

# IDENTIFYING QUALITY INDICATORS FOR SOCIAL PRESCRIBING

## A GROUP CONCEPT MAPPING STUDY REPORT

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## 1. Introduction

Quality indicators are tools to monitor and control efficiency of a system, which provide a basis for corrective measures and continuous quality improvement (Vuk, 2012). Quality standards are sets of statements to help improve quality and provide information on how to measure progress (NICE, 2021).

Quality indicators exist for several healthcare sectors in the NHS including, primary care, emergency care and more recently community health services (Davies et al, 2011). These indicators are useful for commissioners, service providers, practitioners, researchers, regulators and the public (Foot et al., 2010; NICE, 2021). Quality indicators should be clearly defined, objectively measurable, reliable, valid and important (Vuk, 2012).

Whilst there is substantial academic literature around developing quality indicators for health and care services in primary care and the community, there is little about quality indicators in community services, social care or the third sector. Papers discuss ‘performance’ of organisations as opposed to quality (Kendall & Knapp, 2000; Cordery & Sinclair, 2013) and this typically refers to domains such as economy, effectiveness, and efficiency.

The Wales Council for Voluntary Action (WCVA) defines quality as *“the degree to which a product, service or process meets or exceeds the requirements which have been agreed among; directors/trustees, senior management and stakeholders”*.

There are currently no quality indicators or standards for social prescribing services in Wales. The need to develop quality indicators in social prescribing was identified by a diverse group of people delivering social prescribing activities and interventions who have concerns about the variation in quality.

### Social prescribing

In Wales, social prescribing is “connecting citizens to community support to better manage their health and wellbeing” (Rees et al., 2019). Social prescribing interventions are complex and diverse, involving multiple components, varying populations, diverse programme aims and varying pathways (Tierney et al., 2020).

Generally, social prescribing involves a link worker, also known as a community navigator, co-ordinator, well-being advisor, link co-ordinator. Individuals are referred to social prescribing through clinical pathways (e.g. primary care, hospital, other health professionals) or contact with social care, community, allied health professionals, housing, fire service or third sector (see Figure 1; Rees et al 2019). There is also the option for individuals to self-refer directly to social prescribing services. The social prescribing link worker meets with the individual and has a ‘what matters’ conversation with them. Through this they identify goals for the individual and co-produce solution-focused plans to help them meet these goals. They then signpost them to resources in the community, e.g. community groups, debt counselling, volunteering, etc. The overall aim of social prescribing is to improve health and well-being outcomes for individuals.

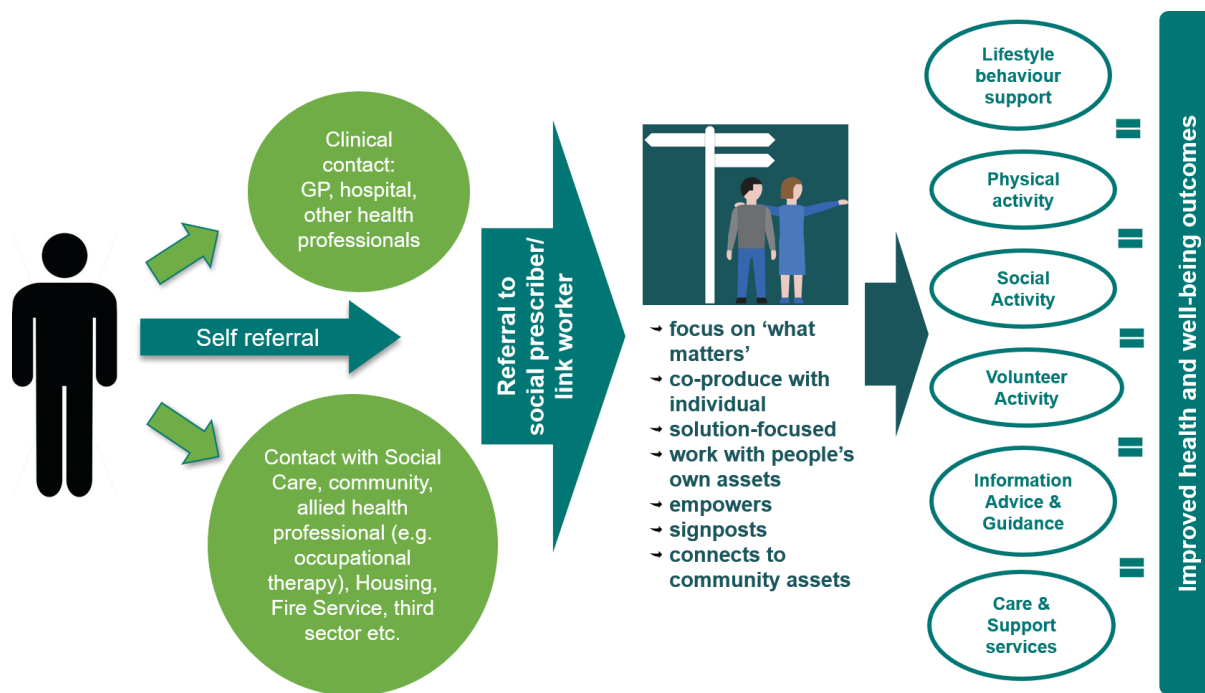


Figure 1. Model of Social Prescribing in Wales (Rees et al., 2019)

Within the complex process of social prescribing, there are multiple stakeholders and pathways, these include; the individual, the link worker, the social prescribing service providers, referral agents and providers of community resources. Given the breadth of the pathway, quality of social prescribing overall is not generally assessed, although quality indicators and standards may be used within certain parts of the pathway (e.g. third sector organisations comply with Wales Council for Voluntary Action standards).

In Wales, social prescribing services and community assets tend to have been developed from the bottom-up, in an organic way, due to short-term funding within the voluntary and community sector. As such, social prescribing programmes and interventions are highly variable. The same applies to the community assets which social prescribers refer individuals to. This poses challenges for assessing quality of social prescribing and community assets, and also in informing a process of continuous quality improvement.

## The Present Study

To address the lack of quality indicators for social prescribing in Wales, researchers at the Wales School for Social Prescribing Research have undertaken a Group Concept Mapping (GCM; Kane & Trochim, 2007) study to identify indicators for social prescribing. The findings from this study will be used to create a quality framework for social prescribing which can be used by practitioners, commissioners, and service providers.

## 2. Method and approach

The study was conducted between 1<sup>st</sup> December 2020 and 25<sup>th</sup> February 2021. Ethical approval was granted by the University of South Wales Faculty of Life Sciences Education low-risk ethics panel [REF: 200909LR].

### Group Concept Mapping

The study used an online consensus method called Group Concept Mapping (GCM; Kane & Trochim, 2007) to explore participants' perspectives on what should be included in quality indicators for social prescribing in Wales. Participants are asked to complete three sequential stages; brainstorming, sorting and rating. Brainstorming asks participants to generate statements in response to a focus prompt. Once statements are generated, participants sort all the statements into 'piles' that make sense to them, which they label. Finally, participants are asked to rate each statement on multiple rating scales.

