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All-Wales Framework to roll out Social Prescribing – Engagement and Consultation Analysis

Final Report v2.0

Welsh Government

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All-Wales Framework to roll out Social Prescribing – Engagement and Consultation Analysis: Final Report v2.0

Kerry KilBride, Hannah Sterritt, Jessica Mann, Sean Heron, Katie Lloyd / Miller Research (UK) Ltd.

For further information please contact:

Hannah Sterritt

hannah@miller-research.co.uk

Pen-y-Wyrlod, Llanvetherine, Abergavenny, Monmouthshire, NP7 8RG, UK

www.miller-research.co.uk | 01873 851880 | Twitter: @miller_research

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Glossary

Acronym	Definition
ACE	Adverse Childhood Experiences
AHP	Allied Health Professions
ALN	Additional Learning Needs
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health Services
CRM	Customer Relationship Management
CWVYS	Council for Wales of Voluntary Youth Services
CVC	County Voluntary Council
EQ5D5L	A descriptive measure of health and care needs developed by EUROQOL
GP	General Practitioner
HCPC	The Health and Care Professions Council
NHS	National Health Service
PCAM	Patient-Centred Accreditation Method
PREMS	Patient-Reported Experience Measures Software
PROMS	Patient-Reported Outcome Measures Software
PRSB	Professional Record Standards Body
PSB	Public Service Board
RPB	Regional Partnership Board
SSWB	Social Services and Well-being (Wales) Act 2016
STAR	An Outcomes STAR is a method of measuring wellbeing
trACE Framework	The National Trauma Practice Framework for Wales
VCS	Voluntary and Community Sector
WBFGA	Well-being of Future Generations (Wales) Act 2015
WCVA	Wales Council for Voluntary Action

Executive Summary

i. Welsh Government commissioned Miller Research in Autumn 2022 to undertake an Engagement and Consultation Analysis to support the All-Wales Framework to roll out Social Prescribing.

ii. The consultation on the National Framework for Social Prescribing went live on 22nd July 2022 and closed on 20th October 2022. The consultation sought views on the development of the All-Wales Framework to roll out social prescribing and questions were split into themes which included language and terminology, referral pathways, leadership and governance, accessibility, sustainability, measurement of impact, workforce, technology and Welsh language.

iii. The formal consultation was supplemented by targeted engagement events, including online stakeholder workshops with relevant professionals and focus groups with identified priority groups.

iv. This report presents the findings from all elements of the consultation and engagement process. This includes the 193 unique responses submitted to the consultation, supplemented by the evidence captured from the stakeholder workshops and focus groups. Responses to the consultation were independently analysed by Miller Research and collated to form the basis of this report.

v. Below are the headline findings for each theme that were consistently highlighted within the responses.

Theme 1 – Language & Terminology

vi. The majority of respondents to the formal consultation (organisational and individual) felt the model captures an appropriate vision of social prescribing within Wales.

vii. Key gaps in the model identified included: a reference to key groups (children and young people, older people, ethnic minority communities, Welsh speakers); opportunities to align with the 'green'

agenda; the potential role of various players in the referral pathways; greater consideration of safeguarding; and the need to prioritise loneliness and social isolation.

viii. Areas for clarification included: the relationship between the national model and the local infrastructure, the role of the third sector, funding and sustainability of the model and the role of community transportation.

ix. There was very limited previous knowledge of the term ‘social prescribing’ amongst focus group participants.

x. There were mixed opinions on the term ‘social prescribing’ amongst formal respondents and workshop stakeholders:

- Advantages: provides credibility and relevance, is an internationally recognised term and could encourage compliance.
- Disadvantages: potentially overly formal, confusing/vague, "medicalised", “paternalistic” and disempowering.

xi. There were differences in opinion on standardisation of terminology:

- Terms used should be consistent across geographies and sectors should not be rigid but that the model should be flexible to encompass language that is already being used in local communities.
- Most focus group participants felt the video offered a good explanation which was easy to understand, albeit with some concerns about particular terms.
- There were a variety of suggested alternatives to social prescribing, including: community connecting, community support, community care coordinating, social signposting, social engagement service, social prescribing screening service and link workers.

xii. Stakeholders in workshops were cautious of proposing alternative terms, given the prevalence of the term social prescribing, both in Wales and internationally.

xiii. There were concerns about the use of the terms “patient”, “third sector”, “referral” and “social prescribing service” – the latter implying provision is identical in range and scale in all areas.

xiv. In terms of developing a common understanding of the language/terminology used to describe social prescribing, amongst organisational and individual respondents there were calls for: ensuring simple language and clear descriptions where needed; testing of terminology with a wide range of stakeholders, a wide-reaching, bilingual national communication campaign, practitioner training and cross-sector and cross-ministry working (and funding).

xv. Workshop stakeholders emphasised the importance of common and consistent terminology across services/sectors and geographies.

xvi. Focus Group members (with the exception of children and young people) provided examples of how they would describe social prescribing to someone else; in most cases, these interpretations of social prescribing aligned with the themes of the social prescribing video.

Theme 2 – Referral Pathways

xvii. Theme 2, which focuses on referral pathways identified a number of recurring topics, including: better communication, robust accountability measures, clarity over signposting and referral pathways, clear feedback processes and a properly equipped service with the required funding, training and resources. A recurring sentiment was the need to build trust and confidence in a social prescribing model in order to achieve buy-in at all levels, including amongst professionals and prospective users of the service.

xviii. With better communication both internally (within the NHS and between service providers and other stakeholders) and externally (with members of the public and patients), respondents felt improvements could be made to the promotion of the service and its efficiency. Associated with this is the need for effective monitoring and evaluation processes, developed from the outset and including the production of case study examples of the way social prescribing can positively impact individuals.

xix. The need for a clear definition of what the social prescribing service could and should look like and a standardised approach to training, ways of working and clear responsibilities was communicated repeatedly within this theme. Also seen as critical is the need to ensure that services have the capacity to meet demand, including a growth in demand associated with an expansion in social prescribing services.

xx. Finally, there were concerns that before such a framework could be rolled out, there would need to be adequate planning to ensure the service is funded to the appropriate level of need, with an equipped and trained workforce. The correct resources - down to the level of detail of effective databases - were seen as essential to ensuring those within the sector can work to the best of their ability.

Theme 3 – Leadership & Governance

xxi. The responses to Theme 3 offered a wide variety of suggestions for national actions that would provide leadership, support effective governance, and assist commissioners, although there was disagreement on the best way forward in some cases.

xxii. A common action across both questions and all response types was the development of common standards for the social prescribing framework and the role that national leaders can have in providing quality assurance frameworks, particularly around issues such as safeguarding. Related to this there was an appetite for the

development of metrics at the national level which would develop into a robust monitoring, evaluation and reporting regime. This would aim to provide consistency and equality of access across Wales.

xxiii. Beyond this leadership there were conflicting suggestions over the need for a distinct leadership for the social prescribing service. Responses commonly suggested the establishment of a national body, often articulated as a steering group or an appointed individual, who would guide the implementation of the framework. As an alternative or an accompaniment, it was recommended that the role of RPBs is re-evaluated to provide a greater leadership role, and an increased role for the community sector. However, there were respondents who felt that new bodies should not be introduced, instead resources should be focused on the sustainability of the sector.

xxiv. There was an emphasis on co-production and grass roots involvement in the leadership and implementation of the social prescribing framework. This included service users, communication organisations, the third and public sectors, and social prescribers represented on any national body, as well as inclusion in the planning and commissioning of services. This could be complemented by greater devolution of powers locally to facilitate community decision-making.

xxv. With regard to Question 7, standardisation of training, evaluation/ reporting and procedures was a common theme which was raised in individual responses, along with organised forms of communication and management with local representation. Organisational responses identified a range of actions at the national level including; the establishment of robust monitoring and evaluation processes, connecting social prescribing to existing health and social care infrastructure, investments in infrastructure, sustainable funding arrangements and training needs. Workshop discussions centred around the themes of accreditation (to ensure trust) and the need for third sector funding

xxvi. For Question 8 specifically, a focus was on the development of clear and consistent guidance for commissioners, particularly, on how to involve the local community, through for example, the provision of smaller contracts. Additionally, it should be recognised in these guidelines and in the framework that not every group which will be providing support needs to be formally commissioned in this way, and they should not be sidelined because of this. Finally, a commitment by Welsh Government to a sustainable funding programme for the community sector was central to this theme.

xxvii. Beyond requesting greater local representation at a national level, individual responses to Question 8 also mentioned that funding and provision should be informed by geographic differences and stressed the importance of national frameworks and campaigns. An action proposed by organisational respondents was the need for long-term sustainable funding to ensure services are present at the local level to meet demand. Workshop stakeholders suggested engaging the public in the process and utilising community advocates who can relate the importance of social prescribing to others. All focus groups mentioned the importance of word of mouth in disseminating information within communities.

Theme 4 – Accessibility

xxviii. In response to Question 9a, mixed feedback was received as to the suitability of existing directories, with improvements suggested such as more thorough information, a single reference point or consolidated platform, and ensuring that information remains relevant and up to date. Some respondents felt these information sources had some use despite these shortcomings and suggested the issue is lack of capacity and investment.

xxix. Individual respondents shared a number of other directories that they use to gather information in response to Question 9. However, a significant number of people opted for traditional methods of

information gathering, such as word of mouth, community networking, and direct engagement with organisations and individuals. Workshop attendees discussed the importance of social media in sharing events and keeping things more current, but that this was reliant on audiences being 'social media savvy' and knowing where to look. The most popular answer from all focus groups except for the group with children and young people mentioned they use local community Facebook pages/groups to keep up to date with community activities.

xxx. Key features that respondents felt online directories should provide to help people access community based support included a well-organised, comprehensive, easy to use and accessible directory containing key information on activities, with paper copies of all information available as an alternative. Suggestions also included mention of possible App integration, accurate search criteria and for it to be adequately resourced.

xxxi. In response to Question 10, many individual respondents pointed out that a lack of community transport schemes was hindering access. In terms of access to information, respondents mentioned alternative, more "analogue" information-sharing methods, as well as the value of mentoring services. Workshop attendees mentioned the need to consider practical barriers preventing individuals from accessing services, investigating the reasons attributed to 'drop-off' between referrals and take up rates, and the communication methods for reaching different groups varying significantly. Barriers mentioned by focus group respondents fell into four themes: not knowing who to ask, finding it difficult to access information online, not seeing information in the local area and not seeing the benefit in looking for community-based support.

xxxii. When asked whether the national framework should contain a set of national standards for community support to help mitigate safeguarding concerns, individual respondents and organisational responses have been collated into Table 1. Workshop Stakeholders

provided mixed feedback for the question – the key things the national standards for community support should cover shared by those who said yes were primarily motivated by safeguarding concerns as a first priority and guidelines which would provide quality assurance and a benchmark to work towards, those that said no had concerns around the impact this could have on smaller groups and community organisations and those that weren't sure were cautious of excluding people and felt that groups/organisations may need incentives if they are to resource for further training and adhere to guidelines.

Table 1 – Consultation and Organisational responses to Question 11a - *Should the national framework contain a set of national standards for community support to help mitigate safeguarding concerns?*

	Response	Count
Individual respondents	Yes	38
	No	5
	Not sure	14
Organisational respondents	Yes	21
	No	5
	N/A	62

xxxiii. With regard to Question 12, individual respondents mentioned the need for a robust network of community hubs, libraries and better broadband infrastructure around rural and digitally deprived communities, which could be alleviated by grants and loans of digital equipment alongside investment in training. Finally, information provided in non-digital formats and relationships fostered through real conversations and partnerships should still be valued. Organisational responses proposed research into barriers associated with access, promotion and funding of digital literacy training, access to devices and extended broadband access and expanding and co-designing the existing digital offer to engage and empower socially isolated and housebound people in online activities. Workshop attendee feedback centred around awareness and adaptation of services especially considering the prevalence of digital poverty in Wales. Digitisation was said to work well but there was also a sense that

some content works better face-to-face, especially when building communities.

Theme 5 – Sustainability

xxxiv. Across all stakeholder groups there was consensus on the need for a strategic overhaul to the funding of social prescribing activities and services. Stakeholders felt that the way funding is currently designed, both in duration and by type, does not meet the requirements of the sector. Another commonly observed comment raised was the lack of cohesion and/or collaboration amongst partners in social prescribing; it was felt that with better collaboration, services could become more effective, avoiding duplication of resources.

xxxv. Several actions were suggested to mitigate the impact of increased demand on local community assets and wellbeing activities which included increasing the resources available (funding, training and staff), the need for greater control and a whole-systems approach to sharing information and resources.

xxxvi. Focus group participants varied in their opinions of the quality of activities that were available and whether they would participate in social prescribing. The range of opinions and views generally echoed the point made by those working in the industry, who stated that social prescribing activities should cater for the individuals and communities involved and not simply be a ‘one size fits all’ approach.

Theme 6 – Measurement of Impact

xxxvii. In response to Question 15, respondents across all three groups agreed that measuring the impact of social prescribing required a mixture of quantitative and qualitative measures that focussed on the individual, community, and health services.

xxxviii. It was stressed that this should not be weighted towards the effect on health services, particularly the ability of social prescribing to reduce

GP workloads. There were concerns raised about over-evaluation and the impact this might have on both individuals and community providers, with respondents recommending that the framework builds on existing approaches.

xxxix. Responses to Question 16b expressed a desire for a consistent national model of evaluation across Wales with built-in flexibility and regional teams to consider regional contexts. In addition, it was important to respondents that any evaluation framework is developed alongside user groups, participants, and providers, and that this evaluation model should be in place before the social prescribing framework is rolled out.

xl. Finally, it was recommended that the evaluation is both qualitative and quantitative to capture as much data as possible, in particular the experience of the individual and the effect of social prescribing on the community.

Theme 7 – Skillset

xli. From analysis across the responses to the consultation it is clear that the core skills within the competency framework, asked within Question 17a, should relate to communication, relation building and an understanding of the wider health sector and healthcare needs, and practices when supporting someone living with complex needs. There was a focus on person-centred support, building additional specific skills such as Adverse Childhood Experiences (ACE)-aware practice, and developing deep knowledge about safeguarding.

xlii. Therefore, respondents to Question 17b as a whole were uncertain how to answer without a clear definition of social prescribing, and clarity on the position of social prescribers in the wider health and social care sector. There were conflicting recommendations for how the competency framework could be linked to existing professional standards, and whether this risked excluding organisations providing valuable services from the framework.

xliii. Overall, Question 18 received a mixed to positive response with respondents emphasising the potential benefits, such as underpinning the new service, quality assurance, career and skills development for the workforce and raising awareness throughout the health service. These were tempered by cautions that accreditation may act as a barrier to those providing valuable services, the cost implications of such an accreditation, and whether accreditations capture everything that is important in the role. Therefore, while education and training were deemed important and beneficial the view was generally expressed that it should also be proportionate and appropriate.

xliv. The responses to Question 19 as a whole focus on three levels of support that can be taken at the national level; the provision of training, which is accessible, affordable, relevant, and proportionate; support for the workforce through funding, wellbeing, and networking; and valuing the workforce by ensuring there is a career pathway with clear and appropriate salary scales.

Theme 8 – Technology

xlv. Individual respondents had a varying experience of using digital technology. Whilst many had no relevant experience at all, digital technology was predominantly used for the management of information such as reporting and the referral process through e-mails and calls.Organisational responses demonstrated a wealth of experience in utilising digital technology for these areas in wide and varied ways. They particularly highlighted the role of the pandemic in transforming usage, and the role that technology had played in increasing access. However, this was tempered by those who lacked experience, and many cautioned against a reliance on technology due to the digital divide in service provision. Workshop stakeholders shared examples of the ways in which digital delivery had been able to engage and reach groups that otherwise would have

been excluded from support (particularly in relation to the restrictions imposed by the pandemic).

xlvi. Individual respondents mentioned a range of ways in which digital technology could improve, mostly the delivery of community-based support. Themes that appeared consistently were the ability to standardise processes, communicate more easily and provide improved support to those with mobility issues. Organisational responses included suggestions for the use of digital technology across each of these areas. There was a particular focus on the referral process with the hope that this would increase the speed and ease of referrals, as well as the access to information. Management of information and reporting of outputs featured prominently, as respondents offered suggested features for a reporting system such as an online portal to upload evidence and stories. Again, this was tempered by the issue of accessibility. Workshop stakeholders highlighted that digital delivery presents valuable opportunities for those who are particularly limited by conditions such as extreme social anxiety, or those who are housebound or face multiple barriers to engaging in a face-to-face setting.

Theme 9 – Welsh Language

xlvii. There was a mixed response to if and to what extent there would be an impact on the Welsh language with the introduction of the national framework. Caveats to this included the diversity of use in Welsh language across the country, meaning impacts could never be equal in every community or setting.

xlviii. The ‘active offer’ was mentioned several times, whilst there were acknowledgements of difficulties in mandating Welsh within community groups, remedies such as training and other additional resources were mentioned. It was felt that implementing the active offer would be easier if resources such as databases, literature,

marketing and paperwork were consistently available through the Welsh language as this could also be a learning opportunity.

xlix. Though there was a general support for further use of the Welsh language, there continue to be concerns from many respondents as to how this additional workload would be resourced. This was especially prevalent when considering the geographical differences in levels of Welsh resource available and the percentage of a population that speaks Welsh which vary in each community. Requests for additional resource in order to support the Welsh language such as training, funding, a labelled directory and workforce were brought up continually as something which could have an impact.

l. Ensuring the service also remained diverse and inclusive by supporting other languages was also repeatedly mentioned, in order to maximise inclusion and reduce barriers to participation.

1. Introduction

1.1 Welsh Government commissioned Miller Research in Autumn 2022 to undertake the Engagement and Consultation Analysis to support the All-Wales Framework to roll out Social Prescribing.

