Appendix 2: Study Information Sheet
Appendix 3: Consent Form
Appendix 4: Ethical approval
Appendix 5: Round Robin tables of responses

HEALTH AND CARE RESEARCH WALES: PATHWAY TO PORTFOLIO DEVELOPMENT FUNDED PROJECT

CREATING SOCIAL CAPITAL/COMMUNITY ASSET EXCHANGE IN SOCIAL PRESCRIBING?

17th July 2019

10 am-1pm (tea/coffee available from 9.30am)

Venue:

Rhydyfelin Community Centre
Duffryn Road
Rhydyfelin CF37 5RW
Pontypridd
Rhondda Cynon Taff
CF37 5RW

AGENDA

1. **10 am: Context to Pathway to Portfolio social prescribing Project/Research Activity - Sara Thomas**

2. **10.10 am: Expected outputs and funding - Dr Sally Rees**

3. **10.20 am: Nominal Group Technique methodology - Dr Carolyn Wallace**

4. **10.30 am: Next steps: Consensus workshop led by Dr Carolyn Wallace**
   - **Agreeing the focus of the activity within the social prescribing research area.**
   - **Identify contributors.**
   - **Establish a Task and Finish Group.**

5. **12. 15 pm: Social prescribing model diagram: Does it work, what's missing? - Dr Sally Rees**

STUDY INFORMATION SHEET FOR WORKSHOP 17th JULY 2019

PATHWAY TO PORTFOLIO: CREATING SOCIAL CAPITAL/COMMUNITY ASSET EXCHANGE IN SOCIAL PRESCRIBING?

Researchers: Dr Carolyn Wallace (USW), Dr Sally Rees (WCVA), Sara Thomas (Cwm Taf Morgannwg University Health Board)

We would like to invite you to take part in a consensus study. Before you decide whether you'd like to take part, you need to understand why the study is being done and what it would involve for you. Please take time to read the following information carefully. Please feel free to ask questions of the research team if anything you read is not clear or you would like more information. Please take time to decide whether or not to take part.

1. **What is the purpose of the study**

You are being invited to contribute to a project that aims to look at research priorities and develop 3 grant submissions (1 large and 2 small) with the focus on one of the Wales Social prescribing Research Network's (WSPRN) research priorities and the following research priority area:

What systems might sustain community assets? How can we make Social prescribing sustainable?

The Pathway to Portfolio Development Fund has been awarded (April-Sept, 2019) to develop a research project/activity within the context of Social prescribing and based upon the research priorities and themes identified by the WSPRN in Cwm Taf Morgannwg. The project funding was awarded to Dr Carolyn Wallace at Cwm Taf Morgannwg UHB through her honorary contract but it sits within WCVA, who will be supporting the development of the work.

Many models of social prescribing in Wales exist, all of which require the NHS, Local Authorities and the third sector to work together for the benefit of the public in delivering social prescribing. Across the Cwm Taf Morgannwg Regional Partnership Board footprint there are a variety of models, which are variously funded. Referrals are generated via different routes (e.g. via a GP) to a social prescriber, link worker, community connector, community co-ordinator or a well-being co-ordinator. All are undertaking a similar role, either working across the age range from 18 upwards or with specific age groups and communities. Currently, there is a lack of consensus as to what work, how and why social prescribing works and in what circumstances and what activities or community assets are beneficial, available or required to achieve better outcomes for people. There is a growing need to develop a robust evidence base through identifying research priorities by involving citizens, local

communities, practitioners and managers across disciplines and sectors, policy makers, commissioners and members of the WSPRN.

2. Why have I been invited to take part?

You have been invited because you have an interest or work in social prescribing. Approximately 50 people will be invited to participate. All participants will be over 18 years of age. We are interested in your views as to what the research priorities should be and how we can work together to develop the evidence for social prescribing.

3. Do I have to take part?

It is up to you to decide. Please read the description of the study in this information sheet to help you decide. Please sign the attached consent form to show you agree to take part. You are free to withdraw at any time without giving a reason.

4. What will happen to me if I take part?

If you agree to take part in the study please return the consent form to Carolyn Wallace or bring it with you to the consensus event, in addition to your three priorities for research.