Using GCM allowed researchers to reach geographically dispersed participants across Wales, particularly as travel and face-to-face events were restricted due to the COVID-19 pandemic. Participants can engage with the research at a time and place convenient to them. The study was led by a trained GCM facilitator (ME) and supported by a research team with extensive GCM experience (CW, DP).

#### Demographic questions

Upon entry to the online research space, participants were asked to answer five demographic questions that were used to analyse the data:

- What is your main role in social prescribing? [List of options: provider, referrer, quality assessment, manager, community asset, commissioner, researcher, training/professional development, user/participant, other].
- How long have you been involved with social prescribing altogether (in years)?
- Which is the main way you provide or receive your social prescribing activity? Is it through... [List of options: Welsh only, English only, Welsh and English, A signed language, Other languages spoken in Wales, Other].
- In which local authority in Wales are you based? [List of options: Blaenau Gwent, Bridgend, Caerphilly, Carmarthenshire, Ceredigion, Cardiff, Conwy, Denbighshire, Flintshire, Gwynedd, Isle of Anglesey, Merthyr Tydfil, Monmouthshire, Neath Port Talbot, Newport, Pembrokeshire, Powys, Rhondda Cynon Taf, Swansea, Torfaen, Vale of Glamorgan, Wrexham, I am based outside of Wales].
- Which description best describes the type of social prescribing that you provide or receive? [List of options: Outside activities, Creative arts activities, Exercise and fitness activities, Mindfulness, Woodlands/gardening, Faith-based, Other].

#### Stage 1: Brainstorming

Participants were asked to generate statements in response to the focus prompt:

*"Thinking about social prescribing, an indicator of quality would be..."*

The focus prompt was generated through discussion between the steering group. The brainstorming stage of the study was open for a 5-week period (01.12.2020 – 07.01.2021).

### *Stage 2: Sorting*

In this stage, participants were asked to sort statements into as many piles as made sense to them. They were then asked to label these piles. The sorting stage of the study opened on 13.01.2021. We planned to close sorting after a 2-week period but due to low completion rates, it was kept open until 25.02.2021.

### *Stage 3: Rating*

In the final stage, participants were asked to rate each of the statements on two 5-point Likert scales:

- Importance  
1 (not important) to 5 (extremely important)
- How easy is it to measure quality using this statement?  
1 (not easy to measure quality using this statement) to 5 (extremely easy to measure quality using this statement)

The rating stage of the study was open for a 4-week period (28.01.2021 – 25.02.2021).

### *Analysis*

The data was reviewed, cleaned, and online software acceptance processes carried out. Four data analysis steps were then followed using the online software:

- Step 1: The five participant demographic responses were analysed using descriptive statistics.
- Step 2: A similarity matrix was created from the participant sorted statements. This demonstrates the number of participants who sorted the statements together.
- Step 3: Multidimensional-scaling analysis of the similarity matrix produced a statement point map. Each participant statement is allocated a point on a two-dimension (XY) axis (Figure 3).
- Step 4: Ward's algorithm was used in a hierarchical cluster analysis of statement clusters to produce a cluster map with cluster labels (see Figure 4), cluster rating maps (Figures 5-6), a pattern match report (Figure 7) and go-zone analysis (Figures 8). The go-zone analysis enabled us to identify the 10 statements that participants perceive to be most important (Table 4) and the ten perceived to be easiest to measure (Table 5).

The study steering group comprised of University of South Wales academics (ME, CW, DP) and colleagues from Betsi Cadwaladr University Health Board (GR), Cardiff South West GP Cluster (KP), Aneurin Bevan University Health Board (SG) and Coed Lleol/Small Woods (AA, NS). The steering group supported data synthesis, analysis and interpretation of findings.

### 3. Findings

#### Participants

Invitations to participate were sent to gatekeeper organisations and networks including the Wales Social Prescribing Research Network, Wales School for Social Prescribing Research, WCVA, PRIME Centre Wales, Social Prescribing Network Development group, Wales Social Prescribing Communities of Practice, Wales Arts Health & Well-being Network and others. Gatekeepers were asked to share the invitation amongst their networks with individuals who may be interested in participating.

Fifty-five ( $n = 55$ ) people registered an interest in participating, and fifty ( $n = 50$ ) returned a completed consent form. Two pairs of participants chose to participate together, so a username was created which both could access. Participants who engaged in the GCM completed the following:

- Participant questions ( $n = 36$ )
- Brainstorming activity ( $n = 21$ )
- Finished sorting activity ( $n = 30$ )
- Finished importance rating activity ( $n = 31$ )
- Finished easy to measure rating activity ( $n = 29$ )

Participants had a variety of roles in social prescribing (see Figure 1), including provider ( $n = 8$ ), community asset ( $n = 6$ ), manager ( $n = 4$ ), referrer ( $n = 2$ ), training and professional development ( $n = 2$ ), quality assessment ( $n = 1$ ), commissioner ( $n = 1$ ), researcher ( $n = 1$ ), user/participant ( $n = 1$ ) and other ( $n = 10$ ; future provider, interested party, service manager, all roles, knowledge mobilisation, evaluator, senior project manager, strategic).



Figure 2. Role in social prescribing

Duration of involvement in social prescribing ranged from 0 to 30 years, with a mean involvement of 5 years and a median of 2 years. Social prescribing services were predominantly provided/received in English only (59%, n = 20), but 35% provided in Welsh and English (n = 12). No services were provided in Welsh only.

Participants were geographically diverse across Wales, with representation from 15 of 22 local authorities in Wales (See figure 2). Participants were split between the South East of Wales (n = 15), South West (n = 12), Mid-Wales (n = 2), North Wales (n = 6) and one participant was based outside of Wales (n = 1).