1.2 Recognising that people's health and wellbeing are largely defined by a range of social, economic, and environmental factors, social prescribing seeks to address people's needs holistically by enabling health, social care and third sector practitioners to refer people to a range of local, community-based, non-clinical services. It aims to optimally utilise the power of communities to generate good health, both physically and mentally, as well as encouraging individuals to take greater control of their own health. The emphasis here is on supporting the individual rather than treating an illness.

1.3 Stakeholders in Wales have over the years developed a range of social prescribing interventions, with the impetus having been bottom-up. There is wide professional and political support for social prescribing in Wales, and a great deal of optimism for what it can deliver, with health and social care policy aligning strongly with social prescribing practices, especially as set out in 2021 the long-term vision of "A Healthier Wales". Previously, in its Prosperity for All national strategy (September 2017), the Welsh Government set out its vision to expand the community health and social care workforce including through creating "community connector" roles to support social prescribing and more formal partnerships with volunteers and the third sector. The vision includes building the capacity of communities as places which support health and wellbeing through avenues such as social prescribing.

1.4 More recently, the Welsh Government Programme for Government 2021-26 set out the commitment to introducing an all-Wales framework to roll out social prescribing to tackle isolation. The framework will include a set of standards and guidance to develop consistency of delivery at a local and national level.

1.5 The consultation on this National Framework for Social Prescribing went live on 22nd July 2022, supported by a communications campaign led by Welsh Government, and closed on 20th October 2022. The consultation sought views on the development of the All-Wales Framework to roll out Social Prescribing and questions were split into themes which included language and terminology, referral pathways, leadership and governance, accessibility, sustainability, measurement of impact, skillset, technology and Welsh language.

1.6 The formal consultation was supplemented by targeted engagement events, including two online consultation stakeholder workshops with practitioners and five online focus groups with identified priority groups. A short film (widely shared by stakeholders) also supplemented the formal consultation document.

1.7 This report presents the findings from all elements of the consultation and engagement process. This includes the 193 unique responses submitted to the consultation, supplemented by the evidence captured from the stakeholder workshops and focus groups. Responses to the consultation were independently analysed by Miller Research and collated to form the basis of this report.

2. Overview of Responses

Summary

2.1 In total, there were 105 unique individual responses submitted to the consultation, with one response submitted in Welsh. This was in addition to 88 organisational responses, of which one response was submitted bilingually.

2.2 In addition to responses to the formal consultation, this report includes analyses from the two stakeholder workshops attended by 83 practitioners, and five priority area focus groups attended by individuals which represent members of the public in Wales in the following priority groups: people with a disability (both physical and learning), older people, children and young people, unpaid carers, and people from ethnic minority communities.

2.3 Welsh Government supported successful recruitment to the workshops via dissemination to a wide range and large number of different third-party organisations through various professional networks. Focus group participants were recruited by Miller Research.

2.4 A short film commissioned by Welsh Government explaining the All-Wales Framework to roll out Social Prescribing was shown at the beginning of the workshops and focus groups to share the information in another format and, in particular, to provide participants of the focus groups who may not be familiar with the term social prescribing some initial context on the concept.

2.5 The questions that were asked in the formal consultation and during the workshops can be found in Annex A. The questions which were asked in the focus groups can be found in Annex B.

Approach to analysing consultation responses

2.6 All substantive responses submitted which aligned directly to the consultation questions were collated into a central database. Each was

reviewed against the relevant question to draw out the dominant and alternative views that were expressed.

2.7 Given the extremely wide range of views and points made, the approach has been to draw out themes where possible and include a range of views within these.

2.8 Responses have been analysed separately by stakeholder groups, i.e.: responses from individuals, responses from organisations, feedback from the workshops and feedback from the focus groups in turn.

2.9 Focus group respondents were asked a different set of questions (Annex B) which diverted from the more professional focus of the consultation questions (Annex A). These have been mapped to the relevant consultation theme where applicable.

2.10 General responses which did not directly reference the consultation questions have been analysed and attributed to the relevant question, where appropriate. This inevitably meant drawing some inferences from the content, and also required some assumptions on the part of the authors with regard to the question being addressed.

2.11 The following sections of the report present the responses to each consultation question in turn grouped by theme and attributed to stakeholder type.

3. Theme 1 – Language & Terminology Analysis

Question 1 – Do you think the model captures an appropriate vision of social prescribing within Wales? If not, why not? Is there anything missing/not appropriate?

Individual Respondents

3.1 Roughly two-thirds of individual respondents (43 out of 64) felt that the model captures an appropriate vision of social prescribing within Wales. About a third of individuals (21) answered no to this question.

3.2 Where respondents had concerns with the model, in most cases they related to perceived gaps, rather than suggestions that there was anything wrong with or inappropriate about the model.

3.3 Four respondents felt that the arts and the contribution that creative activities can make to well-being are not sufficiently represented in the model and could be made more prominent. It was suggested instead the model is more focused on sport and the outdoors, which could be a barrier to some people engaging.

3.4 Three individuals noted that the model fails to convey the diversity of the workforce involved in social prescribing across Wales and the fact that these social prescribers, link workers and community connectors, can be employed by local authorities, health boards or third sector organisations. It was also noted that there is no recognition in the model of the role of social workers and that there is a need to define professional development pathways more clearly for social prescribing staff.

3.5 Two respondents suggested that the model included insufficient acknowledgement of the role of safe, impartial spaces for people to meet for low-risk, free activities – for example, places such as libraries, churches and similar community spaces.

3.6 It was also suggested that the current version of the model has a limited focus on developing individual, family, and community resilience and resources and the opportunities for building on mutual support. One

respondent described the model as “reactive” and “prescriptive” and commented:

> “This is the opposite of building the capacity, resilience, connections, resources, mutual support and non-service options that we so desperately need. It is the opposite of prevention but is dressed up in language from genuine prevention and capacity building approaches [sic].”

3.7 On a similar theme, another individual commented that there is a danger that the model will promote signposting and referral to services rather than supporting individuals to develop independence and to become participating community members. It was suggested that:

> “There is a danger that despite the good intentions, this model will fall short of supporting individuals to become participating independent members of their communities. A true asset based model would pay more attention to the assets, gifts and interests that residents already have and build upon these to create reciprocal relationships.”

3.8 One respondent proposed that the model could provide an example of a complete service user journey through a social prescribing service, instead of simply describing abstract activities in isolation.

3.9 Another individual noted that the model includes no mention of how a social prescribing service would be financially sustainable in the long term.

3.10 A potential gap was identified by one respondent who suggested that the social prescribing framework should include “housing interventions”, for example, a project in Gloucester paid energy bills “on prescription” in an aim to reduce hospital attendance.

3.11 Finally, it was suggested that there is a danger that delineating the five ways that social prescribing can help people risks giving the impression that this range of means of access is universal across Wales, when this is not always the case.

Organisational Respondents

3.12 Just under half of respondents representing organisations felt that the model captures an appropriate vision of social prescribing within Wales (42 out of 88), whilst 14 respondents answered "No" to this question and the remainder either did not answer or provided a mixed response.

3.13 Some of those who responded "Yes" to the first question included a follow-up comment to explain their answer. Identified key strengths of the model included appreciation of the wide range of referral routes/pathways, the fact the model is comprehensive and "depicts [the] whole system", the emphasis on health inequality, the importance of early intervention and prevention, and of offering person centred support, the focus on sustainable community assets and recognition that "not one size fits all". It was commented that the model "appears to support a degree of variation in structure, workforce and processes at the local level."

3.14 Amongst those who provided a more tentative response, several welcomed the concept of the framework, suggesting there is a need for a "consistent definition of what is meant by social prescribing in Wales". However, one respondent felt that a "more radical approach which embraces relational health [is] needed." On a similar theme, another felt that the model "does not challenge entrenched barriers in [the] health and social care system." One respondent suggested that given a lack of awareness amongst health professionals of the types of social prescribing services operating locally, it was difficult to ascertain whether the model is accurate or not.

3.15 Organisational respondents provided a larger range of suggested improvements to the model than individual respondents but in keeping with responses from individuals, the focus was more on building on the proposed framework, rather than suggestions that there was anything fundamentally wrong with it.

3.16 Elements perceived as missing from the model or in need of further emphasis included reference to particular service user groups, of which

the most commonly cited was children and young people. Comments included:

- A lack of consideration of the legislative environment around young people and how a national framework for social prescribing would align with other policies, such as the Additional Learning Needs (ALN) transformation programme, the NYTH/NEST[1] framework, the whole school approach to mental health, the Children and Young People's Plan and the 'no wrong door' approach to supporting mental health and wellbeing amongst children.
- The need for clarification of the role of schools and colleges in the referral pathways and how the framework could capitalise on existing extra-curricular activities, 'buddy' programmes and other schemes running in schools/colleges:

"It is disappointing that there is not currently a vision for harnessing these important institutions, that are often the centre of a community for many, into a framework that seeks to build on the power and opportunities of community-based support."

- The need for detail of how social prescribing can be child- and family-centred.
- A lack of specific acknowledgement of the need for social prescribing amongst children and young people – for example, in the context of the COVID-19 pandemic and the cost-of-living crisis – as well as the potential benefits of social prescribing for children and young people e.g.: preventing referral to Child and adolescent mental health services (CAMHS), reducing anxiety, improving attainment etc.

[1] The NEST Framework is a planning tool for Regional Partnership Boards that aims to ensure a 'whole system' approach for developing mental health, well-being and support services for babies, children, young people, parents, carers and their wider families across Wales.

- Insufficient clarity of how children and young people could access social prescribing services independently of adults, or alongside family members as part of group activities designed to strengthen and protect existing relationships.

3.17 Other, less commonly cited groups that were felt to have been excluded from the framework included older people as well as consideration of relevant issues for older people (e.g.: digital access, engagement of those in care homes), new and young mothers and ethnic minority communities.

3.18 Seven respondents highlighted funding as a key consideration that is missing from the model, particularly in terms of sustainable investment in services provided through the proposed framework. This is particularly important for getting buy-in to the model from the statutory sector: “Needs multi-year funding for social prescribing schemes. GPs are unsure if schemes in their area are running any longer as they have experienced pilots coming to end without their knowledge.”

3.19 Funding will also play an important role in ensuring equitable access to social prescribing; one respondent expressed concerns about poverty preventing some people from engaging, due to travel costs, for example, and noted that “[the] framework needs to be ‘poverty proofed’.

3.20 Some respondents cited gaps in the description of referral pathways, suggesting there was a need to include the private sector, (for example health and leisure venues), the critical role that educational settings can play in referral pathway, the importance of having a two-way referral pathway including feedback systems and the opportunity for community groups to refer service users back into the social prescribing service. In addition, there was concern about a lack of reference to key services and professions[2] supporting children, young people and families[3] within referral pathways.

[2] For example, early years and family support services, health visitors, Flying Start services, childcare providers, nursery, primary and secondary schools, FE and HE settings.
[3] Including “children with particular vulnerabilities and protected characteristics”

3.21 Another reported gap in the framework was attention to the Welsh language, including consideration of bilingual provision of social prescribing services, the potential role of Welsh language organisations such as the Urdd[4], Y Mentrau Iaith[5] and Merched y Wawr[6] in signposting into social prescribing and providing community services, clarification of how social prescribing would be provided in accordance with 'More than just words'[7] and the wellbeing benefits of learning Welsh (and therefore its potential inclusion in a social prescribing model).

3.22 Three respondents noted the need for an increased focus on loneliness and isolation and suggested that an emphasis on "offering outreach to ensure the most isolated and 'seldom heard' can also benefit from social prescribing services."

3.23 It was also suggested that the framework could provide a more holistic representation of the circumstances in which people might engage in social prescribing (for example in preventing mental illness, recovering from mental or physical illness etc.). Linked to this, one respondent felt it was important to demonstrate that social prescribing can provide a continuum of support that is not separated into, for example, prevention, treatment and recovery pathways, as can be the case with statutory services.

3.24 Conversely, one respondent felt that the framework should place emphasis on the preventative role of social prescribing whilst another felt that the focus should be social prescribing as part of a ""step down" model for people leaving intensive support (e.g.: substance abuse, mental health)."

[4] The Urdd is Wales' largest national youth organisation for young people aged 8 to 25, providing opportunities to take part in a range of experiences through the medium of Welsh.
[5] The Mentrau Iaith create opportunities where anyone and everyone can enjoy using Welsh every day within their communities.
[6] Merched y Warw is a voluntary, non-political organisation for women in Wales, similar to the Women's Institute but conducted through the medium of Welsh.
[7] More than just words is the Welsh Government's strategic framework to strengthen Welsh language provision in health and social care. Its aim is to support Welsh-speakers to receive services in their first language.

3.25 Two respondents expressed concern that the framework could be seen to suggest a diversion of focus and investment away the statutory health and social care sectors. It was also suggested that the model "fails to address the wider determinants of health and appears to be more focussed on reducing waiting lists and not on early intervention and prevention."

3.26 Three organisations highlighted the need for further consideration of possible safeguarding issues that could arise in relation to social proscribing, both in terms of people's physical safety but also the risk that someone's situation deteriorates, and they require specialist support: "We are concerned that safeguarding is infrequently mentioned and recommend that safeguarding is better embedded throughout the model. Safeguarding children and vulnerable adults is everyone's responsibility."

3.27 Clarification is also needed on the role of the third sector and how to ensure equity between the different 'players' within a model of social prescribing: "the third sector must be seen as an equal and crucial player, rather than a 'dumping ground' for people whose problems cannot be resolved by statutory partners."

3.28 Respondents also called for further details on how a national framework for social prescribing services would be governed and how any governance arrangements would be embedded at a local level in a way that recognises differences in regional and local implementation.

3.29 Linked to this was a concern expressed by several respondents that a national model risks "over-formalizing" what is commonly a "grassroots process", potentially excluding groups providing support in communities but which may not be formally recognised by, or conform to, a national framework: "evaluating/commissioning against a national framework may disadvantage local, grassroots groups who have been doing this work [sic] but which may not use the model's language."

3.30 More generally, respondents cautioned against attempting to create a 'one-size-fits all' vision or model, given the diversity of geographies, differences in range and scale of available services and variety of needs of different communities (e.g.: urban vs rural):

> "Generally, we like the concept, and the health referral pathway is appropriate but think that the overall model is trying to wrap a framework around a broader system of working...The model is trying to reduce a complex, inter-connected system into a discrete service within a single framework."

3.31 Conversely, another respondent commented that the model is "too broad" and "lacks detail".

3.32 Several respondents suggested there was a need for more clarity on the relationship between the national framework and individual social prescribing services at a local level: "status of framework is unclear - how does the Welsh Government ensure national standards are adhered to whilst allowing autonomy within local communities." Another respondent referred to the proposed framework as a national "project" involving "a grand opening date" and instead recommended rolling out local projects gradually, enabling people to "learn from the failures and successes of other people and groups."

3.33 It was also suggested that more clarification is needed on how a national model is intended to meet gaps in existing provision and avoid duplication at a local level.

3.34 The feedback also included the suggestion of a separate public/professional facing model; proposed amendments/improvements to a public-facing model included:

- Greater diversity of imagery that represents the Welsh population more inclusively
- Simpler language and the inclusion of definitions to account for difference in health literacy
- A broader range of activities (including group activities and non-sporting activities) in order to appeal to individuals who are lonely or isolated and/or who dislike physical activity
- Inclusion of additional colours on the activities icons, given that the current model appears to overly represent green/nature activities

- Addition of a visual representation of ‘connection’ - a key aspect of social prescribing
- Development of a specific children and young persons’ version.

3.35 Suggestions adjustments to a prospective professional-facing model encompassed:

- Clear definitions to aid understanding, e.g.: what is meant by ‘social prescribing’, ‘referrers’ and ‘community-based support’.
- Great clarity over the different pathways, particularly in relation to where people may follow a defined pathway, with clear inclusion criteria (e.g.: National Exercise on Referral Scheme) versus more flexible pathways into general community provision.
- Transparency of the relationship between social prescribing, primary, secondary and social care.

3.36 Most respondents who commented on the visuals and diagrams associated with the model suggested improvements. For example, one organisation appreciated the circular diagram as a good way to highlight ‘a person-centred approach’ but suggested that “it can also be interpreted as the person in the centre being a target in which interventions are delivered to as opposed to co-produced." Similarly, another respondent felt that the model does not capture the idea that social prescribing should be tailored to what matters to an individual.

3.37 Several organisations felt that the visuals were too narrow and failed to capture the diversity of both services that could be provided via social prescribing as well as the type of people who might benefit from social prescribing. This included concerns that the model:

- Gives the impression of being outdoors focussed
- Includes insufficient focus on sport and physical activity
- Does not seem to capture the role of cultural activities and groups

- Fails to acknowledge the possible role for animal welfare charities, given the evidence that regular interactions with animals have mental health benefits
- Excludes potential for alignment with the environmental sustainability agenda in terms of social prescribing's benefits (to nature and to eco-anxiety), the role of 'green social prescribing', the types of activities this might include (e.g.: rewilding), and possible contribution to net zero goals.
- Does not capture the potential role of faith organisations in a social prescribing model
- Excludes the role of community transport in providing access to social prescribing services
- Excludes people with disabilities and includes too many able-bodied representations.

3.38 One respondent felt that the inclusion of a "police helmet" to illustrate the statutory sector referral pathways was unfortunate and implies that someone must be involved with the police to be eligible for this referral pathway.

3.39 Two organisations recommended including a visual representation of a possible service user journey.

3.40 One respondent commented that the video would be "useful for most groups"; another suggested that it was "easy to understand for professionals but confusing for others."

3.41 Another respondent recommended holding dedicated engagement activities to test understanding and reaction to both the images and terminology in the model.