You are asked to participate in a half day workshop using Nominal Group Technique with practitioners and individuals interested in social prescribing, to share experiences and identify research questions to progress.

5. Expenses

You are not expected to incur any costs as a result of participating in this study.

6. What will I have to do?

The consensus event consists of a workshop which takes a four-phased approach led by Dr Carolyn Wallace, who will act as the moderator:

Phase 1: Generation of ideas brought to the workshop by participants. Participants will be asked *'Is the research priority (What systems might sustain community assets? How can we make it sustainable (Social prescribing)?) helpful and within the context of social prescribing*?' Participants will be asked to consider their individual 3 research question, discuss and share.

Phase 2: Series of Round Robins to record the research questions.

Phase 3: Discussion on the research questions and collapse down to a manageable and realistic number based upon the number of people participating who have contributed their three research questions.

Phase 4: Voting process using coloured dots to identify the top research question(s) to progress one large grant proposal and to develop a smaller scale application for research funding.

7. What are the possible disadvantages and risks of taking part?

Although unlikely, we recognise that it is possible for the study to raise some issues related to your experiences in social prescribing. If you become distressed by any topics raised, you will have the opportunity for referral to a suitable counselling service for support, if necessary.

8. **What are the possible benefits of taking part?**

We cannot promise the study will help you directly but the information we get from the study will help to develop grant applications for research into social prescribing in Wales.

9. **Will my taking part in the study be kept confidential?**

Confidentiality is very important and wherever possible will be maintained. However, there are times when confidentiality cannot be guaranteed. For example, if, through the workshop, what you have said causes concern that there may be a risk of harm to you, another person, or a child, the researcher has a duty to report what has been said.

Information collected from the study will be kept strictly confidential and in accordance with Caldicott principles and Data Protection Act 1998 and General Data Protection Regulations (2018).

Individual participant research data will be anonymous. Data collected in the workshop will be anonymous and not be attributed to any individual.

All electronic data will be stored on a password protected computer. The data will be retained securely and then disposed of securely after 5 years in keeping with recommended research guidance.

The consent form, which asks you to give specific permission for participating in the study, will be the only documentation that will show your name and this will be stored separately from the computer software. This will be kept securely locked in a cabinet, within a locked office. The consent form and any other information relating to you will be retained securely and then disposed of securely after 5 years in keeping with recommended research guidelines.

10. **What will happen if I don't carry on with the study?**

If you withdraw from the study we will destroy all your identifiable information.

11. **What will happen to the results of the study?**

A summary of findings will be made available to all those taking part. The results of the workshop may be published in peer-reviewed journals.

After the workshop and analysis the aim will be to hold a series of task and finish group meetings to develop the large and small grant proposals. The PRIME Centre Wales SUPER group of lay members will be asked for their advice and comments, citizens who have or are currently benefitting from a social prescription across the region and those who participated in the consensus workshop.

12. **Who is organising the research?**

The study is being completed by Dr Sally Rees at Welsh Council for Voluntary Action (WCVA), in partnership with Dr Carolyn Wallace from University of South Wales and Sara Thomas from Cwm Taf Morgannwg University Health Board. The study is sponsored by Cwm Taf Morgannwg University Health Board through the Pathway to Portfolio scheme.

13. **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to Dr Sally Rees (srees@WCVA.org.uk or 01745 357561) or Dr Carolyn Wallace (Carolyn.wallace@southwales.ac.uk or 01443 483839) who will do their best to answer your questions.

If you remain unhappy and wish to complain formally you can do this through Jon Sinfield (Research Governance Officer, University of South Wales) on 01443 484518 or by email: jonathon.sinfield@southwales.ac.uk who will direct you to our University complaints procedure.

14. Further information and contact details:

If you have any further queries please contact:

Dr Sally Rees, WCVA

E-mail: srees@WCVA.org.uk
Phone: 01745 357561

Dr Carolyn Wallace

E-mail: Carolyn.Wallace@southwales.ac.uk
Phone: 01443 48383

STUDY CONSENT FORM

Title of Project: CREATING SOCIAL CAPITAL/COMMUNITY ASSET EXCHANGE IN SOCIAL PRESCRIBING?