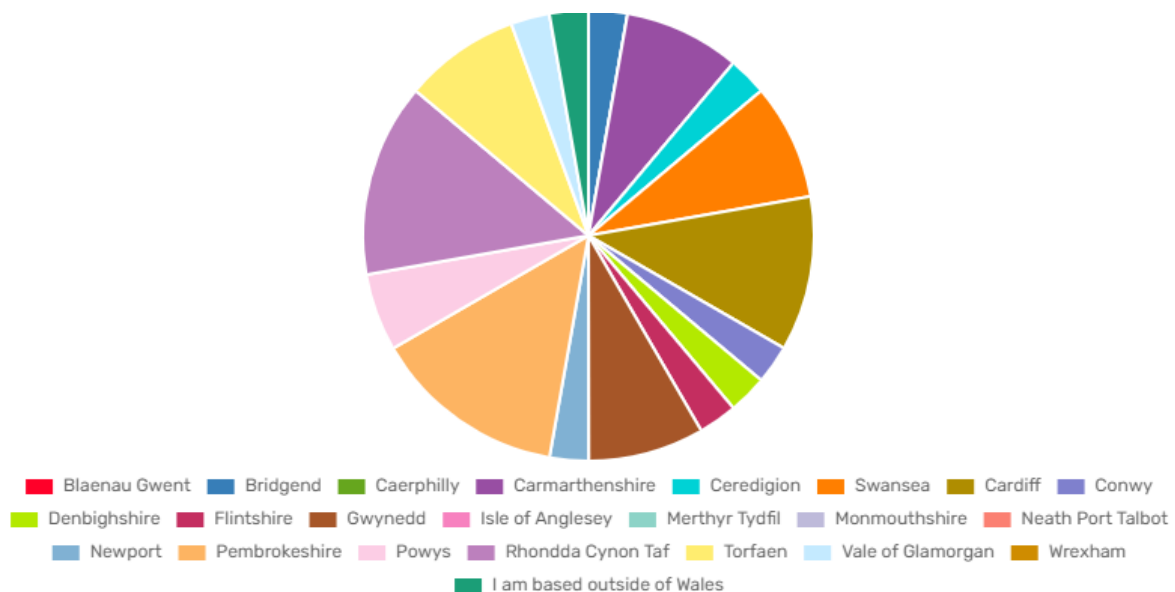


Figure 3. Local authority of participants

Finally, participants described a range of types of social prescribing services that they provided/received, including; creative arts activities (n = 9), exercise and fitness activities (n = 5), outside activities (n = 2), promoting emotional and physical wellness (n = 1), signposting and coaching (n = 1), link worker/community connector referrer service (n = 4), a combination of areas (n = 2), health board (n = 1).

## Development of quality indicators

### Activity 1: Brainstorming

During the brainstorming activity participants (n = 21) generated an initial list of 95 statements in response to the focus prompt, "Thinking about social prescribing, an indicator of quality would be...".

The Key Words in Context (KWIC; Kane & Rosas, 2017) method was used to synthesise the statement list. This involved reviewing the raw statement list, removing redundant/irrelevant statements and editing statements to ensure that they grammatically completed the focus prompt. Compound statements were split, resulting in 157 individual statements, and duplicates were removed, resulting in 141 statements. Keywords that appeared in the original statements were identified and each statement was assigned a code word (e.g. practitioner, signposting, community, outcome, feedback). Each set of statements within a code word were reviewed by the study steering group and synthesised into statements that shared similar sentiment. Both the raw and synthesised lists



were reviewed by steering group members for final comment before being reuploaded to the software for stage 2. The full list of the final 125 statements can be found in Appendix 1 and examples of statements in the final list can be found in Table 1.

Table 1: Examples of statements from the synthesised list

Statement No.	Statement
19	Always using a person centred approach to ensure that the individual is empowered and on control of his/her circumstances
37	That the participant has reduced medical needs at the end of the process
81	Ensuring a clearly defined mechanism and flow process is in place to identify outcomes measured against individuals goals and needs
115	Whether the individual has engaged in the services and activities
121	Tracking an individual's journey - using soft outcomes that elicit 'change' and provide corresponding narrative

### Activity 2: Sorting

In this activity participants were asked to sort and group all the statements into piles and provide each pile with an individual label. From this, the software generated a point map showing all the 125 statements (Figure 3).

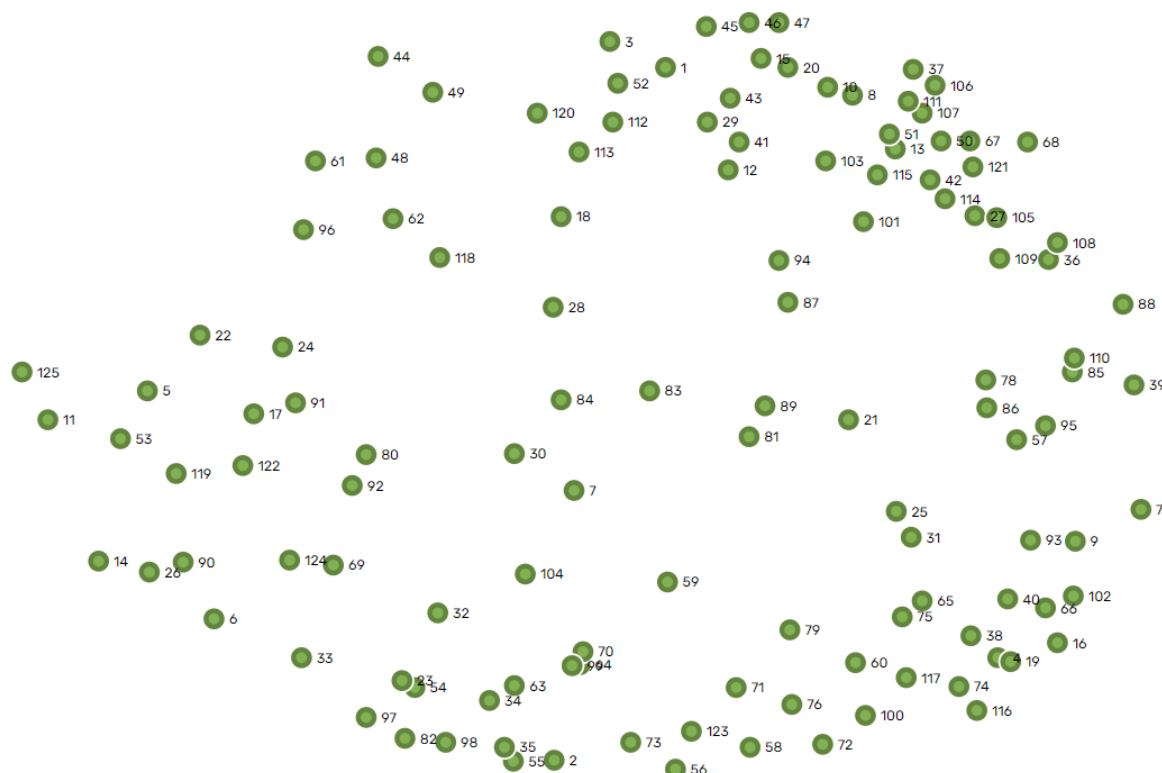


Figure 4. Computer generated point map of 125 statements

The dataset had a final stress value of **0.2769**. The stress value is considered to be similar to reliability, with an acceptable range of 0.205 – 0.365 (Kane & Trochim, 2007), so the map generated is considered to be a good fit. Each point on the map represents a statement. Proximity of statements to other statements indicates how frequently the statements were sorted together by

participants. For example, statements 68 and 121 (upper right of map) are close together and were therefore sorted together frequently. Conversely, statements 125 and 39 are on opposite sides of the map, so were either rarely sorted together or not at all.

The software then generated a number of cluster maps, to gather statements sorted together into similar clusters. The software gave options of 4 – 15 cluster solutions. The study steering group considered the selection and agreed upon a cluster map with **five** clusters. Automatic cluster labels were generated by the software based on cluster labels given by participants. However, the study steering group did not feel that these were appropriate descriptions of the cluster content. All statements within each cluster were inputted to a word cloud generator, and from this, the final cluster labels were decided. These were; **systems indicators (1)**, **participant indicators (2)**, **link worker/community connector indicators (3)**, **service indicators (4)** and **wider contextual indicators (5)** (Figure 4).