3.42 Finally, a number of questions were asked in responses to this question, including:

- How will parity between different referral pathways be managed?

- How will the Framework support marginalised groups from accessing social prescribing, for example with people seeking asylum and refugees?
- How will all partners [involved] in delivering social prescribing be clear on their roles, responsibilities and opportunities?
- What actions will be taken to ensure that there is a consistency of delivery across Wales, avoiding a 'postcode lottery' of potential services?"
- Do social prescribers have enough info on available community support?

Workshop Findings

3.43 Workshop participants provided a variety of initial reactions to the model and their feedback was more polarised than was the case with the formal consultation responses.

3.44 In one workshop break-out group, the consensus was that the model reflected a 'comprehensive vision'; in another group stakeholders described the model as "clear" and felt the short film was "really engaging." A further group felt that the model was "broader" than anticipated, something that was seen as a strength in terms of encompassing the differences in the way social prescribing services work at the local level.

3.45 Other groups were more critical, suggesting that the model was not as clear as the model of social prescribing in England and that more clarity was needed in terms of the types of activities that might be prescribed. It was also noted that Welsh Government should ensure that in referring to activities, social prescribing services need to be mindful of ensuring they are culturally relevant, and do not conflict with or compromise religious beliefs, for example. It was also suggested that services need to refrain from making assumptions about what kind of support would be suitable for particular groups and instead should focus on consulting the individual person and identifying their individual needs and preferences.

3.46 Many of those who wanted more clarity on the model were stakeholders who self-identified as 'unfamiliar' with social prescribing; they described the model as described as 'woolly' and 'fluffy' in places and were uncertain of the purpose of the model and what it is trying to illustrate.

3.47 The main gaps in the model identified by stakeholders in the workshops included:

- Case studies to clearly illustrate how social prescribing services might work within this framework.
- More explanation of /distinction between the referral pathways
- Consideration of the role of allied health professionals and how they can contribute to a model of social prescribing
- Detail on the self-referral pathway
- Specific focus on mental health and, in particular, adolescent mental health
- Greater emphasis on a person-centred approach and what that means in the context of social prescribing
- The need to build population resilience
- Examples of impact / benefits of social prescribing at an individual and community level.

Focus Group Findings

3.48 Focus Group participants were asked whether they had heard of the term 'social prescribing' before attending the respective groups.

3.49 Most respondents in the group with older people had heard of the term social prescribing before the session. In many cases they first became aware of the term via their own or a relative's GP and one person had experience of being referred to a gardening group, which they thought had been a form of social prescribing.

3.50 Less than half of Black, Asian and Minority Ethnic focus group participants were previously aware of the term 'social prescribing'. One participant in

this group was a medical student and so heard about through their training. Another person had a partner with mental health problems who had been "prescribed" light exercise by their GP.

3.51 Amongst unpaid carers existing awareness of the term was also very low. In one case, an unpaid carer had been referred by their GP to an exercise class, but they did not think the term 'social prescribing' had been used to describe the process.

3.52 None of the children and young people or disabled people had heard of social prescribing before the groups; however, having watched the short film, two participants commented that they probably had benefited from a social prescribing service previously (to access swimming and yoga) but that a different term had been used – in one case "wellbeing services".

3.53 In follow-up discussions with disabled participants, two participants were completely new to the concept – whilst others recognised it and had various levels of understanding.

3.54 Overall, group awareness and experiences were very limited and amongst the few with some familiarity with the concept of social prescribing, it had been described in other terms.

Question 2a - What is your view of the language/terminology used in the model and supportive narrative? This may include the language and terminology used in both English and, if appropriate, Welsh.

Individual Respondents

3.55 Thirteen individuals were critical of the term 'social prescribing', specifically, for a variety of reasons including the idea that is has medical or clinical connotations, it is an unfamiliar term and therefore not relatable or accessible, the suggestion that "prescription" does not enable a person to create their own pathways or life they want to live and is therefore not person-centred. Conversely, three respondents supported the use of the

term "prescribing", on the grounds that it is simple and accessible and adds legitimacy to a potentially unfamiliar concept.

3.56 Furthermore, four respondents noted that whilst there are potential issues with the term' social prescribing', changing the wording now could cause confusion, given that awareness is already building amongst professionals and the general public.

3.57 Nine individuals commented negatively on the language in general; criticisms included suggestions that the language does not make sense, it would not be understood by a lay-person and is therefore inaccessible to the general public, the model is too verbose and also patronising in places.

3.58 Five respondents had a positive view of the language, reporting that it was clear, concise, makes sense and is self-explanatory.

3.59 Two individuals noted there was little mention of engaging existing community organisations and this undermines the idea that social prescribing is building on existing community assets.

3.60 It was also noted that there is no reference to "enabling" or "capacity-building", both of which should be pivotal to an effective social prescribing service.

3.61 One respondent felt that a different language and "narrative" is needed for professionals and for the general public, and that for the latter, absolute clarity about what social prescribing involves is key: "In my experience - for the public - the service needs to do what it says on the tin - so the label on the tin needs to be explicit about what the service is providing."

3.62 Two individuals had concerns about using a 'catch-all' term of 'referral', suggesting that in fact a good social prescribing service will involve different "tiers" or "layers" to accessing support through social prescribing, including: signposting (tier 1), referral (tier 2) and follow up and review (tier 3).

Organisational Respondents

3.63 Responding organisations had a range of views on the term "social prescribing, with a small minority in favour of the term, arguing it adds credibility and relevance, is an internationally recognised term and might encourage compliance:

> “We recognise that social prescribing is an accepted term used in Wales and beyond, and for many, is an accurate description of the model. We accept that for the purposes of ease and consistency, it is sensible to continue to adopt this language"
>
> "Some people might not feel they have permission to seek out or engage with support unless they have a ‘piece of paper’”

3.64 It was also suggested that the term if particularly relevant in primary care settings, given the universal familiarity with pharmaceutical prescribing.

3.65 One organisation felt that it could help to strengthen partnerships between community organisations and the statutory health and care sectors, and “alludes to [a] more formalised relationship” between them.

3.66 Many respondents were critical of the term, however, seeing it as overly associated with the health and social care sectors, too formal, and potentially confusing/vague. There were concerns that such a "medical" term would prevent the model from being truly holistic and empowering individuals:

> "Paternalistic nature of the word ‘prescribing’ which is suggestive of an action being done to an individual, rather than as a shared decision with them, through a person-centred approach."

3.67 It was also suggested that using a “medical term” implies standardisation of services, delivery by a ‘qualified’ person and formal outcome monitoring. One respondent felt that it conveys the idea of being a “medical model of disability”.

3.68 Low levels of awareness of the term, particularly amongst the general public but also some professionals, leading to confusion about what it does and does not involve was cited by five organisations as a shortcoming of the terminology:

> "Patients often do not understand what is meant by social prescribing. It is unclear whether services offered will be free of charge and whether they will have to organise their activity themselves."

3.69 It was suggested that the term could be particularly off-putting to people who have had long-term illness (for example cancer), "who may have gone through many, significant and invasive medical procedures, and are learning to live with or after their cancer." It was also suggested it could be a barrier to people who do not have trust in official or formal institutions.

3.70 Another issue with the term suggested by one organisation is that it would necessitate clarification and reassurance that any risk would lie with the individual rather than prescriber or the community service provider.

3.71 One organisation felt it was important for a social prescribing to "maintain its non-medicalised approach", suggesting this could be compromised by used the term 'prescribing'. Another mentioned the risk that individuals falsely assume they will be prescribed medication and could feel let-down or marginalised by being referred to community support instead. Other concerns with the term 'social prescribing' that were cited include:

- The risk it implies obesity and unhealthy lifestyles are "medical issues"
- The fact it will require a certain level of "health literacy" in order to be understood.
- The danger that clinical staff – and those involved in conventional 'prescribing' (of medicine for example) – could be resentful that social prescribers are not subjected to a comparable level of professional rigour and scrutiny.
- The potential for undermining the holistic ethos of social prescribing on the grounds that it "puts the activity into the medical box".
- The risk that it "labels people" as "a case" or needing "treatment", which could deter community organisations from engaging.

- Suggestions that it is too vague / confusing and could mean different things to different people.
- The term is not yet in the common vernacular and therefore would not be understood.
- A lack of consistency and standardisation around the social prescriber role – job titles can include social prescribers, community connectors and link workers.
- The risk that it downplays the human interaction that is intrinsic to social prescribing: “[social prescribing] is not just the "prescription" but also the one-to-one support.”

3.72 Finally, one response emphasised that it is important to be clear that social prescribing is a way of working and not a specific profession or service.

3.73 Similar concerns were expressed over the word "referral” and the implications this has for duty of care and quality assurance of services received, as well as a guarantee of sustainable funding. One respondent felt it best to “"avoid the use of medical terms such as referral pathways etc when describing the simple act of connecting people to activities or advice."

3.74 Six respondents specifically emphasised the need for clear and simple language to promote accessibility and engagement with the model. One organisation highlighted the importance of the language being accessible to people with learning disabilities; another felt that the language in the proposed framework was more suited to professionals than the general public, whilst a third recommended obtaining input from members of the public before finalising the language and producing any promotional materials.

3.75 Examples of terminology or general language which one or more respondent suggested was unclear or needed revising included:

- Language around the pathways (e.g: definition of the term "targeted pathway” and “self-referral pathway”). One

respondent asked for clarification of the difference between referral and signposting.

- Terms such as "self-management“, “non-clinical” and “person centred”, which may be understood by professionals but not the public.
- The term “locality” and the need for clarification of what footprint is being proposed, i.e.: health board/RPB footprint; local authority footprint or a smaller/community footprint.
- Recommendation of the need to be sensitive in defining “loneliness” - using terms like “getting connected” or “meeting people” instead.
- The recommendation that “healthcare referral" was amended to "health professional referral".
- Concern that the word ‘patient’ is “a deficit medical term” and could be perceived as “labelling” an individual and therefore act as a barrier to a person seeking support through social prescribing.
- Suggestion that language around "unhealthy lifestyle choices" could be stigmatizing and impart blame on individuals accessing support.
- A general recommendation to use positive language throughout.

3.76 Respondents also emphasized the importance of standardisation, stressing that the terms used should be consistent across geographies and sectors and also consistent with language used in other UK nations.

3.77 Three organisations had consulted with their respective members/beneficiaries before submitting a response and were able to provide feedback on the relevance of the language to specific audiences; in one case this was positive and in the other two cases the feedback was negative:

- People with disabilities reported that the visual aids in the easy read document were helpful

- Children and young people felt that the language did not make sense to them or speak to them in a way that they found useful.
- “Parents ... felt alienated by language that didn’t feel as though it had been designed for them and doesn’t speak to them. The referral pathways, and even ‘social prescribing’ itself, falls into this category for these parents."

3.78 Seven respondents felt that the language used overall in the model was appropriate, suggesting it was clear and easy to understand and “appears sufficiently broad in scope”. One organisation suggested that the language “is appropriate as long as it is explained, particularly for older adults and for people with intellectual disabilities.”

3.79 Only two respondents referred to the Welsh language in response to this question; one was unable to comment as they did not have access to Welsh medium versions of the documents[8]. Another respondent suggested it is important that the terminology used in the model should be developed in English and Welsh at the same time rather than developing the English version and then translating it into Welsh.

3.80 Two organisations cited the need for flexibility in the language used, particularly at the local level: “We should not seek to replace the language that is already being used by communities, service-deliverers, or networks, but make the national-level language flexible and relevant."

3.81 Another respondent suggested that “[the] existing term can remain within the pedagogic landscape but should be broken down into simpler terms with key words like; connected communities, community connections, community support and so on."

3.82 One respondent suggested that the language should be integrated with language used in education policy and programmes, for example the whole school approach to Mental Health, the NYTH / NEST framework

[8] Welsh versions of the documents were available during the consultation and can be found here: https://www.llyw.cymru/datblygu-fframwaith-cenedlaethol-ar-gyfer-presgripsiynu-cymdeithasol

and Curriculum for Wales. Another organisation advised linking to the terminology used in Vision for Sport in Wales, such as "sport" and "physical activity" in the interests of establishing “an active nation where everyone can have a lifelong enjoyment of sport”.

Workshop Findings

3.83 Stakeholders across all six workshop breakout groups referred to the fact that the term ‘social prescribing’ implies a medical model and in most cases, this was seen to be a shortcoming. Some stakeholders felt that the term ineffectively reflects the wider vision for the framework; others felt that it could be alienating to some groups. It was suggested that the word ‘prescribing’ implies something that is done *to* an individual and is therefore less empowering and also conflicts with the concept of self-referral.

3.84 The language used generally in the model was described by some as being “health and social care centric” and would require “assumed knowledge” on the part of the public and professionals outside of health and social care to understand it.

3.85 Examples of this kind of language that was cited included the term ‘statutory sector’; in this case it was felt that it would be more accessible to simply describe the organisations that would be considered part of the statutory sector.

3.86 Another example was using the term ‘frameworks’, which some suggested could exclude non-professionals.

3.87 In one group there was a discussion around the fact that social prescribing describes the concept but not the job of a person working in social prescribing and that both are needed to fully convey what a social prescribing service involves.

3.88 In another group, stakeholders observed that the model uses the terms “sign-posting” and “social prescribing” interchangeably and that there is a

need for clarity over the different terms and consistent use of them in the model.

Focus Group Findings

3.89 Focus group participants were asked whether the YouTube video clearly explained the model.

3.90 The majority of participants agreed that the video offered a good explanation that was easy to understand.

3.91 Some children and young people questioned the intended audience for the video as they did not feel that it was specifically aimed at them. They suggested including clarifications in the video that it is relevant for all age groups. They also noted that there is only so much that can be shared in a short video so additional follow up information would be useful as they all felt quite confused about what social prescribing entails, having only watched the video: “I’m not sure what it is or what it includes.”

3.92 Within the Black, Asian and Minority Ethnic group, whilst the consensus was that the video clearly conveyed the general concept, one participant felt they would query the long-term viability of the model (without more information), another wanted more detail about where referrals “go” following the five referral routes and a third felt that they would not feel comfortable using any referral route other than through their GP (i.e.: the healthcare referral pathway) without more detail.

3.93 Focus group participants were then asked if there were any words or expressions used to explain the model in the video that were difficult to understand or confusing.

3.94 Several disabled people felt that although the video generally made sense to them, some people would not understand what it means; one individual suggested it might be “seen as all about medicine”. Another felt that there is an assumption that people know what terms mean – for example “statutory” and “third sector”.

3.95 Participants in this group also emphasised the importance of providing information about the model in a variety of mediums and not just producing it digitally.

3.96 Participants of the Black, Asian and Minority Ethnic group asked whether the video would be available in different languages to ensure everyone can understand it. One person suggested including links to PDF summaries of the model in different languages.

3.97 Participants across all groups recommended that jargon should be avoided, using simple words as much as possible to enable all audiences to understand and to avoiding people losing interest. One older person commented: "it was government speak throughout, [the video] … you could lose interest … need one syllable words – straightforward language." Similarly, one unpaid carer identified "certain language that is used within the Welsh Government … jargon not easy for the general public to understand." This included terms such as: "health professional" and "statutory sector".

3.98 The term 'prescribing' was highlighted by some participants from the older people group, who suggested that it is something you associate with coming from a medical professional, which caused them to question how a "self-referral" pathway could fit into this. It was commented that more clarity and detail on the different referral pathways would be useful. One person in the group of older people recommended focusing upon the idea of 'self-help', which is a more familiar term that could help to describe the concept of social prescribing: "for example, attending a Men's Sheds group is easy to understand."

Question 2b - Do you have any suggestions on alternative language / terminology? This may include the language and terminology used in both English and, if appropriate, Welsh.

Individual Respondents

3.99 Roughly a sixth of individual respondents (12) answered 'No' to this question, of which some provide a follow-up comment recommending that in general the language needs to be simple, clear and consistent.

3.100 Most respondents who suggested other language provided an alternative to the term ‘social prescribing’, most of which included the word ‘social’ and/or ‘community’; notably all suggestions avoided the word ‘prescribing’. Proposed alternatives included:

- Social Connecting – which was felt to capture a sense of “community belonging”
- Social Wellbeing Support
- Social Participation – which can convey the idea that it is “participatory, empowering, encouraging, engaging”
- Community Support Referral
- Citizen Community Connecting ('CCC')
- Community Wellbeing Support Service
- Community Wellness Service
- Community Lifestyle Service
- Community Health Service.

3.101 It was also suggested that the term “Community Connectors” should be used instead of “Social Prescribers”.

3.102 One respondent suggested that "opportunities in your community" should be used instead of the term "community-based support" and that "activities in your community" would be more easily understood than "community assets".

3.103 One respondent suggested the following 'layperson's description' of social prescribing: "A proactive non-medical approach, which enables a person to improve their wellbeing by providing them with options that allow them to make informed choices to improve their lives."

3.104 Another individual suggested: “prescribing activities and conversations that are good for you."

Organisational Respondents

3.105 Organisations responding to the consultation also offered a range of alternatives to "social prescribing"; eight respondents suggested terms that included the word “community”, such as community connecting, community support and community care coordinating. One organisation commented: “‘community referral’ is often used as an alternative which perhaps better describes the process of referring people to local, non-clinical services, activities and interventions within their local area.”

3.106 Another organisation, however, expressed caution over the term ‘community connecting’, suggesting “this term may not have face value for the public and [could] be perceived as jargon.”

3.107 Some other suggestions involved the word ‘social’ and included:

- Social signposting
- Social engagement service
- Social prescribing screening service

3.108 The terms “lifestyle medicine", “wellbeing support” and “community-based health and wellbeing support” were also suggested as alternatives to social prescribing.

3.109 Two organisations proposed using the term “link workers” instead of “social prescribers”, whilst another respondent recommended “mixing in” a variety of other words to illustrate the concept of social prescribing, including: “interventions; support; network; connection; recovery empowerment; holistic care, positive lifestyle”.