Name of Researcher: Dr Carolyn Wallace, Dr Sara Thomas and Dr Sally Rees.

Please **(initial)** all boxes

1. I confirm that I have read and understand the information sheet dated 21/06/19 (v1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any consequence to myself. ☐
3. I agree to my anonymised data being used in study specific reports and subsequent articles that will appear in academic journals. ☐
4. I consent to the processing of my personal information for the purposes of this research study. I understand that such information will be treated as confidential and handled in accordance with the Data Protection Act 1998 ☐
5. Please note: declaration of unprofessional, illegal activity or activity that can lead to the harm of some person, including the interviewee, will be presented to the relevant authorities. ☐
6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of person - taking consent.	Date	Signature

University of South Wales
Prifysgol De Cymru

Professor Julie E Lydon OBE, Vice-Chancellor
Yr Athro Julie E Lydon OBE, Is-Ganghellor

Friday 12th July 2019

Dr Carolyn Wallace
C/o Faculty of Life Sciences and Education
University of South Wales

Dear Carolyn,

Faculty School Ethics Sub Group Feedback – 'Creating social capital/community asset exchange in social prescribing' [19CW0702LR]

I am writing to confirm that on the 12th July 2019, the Schools of Health, Sport and Professional Practice and Care Sciences Research Ethics Sub Group, approved your submission for ethical approval.

Please note:

i. Approval is valid for 2 years from the date of issue, you will be notified when approval has expired but you are expected to be mindful of this expiration. Upon the expiration of this ethics approval you may apply for an extension.

ii. The approved documents are attached. If you intend on deviating from the approved protocol, research team, or documentation you will need to seek approval for any changes.

iii. This approval does not confirm that indemnity or insurance are in place for this project.

iv. Please confirm when your research project has closed (a one page closure report highlighting any recruitment issues, adverse events, publications etc. should be appended).

If you have any queries about the committee's decision, please do not hesitate to contact me.

Yours sincerely,

Professor Peter McCarthy
Chair of Faculty Ethics Committee

Appendix 5

Table 1. The 'green paper': individual top 3 questions (45 participants)

1.	What learning can be taken from the community to ensure that the community assets become sustainable and learning is acknowledged and acted upon?
2.	How can communities make their assets sustainable?
3.	How do we break down systemic barriers in asset transfer processes?
4.	What professional and community support do we have to empower the sustain local capacity?
5.	How is Information, Advice and Assistance communicated?
6.	How do projects/services and commissioners consider the long-term impact of their delivery?
7.	How are we going to make the community assets sustainable – sustainable funding, both short-term?
8.	Provide opportunities to community groups i.e. training, coaching.
9.	Make a commissioning process simple enough that all can access; reducing bureaucracy and barriers.
10.	How do we ensure 'best practice in social prescribing? Who audits best practice to ensure confidence in the system? Code of conduct - how do we balance this without putting people off?
11.	How do we have long-term impact when we can only get short-term funding to deliver social prescribing?
12.	How do we make sure that social prescribing options meet the needs of all in society (i.e. how do we provide enough choices to satisfy the interests of 'the many?).
13.	How do we understand the sustainability of community assets in the context of severe/long-term cuts in state funding?
14.	How do we understand the sustainability of community assets to notions of resilience (avoiding the deficit model) and social exclusion and disadvantage?
15.	How do we understand the sustainability of community assets in the context of the Welsh well-being agenda – the 7 goals in the Well-being of Future Generations Act?
16.	How do we ensure quality of services (where applicable)?
17.	How do we measure and determine the needs of the population?
18.	How do we avoid duplication?
19.	Co-production to be more fluid between third sector, health, local authority and community?
20.	Longer-term/sustainable funding evidence-based not stats driven, monitoring needed.
21.	Delivery of quality-based services, household name, not services changing all the time.
22.	Quality: of service, procurement, practitioners, continuity, training.
23.	Uptake: ensuring referrals are used?
24.	Evidence of need and impact: proof of value, case studies as well as data, fluid relationships and infrastructure.
25.	How can we better understand and provide information on the availability of public sector land and assets for community use?
26.	Provision of technical support (land management, environmental sustainability) for community projects?
27.	How could co-production help? How can social prescribers form better links with other organisations such as planning and housing to ensure that social prescribing is embedded into design from the start?
28.	How do we involve service users?
29.	Do communities see the importance of social prescribing?
30.	What support/community assets are already available for communities?
31.	Equitable opportunity of funding.
32.	Recognise 'assets': identify what's available and ensure any commissioning and procurement rules out any element of duplication.
33.	Evaluate all identified current social prescribing projects similarly to ensure a baseline – work with what's working.
34.	Commissioning: fair and sustainable.
35.	Mapping: keeping up to date with the diverse, dynamic nature of the community and third sector.
36.	Community development: Who, how, where, what? Co-production.