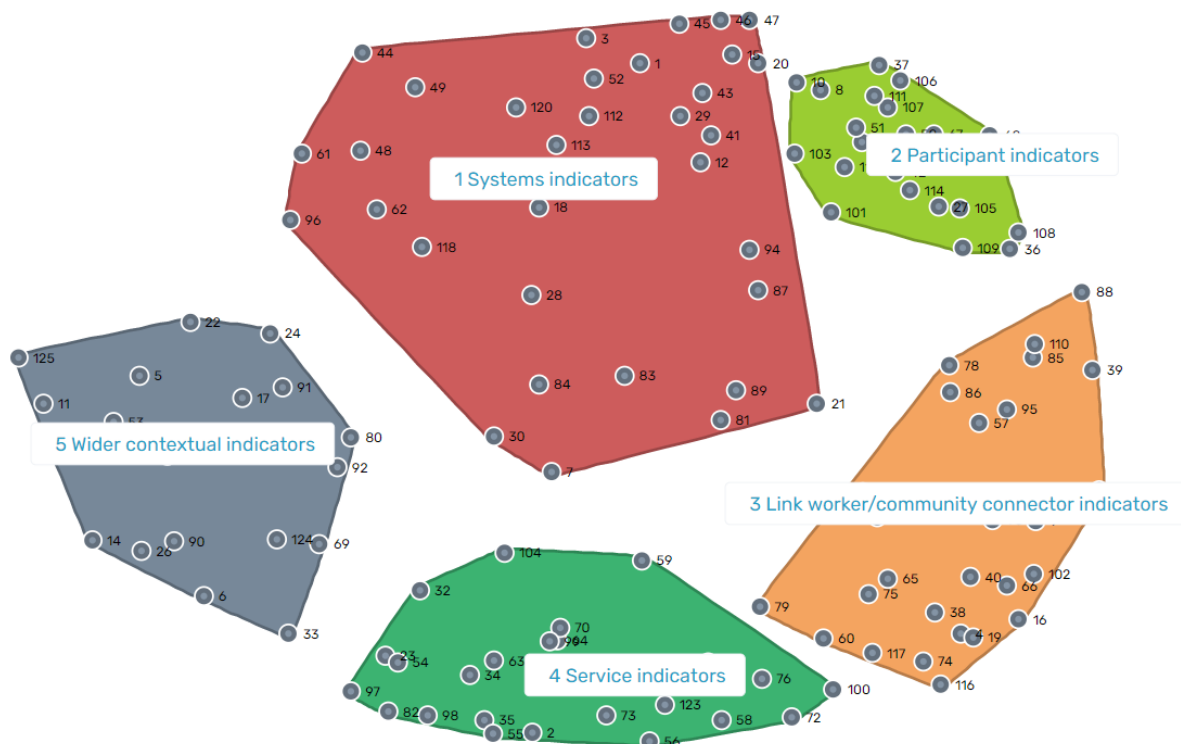


Figure 5. Cluster map with labels from the participant sorting exercise

The placement of each statement within a cluster is based on participant's grouping of each statement. For example, statement 109, 'that participants felt good about the experience they had' is placed in the 'participant indicators' cluster because this is where it was most commonly placed by participants. The conceptual relationship between clusters is shown by the distance between them. The closer the clusters, the stronger relationship they have. Therefore, the cluster 'link worker/community connector indicators' is closer to 'participant indicators' and 'service indicators' than the other clusters.

The 'systems indicators' [1] cluster had the most statements (n = 33) and 'wider contextual indicators' [5] had the least statements (n = 19). Bridging values indicate how closely a statement is related to the items within the cluster it is placed, they range between 0 and 1. High bridging values indicate that a statement has been sorted with ideas in a number of other clusters. Low bridging values indicate that the statement was sorted more consistently within that cluster, these

statements represent the ‘anchor statements’ within a cluster. Table 2 shows the number of statements per cluster, the cluster bridging value and the two statements with the lowest bridging values within the cluster (i.e. the anchor statements).

Table 2: Anchor statements for each cluster, number of statements per cluster and bridging value for clusters and anchor statements (lower bridging values represent a closer fit to the cluster).

No.	Cluster	Bridging value
<b>1 – Systems indicators (n=33)</b>		<b>0.37</b>
20	Number of people passing through the scheme, that did not have to return. i.e. People accepted the help and used it to move on with their lives.	0.05
15	number of individuals returning to the social prescriber rather than a GP	0.07
46	Reduced GP visits	
47	Reduced A&E visits	
<b>2 – Participant indicators (n=22)</b>		<b>0.13</b>
10	number of people who have made a desired change, e.g. lost weight, improved sense of well-being, increased physical activity	0.00
51	feedback from participants on impact on their lives	0.01
<b>3 – Link worker/community connector indicators (n=27)</b>		<b>0.38</b>
4	listening to what people want	0.23
38	that a genuinely open and honest discussion about needs is carried out	0.23
<b>4 – Service indicators (n=24)</b>		<b>0.39</b>
64	reliable timetables	0.30
76	use of coaching and mentoring technique	0.30
<b>5 – Wider contextual indicators (n=19)</b>		<b>0.7</b>
69	a standardised approach from all who provide social prescribing	0.49
80	looking to successful/established models	0.49

### Activity 3: Rating for ‘importance’ and ‘ease of measurement’

In the final activity, participants were asked to rate all 125 statements on two Likert scales ranging from 1 – 5 on *importance* and *how easy it is to measure quality using that statement*. Table 3 shows the average rating on each scale for each of the seven clusters.

Table 3: Number of statements per cluster, bridging value and average rating for each cluster on scales of importance and easy to measure.

	Systems indicators	Participant indicators	Link worker/ community connector indicators	Service indicators	Wider contextual indicators
Number of statements	33	22	27	24	19
Bridging value	0.37	0.13	0.38	0.39	0.7

<b>Average importance rating of cluster</b>	3.99	4.19	4.24	4.07	4.03
<b>Average ease of measurement rating of cluster</b>	3.4	3.79	3.45	3.49	3.48

The cluster-rating importance map (Figure 5 and Table 3) demonstrates that participants rated the 'link worker/community connector indicators' [3] cluster as the most important ( $M = 4.24$ ), closely followed by the 'participant indicators' [2] cluster ( $M = 4.19$ ). Conversely, the 'systems indicators' [1] cluster was rated the least important ( $M = 3.99$ ).