3.110 Responses suggested the term should be understandable as a "brand" in both English and Welsh and should have a relational focus (as opposed to a transactional one): “it is not just a “hand off” to another service or the provision of information. It [the language] should reflect its focus on wellbeing."

3.111 Three respondents felt that the actual terminology was of less importance than giving a clear description of what it involves, and the kind of services and assets people might access: “reframe this as an offer to support a

fuller lifestyle –to develop an enhanced universal service involving amongst other things sports facilities, libraries and community centres."

3.112 Another respondent suggested a simple definition: "The social prescribing service/offer need only be known by users as 'people here to help people'".

3.113 Conversely, a minority of respondents used this question as an opportunity to repeat the recommendation to retain the term 'social prescribing'.

3.114 Other suggestions for alternative terms included:

- "Request for assistance" rather than "referral"
- "People/persons/individual/adults and children and young people" instead of "patients"
- Specifying "charities/community organisations/voluntary sector" instead of "third sector"
- Using the term social prescribing "offer" rather than social prescribing "service" – to capture the variation and nuance in the way it works in different areas
- "Publicly funded services" or "other public services" instead of "statutory sector"
- "Nature-based" activities rather than "green prescribing", which "ties in with nature-based solutions in current legislation."

3.115 In several cases, respondents did not make any specific suggestions for alternative language but provided more general comments or suggestions, such as:

- Clarity over the meaning of the term 'local'
- Concern that the word 'social' in 'social prescribing' may suggest a link with social care – one respondent also commented that "the Welsh model of SP is more linked to social services than health."
- Questioning why "health" is different from "statutory"

- Suggestion to look at the terminology used in the Care Aims Framework being rolled out for professionals in the health, social care and education sectors.
- Ensuring any language is co-produced with potential service users or members of the public; one respondent suggested "building a narrative to identify terms that already exists within local communities."
- Suggestion that terminology around education should be used in describing referral pathways.
- Concern about the term "targeted", which sounds overly authoritative and is potentially not inclusive
- Recommendation to include a glossary of terms and easy read/abridged versions of the model: "It should include [an] edited down narrative section which simply explains the key elements of the model without a focus on how it works or evidence. An overview on a single page that can be easily and quickly understood."

3.116 One respondent seemed to interpret this question as asking about language mediums and suggested undertaking "a language audit of the delivery bodies involved to 'match' any additional language needs with delivery organisations…", by implication, to ensure the model considers all languages spoken amongst all partners involved in delivery of social prescribing services.

Workshop Findings

3.117 Stakeholders in workshops expressed a hesitancy towards suggesting alternatives – based on an acceptance that a common language has already been developed, at least to some extent.

3.118 In one breakout group, participants felt that as professionals, they perhaps were not best placed to suggest more accessible language, describing themselves as already "too institutionalised".

3.119 Some stakeholders thought it could be better to emphasise a clear and simple description for the term social prescribing such as “linking people to non-medical support.”

Focus Group Findings

3.120 Focus Group participants were asked whether there was anything they could suggest that would make the model easier to understand.

3.121 Participants from the disabled people group stated the importance of ensuring that an easy read version of materials was available. Some participants in this group also shared that the text on the video was a bit small and would benefit from more pictures. Others, however, felt that the video was good: “nothing wrong with it … explained it bit by bit … good as you don't have to take too much in.”

3.122 One disabled person recommended using the term “friendships” instead of “relationships”, given that the latter could be misinterpreted.

3.123 Participants from both groups with older people felt that it would be useful to include guidance for people who run groups (u3a etc.) on how to get information about their activities into GP surgeries, for example, to enable them to get involved in a social prescribing service.

3.124 Some individuals from these groups also questioned how “everyday people” could get involved and how they would be expected to share information about social prescribing with friends and acquaintances. It was suggested that inclusive language aimed at lay-people was essential.

3.125 Individuals from the children and young people focus group suggested that adding a reference to what this model would mean for their age range and school settings would be useful.

3.126 Furthermore, a suggestion made by an individual in the children and young people group (and supported by other participants present) was placing emphasis on related research or sharing examples of when it works, to enable them to further understand how it benefits patients and how it differs from a medical model of care.

3.127 Black, Asian and Minority Ethnic group representatives suggested including some phone numbers and links as well as more detail on the workforce involved in delivering a social prescribing service.

3.128 It was also suggested that because the nature of a social prescribing service will vary in different areas, any explanation of the service – for example a video – would need to be tailored to the local offer.

3.129 One member of the Black, Asian and Minority Ethnic group highlighted the lack of any intended outcomes from the framework or clarification of what it is trying to achieve and suggested it appeared "open-ended". Another participant in this group suggested it would be useful to demonstrate how people could become involved in helping delivering social prescribing services, as a volunteer, for example.

Question 3 - How do we at a national level develop a common understanding of the language/terminology used to describe social prescribing for both professionals and members of the public alike? This may include the language and terminology used in both English and, if appropriate, Welsh.

Individual Respondents

3.130 Broadly, respondents agreed on the need for a wide ranging, accessible, ambitious, national campaign to build understanding about social prescribing and of how to access social prescribing services. It was suggested that the campaign should be backed by Welsh Government and targeted on the general public rather than people working in the system.

3.131 It was suggested that bilingual communication should be disseminated via a variety of platforms and methods, including the following:

- Visual advertisements (billboards etc).
- Brief testimonials/videos that are outcome related
- Social Media

- TV, radio and newspaper advertisements (particularly important for older people).

3.132 Two respondents noted that social prescribing should be promoted at GP surgeries.

3.133 Six respondents noted that social prescribing needs to be developed and promoted at the local authority and/or health board level, involving local health care professionals and/or social care teams.

3.134 One individual suggested that it is critical that Public Health Wales builds on the baseline study that informed this consultation and maps the social prescribing offer in each region.

3.135 Four respondents suggested developing a glossary of terms and definitions around social prescribing to inform consistently worded and accessible literature in paper and digital formats.

3.136 As was emphasised in responses to previous questions, respondents recommended “de-professionalising” language and terminology and to focus instead on capturing what social prescribing is trying to achieve.

3.137 One individual suggested that existing social prescribing organisations could engage with local citizens to get their perspective on how they would define the support that they receive. Another called for getting service users engaged from the start: “so that they co-design the service model, rather than designing it and then asking them what they think.”

3.138 Respondents emphasised the need for ‘consistency' and for all social prescribing projects to be using the same language: “people get confused with community navigator, community agent, community link, third sector co-ordinator etc.”

3.139 One respondent suggested that terminology is irrelevant as long as people are able to access the service and benefit from it. Similarly, another felt that it was unnecessary for the general public to be aware of the different pathways into the service; instead, they should just be given information on how to contact social prescribing services, either directly or via their GP.

Organisational Respondents

3.140 As in other questions, organisational responses emphasised the importance of simple and consistently used language that clearly communicates the goals of social prescribing and avoids acronyms, jargon and short-hand terminology. Three respondents suggested developing a glossary of terms; one of these respondents recommended that the glossary is informed by appropriate groups of individuals and contains simple vocabulary to avoid exclusion and discrimination.

3.141 One respondent suggested providing a clear explanation of the goals of social prescribing whilst another felt that it would be important to clarify the difference between the social prescribing service and the activities that people might access through a social prescribing service.

3.142 Public engagement (including engaging those with lived experience, children and young people, those with varying levels of literacy and health literacy and those in ethnic minority communities) was seen to be crucial, both to inform the language and terminology used but also to place control and ownership of the framework in the public's hands: “have professionals learn public terminology rather than public learning jargon.”

3.143 One respondent suggested convening a task group of people with lived experience to create an agreed approach to language and terminology. Another noted the importance of testing any language or materials (in both English and in Welsh) with a range of different audiences (including those with varying levels of health literacy) to minimise barriers to understanding and engagement.

3.144 Six respondents recommended a national awareness campaign highlighting social prescribing and its benefits, disseminated via television, social media and the press and including case study examples of how social prescribing can help. As part of this, one organisation suggested engaging marketing professionals or a market research company to understand the different audiences for a prospective campaign(s).

3.145 Again, in keeping with answers to earlier questions, several respondents emphasised the need to cater for different audiences when describing social prescribing; three noted the need for any communication to be in a range of different languages, not just English and Welsh. There will also need to be easy read versions and short, engaging films that professionals can share with individuals when introducing the concept of social prescribing.

3.146 Caution was expressed against portraying social prescribing as an “easy-fix” panacea for all problems, which could cause professionals and the public to disengage.

3.147 Training for all professionals involved in social prescribing was also seen as a key part of this process. Those referring into the service need to be trained to ensure they are referring the right type of people and are able to identify those who might need more specialist care.

3.148 It was also suggested that social prescribing champions are established in different organizations and should receive ongoing guidance and that the concept of social prescribing should be mainstreamed into training delivered in the NHS and within Welsh Government departments.

3.149 It was suggested that Welsh Government could support the development of a central hub of good practice examples for professionals to use.

3.150 Six respondents referred to the importance of cross-sector working, including cross-ministry working (and funding) and the identification of areas of connectivity, common understanding, and common outcomes.

3.151 It was suggested that this would enable social prescribing to become “embedded into every part of civil society, so that individuals engage with social prescribing as readily as they do [with] community groups, GPs surgeries and dentists."

3.152 Other suggestions included:

- Setting up a national event for relevant representative groups to enable shared understanding of the respective roles of key players in the social prescribing service.

- Developing a central database of all services which should be accessible to both patients and professionals.
- Ensuring language is developed concurrently in Welsh and English “using international procedures on standardization”.
- Ensuring flexibility to enable the language associated with the model to “be nuanced and flexible to local contexts, not seeking to replace language or networks that already exist in communities.”
- Developing a concrete plan to communicate the framework’s impact.

Workshop Findings

3.153 Workshop stakeholders had a range of suggestions on how to develop a common understanding of the language/terminology used to describe social prescribing, including:

- Tying in with schemes which already focus on the prevention agenda.
- Prioritising simplicity – helping the concept to immediately resonate and enabling people to make the connection that social prescribing “is for them”.
- Ensuring that terminology across services is shared, common, and consistent.
- Designing marketing and promotional materials that “start with the problem”, for example “are you lonely?”
- Providing case studies that can bring the model to life and help people understand the impact social prescribing can have on real people.
- Including examples that reflect all members of society and sectors – for example, in one breakout group there were concerns that educational settings seem to be excluded from the pathways, despite the fact that nurseries and schools are often central to communities. It was suggested that this

therefore creates the impression that the model does not apply to children and young people.

- Ensuring that any promotion is not just limited to online, so as not to exclude certain groups, for example older people or people with certain disabilities.
- Working closely with Regional Partnership Boards as they already have the networks and resources required to make it work.

Focus Group Findings

3.154 Focus Group participants were asked how they would describe social prescribing to someone else, to draw out themes related to this question.

3.155 All groups were able to share different interpretations of social prescribing with the exception of the group containing children and young people who were not confident as they believed more awareness was needed of social prescribing before they could confidently define the term.

3.156 One person in the group of older people described social prescribing as a broad concept, sharing that “as I see it, virtually anything could be included if it works for that person”. Another person in that group defined it as “non-medical help for people who need it” and suggested emphasising that there are other ways of helping people beyond medical treatment. Another older person said that they would be confident using the term “social prescribing” when describing the concept to some people but felt it would not be appropriate to use with someone who was “poorly educated”.

3.157 Black, Asian and Minority Ethnic group representatives felt it would be important to emphasise the idea of social prescribing being a group activity and involving connecting with other people. Others in this group felt it would be worthwhile to build on existing promotion and awareness of the benefits of social interaction, sport and getting out into nature.

3.158 Participants in the group of people with a disability suggested referring to the fact it is about developing relationships but (re)emphasised the

importance of being clear that this does not mean romantic relationships. One person in this group said they would probably talk about “wellbeing and support” if they were trying to describe social prescribing to a friend. Another gave a suggested illustration of social prescribing: “instead of the doctor giving you tablets, they might prescribe you to go to the gym or other activities, doing light weights or swimming … maybe instead of sending you to a psychiatrist, the GP might send you to a walking group or yoga”.

Theme 1 Conclusions

3.159 The majority of respondents to the formal consultation (organisational and individual) felt the model captures an appropriate vision of social prescribing within Wales.

3.160 Key gaps in the model identified included: a reference to key groups (children and young people, older people, ethnic minority communities, Welsh speakers); opportunities to align with the ‘green’ agenda; the potential role of various players in the referral pathways; greater consideration of safeguarding; and the need to prioritise loneliness and social isolation.

3.161 Areas for clarification included: the relationship between the national model and the local infrastructure, the role of the third sector, funding and sustainability of the model and the role of community transportation.

3.162 There was very limited previous knowledge of the term ‘social prescribing’ amongst focus group participants.

3.163 There were mixed opinions on the term ‘social prescribing’ amongst formal respondents and workshop stakeholders:

- Advantages: provides credibility and relevance, is an internationally recognised term and could encourage compliance
- Disadvantages: potentially overly formal, confusing/vague, "medicalised", “paternalistic” and disempowering.

3.164 There were differences in opinion on standardisation of terminology:

- Terms used should be consistent across geographies and sectors should not be rigid but that the model should be flexible to encompass language that is already being used in local communities.
- Most focus group participants felt the video offered a good explanation which was easy to understand, albeit with some concerns about particular terms.
- There were a variety of suggested alternatives to social prescribing, including: community connecting, community support, community care coordinating, social signposting, social engagement service, social prescribing screening service and link workers.

3.165 Stakeholders in workshops were cautious of proposing alternative terms, given the prevalence of the term social prescribing, both in Wales and internationally.

3.166 There were concerns about the use of the terms “patient”, “third sector”, “referral” and “social prescribing service” – the latter implying provision is identical in range and scale in all areas.

3.167 In terms of developing a common understanding of the language/terminology used to describe social prescribing, amongst organisational and individual respondents there were calls for: ensuring simple language and clear descriptions where needed; testing of terminology with a wide range of stakeholders, a wide-reaching, bilingual national communication campaign, practitioner training and cross-sector and cross-ministry working (and funding).

3.168 Workshop stakeholders emphasised the importance of common and consistent terminology across services/sectors and geographies.

3.169 Focus Group members (with the exception of children and young people) provided examples of how they would describe social prescribing to someone else; in most cases, these interpretations of social prescribing aligned with the themes of the social prescribing video.

4. Theme 2 – Referral Pathways Analysis

Question 4a - What actions could we take at a national level to help professionals (from healthcare, statutory and third sector organisations) know about, recognise the value of and be confident in referring people to a social prescribing service?

Individual Respondents

4.1 Fifteen respondents said that training is key. Recurring training themes that were mentioned included consistent initial training of and regular updates (for example on developments within the sector) for social prescribing workers. Several respondents suggested the sharing of case-studies, reviews, reports, feedback, successes, and 'what has gone well' (i.e.: best practice) would be a valuable integration to the service.

4.2 Eight respondents said that a national standard of governance, accountability and quality assurance relating to social prescribing is of high importance. This was felt to ensure that those who are using the service would feel supported and safe. Further detail on this is provided later in the consultation, through discussion on the prospect of introduction national standards.

4.3 Five respondents highlighted that social prescribing workers themselves should already have a good understanding of what social prescribing is, what it offers, what is available, and their responsibilities are in relation to confidentiality and safeguarding.

4.4 However, five respondents said that there needs to be a single "point of truth" or reference regarding the process of social prescribing and what is available – a "one-stop shop" of information. Linking to this, five respondents mentioned transparency and effective communication between sectors so that *everyone* knows what is on offer.

4.5 Three respondents mentioned the importance of understanding the needs of social prescribing workers, so that they are confident about their own

provision – this links back to the first points on social prescribers' understanding of what they do.

4.6 Overall, the responses reflect a desire for clarity *across* the various professions and services that are required to work in alignment to deliver social prescribing.

Organisational Respondents

4.7 Organisational responses largely reflected the same core themes but provided further detail and a number of additional suggestions. Primarily, organisational suggestions can be understood through the following key topics:

- Need for clarity (five organisations) – including clear understanding of what it is, clear pathways for signposting and referrals, clarity in relation to limitations of the support that can be offered
- Provision of a single point or platform of reference/access to information on registered providers (nine organisations)
- Funding (seven organisations) – with commitment to funding reflecting confidence and sustainability for the service
- Collaboration (four organisations) – between willing partners and within the local community, strengthening relationships between professionals and social prescribing services
- Training/awareness raising (four organisations)
- Identification and knowledge of local services
- Confidence and recognition of value between elements of the social prescribing system
- Support, including robust plans in place for community organisations
- Systems to provide feedback, helping to build trust and maintain engagement
- Strong governance

- The provision of information on the availability and quality of Welsh language provision within the local social prescribing service.

4.8 To assist with the reasoning supporting these suggestions, some organisations raised the associated issues that can be faced in relation to social prescribing. Examples of this included difficulties in building trust in the system, with one organisation drawing on evidence that suggests it takes around 12 months to build trust in social prescribing amongst GPs.

4.9 Another organisation shared their experience – as an example of what to avoid – of having more referrals than staff resources could support effectively.

4.10 In terms of building trust and confidence, a substantial volume of organisational feedback concentrated on creating robust standards and the need for quality assurance and a competency framework.

4.11 Finally, organisational responses also commented on the importance of sharing successes in order to encourage more engagement and evidence outcomes. This point was also directly linked to the notion of trust, particularly amongst GPs, with one organisation highlighting that a perceived weakness or shortfall in existing evidence can be used to question the time and expense of expanding social prescribing services.