37.	How do we appeal to funders (e.g. National Lottery to provide continuous funding rather that short-term projects? One of their key features is for projects to change, but sometimes consistency and continuity are good!
38.	Should we be mapping venues in each area that could provide bases for services? It's hard sometimes to know where in people's individual communities that projects can be based.
39.	Do we need a 'baseline' of what needs to be offered to meet a social prescribing agenda?
40.	How can we ensure people access services/assets after they have been told about it?
41.	How do services/assets become sustainable and reliable when funding is often short-term?
42.	Why do people self-refer?
43.	How can we ensure consistent revenue/funding steams?
44.	How do we employ, train and retain the workforce?
45.	How do we ensure consistent messaging and a good general understanding (both public and professional) of social prescribing/community assets?
46.	How can we develop a database of organisations that GPs can access to refer patients for social prescribing?
47.	How best can we promote social prescribing to the public?
48.	How can we access those individuals who don't engage with healthcare service, but need support to reduce isolation?
49.	Making 'assets' sustainable: securing long-term funding in the context of short-term funding pots.
50.	Ensuring the assets are 'right' as decided by the community, not for the community (defining/prioritising assets).
51.	Not assuming 'volunteering is the answer: need to understand the strengths and interest of volunteer base.
52.	Funding.
53.	Access to service users e.g. opening times.
54.	Staffing, training, quality control.
55.	Making facilitators/leaders of groups sustainable through people in the community rather than staff from organisations.
56.	The way third sector is funded i.e. time limited, restrictions on funding and what it can be used for, wining tenders/re-commissioning.
57.	Communication: building up awareness if the assets and groups in the community so people know they are there.
58.	Funding: constant and steady stream.
59.	Transport: there are many isolated communities that public transport does not reach, geography of the Valleys needs to be considered.
60.	Assets: Identify and protect i.e. building, facilities, organisations, people and volunteers.
61.	Robust infrastructure in place.
62.	Reliable and flexible services.
63.	Access
64.	Many community groups have informal systems and that is why they are not successful and sustainable.
65.	How can we make the link between those groups more formal and professional, complimentary and supportive?
66.	How can we support smaller community groups to be in a position to welcome new members who have more complex needs?
67.	All needs to be enabled by technology and evaluated (e.g. Elemental as an example.
68.	On-going funding i.e. permanent contracts.
69.	Investment in training.
70.	How do we make funding sustainable to ensure long lasting community assets?
71.	How do we ensure the client gets the best 'client journey' without frequent signposting before specific need is met? (i.e. GP refers to GPSO, GPSO refers to organisation, organisation refers to another organisation etc…)
72.	How do we ensure a close tight community asset base – avoiding duplication for client?
73.	Funding – year on year funding does not allow organisations to fully plan and develop.
74.	People don't have money, many live in poverty, they can't afford to travel. Barriers with transport – poor timetables.