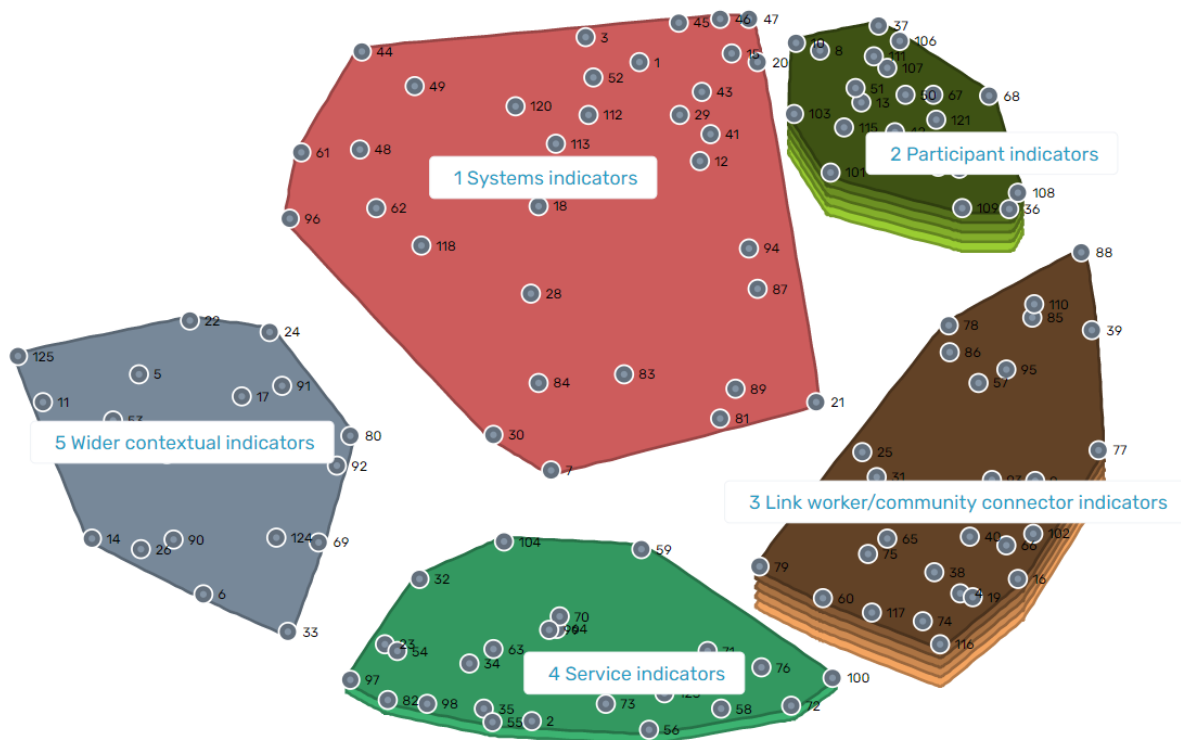


Figure 6. Cluster rating map: importance of quality indicator statements.

The second cluster-rating map (Figure 6 and Table 3) indicates that participants rate the 'participant indicators' [2] cluster as easiest to measure ( $M = 3.79$ ) and the 'systems indicators' [1] cluster ( $M = 3.40$ ) and the 'link worker/community connectors indicators' [3] cluster ( $M = 3.45$ ) as the most difficult to measure.

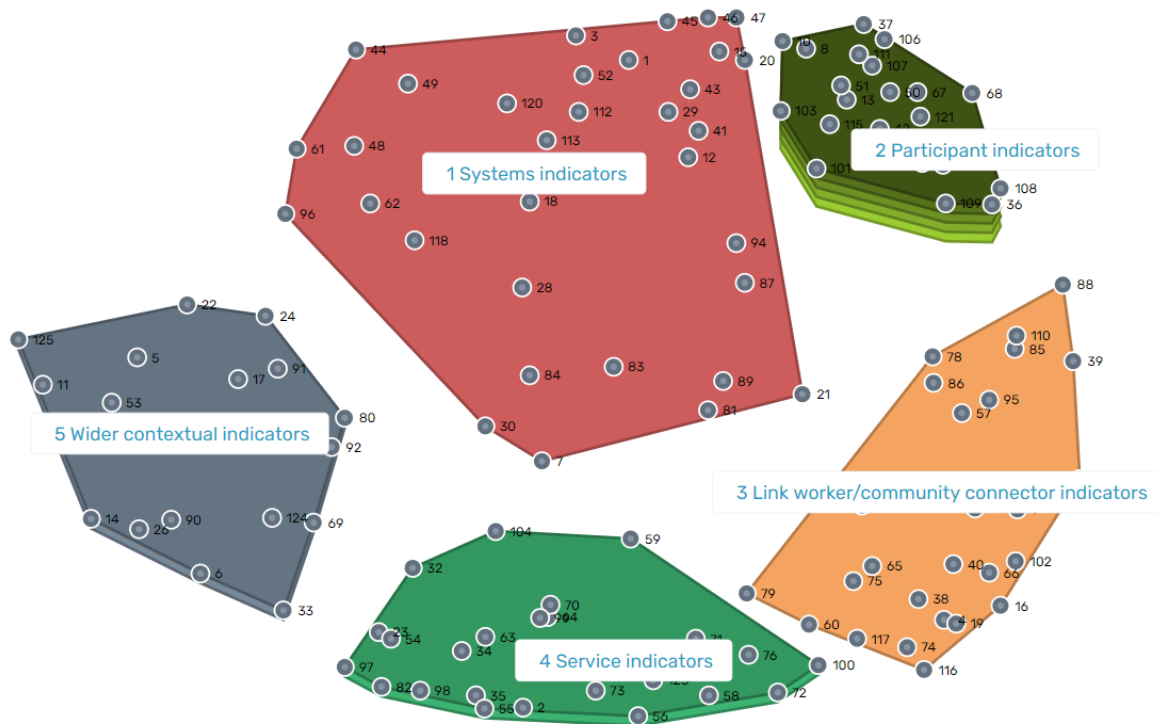


Figure 7. Cluster rating map: Ease of measurement of quality indicators

These cluster ratings can be further understood with Pattern Match reports. Figure 6 shows the average rating per cluster on the two scales. This is a relative pattern match, and as such presents the cluster averages within the range of ratings for each scale, rather than on a fixed, absolute scale. The relative pattern match enables the researcher to compare multiple measurements to establish a trend (Kamat, 2019). As the rating scales measure different concepts (i.e. importance and ease of measurement), it is more useful to compare the ranking of clusters on the different scales, as opposed to the absolute numbers, which may not be comparable.

The pattern match (Figure 7) indicates moderate consistency between the importance and ease of measurement rating scales ( $r=0.46$ ), with the exception of the 'link worker/community connector indicators' [3] cluster, which was rated as the most important cluster ( $M = 4.24$ ), but the second hardest to measure cluster ( $M = 3.45$ ).