Workshop Findings

4.12 Stakeholders highlighted the need to promote shared understanding of the impact that social prescribing can have on individuals. To achieve a better understanding, it was suggested that there is a common language across individuals, organisations, and services. This should be maintained across all materials, resources, and platforms which are used to promote and facilitate social prescribing – to avoid confusion. Stakeholders also proposed that this should include agreement on a common vision/shared understanding for what a good social prescribing service looks like.

4.13 It was also noted that some areas of the workforce could be better included in plans to roll out and deliver social prescribing at a wider scale. In this case the example of allied health professionals was given, based on the understanding that they 'should be equipped with a better understanding of health inequalities.' It was stated that AHPs are keen to be involved in social prescribing and there is a recognised need to strengthen a wider public health workforce.

4.14 Other comments linked back to the importance of trust and credibility. Stakeholders also suggested promoting confidence in the value of social prescribing through using case studies and examples – creating a 'feedback loop'.

4.15 With the theme of credibility and evidenced outcomes in mind, stakeholders discussed the need to address the fact that health services are often run like businesses. Consequentially, it becomes increasingly important to promote social prescribing as a viable, credible option that creates demonstrable outcomes. In terms of recognising the value of social prescribing, stakeholders also raised the notion of the prevention agenda and the awareness that the benefits of social prescribing may lead to cost-savings in the long-term.

4.16 In terms of building confidence in the referrals process, stakeholders highlighted the need to maintain the philosophy that there is 'no wrong door'. It was felt that it should always be possible to send someone in the right direction, and that those involved in the referrals process should be equipped to handle complex cases. In relation to this, stakeholders also placed a strong emphasis on risk mitigation, forming tangible care plans and ensuring that those making referrals can trust in what the outcome will be.

Focus Group Findings

4.17 Focus group participants were not asked this question.

Question 4b - In the case of self referrals, what actions could we take at a national level to help members of the public know about, recognise the value of and be confident in contacting a social prescribing service?

Individual Respondents

4.18 Seven respondents commented that people will know about social prescribing and its value if there are multiple routes that they can be reached (and vice versa, i.e.: fewer routes is likely to equate to lower awareness). This point also tied in with early comments on the need for a comprehensive platform for accessing information about social prescribing. Four respondents said that there should be an accessible database of information that is clear, simple and easy to use, and up to date.

4.19 In terms of communicating the service to the public, respondents indicated that this included promotion of the model through general awareness-raising campaigns. Some suggested that this could also be done through the use of social media marketing.

4.20 Others urged the importance of more traditional methods such as leaving information booklets/leaflets in GP offices, libraries, pharmacies, leisure centres, family centres, community boards and so on. Advertising via more traditional media was referenced too – such as newspapers, radio, and television.

4.21 To help the public in recognising the concept and identifying their needs, it was suggested that there should also be a re-framing of social prescribing where necessary. For example, people may not want to admit that they are seeking a service for being "lonely" or "isolated" - so care should be taken to frame it more positively, in order to discourage stigma.

4.22 Six respondents said that promoting confidence for members of the public would also be possible if people know that the scheme is reliable and trusted, linking back to the central issue of credibility. To help achieve this, some respondents suggested a guarantee of quality, full visibility, and a "demystification" of social prescribing in general would be required.

Similarly, two respondents emphasised the need for social prescribing to be a well-governed and well-managed service for which performance is regulated.

Organisational Respondents

4.23 Organisations had a number of suggestions in the case of self-referrals, the majority of which focused upon making the process as simple as possible and raising awareness.

4.24 In terms of simplifying the process, three organisations emphasised the need to 'minimise bureaucracy in any new approach'. To do this, they suggested simple booking processes, keeping signup sheets and enquiry forms straightforward, and moving away from 'medicalised' access routes which are still reliant on GP involvement. Additional options raised included co-locating link workers within easy reach of other services and alternative access routes for those who aren't online and/or those who do not have English as a first language.

4.25 To help raise awareness of social prescribing services within the community, organisations also recommended working with existing grassroots groups to embed social prescribing into systems and places where people already go. As well as trusted grassroots groups, more established organisations were mentioned in terms of helping to boost publicity and credibility, examples included linking in with the Public Health Wales 'Hapus' campaign[9] which would be particularly relevant. Third sector services and councils were thought to be important avenues too.

4.26 On a similar note, some also suggested that awareness of social prescribing could be raised through integration with education and relevant curriculum topics. The New Curriculum for Wales Health and Well-being Area of Learning and Experience was thought to be a good fit

[9] This national mental wellbeing campaign run by Public Health Wales was launched in 2020 aimed at encouraging people in Wales to focus on and do more of the activities that promote and protect.

for this, and the opportunity was also identified to link in with new GCSE content under development.

4.27 Further ideas included the messages/content to include in the promotion of social prescribing. Organisations wanted to communicate how effective it can be, its benefits in comparison to clinical treatments, and how tailored it can be to suit individual needs. Other considerations included providing clear criteria for exactly who social prescribing is for, and that it can be a form of less formal support which does not need to rely on formal services.

4.28 In terms of a designated publicity campaign, ten organisations supported a need for this and there were suggestions that it could illustrate particular activities which help to improve well-being. As well as ensuring any campaign has all standard accessibility considerations (simple language, effective graphics, is easy to understand and provides a clear route map for access) some organisations provided additional factors. These described the impact that effective case studies could have on the public, and in particular, the impact that trusted public figures (e.g.: sports personalities) could have on capturing interest.

4.29 The need to ensure capacity before opening up the self-referral pathway was emphasised by four organisations – who highlighted that reasonable waiting times for social prescribing services would be imperative to its success.

4.30 A minority of organisational responses (two) stated their belief that social prescribing should not be open to self-referrals. From this perspective, the 'value' in social prescribing was characterised by 'the formalised referral route from a health professional to a social prescriber'. That said, the organisation sharing this still advocated for the value of individuals being able to access the information they need to be able to 'self-signpost' to groups and activities.

Workshop Findings

4.31 Participants suggestions centred primarily around the themes of sharing case studies and promoting social prescribing services:

4.32 It was suggested that social prescribing services need to be prepared to meet people where they are, rather than expecting people to be able to self-refer – this would require investment in community connectors going to cafes, public spaces, using social media to engage etc

4.33 Others highlighted that the pandemic 'opened the door' to self-referrals, showing the power of signposting and raising awareness

4.34 Stakeholders highlighted a need to communicate stories to people who have experienced social prescribing and the show the value it has had for them – some participants discussed ideas such as a platform for sharing experiences (beneficial both for the public and for helping to shape the organisations providing services).

Focus Group Findings

4.35 Focus group participants were asked what they would consider to be the best ways to be informed of their local social prescribing service.

4.36 Several methods of finding out about local social prescribing services were mentioned in all groups, with both digital and non-digital sources mentioned. This included TV advertising, social media, GPs, word of mouth, local newspapers and leaflets in community centres with an emphasis on the information shared sounding important and credible as well as in a way that is not patronising.

4.37 Participants from the black and ethnic minority group emphasised that there are lots of different cultural and ethnic communities, each with their own centres, who need to be brought in. Some communities may need more intensive engagement.

4.38 Participants from the group with people with a disability enforced the need to provide Easy Read leaflets with pictures available in prominent locations as well as the need for more widespread learning disability

awareness training, sharing that often a ten-minute GP slot is not enough time.

4.39 Participants from the group with children and young people as well as the group with older people shared that sometimes peers are not inclined to listen to family and would more readily speak to experienced healthcare professionals. Older people group members also shared that care homes would be a useful place to share this information as well as ‘places we already go like church halls and bingo’.

4.40 The group with children and young people also suggested including information in school assemblies would be a useful way to engage their age group.

Question 4c - In the case of targeted referrals, what actions could we take at a national level to help organisations identify specific populations/groups of people who might benefit from contacting a social prescribing service?

Individual Respondents

4.41 Of the individual respondents, five said that for targeted referrals to be successful, there needs to be a deep understanding of local communities – the people, places, aspirations and challenges of a specific place. This includes social prescribing teams in local areas, a contact point/person in the area, as well as staff knowing the needs of people in their area. One respondent explained that: “people are not "hard to reach" - services are poorly designed and have limited knowledge of local people and communities”.

4.42 Five respondents that said monitoring and reviewing data will help with targeted referrals. This would be in conjunction with undertaking a local-needs assessment and reviewing population data to see where needs are greatest, which four respondents said would be possible through effective intra-service networking and communication.

4.43 Three respondents said that it comes down to an individual wanting support, as well as their community knowing them well enough to encourage them to reach out to a social prescribing service.

4.44 Two respondents mentioned looking at other models such as the Local Area Coordination (LAC) Approach which are deeply embedded and accessible in some local communities.

4.45 There were, however, several respondents that mentioned why targeted referrals should not be used. This included hesitancy of how this can be applied at a national level, sharing that target referrals should be local enabling them to be locally relevant and more easily trusted. It was also shared that there would be GDPR challenges around organisations identifying people as well as difficulties with targeting people. It was shared by some respondents that whatever referral targets are set for specific groups or populations, there will inevitably be instances where it will miss out vulnerable individuals who does not fit the "criteria", or that some people will simply be or be placed into a collective "group".

4.46 One respondent shared their hesitancy toward targeted referrals, sharing that:

> “Targeted 'referrals' are too late - we need to start earlier, build knowledge of the issues facing people and families in our communities, understand the resources within our communities that can help people and the mutual support available within communities, with service responses supporting where 'socialist' support is required.”

4.47 Some ways of mitigating difficulties with targeting people were discussed by some participants as a response to this question and are further explored in later consultation questions. Three respondents highlighted the importance of targeted campaigns with a strategic and specific reach.

Organisational Respondents

4.48 A primary action that can be undertaken at national level in this regard is building the evidence base. Organisation responses suggested that the Welsh Government should lead in assessing who is currently accessing social prescribing services to identify gaps, support organisations in accessing local population needs assessments, collating data from both the health and voluntary sectors, and work with national organisations to gather data on social prescribing best practice.

4.49 Respondents suggested that work could be carried out at national level to consider the needs of particular groups in relation to social prescribing; unpaid carers, Welsh speakers, people with substance misuse issues, black and minority ethnic groups, children and young people, people with mental health issues and social issues. One respondent suggested that this work should be carried out with The Wales School for Social Prescribing as a priority.

4.50 Training was also seen as an important factor in this, particularly training on working with targeted groups. For several respondents this was a resourcing issue and organisations that are already working with targeted groups should be funded long term. Additionally, more can be done to work with these organisations for example, sharing data and information with them from the public sector. Link workers were seen to have an important role here and should be invested in. As they are based in the community it enables them to access community-based groups, they can identify gaps in provision, establish trust, and identify people that might benefit from social prescribing. Several responses built on this, identifying that understanding the needs of the community is an important solution.

4.51 Finally, it was suggested that effective marketing of social prescribing should support this. This includes, leaflets, radio and TV adverts, social media, and social prescribing champions based locally.

Workshop Findings

4.52 The majority of workshop stakeholders stressed the importance of community connectors, aligning the resource elsewhere from GPs. One

stakeholder shared that GPs do not have the time to make targeted referrals and get to know patients' interests. In addition, having two-way support between the GP and other community groups who understand the benefits of the different activities on offer would be essential.

4.53 Some stakeholders felt this was difficult to answer based on the fact that the needs of participants and groups can be so varied. For people with specific needs, it is possible to have closed and open groups, with closed groups ensuring specific needs can be addressed, and open groups offering a mixture of services. It was suggested that this differentiation could help identify specific groups in need of support.

4.54 Stakeholders also discussed the importance of up to date databases and comprehensive mapping of services, citing ALISS[10] (A Local Information System for Scotland) as an example of best practice. Developed in 2016, and funded through National Alliance Scotland, it is a co-produced web-based system for finding and sharing information about community assets across Scotland. Stakeholders shared that this resource is constantly updated by a team of people and therefore is used locally and nationally.

4.55 It was shared that the provision of a national forum and space where organisations are listened to which would providing resource and security to allow people to run their services well would be useful in Wales in support of this question.

Focus Group Findings

4.56 Focus group stakeholders were not asked this question.

Question 5 - What actions could we take at a national level to support organisations/groups offering community based support to engage with social prescribing services?

Individual Respondents

[10] https://www.aliss.org/

4.57 Thirteen respondents highlighted the need for sustained long-term funding, particularly for staffing and training**.**

4.58 Seven respondents spoke about the need for greater community connectivity in terms of transport links, hubs and digital infrastructure, particularly for the elderly and those living in remote areas.

4.59 Six respondents advocated for a centralised database:

- Allowing healthcare professionals to refer to community projects.
- Containing social prescribing opportunities and the respective providers.
- Such as a cooperative provider network enabling different organisations to work together to provide a nationally consistent range of support.
- Similar to a 'one stop shop' and includes referral criteria.

4.60 One respondent, however, felt that while a single national framework for social prescribing is a good idea, "regional support would be needed to facilitate those offering social outcomes on a local level to have sufficient resources to engage with the scheme."

4.61 Similarly, four respondents emphasised the need for personal engagement with social prescribing providers at the local level.

Organisational Respondents

4.62 Thirteen respondents mentioned funding as a part of their response to this question, of which eleven emphasised the need for long term funding to ensure sustainability of services. This would enable schemes to become established and trusted by local community organisations.

4.63 Several respondents emphasised that it will not be enough simply to invest in the “the mechanics of social prescribing, like the post of the link worker” but that funding will be needed to help community organisations meet the cost of additional demand for their services; not providing

funding will “simply shift the burden of demand from statutory to voluntary service”. Another organisation commented that:

> “*Ensuring that there is adequate and sustainable funding for the whole service, not just parts of the process, is crucial … i.e.: support for both larger and smaller VCS organisations, the link worker role and the delivery of services."*

4.64 On the topic of funding, another respondent recommended providing support to help smaller groups/organisations apply for funding. One organisation recommended investing in black spots with limited provision to build capacity in accessing grants.

4.65 Working with existing organisations already doing social prescribing work was another popular suggestion – made by six organisations. It was perceived that this would help to establish a more joined-up approach, ensuring the right links are made early on. CVCs and Community Connectors stated their preference to be mentioned and involved in this process, given their relevance and the collective assets they already provide. Organisations advocated that this work should be done at the local level, but that there was a role to be played at the national level in supporting organisations to facilitate their services in Welsh.

4.66 Three respondents felt that developing an approved provider scheme would guarantee sustainable delivery and offer security to community groups, linking in with positive sentiments towards the prospect of standards and accreditation.

4.67 Organisations also made a number of comments which indicated a need to address assumptions about /expectations of the service. These included making clear distinctions between social prescribing services and community asset providers and preventing assumptions about where activity attendees have been referred from.

4.68 Other organisational responses reinforced many of the common recommendations related to improving the engagement process, but from the perspective of community-based support groups. In summary, these covered:

- Learning from elsewhere (i.e.: existing examples of good practice)
- Creating effective feedback mechanisms
- Introducing an award for schemes/organisations which make a difference to people's lives (recognition for the value of community-based support)
- Provision of training opportunities for community organisations
- Welsh language provision and other language considerations beyond English
- Providing prospective organisations with access to branding/marketing so that they can promote their services
- Support with quality assurance/governance
- Ensuring understanding of how data can be shared at the outset in line with GDPR, whilst minimising unnecessary administration.

Workshop Findings

4.69 Stakeholders suggested identifying potential trigger points that might lead to people becoming socially isolated – for example: bereavement, becoming a new parent and the loss of an existing community service. It was thought that this could help community-based support groups to better understand who might need their support and who might benefit from social prescribing.

4.70 There was also a suggestion that organisations who have not been linked with social prescribing before should be provided with information or resources in order to understand what role they can play (e.g.: one stakeholder represented a heritage organisation and wanted to know how their work could support a social prescribing model).

4.71 Under the current system, each organisation has their own ways of working and their own referral processes. A new model could reflect an overarching service that external organisations would follow in order to

standardise and streamline the process. The point of consistency was also made here, to clarify the boundaries of what could be considered social prescribing.

4.72 Stakeholders also suggested that information about social prescribing and how it works could be included in induction frameworks for a variety of relevant organisations and sectors – for example the National Social Care Induction Framework.

4.73 Accessible and uncomplicated training to support engagement with social prescribing was also noted as important.

4.74 Lastly, it would be important to minimise competition between different community organisations.

Focus Group Findings

4.75 After having watched the video about social prescribing, focus group participants were asked: *'what do you think would make a good social prescribing service for you?*'

4.76 Participants from all groups emphasised the need to have a broad range of activities on offer to cater for all ages, genders and belief systems to reflect the diversity of Wales as well as to ensure there are groups that are applicable to them. One group participant also shared that the type of engagement needed may change over time.

4.77 Some participants mentioned that the wide variety of services offered by local councils and health boards can be confusing, so narrowing it down to a local level would be more easily understood.

4.78 One participant shared that they would like a mobile application to access the service, which supported another participant's suggestion of an online user feedback service that can be "rated" by beneficiaries of social prescribing services.

4.79 Members from the group of people with a disability spoke more extensively about the need for services and support groups which can connect them to others experiencing similar conditions and circumstances, so that they could relate to the same challenges. This was

particularly important for disabilities that are rare, which can increase the sense of isolation for those affected by them.

4.80 One participant shared their experience as an amputee, describing the severe lack of follow-up support received after being discharged from hospital. Following this experience, the need to socialise, connect with, and support others in the same situation became a necessity.

4.81 In more extreme cases such as this, it can be difficult for some people with a disability to consider what would make a good service – as current experiences in their areas had been so limited. To consider social prescribing as a realistic option, some participants with a disability said that they would like to see a real increase in funding for service provision in their communities.

4.82 Fundamentally, all group members emphasised the importance of publicising existing activities to improve levels of engagement.

Question 6a - What actions could we take at a national level to minimise inappropriate referrals into a social prescribing service?