75.	People in poverty: social activities are not high on their list of priorities when they can't afford to eat etc. How can we overcome poverty as a barrier?
76.	Funding: Long-term and not relying on a year to year basis.
77.	Community transport: People can't afford to use private transport and public transport isn't always suitable.
78.	Community development: Who is going to support staff in the long term to run community assets?
79.	How can community assets inform about their activities and opportunities, where they are, when, what, how? How to get this information to where it is needed?
80.	How can young people be encouraged to become active in their community to have a sustainable resource of people coming through?
81.	How can community assets/groups be helped with 'red tape', e.g. licences, permissions, buildings?
82.	Venues: Ideal venue fit for purpose, who maintains it in the right location for the right people, is it open to the right time, does it have a green space, parking on a bus route, is it well advertised, do people use it, if not why? Does it offer group mentoring, have the equipment etc.
83.	Volunteers: People engaging - do we have people volunteering to help in these areas, to advertise to get everyone involved. Is there a stigma behind it, as volunteering is social, build confidence, skills, gets you engage with the community?
84.	Young people: The community getting them (young people) to build these skills to understand the need going forward.
85.	Up to date information.
86.	Better understanding of the benefits of groups (community assets).
87.	Financial support/sustainability
88.	How do we ensure continuity of funding that enables long-term planning and reliability at a time when funders/commissioners/local authorities/health boards and trusts are experiencing reduced funding as a result of 'austerity'?
89.	How do we ensure quality assurance of community organisations that we hold out to people who are referred via social prescribing?
90.	How do we encourage full range of activities so that something to suit everyone, but then ensure right match between wishes, needs and activities?
91.	Universally available.
92.	Priority groups – people and services.
93.	Outcomes and quality.
94.	Ensuring service users are involved.
95.	How do we ensure all groups/assets/venues are onboard; clear partnership working.
96.	Ensuring support services are able to respond to localised need.
97.	How does the individual navigate their way through?
98.	How is a person supported in their own community (i.e. if GP or alternatives needed are in another place)?
99.	How do we know that once a person is sign-posted that it was followed through and there was a positive result?
100.	Funding: Longevity/sustainability (comes in varying degrees programme as opposed to project.
101.	Consistency: Although, certain aspects need to be specific-based in an individual's needs, needs to be a consistent level e.g. support, guidance, help provided.
102.	Knowledge (the evidence base): Raising awareness on a large scale (consistently) and where are we basing our findings on?
103.	Sustainable funding – not just short-term funding for projects
104.	Effectiveness of assets, services, are they suitable and helping?
105.	Shared understanding and a definition of social prescribing.
106.	How can they (community assets) be funded so that they can be financially sustainable?
107.	How can we ensure that volunteers are recruited and supported?
108.	How can we attract the right people to paid employments and keep them in post?
109.	How can we better communicate between organisations, information on what is available, how can we communicate to all?
110.	How can we have easier systems to access physical activity opportunities i.e. simple referral into schemes such a NERS?
111.	How can we get a better understanding of what is needed?

112. Communication between communities and organisations (no duplication of services) 113. Evaluations of what is working in your group/area. 114. What is the need in your groups/area (ask the people).
115. Communication: who, what, where. 116. Co-ordinating: Who is ensuring what is out there is known about, what providers? 117. Funding: How to make it sustainable, who/how?
118. Co-ordination: What's out there, what's missing? 119. Connecting: To community, partners, GPs. 120. Collaboration: In delivering community activity programmes.
121. Health care professional buy-in – 100%, the question is 'How'. Need a belief in prevention and not cure. 122. Better access to simple lifestyle advice and a range of community venues and platforms. 123. Develop a network o trusted 'community champions' to work in their community yo encourage self-referral and if required hand hold to build confidence.
124. Empowerment and training of communities. 125. Look for volunteers/existing groups to drive change. 126. Investment in communities initially at least to encourage support, sustainability and give the community the tool required to be resilient.
127. How to ensure that everyone has access to outdoor space where they can feel comfortable? 128. The mental health benefits of the outdoors. 129. How to develop support for social prescribing in the environment sector?
130. Funding: Making sure there is enough financial support for charities/third sector services to continue. 131. Accessibility: Providing opportunities to provide needed services in all areas of Cwm Taf Morgannwg for the service user, e.g. premises etc to provide services in local areas and resources. 132. Training/volunteers: Making sure the training is universal.
133. Funding: Can we afford social prescribing or is it sustainable? There are organisations that are delivering identical services. 134: During commissioning how do we ensure our processes don't jeopardise the organisations we wish to fund. 135. Fairness and transparency: Are we going to be honest about the cost, the outcome and evaluation? How will we know we have it (social prescribing) right, who do we ask? There cannot be complete consistency of evaluation and monitoring. This should be relevant to the organisation or delivery