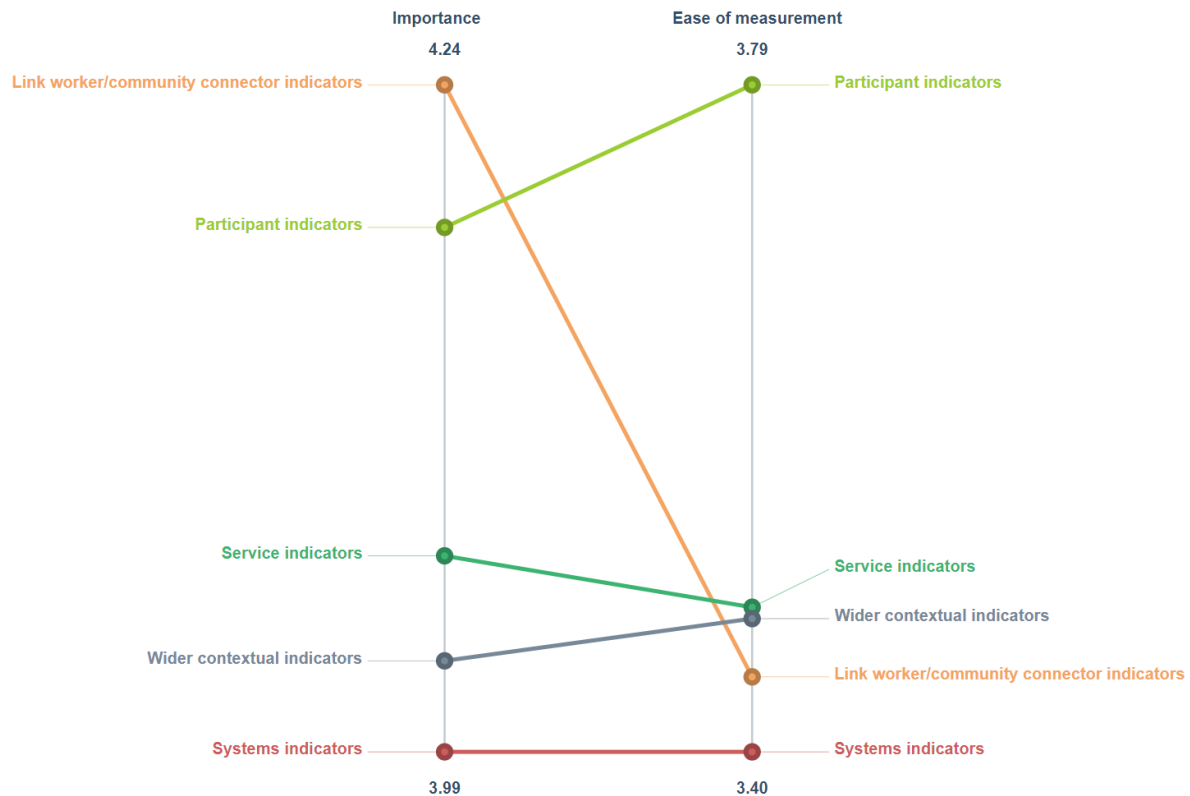


Figure 8. Relative pattern match report comparing cluster ratings for importance and ease of measurement.

Group Wisdom™ software also enables the researcher to produce a ‘Go-Zone’ report. This places statements on a graph based on their average rating on the two scales used in activity 3. The Go-Zone is split into four quadrants based on the average rating for all statements for each of the two scales. Figure 8 shows the Go-Zone report for the importance-ease of measurement ratings. The Go-Zone correlation ( $r$ ) for the Importance-Ease of measurement report was 0.22. This indicates a weak correlation between how participants rated a statements’ importance and how easy it is to measure.

The Go-Zone reports can be used to identify areas of future research to identify ways to measure indicators which are currently rated as important but difficult to measure. The green and blue quadrants represent agreement on the two scales (i.e. a statement rated as high in importance and high in ease of measurement will be in the green quadrant). Whereas the orange and yellow quadrants represent divergence between the two scales (i.e. orange represents high ease of measurement but low importance and yellow represents low ease of measurement but high importance).

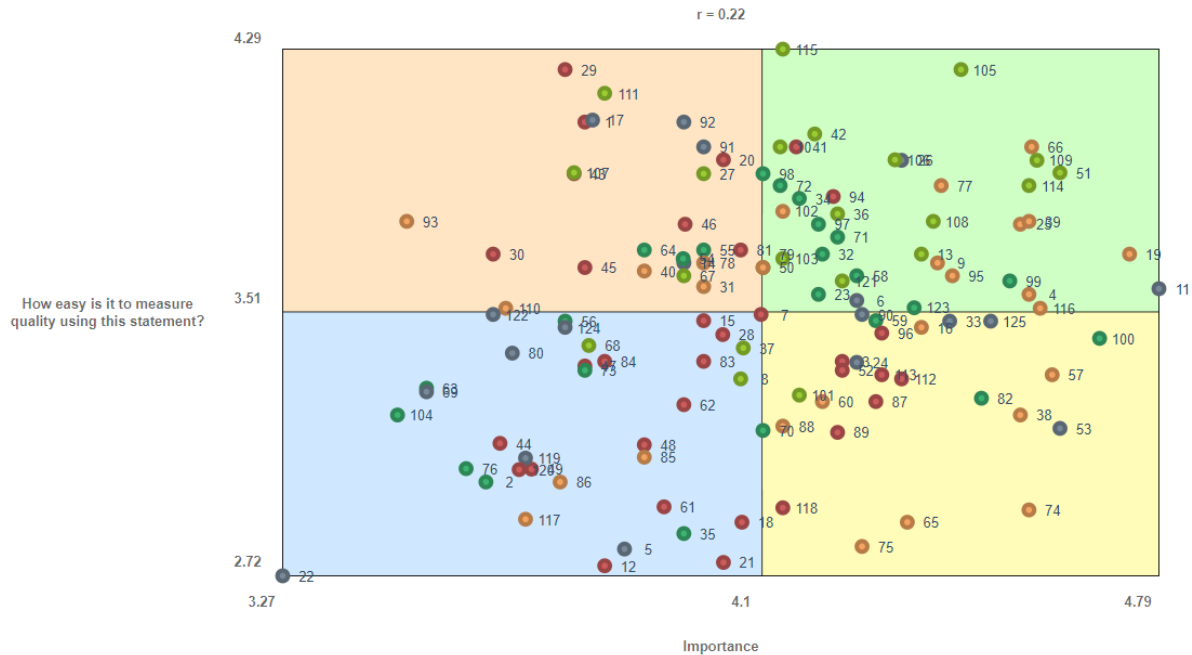


Figure 9. Go-Zone report displaying how each statement is reported in relation to importance and ease of measurement. Note, statement point colours relate to which cluster the statement sits within.

The top ten statements rated highest on *importance*, *ease of measurement* and collectively *most important and easy to measure* can be found in Tables 4, 5 and 6 respectively.

Table 4: Statements rated as most important.

Cluster	No	Statement
5	11	adequate funding for organisations to deliver quality social prescribing projects in communities
3	19	always using a person-centred approach to ensure that the individual is empowered and on control of his/her circumstances
4	100	support for mentally vulnerable individuals to engage in the chosen activity
2	51	feedback from participants on impact on their lives
5	53	sustainability
3	57	that people with long term conditions feel seen and heard
3	116	addressing any barriers for the participant
2	109	that participants felt good about the experience they had
3	66	offering a "what matters" conversation
2	114	whether the individual has received the support they need

Table 5: Statements rated as easiest to measure.