Individual Respondents

4.83 Individual responses were generally geared towards the need for clear awareness training around referrals. This included suggestions on jointly commissioned training for health and social care professionals, as well as a suggestion to integrate social prescribers into multi-disciplinary teams including health and social services so that referrals/cases can be shared and discussed and the best avenue for support can be agreed.

4.84 The need for well trained and experienced referrers who know their communities and the services available locally was reinforced, especially in relation to referral pathways, which individuals felt need to be clearly defined in the first place so that training is robust.

4.85 One respondent suggested "online self-referrals with appropriate schematics which filter out inappropriate referrals automatically". This was

furthered by another respondent who suggested that creating a matrix whereby it is possible to identify issues/conditions which are not suitable for referral would be useful, building upon experience they had in their own profession.

4.86 There was some feeling (expressed by five respondents) that there is no such thing as an 'inappropriate referral' if the referrer deems an activity to be beneficial. Some felt that the notion of an 'inappropriate referral' implies a "service which is based on a medical model of professional referral and pathology" rather than social prescribing, which should focus on the needs of the individual.

Organisational Respondents

4.87 Organisations suggested that working across sectors would limit inappropriate referrals, particularly connecting community with statutory services, both clinical and non-clinical. The county-wide Community Connector approach was identified as a beneficial example. Additionally training for social prescribers was seen as a key issue as they need to be knowledgeable about supporting people with complex needs in particular.

4.88 An effective referral system that could tailor services to the individual was seen as a solution to this issue. In particular this would include time spent getting to know the service user, effective communication so that each party could understand the intervention and regular reviews of the intervention.

4.89 The referral process was subject to considerable attention, in particular the need for clear guidelines, consistent and clearly defined criteria and an effective process for what happens after an inappropriate referral. One respondent recommended making it a mandatory requirement for a social prescriber to inform the referrer whether the referral was inappropriate.

4.90 Respondents also felt that a triage service which could direct referrals from healthcare professionals as well as individuals would minimise inappropriate referrals, while others suggested greater standardisation with a standard referral form and access to the same IT system. The

development of an interactive flow chart or decision-making tool would help to strengthen understanding of and adherence to any referral criteria.

4.91 Additionally, they suggested that Welsh Government should implement a statutory feedback process across services to ensure quality of feedback is consistent, and maintained over time. In addition to supporting referrers, social prescribers and service users the feedback process could also identify where the service is being used to divert pressure from other services.

4.92 The development of clear guidance for and responsibilities of each organisation, was seen as a potential measure for preventing inappropriate referrals into a social prescribing service. Overall, a consistent feeling was the need for clarity over social prescribing, in terms of its role, remit and purpose. This could be supported by education as well as a national publicity campaign which could engage the population in Welsh and English by sharing good practice examples.

Workshop Findings

As with formal respondents, some of those who attended these workshops questioned whether it was ever possible to consider a referral as 'inappropriate'; one individual commented: "people's issues change, and there's no end-point until the individual feels they are at an end." Another asked: "how do we define inappropriate?"

Stakeholders participating in the workshops suggested a number of actions, including:

- Standardizing the process for all statutory sector professions for determining whether (or not) to refer someone into a social prescribing service – this would need to include consider for duty of care, risk assessments etc.
- Clear communication from Welsh Government on what the social prescribing framework encompasses and how stakeholders can refer into a service.

- Clarifying whether the system will be consistent across Wales or vary in local areas – and develop guidance accordingly.
- Capturing examples of the impact that social prescribing can have on individuals.

Some stakeholders noted points of caution that would need to be considered, including:

- In mental health or medical crisis situations, social prescribing may not be the most appropriate option.
- Concerns about following up after someone has been referred into a social prescribing service, given the fact that some people do not like feeling they are being "tracked".
- The need to ensure confidentiality and quality assurance.
- Concern that with statutory resources already stretched, people are being "pushed into social prescribing" inappropriately.

Focus Group Findings

4.93 Focus group stakeholders were not asked this question.

Question 6b - What actions could we take at a national level to minimise inappropriate referrals from a social prescribing service into community-based support?

Individual Respondents

4.94 Seven respondents spoke about the need for guidance, clarity and structure around training as well as effective communication with local communities to explain the social prescribing process.

4.95 Suggested conduits for training and information sharing include:

- Community Resource Teams
- Community Navigators
- Link Workers/Mentors
- Volunteers supported via Edge of Care (in house)
- Peer forums
- Cluster Meetings
- Informal support and networking.

4.96 Five respondents noted the value of an effective feedback system whereby social prescribing users can convey their experience(s).

4.97 Similar to responses given to Question 6a, respondents noted the need for a clearly defined referral criteria that includes the reason for referral and how the individual would be likely to benefit from the referral.

Organisational Respondents

4.98 The organisational responses to Question 6b focussed on training, knowledge, data, feedback and resourcing. The focus on training emerged as several respondents thought that all third, public and private sector employees should be given training on social prescribing. Specifically, the role of link workers was highlighted as requiring a high-level skill set, particularly around knowledge of what support is available in their community.

4.99 Knowledge of support availability was the second most commonly identified theme in this question with suggestions that community asset mapping to determine this would prevent inappropriate referrals. This knowledge may involve detailed information about the capacity limits of organisations, which would involve growing links between statutory services and community groups.

4.100 Respondents recognised a need for a robust and relevant information sharing process between the referred and the provider, particularly concerning capacity, the needs of the referred individual and the context of the community group. This will require resources to ensure that both

social prescribers and community-based support have the time to meaningfully engage with one another.

4.101 There was also an identified need to build an effective feedback mechanism between referred and provider. This would support both in identifying training needs, ensure the service user does not experience delays in support and prevent them from having to start the process again; it would also give the social prescriber information on capacity and appropriateness of community support groups in the future.

4.102 Respondents also felt that robust referral pathways could be used to prevent inappropriate referrals in a number of ways. The first was in developing a clearer understanding of referral criteria and pathways, particularly guidelines for the social prescriber. This could include the development of a decision-making tool. A key aspect of this is the provision of resources, primarily time and funding, to ensure there is capacity to make appropriate decisions.

4.103 Finally, there must be clarity of what social prescribing is, including expectations of what social prescribing can achieve and who is responsible at each step along the way.

Workshop Findings

4.104 Workshop participants felt that it was important to ensure clarity on criteria for provision of services, and that this works both ways between social prescribing services and community-based support.

4.105 During the workshops, it was reinforced by participants from the voluntary sector that they are keen to make sure they are doing the right thing, therefore they want to know what the framework is and how they can get involved in the most appropriate way.

4.106 Some participants stated it would be useful for organisations to be provided with a space or database to state exactly which services they can and cannot offer, to minimise any misunderstandings or assumptions about what support can be given.

Focus Group Findings

4.107 Focus group stakeholders were not asked this question.

Theme 2 Conclusion

4.108 Theme 2, which focuses on referral pathways identified a number of recurring topics, including: better communication, robust accountability measures, clarity over signposting and referral pathways, clear feedback processes and a properly equipped service with the required funding, training and resources. A recurring sentiment was the need to build trust and confidence in a social prescribing model in order to achieve buy-in at all levels, including amongst professionals and prospective users of the service.

4.109 With better communication both internally (within the NHS and between service providers and other stakeholders) and externally (with members of the public and patients), respondents felt improvements could be made to the promotion of the service and its efficiency. Associated with this is the need for effective monitoring and evaluation processes, developed from the outset and including the production of case study examples of the way social prescribing can positively impact individuals.

4.110 The need for a clear definition of what the social prescribing service could and should look like and a standardised approach to training, ways of working and clear responsibilities was communicated repeatedly within this theme. Also seen as critical is the need to ensure that services have the capacity to meet demand, including a growth in demand associated with an expansion in social prescribing services.

4.111 Finally, there were concerns that before such a framework could be rolled out, there would need to be adequate planning to ensure the service is funded to the appropriate level of need, with an equipped and trained workforce. The correct resources - down to the level of detail of effective

databases - were seen as essential to ensuring those within the sector can work to the best of their ability.

5. Theme 3 – Leadership & Governance Analysis

Question 7 - Which actions could be taken at a national level to support strong leadership and effective governance arrangements?

Individual Respondents

5.1 When considering actions at national level to support strong leadership and effective governance, individual respondents broadly focused on two issues: support for consistency across the framework and the desire for relatively centralised leadership.

5.2 For the former trend, eight respondents believed that a set of standards or procedures should be available including national metrics, quality assurance, benchmarking and frameworks. Five respondents added to this stating that there should be a form of evaluation and reporting on performance to gather feedback and improve the service. One respondent suggested that the scheme should be assessed by an external party. For five respondents, they felt that the service should be underpinned by some kind of formal education or setting, with three suggesting a formal qualification. Finally, to ensure effective governance of the framework one respondent felt that it should be linked to the WBFGA.

5.3 On leadership, respondents suggested the creation of either a steering group or an appointed individual. A steering group was also suggested by four respondents to include various stakeholders, community interest groups and commissioned service providers. Six respondents mentioned appointing individuals/teams to assist in local leadership with dedicated staff.

5.4 The issues of effective communication, funding and language provision were also mentioned, with three respondents mentioning clearer communications and collaboration with local teams, one respondent suggesting mapping of available funding and another highlighted the importance of ensuring services are provided in a range of languages and formats to enable all members of the community equity of access.

Organisational Respondents

5.5 Organisational responses to this question were mixed with suggestions on new structures which can support strong leadership and effective governance arrangements, as well as those that would prefer if existing structures were better utilised, and those who would caution against bureaucracy.

5.6 There was support for the creation of an additional body to oversee/advise the implementation of the social prescribing framework. Representation on this body was a crucial point for respondents with the suggestion that the following be represented:

- Service Users – both adults and young people
- Public bodies such as local authorities, Public Health Wales, RPBs, health boards and Primary Care Clusters
- Third sector providers and referrers
- Social prescribers
- Marginalised people
- Grassroots organisations.

5.7 It was particularly stressed that marginalised people such as disabled people and chronically unwell people are often not included as a priority and are considered “hard to reach”, or that grassroots organisations tend not to be represented at decision-making tables.

5.8 The suggestions for what role this group should play varied depending on whether the body was seen as a steering/monitoring/oversight/advisory body. Suggestions for that role were:

- Responsibility for the monitoring and evaluation framework
- Lead on any required systemic reviews based on evidence and feedback
- Lead on national communication around awareness as well as consistency of language and approach
- Respond to problems as they arise in different areas
- Commission the implementation of service

- Facilitate the collaboration between the diversity of sectors which to not traditionally come together
- To create opportunities for joint working at national, regional and local levels
- Provide national guidance to commissioning – consistent ways of measuring and reporting on impact
- Provide accountability for the framework.

5.9 These proposals remain consistent regardless of proposed structure, however, it is important to consider the alternative structures put forward that do not involve the establishment of a national body. A common suggestion throughout the responses was giving a leadership role to the RPBs including a specific job role within RPBs with responsibility for social prescribing and leading on a multi-partnership approach, expanding the membership of RPBs to include social prescribers who are currently excluded, RPBs leading the development and implementation of the framework in partnership with PSBs, CVCs, health boards, local authorities, community groups and other bodies. Overall, RPBs were thought to have a key role to play in monitoring, oversight, and accountability of the framework.

5.10 Further alternatives, or complementary suggestions included establishing an approved provider scheme for social subscribing organisations, including a specific Green Health Sub Group to support Green Social Prescribing as has been done in Betsi Cadwaladr Health Board, and setting up professional associations which would develop their own standards and governance structures. A consistent component of responses was that the governance of social prescribing at national or local level should be cross sector, collaborative and inclusive across all tiers of stakeholder.

5.11 Respondents cautioned against “re-inventing the wheel” and adding bureaucracy to what they felt was a community led bottom-up process. Rather, an alternative view of governance in this context was the provision of advice and guidelines on effective governance at the local level. It is proposed that rather than a national set of governance

arrangements being developed, a set of guiding principles would be more effective and would support the development of provision in a manner that creates a national approach to social prescribing without detracting from local provision and avoids duplicating and/or conflicting with funders' requirements.

5.12 This support would allow the Welsh Government to draw on expertise to develop quality assurance frameworks and minimum standards as well as supporting local communities by providing templates for policies including on safeguarding, health and safety, and risk assessments. Respondents also felt that Welsh Government could support communities by capturing best practice examples that are flexible and applicable in different contexts in Wales. In addition to this there was also support for investment to scale up these examples. Best practice examples included Cardiff and Vale Recovery & Wellbeing College and Social Leaders Cymru.

5.13 At the national level a consistent suggestion was the establishment of robust monitoring, or reporting, and evaluation processes. It was recommended that the framework build in opportunities to learn lessons over time, that information should be made public to aid transparency and accountability and that the reporting structure was clear. In particular, it was highlighted that there needed to be a reporting mechanism from each funded partner to the commissioning body, and from there to the Welsh Government on an annual basis.

5.14 The form this assessment should take included: the Warwick-Edinburgh Mental Wellbeing Scale, Sustainability in Quality Improvement, a performance management framework, and the use of a CRM system to capture positive impacts stories and measure social interventions.

5.15 An important action at the national level for organisational respondents was the development of the social prescribing workforce. This involved the development of a competency framework, career pathway and national training programmes. As well as this it was felt that social prescribers should be recruited from diverse backgrounds, have a code of

conduct, and should be sufficiently supported so as to enable person centred approaches to improve health and wellbeing.

5.16 Safeguarding was a prominent issue throughout the consultation process, and a number of potential governance issues were highlighted in relation to safeguarding. A need for robust and clear data protection policies and procedures was expressed with a concern about the governance of data where commercial sector is involved but without the same rigorous quality assurance safeguarding processes in place. There was also a need for clarity over levels of responsibility and risk to the user. This was re-iterated as a respondent stated it was important to consider how to manage risks associated with community groups and services which have not been risk assessed. These contributions should be considered alongside other safeguarding questions raised in the consultation.

5.17 A key national action was the establishment of sustainable funding arrangements, however, this was also central to Question 8 and Theme 5 so will be discussed at greater length there.

Workshop Findings

5.18 Discussion for this question centred around accreditation and funding, which participants perceive to work in conjunction. Stakeholders emphasised that an appropriate set of standards, clarity and consistency across the space were all essential. Accreditation was viewed as important, supporting the credibility of individuals involved. Any actions which can ensure accountability were perceived in this way, particularly link with the PRSB/PSBs. This might support in working with GPs which was a concern as there was a lack of engagement and referrals from GPs.

5.19 With regards to funding stakeholders were concerned that the third sector will not engage fully without funding. In particular there was an expressed need to fund the third and community sector to provide the services that people will be referred to through social prescribing. It was suggested that funding that is awarded should be targeted at unifying the third sector,

and health and social care whilst trying to understand each of their needs. Collective funding was a popular idea in this regard. Finally, stakeholders felt that a governance structure that provided funds to ensure the current social prescribing/community platforms are kept up to date and communicate with each other was important.

5.20 In addition to these two themes stakeholders were concerned about the consistency of the workforce as clinical and on-clinical leaders often move to new roles which results in a loss of knowledge. They recommended a short-term task force across clinical and non-clinical needs to address the issue of the governance of social prescribing in this context.

Focus Group Findings

5.21 Focus group stakeholders were not asked a question related to this theme.

Question 8 - What actions could we take at a national level to support the commissioning process and help engage the public in developing a local level model which meets the needs of their community?

Individual Respondents

5.22 Local representation at a national level was mentioned by nine respondents, the kind which included communities, service users, stakeholders and professionals, predominantly. One respondent suggested that this could take the form of a steering group, or the presence of community champions.

5.23 Three respondents mentioned the development of a commissioning framework and fund which could carry out regular reviews. To support commissioning two respondents felt that existing data could be used to form the service response while two respondents suggested that a mapping exercise to map current provision availability would be useful.

5.24 Funding was a common topic throughout the consultation with seven respondents mentioned re-examining how funding is distributed by region and geographic area, with one respondent also mentioning participatory budgeting as a possibility. In addition, one respondent recommended uplift funding.

5.25 Three respondents mentioned promotions and campaigning at a national level, two of which mentioned the usefulness of a digital platform to be used as a referral pathway and intelligence gathering.

5.26 A 'hub' model and clear communication channels from local to national teams were each mentioned by one individual.

Organisational Respondents

5.27 Organisational responses suggested a range of actions that would support the commissioning process and help engage the public in developing a local level model.

5.28 The first of these possible actions was the establishment of a national lead, whether that was a steering group or an appointed individual whose aim was to drive forward reporting, inform decision making and create guidance.

5.29 Monitoring, evaluation and reporting were key components of organisational responses with respondents stressing the importance of measuring outcomes including the process of communication and engagement. One respondent suggested that the Welsh Government formally consult with the social prescribing workforce to gather intelligence on what has worked well for particular groups and why. This could build into the development of monitoring indicators, and assist with clear defined methods of collecting, storing and reporting data. It was felt that the lack of shared intelligence hampered the commissioning process and that development of this data collection and storing system would support commissioners in making effective decisions, particularly at the local level.

5.30 Several respondents suggested that the clear and consistent guidelines for commissioners should be developed at national level. These could include;

- A focus on the desired outcomes
- A focus on local level flexibility within a national approach
- The inclusion of the role of the natural environment as a cost-effective method
- Specifications for commissioners
- The development of a national good practice model of commissioning
- Population needs assessment
- Strategy and planning through procurement
- Service delivery and monitoring
- Review and implementation
- A requirement that commissioners should ensure that third smaller third sector organisations are not excluded
- A requirement to consider engagement with communities in commissioning
- Meeting the Social Services and Wellbeing Act
- Clarity on the role of young people and children
- Specialist guidance on how to engage with “co-production” organisations, and how to “co-produce” services.