Table 2. The 'pink paper': in pairs top 3 questions/comment

1. How do we 'balance' obligations to safeguard verses giving smaller organisations/informal groups to not be constrained by formal processes? 2. Non-deficit models drawing from organic development of groups and how to facilitate this process; thinking about the notion of 'need' and the complexities of a strong structure. 3. Relationship between GP and link worker and the small informal groups: Issue – GPs are making positive noises but not translating into referrals.
4. How do we marry projects, communities and commissioners to ensure long-term impact of delivery and support communities to make their assets sustainable? 5. How do we breakdown systemic barriers to better link communications to improve the IAA (Information, Assistance and Advice) offer? 6. What support do we already have and how to we ensure there is no duplication?
7. How can we ensure that the community assets are financially sustained? 8. How can we attract and the most skilled and knowledgeable people? 9. How can we get a better understanding of what is needed?
10. How could we ensure there is sustainable funding available for small groups and organisations? Making sure best practice is in place through monitoring systems to ensure it builds confidence within the system, without bureaucracy and barriers? 11. How can we ensure groups access training and coaching to build the required skills?

12. There needs to be a 'duty of care' of people developing groups for safeguarding and transparency, through a balance of training, development and support awareness.
13. Users involved in the designs o they can make choices.
14. How do we ensure all groups from across sectors are onboard and work together with shared vision of what 'good partnerships' look like?
15. How do we know fragmented, local support is working – what criteria are we all supposed to meet?
16. Empower communities to use outdoor spaces within communities.
17. Look for existing groups to drive change and promote mental health benefits outdoors.
18. Invest in the development of communities to encourage confidence, empowerment, sustainability and resilience. Support communities to give them the tools.
19. Social prescribing universally funded and available across Cwm Taf Morgannwg.
20. Quality: safe, adequately resourced, consistent and robust.
21. Evidence based: commissioning based on identified need and on outcomes.
22. Quality: Infrastructure (fluid relationships), governance, delivery and services and training.
23. Uptake: Ensuring referrals – people turn up!
24. Evidence of need and impact: case studies, statistics, value for money and social return.
25. 'Prevention not cure' – Health care professional buy-in 100%. The question is how as it relies on relationships.
26. Better access to simple well-being advice at a wide of accessible community venues and platforms.
27. Develop a network of trusted 'community champions' (not the loudest) to work in their community to encourage self-referral and if required 'handhold'?
28. Communication.
29. Evaluation of need.
30. Initiate the need – action (funding).
31. How ca we develop a database of organisations that GPs can access to refer patients to organisations for social prescribing?
32. How can we promote social prescribing to the general public?
33. How can we access those individuals who don't engage with healthcare services but need support to help reduce isolation?
34. Funding: How do we appeal to funders to give longer term funding to allow assets/services to be sustainable and longer term?
35. How can we ensure people access services/assets after they have been told about it?
36. Mapping of services and venues.
37. Consistency: evaluation, monitoring, funding/time against demand for outcomes, data expectations.
38. Volunteering: understanding expectations, taking it back to basics – looking at the person and their abilities, skills/training and demands.
39. Sustainability: is this one-off project or is it going to be delivered by those who can deliver it? Commissioning process needs examining (expectations – jobs are varied).
40. Training volunteers: 1:1 skills, counselling training on 'how to' e.g. interviewing, red tape, who to contact, training for volunteers to deal with complex needs.
41. Accessibility: keeping/making facilities local so easy transport links, physical access to bases and hubs in the community.
42. Funding: Short-term funding and reduction on funding increases in costs e.g. premises.
43. Funding: Longer term visions, time to set up as well as deliver and support for funding applications.
44. Co-production: Identifying 'right' assets, support at the right' time and level. Incorporating an agreed standard of support/quality assurance.
45. Access: Opening times, transport, staffing (not assuming volunteers), skills and training.
46. Robust infrastructure in place (venues and services).
47. Recurrent funding and permanent contracts.
48. Accessible resources for all service users i.e. disability and protected characteristics.
49. Funding issues: Not to be time limited e.g. 1 year, less restricted e.g. postcodes, more constant/steady stream.
50. Assets: Identify and protect them, e.g. buildings, people, volunteers etc. Making groups self-sustainable, giving appropriate support so they can sustain longer term e.g. when staff/organisations not there.
51. Communication: making sure people are more aware of assets/groups in their community they can access.