Cluster	No	Statement
2	115	whether the individual has engaged in the services and activities
2	105	that the participant reports an improvement in wellbeing
1	29	a yearly audit of the number of referrals is undertaken
2	111	knowing for how long/how many times the person engaged

5	17	holding a quarterly local/regional forum for all social prescribers to come together and identify strengths/weaknesses etc.
5	92	a database of all organisations signed up to participate within the system
1	1	attendance - do people attend regularly?
2	42	whether the person has achieved the goals that they had identified for themselves
3	66	offering a "what matters" conversation
1	41	using agreed consistent measuring tools and patient reported outcome measures

Table 6: Statements rated as collectively most important and easiest to measure.

<b>Cluster</b>	<b>No</b>	<b>Statement</b>
2	105	that the participant reports an improvement in wellbeing
3	66	offering a "what matters" conversation
2	51	feedback from participants on impact on their lives
2	109	that participants felt good about the experience they had
2	114	whether the individual has received the support they need
2	115	whether the individual has engaged in the services and activities
3	19	always using a person centred approach to ensure that the individual is empowered and on control of his/her circumstances
5	11	adequate funding for organisations to deliver quality social prescribing projects in communities
3	39	a positive sustainable outcome for the individual that has been designed by 'what matters to them'
3	25	clear evidence of inclusivity in people receiving social prescriptions, e.g. people with mental health difficulties, learning disabilities, physical and sensory disabilities - young, middle and older age, male, female and transgender.

### *Identifying evidence-based quality indicators from the dataset*

In order to select a set of initial quality indicators from the set of 125 statements, we drew upon the following data about each statement:

- Cluster location of each statement
- Importance rating of each statement
- Ease of measurement rating of each statement
- Bridging value of each statement (how closely the statement is related to other statements within the cluster).

Using this data, we selected five statements from each of the five clusters, based on a composite inverse mean score, derived from the importance rating and the bridging value (importance – bridging / 2). This gave the statements that were rated as most important and most central within each cluster. Where there were tied scores, the ease of measurement rating was used to identify the top five statements.

Of the list of 10 statements rated as most important overall (Table 4), eight featured within the 25 statements identified through this method. Statements 57 (that people with long term conditions feel seen and heard) and 116 (addressing any barriers for the participant), both from the 'link worker/community connector indicators' [3] cluster, were not identified through this method. Therefore, these two statements were also added to the list of quality indicators generated. This



resulted in a final list of 27 quality indicator statements (See Table 7), representing the five clusters identified through this Group Concept Mapping study, that were rated as important by participants.

Table 7. List of 27 quality indicator statements rated as most important and most central to each cluster.

		Importance	Bridging	Inverse Mean	Ease of measurement
<b>1] Systems indicators</b>					
87	A heightened sense of belonging	4.3	0.26	2.02	4.07
41	Using agreed consistent measuring tools and patient reported outcome measures	4.16	0.13	2.015	3.36
94	A commitment to a review and evaluation of progress	4.23	0.23	2.00	3.50
20	Number of people passing through the scheme, that did not have to return. i.e. People accepted the help and used it to move on with their lives.	4.03	0.05	1.99	2.75
52	Impact on health determinants	4.24	0.27	1.985	3.48
<b>2] Participant indicators</b>					
51	Feedback from participants on impact on their lives	4.62	0.01	2.305	3.92
114	Whether the individual has received the support they need	4.57	0.11	2.23	3.88
109	That participants felt good about the experience they had	4.58	0.23	2.175	3.96
105	That the participant reports an improvement in wellbeing	4.45	0.14	2.155	4.23
13	What has been learnt from individuals receiving the service	4.38	0.08	2.15	3.68
<b>3] Link worker/community connector indicators</b>					
19	Always using a person-centred approach to ensure that the individual is empowered and on control of his/her circumstances	4.74	0.33	2.205	3.68
4	Listening to what people want	4.57	0.23	2.17	3.56
74	Actively listening and being present with an individual	4.57	0.25	2.16	2.92
38	That a genuinely open and honest discussion about needs is carried out	4.55	0.23	2.16	3.2
66	Offering a "what matters" conversation	4.57	0.35	2.11	4
57	That people with long term conditions feel seen and heard	4.61	0.4	2.105	3.32
116	Addressing any barriers for the participant	4.59	0.4	2.095	3.52
<b>4] Service indicators</b>					
100	Support for mentally vulnerable individuals to engage in the chosen activity	4.69	0.39	2.15	3.43

99	Support for physically vulnerable individuals to engage in the chosen activity	4.53	0.41	2.06	3.6
123	Redirecting inappropriate social prescribing referrals to appropriate pathways of care	4.37	0.37	2	3.52
82	That social prescribers know what's out there and do not miss opportunities	4.48	0.50	1.99	3.25
59	Providing activities that restore a sense of achievement	4.30	0.36	1.97	3.48
<b>5] Wider contextual indicators</b>					
11	Adequate funding for organisations to deliver quality social prescribing projects in communities	4.79	0.81	1.99	3.58
53	Sustainability	4.62	0.75	1.935	3.16
33	A means of providing financial help where required, to enable an individual to participate in the agreed activity without causing discrimination or financial hardship	4.43	0.67	1.88	3.48
125	Long-term funding for community groups/organisations that deliver activities	4.5	0.87	1.815	3.48
26	A diverse range of community activities within all participating communities	4.34	0.78	1.78	3.96

## 4. Conclusion

This Group Concept Mapping (GCM; Kane & Trochim, 2007) study engaged thirty-six ( $n = 36$ ) geographically diverse participants across Wales, with representation from different stakeholder groups and sectors in social prescribing. These participants undertook three sequential tasks to identify quality indicators for social prescribing. The online nature of GCM facilitated a breadth of participation, particularly given the restrictions imposed by the COVID-19 pandemic.

Analysis of the data within GCM has enabled us to identify five groups of quality indicators for social prescribing. These are; '**systems indicators**' [1], '**participant indicators**' [2], '**link worker/community connector indicators**' [3], '**service indicators**' [4] and '**wider contextual indicators**' [5]. Further analysis explored differences in the appraisal of these clusters and the associated statements based on two scales; importance and ease of measurement.

Drawing upon the cluster information, bridging values and importance ratings, we were able to identify the five most important and most central indicators for each cluster, resulting in a selection of 25 quality indicators. Two additional indicators were added as these were rated amongst the ten overall most important indicators. This resulted in a final set of 27 quality indicators for social prescribing (see Table 7).

### *Limitations*

As discussed, the present study was undertaken amid the COVID-19 pandemic and restrictions. In Wales, many organisations utilised the Job Retention Scheme, which meant that staff who were not able to perform their role due to physical social contact limitations were granted a temporary leave of absence from work, known as furlough (CIPD, 2021). As many services and groups involved with social prescribing rely on face-to-face interaction, many staff from these organisations in Wales were furloughed (WCVA, 2020). Therefore, staff on furlough may have missed the opportunity to participate in the present study. To resolve this, the report will be widely disseminated throughout Wales and there will be opportunities for contributing to the development of the quality indicators and standards in this way.

Secondly, although participant demographic questions were co-developed with the steering group, with representation from multiple organisations, for two of the questions (1 & 5), many participants selected 'other', rather than a provided option from the list.