5.31 In addition to these suggestions respondents pointed to existing guidance such as the work being undertaken by the Welsh Government’s Equality, Race and Disability Evidence Units and the Carers Partnership Top Tips for Commissioners and Providers. It was put forward that developing an information hub of good practice models would be helpful to both commissioners and communities in developing new services.

5.32 Several respondents cautioned against the need for formal commissioning in all cases, for example, a service user may be referred to a “knit and natter group” which may not have or need ‘standards’. It was also felt that commissioning should be appropriate to the level of

funding made available, and finally there was a concern of the potential for unintended consequences whereby the formal commissioning process favours those that receive more referrals via the social prescribing route which places those groups which operate outside of this at a disadvantage in receiving funding. Three organisational respondents re-iterated the need to ensure that services on a small scale were valued by commissioners. This included removing barriers on smaller organisations around data collection and monitoring, and working with community groups to build trust and confidence.

5.33 Eleven organisational respondents considered the co-production of services at local level an important component of commissioning social prescribing. This could involve;

- User involvement at the start of the commissioning process including a feedback loop which is an essential component
- Establish focus groups early on and maintain throughout process
- Initial upfront investment/resources to support local participation and development of offers that meet local community needs led by the voluntary sector
- Building upon the value of lived experience as expertise
- Building upon existing good practice such as the Pembrokeshire Active, Connected, Resourceful, Sustainable and Kind Communities
- Use of existing mechanisms for engagement such as citizen panels
- The creation of community-led groups with funding and expertise to identify requirements of the community.

5.34 Importantly this would require a commitment from the national body or the Welsh Government to co-production.

5.35 One organisational respondent felt that better commissioning could be achieved in these ways by greater devolution of powers to communities and local authorities. This would allow them more influence in developing

community gardening schemes as an example. Additionally, organisation respondents sought to broaden the conversation locally by including key gateway infrastructure services such as transport services, as well as those with important signposting roles such as Community Pharmacy Wales. This engagement role was envisaged for the national level through public awareness events, awareness raising campaigns, promoting case studies and producing guidance on engaging the public that can be delivered at local level. One respondent suggested that this take the form of a single platform or brand at national level. Alternatively, two respondents suggested that the Welsh Government could encourage and support RPBs to sign up to the voluntary charter engage with the community sector.

5.36 The provision of sustainable funding streams was a key ask from consultees which is focussed on in Theme 5, however, there were some distinct suggestions relating to commissioning. The first was the suggestion that some elements are commissioned and managed on a 'once for Wales basis' for example the development of a CRM such as Elemental. The second was a focus on collaboration, pooling resources and encouraging collaboration through funding, as well as supporting communities to purchase community assets such as empty community buildings. Finally, there was the proposal to commission far smaller contracts which the respondent felt would result in better compliance, quality and profits that benefitted the community.

5.37 For two respondents funding should be offered for piloting early approaches, of both services in the community, and the framework itself. In addition, a respondent felt that quick wins should be promoted to build momentum for the framework. In addition to these early needs, organisational respondents felt that support could be given to map existing provision, identify gaps in provision, and identify need. In particular support should be given for commissioners to gain awareness of the local service environment.

5.38 Finally, organisational responses offered a range of digital solutions which could be initiated at the national level including the development of a

digital strategy for social prescribing which should involve collecting and sharing accurate, real-time information on community assets, from both providers and services, that can be socially prescribed. This has to be driven by the local need, inclusive and measurable.

5.39 Where possible, implement appropriate social prescribing referral management platforms that connect to GP systems to make it easier for those making referrals in primary care and improve the management of community-based services and experiences to individuals.

Workshop Findings

5.40 Workshop attendees felt that it was important to ensure there was equitable access of social prescribing services across Wales. With this in mind it is important for social prescribing services to take into account the differences between locations including existing assets and population needs. This is particularly the case for differences between urban and rural areas.

5.41 Participants felt that it was important to acknowledge that different audiences require different communication means, for example, older audiences can often need more targeted communication through mediums such as the radio and TV. In addition to this there was an expressed need to utilise community advocates who have been through the process and can relate the impact to others/help others have confidence in it. Another route for engagement recommended was Community Health Councils, while participants stressed the importance of engaging with the public at the local level.

Focus Group Findings

5.42 For this question focus group participants were first asked how well they know what community-based support (groups and activities) are available locally. This was followed by how they currently find out about what community-based support is available locally.

5.43 All group participants varied in the number of activities they were aware of locally. The group of participants who had the largest awareness of activities were from the group with disabled people due to the proportion of group participants who lived in supported housing or who are part of a central support group.

5.44 Participants in the group with older people listed the biggest variety of physical locations that they go to find out about what community-based support is available locally. This included mentioning of posters in the library, village hall, places of worship and the workplace.

5.45 All groups mentioned the importance of word of mouth in disseminating information within communities. Online resources mentioned in answer to this question are covered in Question 9b in Theme 4.

Theme 3 Conclusion

5.46 The responses to Theme 3 offered a wide variety of suggestions for national actions that would provide leadership, support effective governance, and assist commissioners, although there was disagreement on the best way forward in some cases.

5.47 A common action across both questions and all response types was the development of common standards for the social prescribing framework and the role that national leaders can have in providing quality assurance frameworks, particularly around issues such as safeguarding. Related to this there was an appetite for the development of metrics at the national level which would develop into a robust monitoring, evaluation and reporting regime. This would aim to provide consistency and equality of access across Wales.

5.48 Beyond this leadership there were conflicting suggestions over the need for a distinct leadership for the social prescribing service. Responses commonly suggested the establishment of a national body, often articulated as a steering group or an appointed individual, who would guide the implementation of the framework. As an alternative or an accompaniment, it was recommended that the role of RPBs is re-

evaluated to provide a greater leadership role, and an increased role for the community sector. However, there were respondents who felt that new bodies should not be introduced, instead resources should be focused on the sustainability of the sector.

5.49 There was an emphasis on co-production and grass roots involvement in the leadership and implementation of the social prescribing framework. This included service users, communication organisations, the third and public sectors, and social prescribers represented on any national body, as well as inclusion in the planning and commissioning of services. This could be complemented by greater devolution of powers locally to facilitate community decision-making.

5.50 For Question 8 specifically, a focus was on the development of clear and consistent guidance for commissioners, particularly, on how to involve the local community, through for example, the provision of smaller contracts. Additionally, it should be recognised in these guidelines and in the framework that not every group which will be providing support needs to be formally commissioned in this way, and they should not be sidelined because of this. Finally, a commitment by Welsh Government to a sustainable funding programme for the community sector was central to this theme.

6. Theme 4 – Accessibility Analysis

Question 9a - Do the current online directories and sources of information provide you (in an easily accessible format) with the all the information you need to make decisions on the appropriateness and availability of community based support?

Individual Respondents

6.1 Five respondents answered “Yes” to this question and felt that online directories and other information sources do provide what is needed to be able to make decisions about the appropriateness and availability of support. Sixteen respondents however answered “No”, for several reasons.

6.2 Those who gave a positive response to the question largely cited DEWIS-Cymru to be navigable and comprehensive as a platform. Others used the opportunity to express that online directories are helpful, but primarily for finding national-level services – whereas more emphasis was felt to be needed on information sharing for services at the local level.

6.3 For those who responded “No”, discussion centred around two primary themes. These were that DEWIS-Cymru has ‘navigation difficulties’ in terms of the ease and accessibility of searching for support. Of most concern was the issue of the site retaining entries for services that are now outdated (perhaps no longer existing) and therefore the lack of accurate and reliable information which can be gained through the site, which in turn undermines confidence in using it.

6.4 Furthermore, four respondents commented that there should be one consolidated platform which can be consulted as a ‘point of truth’. This would help to avoid duplication, misinformation, and ensure that efforts to update entries would be concentrated in one central location.

6.5 In recognition of resource requirements, three respondents highlighted that given the pace at which community-based services change – the task of keeping information up to date would be substantial and require significant funding investment.

6.6 In addition to online directories, three respondents also commented on the usefulness of social media, which in some cases has been the 'go-to' for organisations to share their information independently and directly.

6.7 Finally, in contrast to the majority of commentary which remained focused on online resources, three respondents warned against directories which could only be accessed online. Concerns here centred around digital exclusion and respondents suggested that information should also be available in a hard copy format.

Organisational Respondents

6.8 One organisation provided a clear 'Yes' response to this question. It is worth noting that even amongst those who were more positive about the current directories available, several reported that whilst they often get information about new services, they never get updated about those which are discontinued.

6.9 Ten organisations responded with a clear 'No'. The most common reasons presented for current online directories being perceived as ineffective are summarised below:

- Confusion (created by the introduction of too many platforms)
- Lack of up-to-date information (in some cases rendering them as not fit for purpose)
- Insufficient advertising and promotion, meaning that in most cases awareness is too low
- Limited information provided for listings
- Preference for organisations to rely on their own directories and internal contact lists.

6.10 Comments shared by organisations heavily reflected sentiments from the individual responses, with organisations accentuating the need for directories to provide a central source of trusted information.

6.11 Several organisations commented on DEWIS-Cymru directly, highlighting that whilst it was a known source of information, there are several issues which make using it problematic including:

- No clear communications to local authorities
- Homepage offering 'few clues' in terms of the full scope of the site and what can be accessed
- The site search being unreliable, too sensitive when using search terms
- Feeling that it is hard to browse, and there is no robust or clear classification of services.

6.12 Ultimately, DEWIS-Cymru was felt to be good in practice, but still affected by a number of issues which had meant that it had not yet been seen as a "go-to place for info".

Workshop Findings

6.13 Discussions in workshops largely echoed the sentiments of consultation responses.

6.14 DEWIS-Cymru was mentioned proactively by several stakeholders in terms of awareness, though these stakeholders also raised concerns in terms of the functionality of the platform. Some recognised the platform as a positive starting point and felt that it could be suitable for building upon, suggesting there was "no need to reinvent the wheel".

6.15 A minority of stakeholders shared that they had struggled to find their own services through the site, which led to accessibility concerns in relation to the general public. Lack of confidence surrounding the reliability and accuracy of the information available was again cited as the central point of concern. In relation to social prescribing, which is so reliant on the success of effective referrals, gaps and discrepancies in information is seen to be a notable weakness.

6.16 When discussing these themes, stakeholders drew on important implications that poor information can have such as lack of trust, confidence, and credibility of the service.

Focus Group Findings

6.17 During focus groups, participants were asked about the methods they use (or would use) to find out about social prescribing services. The majority of participants were unaware of targeted directories which could be used for this purpose and suggested they might use general search engines. Some participants (who were already engaging in social support groups) did share that they used social media to keep up to date with events and activities within their networks.

6.18 Participants were asked whether it would help them to access community-based support if they could *know* (through information being advertised) that it would be able to cater for their needs. All participants agreed that this would be useful and saw value in ensuring that services are as open and accessible as possible.

Question 9b – Are there other online directories / sources of information you use?

Individual Respondents

6.19 In terms of directories, respondents listed several that include DEWIS, Turn2Us, Connect services (i.e. Connect Ceredigion, Connecting Carmarthenshire), Volunteering Wales, Family Information Service (FIS), InfoEngine, Carers A-Z guides, the Health Boards, and the National Association of Link Workers website.

6.20 Where people were not aware of/did not specify particular platforms, respondents commented that general Google searches are used to try and source relevant information. Beyond this, participants mentioned a number of alternative options including:

- Individual websites/social media pages for organisations and services (seven respondents)
- Direct engagement with local community groups (six respondents)
- Word of mouth through networking meetings, at libraries and public spaces, messages on community notice boards etc (felt to be especially relevant in rural areas)
- More traditional media (i.e., newspaper adverts, newsletters, radio adverts etc.).

Organisational Respondents

6.21 Organisations shared a number of information sources that they had consulted for information on social prescribing services, including:

- Infoengine (four responses)
- General web searches (three responses)
- National Directory led by the Oxford Observatory (which provides a social prescribing map)
- Council for Wales of Voluntary Youth Services and Wales Council for Voluntary Action
- Meic (helpline resource for children and young people)
- Information on services and activities being run in Welsh through Lleol Cymru
- West Wales Action for Mental Health Directory of Mental Health Services/Nature Based Health Services
- Carers Trust Networks
- Own resource documents

6.22 Organisations also echoed the importance of word-of-mouth recommendations and using their own contacts, as well as the value of local sources to ensure that knowledge of services is community-specific.

Workshop Findings

6.23 In workshops, stakeholders reported that social media was a popular option and could be favoured for being more current. This was emphasised in relation to advertising and promoting events/activities directly to communities.

6.24 It was however recognised that prospective users need to be 'social media savvy' in order to follow this information, and that this would vary heavily depending on target audience.

6.25 As a specific alternative, one group shared that they were found through 'Integrated Autism Services' and that this had worked well for them as a connector.

Focus Group Findings

6.26 When asked about how they might approach searching for a particular service, participants suggested they might start with a simple Google search – and also referenced other sites they have found to be helpful such as Reddit, Quora etc.

6.27 Participants in all groups apart from the Children and Young People's group reported that they use local Facebook groups and community pages to keep up to date with community activities. In the Black, Asian and Minority Ethnic group's discussion, some participants considered the implications of social media algorithms, and whether this might be utilised as a positive to link people with content that is relevant to them. In this case, it was thought that social media might help to recommend local services to target audiences.

Question 9c - What are the key features you think online directories should provide to help people access community based support?

Individual Respondents

6.28 Individual respondents provided a wealth of feedback in terms of features that online directories should provide, to enable access. The most

common suggested feature (by 14 respondents) was the inclusion of comprehensive information for all activities. Respondents described that this should cover details such as:

- What is involved in the activity
- Who it is for (who is eligible, who is the target audience)
- What is required to join
- Contact details
- Any associated costs
- Transport options (public transport, community transport, location, parking etc).

6.29 Eight respondents highlighted the need for online directories to be easy to navigate and accessible – with a good user-interface. This should include easy-read text, clearly signposted headings and search categories etc. Providing further detail, six specifically encouraged simplicity, to avoid further access issues for those who find digital engagement challenging.

6.30 Six respondents mentioned again that opposed to multiple directories, there should be one singular directory/hub or access point for information that is regularly updated. Five respondents suggested that online directories could also be a place for organisations to promote the good work that they do (serving a dual-purpose for both service users and providers). This could include information on the benefits of their service, a space for case studies, positive news, testimonials, and making connections.

Organisational Respondents

6.31 The features prioritised by organisational respondents aligned closely with individual responses and workshop feedback. The most popular features that organisations wanted to see were:

- Easy access, simple navigation (seven organisations) – including online and offline features, read-aloud and easy-read text, multiple contact options

- Simplistic language (six organisations) – including use of language that is easy to understand and is presented in a friendly tone
- Easily searchable (five organisations) – including searchable by region not just postcode, searchable by theme and activity, filters for relevant options and clear use of categories
- Up to date information (three organisations) – including making use of intelligent data gathering in the same way that apps and platforms do.

6.32 Expanding further on the 'easy search' feature, organisations also suggested that this should include the ability to recognise what people will be looking for and therefore overcome typos etc. As an example, 'foodbank vs food bank' should turn up the same results. In addition, there were suggestions that it would be useful to have categories that would relate to support that is suitable for specific health conditions, as well as associated situations and challenges (such as being on a waiting list to receive treatment).

6.33 In terms of language supported by directories, organisations also highlighted the need to ensure platforms would be fully bi-lingual as a standard, where both Welsh and English are fully integrated. However, one organisation suggested that an online directory should be multi-lingual, supporting multiple languages beyond English and Welsh. The theme of including additional languages to overcome access barriers has recurred throughout this section.

Workshop Findings

6.34 In workshops, stakeholders placed emphasis on ensuring that the search criteria for online directories is accurate, and that records can be easily maintained by those listing information. Stakeholders highlighted that a directory can only be as good as the information it contains, putting detail and content at the forefront of considerations.

6.35 Stakeholders also wanted to see a directory that contains specific local knowledge. This would mean that service users can rely on the accurate, up to date information when searching by region or within a particular distance. Some also suggested that there could be value in integrating a directory with an app (to increase ease of access) so that people know exactly what is happening in their local area and how to engage. Some comparisons were drawn to the NHS COVID-19 app, in terms of rolling out apps to assist with healthcare provision and user access.

6.36 Again, the primary concern for stakeholders in relation to updating or launching a centralised directory, was the reality of resourcing it on a continuous basis to ensure the platform could be reliable.

Focus Group Findings

6.37 During the focus groups discussions, some participants felt that being able to search a directory by condition (particularly participants with disabilities) would be valuable. This was discussed in the context of having previously joined sessions or been recommended activities that were not fully suitable for their individual needs.

6.38 Additional insights on the importance of having a central, trusted source of information included a straightforward name which could be linked to the concept (e.g.: – SocialPrescribing.Wales). One participant with several health conditions suggested that the ability to search for services independently online can be particularly important for disabled people, given that the nature of complex health conditions can be deeply personal.

6.39 This was met with agreement from another participant, who reinforced the value of sourcing information independently, in contrast to challenging experiences they had encountered with their GP.

Question 10a - What actions could we take at a national level to help address the barriers to access?

Individual Respondents

6.40 The largest access barrier identified by individual respondents centred around lack of transportation. In total, 15 respondents mentioned the necessity of the provision of funding for community transport schemes. This was felt to be particularly important for barriers associated with rurality, which are widespread across Wales. Current options for public transport were felt to be unsuitable across individual responses.

6.41 Six respondents highlighted alternatives for people who might require access in different ways, other than digital. For example, through the introduction a national telephone helpline for the service. The need for hard copy information was again raised here, to mitigate against exclusion.

6.42 Three respondents commented that at the national level, there should be a strong and intentional focus on building capacity and resilience in terms of supporting people to be able to comfortably manage their own health and wellbeing.