52. To sustain community assets; funding needs to be guaranteed longer – this allows staff with experience to sustain assets for social prescribing? 53. Community transport – people can't get to the places either due to infrastructure or cost. 54. Commissioners need to re-consider requesting qualitative over quantitative monitoring and data. Need to consider barriers related to 'human' issues, disabilities and poverty etc.
55. Funding: fair, equitable and sufficient. Ensure any commissioning/procurement eradicates any element of duplication and all stakeholders are involved in the process 56. Assets: Definable – what is an asset? Person, building, group, project, volunteer? 57. Consistent evaluation across the piece.
58. How to ensure quality and effectiveness of assets are suitable and helping? 59. How to measure/determine the 'needs of the population'? 60. What needs to be done to ensure sustainable funding?
61. How do we ensure continuity of funding that enables long-term planning and reliability at a time when funders/commissioners are experiencing reduced funding as a result of austerity? 62. How do we ensure up to date and relevant information about groups especially very small community groups, and make sure that people (links workers and people) know how/where to find/access that information? Need to maximise full range of activities available (not all on-line)? 63. Better understanding of benefits of groups and ensure (proportionate) quality assurance of the organisations that we roll out to people. Very small organisation might not have any policy for safeguarding, nothing formal, just started meeting, but valuable, but what's the levels of expectation do we have? How do we know activities are 'safe'?
64. How do we marry projects, communities and commissioners to ensure long term impact of delivery and support communities to make their assets sustainable? 65. How do we break down systematic barriers to better link communications to improve the IAA offer? 66. What support do we already have and how do we ensure there is no duplication?

Table 3. The 'yellow paper': in groups of 8/9s top 3 questions/comment

1. Funding (Commissioning and Procurement): Sustainable, equitable, sufficient and all stakeholders involved in the process. Protection of assets once identified. 2. Co-production at the heart of commissioning; compassionate commissioning. 3. Evaluation: consistent access the patch, more emphasis on qualitative impact on the citizen's well-being as oppose to quantitative data gathering.
4. Training and volunteering: skills to meet the demand, understand the expectations, red tape, bringing back to basics. 5. Accessibility and information: Keeping/maintaining facilities, local to transport, advertised within the community keeping people informed of what is happening where and when. 6. Sustainability and funding: short term contracts, people, jobs, realistic expectations and re-examination of commissioner process. Allowing things to be consistent for the provider and their community.
7. What support do we already have and what is need is out there and how do we ensure that isn't duplication? 8. How do we break down systematic barriers to better link communications to improve the IAA process? 9. How do we marry project, communities and commissioners to ensure long term impact of delivery and support communities to make their assets sustainable and retain well skilled staff.
10. Communication: Develop a network of trusted 'community champion' to work in their community to encourage self-referral and if required 'handhold'? 11. Evaluation: better access to simple well-being advice at a wide range of accessible community venues and platforms? 12. Health care professionals: pilot the action.
13. Evidence of need and impact: case studies, statistics, building resilience, distance travelled tool kits, outcome monitoring, value for money, looking at models of social return on investment. 14. Quality: communication, infrastructure, fluid relationships, delivery and services, consistent and reliable, training, safe, ethical, effective partnership working and a shared vision, mapping services, giving a voice to the community, consultation and engagement. 15. Securing resources: funding, universality of provision and place/venues/hubs.