### *Conclusions and next steps*

The findings from the present study have identified five clusters of quality indicators for social prescribing and identified 27 quality indicators that were most central and rated as most important by participants. The present Group Concept Mapping study was conducted in conjunction with a scoping review exploring quality indicators, quality standards and how they have been formed in other health and social care contexts (Nicholls et al., 2021). Findings from the scoping review will be used to inform the development of the quality standards, based on the indicators reported here. Drawing upon stakeholder experts, the researchers will use consensus methods to build these standards. The findings of subsequent work will be reported by the Wales School for Social Prescribing Research to the Welsh Government Ministerial Office of the Minister for Mental Health, Well-being and Welsh Language Social Prescribing Task and Finish Group.

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## 6. Appendices

### Appendix 1: Full list of statements generated by participants (n=125)

1	attendance - do people attend regularly?
2	awareness of facility
3	improvement in population health
4	listening to what people want
5	use of social prescribing to create communities of interest that can be sustained and grown
6	making funding available to prescribe what matters to people
7	using what we know about health inequalities to target effectively
8	participants motivation to connect with others after the social prescribing project is finished
9	empowering the individual to join in with further activities having gained confidence from initial social prescribing experience
10	number of people who have made a desired change, e.g. lost weight, improved sense of well-being, increased physical activity
11	adequate funding for organisations to deliver quality social prescribing projects in communities
12	measuring the quality of managers who are managing social prescribing projects
13	what has been learnt from individuals receiving the service
14	commissioning 3rd sector to deliver services that can be prescribed
15	number of individuals returning to the social prescriber rather than a GP
16	enabling individuals to make their own decisions
17	holding a quarterly local/regional forum for all social prescribers to come together and identify strengths/weaknesses etc.
18	if people spread the word about having received social prescribing advice with friends and family - sharing of positive experience
19	always using a person centred approach to ensure that the individual is empowered and on control of his/her circumstances
20	Number of people passing through the scheme, that did not have to return. i.e. People accepted the help and used it to move on with their lives.
21	clear evidence of relational rather than procedural ways of working
22	the development of local employment, e.g. through development of micro-enterprises
23	a diverse range of social prescriptions that illustrate creative 'outside the box' thinking
24	evidence of necessary community capacity across all participating communities - people are not short changed in more disadvantaged communities.
25	clear evidence of inclusivity in people receiving social prescriptions, e.g. people with mental health difficulties, learning disabilities, physical and sensory disabilities - young, middle and older age, male, female and transgender.
26	a diverse range of community activities within all participating communities
27	most significant change stories by individuals that are very personal
28	how complaints about a particular activity are addressed
29	a yearly audit of the number of referrals is undertaken
30	a published set of data informing the public of the waiting time expected from receipt of referral to a consultation

31	support the individual recipient during the agreed monitoring period
32	a clear and unambiguous statement as to what is meant by social prescribing
33	a means of providing financial help where required, to enable an individual to participate in the agreed activity without causing discrimination or financial hardship
34	a consistent process of referral to enable a person to access the 'social prescription' system
35	the definition of social prescribing enables an individual to understand a desired outcome which would be of benefit to them
36	that the participant feels that the process has been useful
37	that the participant has reduced medical needs at the end of the process
38	that a genuinely open and honest discussion about needs is carried out
39	a positive sustainable outcome for the individual that has been designed by 'what matters to them'
40	if the person is able to access the prescriber for the entirety of their journey
41	using agreed consistent measuring tools and patient reported outcome measures
42	whether the person has achieved the goals that they had identified for themselves
43	use case studies, comparative studies and films
44	costs saved for traditional services
45	reduced prescriptions
46	reduced GP visits
47	reduced A&E visits
48	cost effectiveness
49	value for money
50	feedback from participants on value
51	feedback from participants on impact on their lives
52	impact on health determinants
53	sustainability
54	activities led by trained practitioners who had appropriate activity expertise
55	activities led by trained practitioners who had mental health first aid training
56	activities led by trained practitioners who were trauma-aware
57	that people with long term conditions feel seen and heard
58	providing activities that restore a sense of purpose
59	providing activities that restore a sense of achievement
60	providing activities that restore a sense of motivation
61	the additional benefits of social prescribing to communities in being part of social prescribing activities
62	the additional benefits of social prescribing to volunteers in being part of social prescribing activities
63	consistent venues
64	reliable timetables
65	how the prescriber interacts with the individual
66	offering a "what matters" conversation
67	feedback from carers as they will often observe changes in behavior
68	feedback from family members as they will often observe changes in behavior
69	a standardised approach from all who provide social prescribing
70	consistency in service delivery for all individuals accessing these services
71	appropriate signposting to follow on groups

72	appropriate signposting to follow on activities
73	appropriate signposting to follow on education
74	actively listening and being present with an individual
75	valid quality communication exchange with individuals
76	use of coaching and mentoring technique
77	patients setting their own goals/intentions/hopes
78	creating a personal growth success criteria frame, to aid self evaluation and to inform measurable outcomes
79	supplying a clear transition plan for post engagement
80	looking to successful/established models
81	ensuring a clearly defined mechanism and flow process is in place to identify outcomes measured against individuals goals and needs
82	that social prescribers know what's out there and do not miss opportunities
83	an increase in peer support
84	an increase in peer mentoring
85	a heightened sense of security
86	a heightened sense of continuity
87	a heightened sense of belonging
88	a heightened sense of significance
89	building resilience
90	expanding community networks of support
91	a database of all activities
92	a database of all organisations signed up to participate within the system
93	a written statement detailing personal goals and timescales
94	a commitment to a review and evaluation of progress
95	building confidence
96	a connection to community
97	a clear and well advertised referral route into the system
98	a clear and well advertised self-referral route into the system
99	support for physically vulnerable individuals to engage in the chosen activity
100	support for mentally vulnerable individuals to engage in the chosen activity
101	a mechanism for follow-up long term on progress due to participation in a social prescription activity
102	a process of setting mutual goals for an individual to achieve
103	the means to monitor and review progress in achieving the objectives
104	evidence led activities
105	that the participant reports an improvement in wellbeing
106	that the participant reports an improvement in mental health
107	that the participant reports an improvement in physical health
108	that participants felt good about themselves
109	that participants felt good about the experience they had
110	knowing if the person had attended the signposts
111	knowing for how long/how many times the person engaged
112	tackling loneliness indicators
113	tackling isolation indicators



114	whether the individual has received the support they need
115	whether the individual has engaged in the services and activities
116	addressing any barriers for the participant
117	linking an individual's circumstances to the wider community context
118	the holistic experience of engagement with self and community
119	use of community development approaches
120	using a standard social model to demonstrate any return on investment
121	tracking an individual's journey - using soft outcomes that elicit 'change' and provide corresponding narrative
122	alignment of work to legislation
123	Redirecting inappropriate social prescribing referrals to appropriate pathways of care
124	alignment of work to policy
125	long-term funding for community groups/organisations that deliver activities