16. Empower communities to be part of the design, implementation, positive choices and have a voice.
17. Knowing the community, spaces indoor and out and utilising both and not losing existing services, groups and experience of users. This includes effective partnership working and having a shared vision.
18. Using good practice tool kit, distance travelled tools to show the support, partnerships and consultations are working towards building resilience and this is fed back to the communities.
19. Rigid infrastructure in terms of funding (short term and siloed) KPIs/measures 'hitting target, missing target'. Target driven, not outcome.
20. Accessible resources for all service users: opening time, staff (not assuming reliance on volunteers), skills, training and transport.
21. Co-production: keeping the community/service user involved and listening to their voice, including adopting an agreed standard for support/quality assurance for the confidence of the 'referrer'.
22. Information and communication about what assets (groups but also land resources) are available and how people are able to access them (needs to include very small community groups, not all on-line).
23. How to ensure continuity of funding to enable long-term planning and reliability of offer, but also avoid duplication?
24. Better understanding of benefits of groups and ensure (proportionate) quality assurance of the activities/organisations we hold out to people?
25. Mapping of services: How can we develop a database of organisation that GPS can access to refer patients to organisations for social prescribing? And the public.
26. How can we make sure people get the right support to access services?
27. How do we appeal to funders to give long term funding to allow assets/services to be sustainable and longer term?
28. How do we balance safeguarding obligations versus giving smaller/more informal groups to not be constrained by formal processes?
29. Non-deficit models – drawing from organic development of groups and how to facilitate the process? Thinking about the notion of 'need' and its complexities.
30. Process around educating GPs about community assets. Often positive noises about social prescribing but not transferring into referrals.

Table 4. The 'blue paper': down to 4 groups

1. **Funding:**
   - Sustainable
   - Long-term
   - Less restricted for consistency
2. **Communication and accessibility of assets:**
   - Mapping
   - Awareness
   - Transport
3. **Evaluation:**
   - Consistent and realistic for staff and service users
   - More qualitative, not just about numbers
4. **Funding:**
   - Joined up approach
   - Awareness and communication
   - Reduce competition
   - Flexibility
   - Continuity and reliance
     - Switch to outcome rather than output driven
     - Valuing volunteering
5. **Knowledge communication and accessibility of assets:**
   - Ability for all users to access
   - Transport and timings
   - Understanding what's out there
   - Role of technology (e.g. Elemental) for provision and evaluation
6. **Co-production and involvement:**

- Community to identify their needs and assets
- Quality assurance
- Confidence in groups and appropriateness of referral

7. **Evidence of need and impact:**
   - Case studies
   - Statistics
   - Building resilience,
   - Distance travelled tool kits,
   - Outcome monitoring,
   - Value for money,
   - Looking at models of social return on investment
8. **Quality:**
   - Communication,
   - Infrastructure,
   - Fluid relationships,
   - Delivery and services
   - Consistent and reliable
   - Training
   - Safe, ethical
   - Effective partnership working
   - Shared vision
   - Mapping services,
   - giving a voice to the community
   - Consultation and engagement
9. **Securing resources**
   - Funding
   - Universality of provision
   - Place/venues/hubs.
10. **What barriers are there to ensuring effective communication and there is 'buy-in' between and with all parties involved? GPs – link worker – community assets – community assets between each other.**
11. **Consider the effectiveness and success of what is already in place and what need is out there to ensure there isn't duplication. What does best practice look like?**
12. **Creating sustainable capacity within existing resources:**
    - **Collaboration**
    - **Partnership**
    - **Co-production**

Table 5. The 'white paper': 2 large group

Group 1:

1. **Systems:**
   - Quality assurance
   - Mapping: what is out there and the gaps
   - Relationships across sectors
   - Enabling smaller groups to be part of the system; a richness of information
   - All stakeholders influencing funding structure
   - Give individuals a voice
   - Compassionate commissioning
   - Power relationships in co-production need to equal
   - Flexibility: support for culture change, evolution of project and fluidity
2. **Quality:**
   - Different levels of quality assurance
   - Safety
   - Evaluation of impact on individual journey (difference between health and well-being
   - How each part feeds into the system

- Consultation
- Person-centred

3. Dissemination and information sharing

- Technology: data sharing
- Shared values and a shared language
- Taking learning from community hubs
- Reduction of duplication
- Effective communication across levels

Group 2:

1. **How do we understand the process of education and communicating with GPs, groups and others about community assets and translate this process into referrals, mapping services etc based upon co-production principles?**
2. **How do we evidence sustainability, recognising that there are competing notions of 'what matters' and that there are many different types of community assets (e.g. formal and informal) and different 'roads/journeys' to sustainability?**
3. **Infrastructure needed to establish mechanisms for planning and commissioning in this area. Ensuring engagement in the pre-implementation phase considering the resource we have.**