6.43 Five respondents felt that addressing barriers to access was better handled at the local level, through consultation with the needs of individual communities. Suggestions for enabling this included engaging people at local social prescribing 'hubs', or at existing physical spaces that offer support (such as libraries).

6.44 Four respondents mentioned that befriending, mentoring, and buddying services could be very helpful in this context. Across the feedback gathered more broadly, several participants spoke highly of the impact mentoring and befriending services has had (in their experience) and could have on helping people to overcome anxiety and confidence related barriers.

Organisational Respondents

6.45 For organisations, addressing the lack of suitable transportation options also represented the most common choice for tackling national barriers to

access. Thirteen organisations highlighted this point in total, with some organisations linking social prescribing to the current Welsh Government transport consultation. Furthermore, one organisation made direct reference to the 2021 Transport Strategy, underlining the action points set out within it. The organisation emphasised the importance of affordability of public transport options, alongside availability – stating that this is directly related to access.

6.46 Four organisations commented on accessibility more generally, covering topics such as digital exclusion, childcare costs, lack of access in rural areas, and encouraging out-of-hours service delivery.

6.47 One organisation commented specifically on the need to consider access when designing public spaces, which could be 'guaranteed' by using the Universal Service design principles – which ensure that spaces are accessible to the widest range of people. Approaching design from this perspective at the start then mitigates the need for adaptation, modification, or additional costs associated with assistive devices.

6.48 In addition to this, organisations recommended training to ensure practitioners are equipped to work with vulnerable groups, and further research into what the nature of any barriers.

6.49 One respondent stated a concern at the lack of data available for measuring usage of social prescribing by area and stated that they would expect more to be collected/understood on the barriers for those in areas of greater economic deprivation.

6.50 On a similar note, other organisations proposed that more should be done to understand underlying issues first, which also have a huge impact on health and wellbeing. Examples of these included:

- Debt cycles, benefits, housing, and social welfare
- The impact of poor employment and the benefit of healthy occupations
- Recognising that some barriers are a mix of practical and emotional (e.g.: 'Help through Crisis' projects found that simple, inexpensive actions were really effective, such as

providing a diary and writing in appointments, texting reminder updates before appointments etc.)

- Instability of family circumstances and exploring the need to support the whole family system.

6.51 Four organisations advocated for support at the national level which should address different languages and cultures. It was suggested that this should also sit in alignment with Welsh Government's Anti-Racist Wales Action Plan – specifically the action to map out the existing cultural, language, and interpretation/translation needs of minority ethnic people using social care services to aid current and future service planning.

6.52 At the national level, organisations also suggested that there should be an affordable payment structure for social prescribing services, for both the Government and service providers.

Workshop Findings

6.53 In the workshops, stakeholders urged recognition of the importance of reaching those who typically do not leave their homes – and therefore might only hear about this via their TV, GPs, or local shop. It was thought that the role at the national level here could be in ensuring effective TV promotional campaigns.

6.54 Stakeholders also suggested that it was vital to investigate the reasons currently attributed to 'drop-off' between referrals and actual take-up rates, reporting this to be a common occurrence. It was felt that gaining a better understanding of this would direct and inform more effective actions to maintain engagement.

6.55 The issue of clarity and openness was another key theme during stakeholder discussions, with many highlighting the importance of setting clear expectations at the outset – and proactively addressing concerns/questions that service users might have. Primarily, it was suggested that these concerns would centre around cost, implications relating to current circumstances (for example having a disability),

transport requirements and general uncertainty. With anxiety being identified as another significant barrier, stakeholders linked this to fear of the unknown – reinforcing the value of providing as much information as possible.

6.56 In terms of applying national communications to overcoming barriers and raising awareness, some stakeholders had conflicting views with regards to 'who' social prescribing services should primarily target (between older and younger groups). Some made the case that older people were more likely to be isolated and impacted by digital exclusion, placing them in a position of greatest need. Others highlighted the mental health crisis being faced by young people, and the fact that young people can be equally isolated in terms of having health needs met – as they are less-likely to have had ongoing support/access to a consistent GP.

6.57 The majority of stakeholders agreed that at the national level, attention would be needed to determine a 'target audience' or understand the groups of greatest need, in order to concentrate advertising efforts accordingly. This was seen to be necessary given the fact that effective communication methods for reaching these groups now vary significantly by age range.

Focus Group Findings

6.58 Focus group participants were asked whether any factors get in the way of them finding out about community-based support in their local areas. Feedback fell into four main categories covering lack of confidence in seeking help, difficulty accessing good information online, low awareness/perception of activities in their areas, and potential apathy or disinterest (as a concern rather than direct experience).

6.59 Participants in the older people, children and young people, and Black, Asian and Minority Ethnic groups all mentioned that they generally do not know who to ask for help, and would not know who to approach for social prescribing services. A participant in the children and young people group said they would feel embarrassed about possibly looking 'stupid' for

asking the wrong person. Lack of confidence and clarity in this area might suggest that more information would need to be provided to overcome barriers to self-referral.

6.60 Some participants also shared that they found it difficult to access and follow information online. In particular, those with complex needs and/or disabilities might need a carer, social worker, or family member to be made aware of information too and have this shared with them.

6.61 A number of participants across the older people's group, and participants with a disability revealed that some individuals have no current awareness at all of activities or services that are available in their own areas. These participants were generally positive and welcoming of the concept of social prescribing and felt that others in their social circles would benefit from social prescribing services too if it was more widely publicised.

6.62 A small number of participants in the older people's group mentioned that some of their peers were unlikely to see the benefits of looking for community-based support. They felt this could be attributed to lack of confidence in and/or apathy towards the concept – in terms of believing that participating could actually make a difference to them.

6.63 Other concerns mentioned by focus group participants included the worry that GPs (already under pressure) would be unlikely to welcome appointments being booked for the purpose of discussing social prescribing. Again, clarity may be needed in this area to help the public understand (especially those who have never sought support before) what the referral pathways mean in practice, for them.

Question 10b - What actions could we take at a national level to help address barriers to access faced by more vulnerable and disadvantaged groups?

Individual Respondents

6.64 Both individual and organisational respondents were able to suggest actions which could provide specific support to more vulnerable and

disadvantaged groups, based on their experiences. Again, 10 individual respondents identified transport links (or lack thereof) and digital connectivity as the main barriers.

6.65 Further barriers included consideration of language and cultural barriers. It was felt to be important that communities are able to see social prescribing services framed as something which is 'for them', which requires genuine representation across all groups. Some key recommendations surrounding this were to ensure that social prescribing activities can encompass a diverse range of interests and be delivered in lots of different ways.

6.66 Vulnerable and disadvantaged groups were especially identified as older people, Black, Asian and Minority Ethnic groups, disabled people as well as individuals living in high poverty areas and rural communities. Respondent suggestions for addressing these barriers included:

- Learning from existing organisations, stakeholders and charities
- Providing longer term partnership funding
- Giving people the option for face-to-face input
- Providing physical spaces; libraries, IT hubs etc
- Providing the option for home-visits.

6.67 Five respondents also advocated for the need to speak directly with more vulnerable and disadvantaged groups and ask them what the barriers are, using co-production methods. It was acknowledged that barriers can often be complex, and those seeking to develop actions to overcome them must either have lived-experience – or work extensively with those that do.

Organisational Respondents

6.68 Alongside suggestions for actions, organisations also shared the numerous barriers that they had identified/were aware of in relation to accessing social prescribing services. In addition to the issues raised in

the previous question, organisations also commented in more depth on poor mental health as a barrier, rurality not just in terms of lack of transport but also service provision, and low income.

6.69 One organisation addressed several areas which will need additional support, summarised by a “need to focus on removing barriers for those who experience a higher risk of poverty, social exclusion, discrimination and violence”.

6.70 To address these issues, organisations shared a number of recommendations primarily focusing on:

- Establishing a deep understanding of the current barriers
- Funding support for organisations supporting people with different linguistic and cultural requirements
- Funding support for those with children
- The expansion of referral pathways (to ensure ‘inappropriate referrals still get appropriate support)
- Providing courses/training which are about breaking down barriers to access, increasing staff experience and confidence
- Building more effective partnerships and networks with diverse groups
- Co-producing services, embodying the principles of ‘user design’ so that services are purpose-built to meet the needs of the user group
- Welsh Government working toward actions that help to encourage ethnic and social diversity in the social prescribing workforce
- Greater consideration to the routes of access for children and young people
- Using video as a tool to communicate, and introducing a dedicated phone support line
- Creating a national communications toolkit that adheres to the ‘think global, act local’ mantra – showcasing the benefits

of social prescribing on a wider scale, but with a particular focus on engaging those from disadvantaged groups and highlighting the benefits it can have on them.

Workshop Findings

6.71 In workshops, stakeholders detailed a number of practical access barriers that should be considered in all settings. These particularly included barriers that prevent those with health conditions and older populations from accessing services (e.g. appropriate toilet facilities, public transport routes, the infrastructure and environment at activity sites).

6.72 Other important considerations included:

- Considering those with sensory loss and methods for enabling them to access services
- Considering how services are targeted and delivered for neuro-divergent people
- Exploring why Black, Asian and Minority Ethnic groups seem to be under-represented in social prescribing referral rates
- Identify the areas of greatest need in order to target efforts; one stakeholder (a GP) highlighted that opportunities to interact with young people are particularly limited (whereas older people are more comfortable with approaching their GP).

Focus Group Findings

6.73 Focus Group participants were first asked what is currently stopping them accessing community based support in their local area followed by what would help them to access community based support.

6.74 Several barriers to access were listed across multiple groups which included a lack of confidence going out, lack of motivation, lack of transport, lack of disposable income, nervousness to meet new people

(sometimes after the COVID-19 pandemic), not knowing what to expect and living rurally.

6.75 The issue of time was also mentioned by several respondents. In the context of caring responsibilities was mentioned by two groups (older people and unpaid carers) and mentioned in relation to lots of activities being in the middle of the week so not feasible to attend by those who work 9-5.

6.76 It was also clear through discussions that the issue of time overlaps with the lack of public transport available. Several participants (particularly those with disabilities) highlighted that groups and activities taking place in the evenings weren't accessible to them at all – given the prevalence of bus services ending in the early evening.

6.77 Actions which could be undertaken to mitigate these factors could be summarised as *specific* accessibility information being provided, which would benefit older people, and disabled people specifically.

6.78 One participant in the group with older people mentioned that knowing there is an option to improve wellbeing by participating in activities from home was revolutionary for them becoming involved in their community. Numerous anecdotal examples shared by participants showed that the opportunity to engage digitally had opened new possibilities for them.

Question 11a - Should the national framework contain a set of national standards for community support to help mitigate safeguarding concerns? Yes / No / Not sure

Individual Respondents

6.79 Of the individual respondents, 38 answered that yes, there should be a set of national standards to help mitigate safeguarding concerns. Five clearly answered 'no', however, 14 answered 'not sure'. Individual respondents shared a number of concerns surrounding the introduction of national standards.

Organisational Respondents

6.80 Of the organisational respondents, 21 responded 'yes', though many of these responses came with caveats, with organisations pro-actively highlighting what the negative implications of this may be. Those that said 'yes' presented reasons for their answers including that it would help to ensure accountability, and there was some feeling that it should be an 'essential requirement'.

6.81 Six organisations answered with a clear 'no', however multiple organisations responded with inconclusive answers. These presented their concerns surrounding national standards – leaning more closely towards a no response – but did not definitively state this.

Workshop Findings

6.82 Workshop Stakeholders provided mixed feedback for the question - those that said yes were primarily motivated by safeguarding concerns, those that said no were primarily motivated by the impact this could have on smaller groups and community organisations and those that weren't sure were cautious of excluding people and felt that groups/organisations may need incentives if they are to resource for further training and adhere to guidelines.

Focus Group Findings

6.83 Focus group stakeholders were not asked a question related to this theme.

Question 11b - If yes, what are the key things the national standards for community support should cover?

Individual Respondents

6.84 For individual respondents, safeguarding was the primary motivation for those who answered yes – with 15 respondents noting that national standards should cover this.

6.85 Additional suggestions of key things that the national standards for community support should cover included:

- Training standards/evidence of appropriate ongoing training
- Health and safety
- First aid training
- Monitoring standards
- Insurance
- GDPR
- Risk/red flag indicators
- A set of behaviour standards
- A complaints procedure
- DBS checks.

Organisational Respondents

6.86 Organisations suggested all of the above, but tended to focus more closely on areas associated with the delivery of services and activities. These included for example, an emphasis on equality, diversity, and inclusion training, as well as training and competency in communication skills. As part of this, it was suggested that organisations and services should ensure a good understanding of the Equality Act and the Social Services and Well-being (Wales) Act.

6.87 The Conservation Volunteers response outlined their role in developing a quality assurance process for social prescribing in England, in partnership with the Social Prescribing Network. Their consultation recommended covering all of the areas above. Additionally, offers came from Sport Wales to advise based on current safeguarding frameworks in the sector. Overall, many organisations suggested building upon existing frameworks and resources that they were aware of.

6.88 Other features identified by organisations focused on principles and values, for example providing clarity on choice and control for service users, and establishing a feeling of empowerment.

6.89 Notably, a number of organisations specifically highlighted that national standards should not be 'just about safeguarding', drawing on considerations of the above, as well as responsibilities for organisations. Three organisations described the importance of quality assurance, which was also linked to a desired need for improving the credibility of services. Suggestions included looking at existing quality marks like 'Trusted Charity' and 'Investing in Volunteering' as benchmarks for governance. Organisations also suggested that this could support scaling and ensure that a demonstrable level of consistency for services.

6.90 Additionally, organisations shared important considerations which would be more specifically relevant to the safeguarding of particularly vulnerable groups. These included:

- Understanding and recognising signs of abuse
- Who to approach with concerns and how to respond to a young person talking about abuse
- Safe recruitment (for volunteers and staff)
- Safe behaviour Do's and Don'ts
- Prevent
- Medication and Personal Possessions.

Workshop Findings

6.91 Further to echoing the responses already covered above, workshop stakeholders that supported having national standards recognised a distinct need to work 'within the parameters of safety', that a 'one-stop-shop' approach would be beneficial to ensure that organisations are looking after their staff and volunteers appropriately.

6.92 It was felt that having clear and definitive standards would give the workforce a benchmark to work towards.

Focus Group Findings

6.93 Focus group stakeholders were not asked a question related to this theme.

Question 11c - If no or not sure, what are your main concerns around the introduction of national standards for community based support and how might these be addressed?

Individual Respondents

6.94 In terms of the individual respondents that said ‘no’ or ‘not sure’, written responses were inconclusive as detailed in the previous question. The ‘yes’ responses (with caveats) provided greater detail in terms of what should be covered and where potential issues could arise.

Organisational Respondents

6.95 Organisations were far clearer in terms of their reasons for warning against national standards.

6.96 Primarily, these reasons revolved around a perception that a further level of standards would be an unnecessary addition, and the concern that smaller organisations may struggle to meet them.

6.97 Of those that were explicitly clear that national standards would not be needed (stated by three respondents) reasons cited were that organisations are already subjected to local and regional safeguarding standards. One organisation felt that in the three years they had been operating, existing standards had been adequate – taking no problems arising during this time as evidence.

6.98 Specifically, one organisation stated their belief that the National Framework should be more focussed on ensuring that organisations are complying with the All Wales Safeguarding Policy and Procedures, not a separate set of standards.

6.99 Reinforcing these views, other organisations felt that the introduction of national standards would not 'add value' – urging Welsh Government to be cautious about adding bureaucratic requirements to community services. In a similar sense, organisations suggested that the genuine need for national standards should be interrogated, and weighed up against risks.

6.100 Others also had further questions about how national standards would work in practice, for example how the standards would be managed across the country, who would be carrying out impact monitoring, and how these would impact the workforce.

6.101 Finally, in relation to concerns surrounding the consequences for smaller organisations expected to adopt national standards, organisations queried how standards would be met in the contexts of limited capacity, resources, and funding. Multiple organisations raised the consideration of how standards would differentiate between different sized organisations – with some suggesting that a tiered approach might be needed to mitigate against the risk of exclusion.

Workshop Findings

6.102 In workshops, the concerns about the impact for smaller organisations was somewhat more prominent. Some stakeholders talked about the risk of losing the valuable contribution that local and community groups make to social prescribing. Others suggested that this might act as an indication that integrating with social prescribing may not be a viable route for all organisations – particularly in relation to provision for people with complex needs.

Focus Group Findings

6.103 Focus group stakeholders were not asked a question related to this theme.

Question 12 - What actions could we take at a national level to help overcome barriers to using digital technology for community based support?

Individual Respondents

6.104 The majority of individual respondents made suggestions relating to the immediate introduction of practical infrastructure, to help overcome barriers associated with digital technology. Twelve respondents mentioned the need for a robust network of community hubs, and libraries in particular. Similarly, twelve respondents cited the need for better Wi-Fi and broadband infrastructure, specifically around rural and digitally deprived communities.

6.105 Out of eight respondents who suggested that there should be greater access to digital hardware, six suggested specific grants and loans of digital equipment. It was also suggested by nine respondents that investment in training would help to overcome barriers.

6.106 It was noted that information should also be available in formats other than digital, summarised by the response:

> "A huge part of the benefit of social prescribing is that human listening ear and the conversations had when identifying support. This is lost when pushing on to digital."

6.107 A number of respondents used the opportunity to emphasise that relationships should be fostered through real conversations and partnerships with local people and the wider community.

Organisational Respondents

6.108 Organisations recommended providing access in the forms of hardware for organisations and assistance with the additional ongoing subscription costs associated with some platforms. A substantial number of organisations highlighted a need to promote and fund digital literacy efforts, as a distinction for those who aren’t confident in using technology.

Suggestions included funding for training and confidence building, which organisations felt was harder to come by.

6.109 Organisations also suggested purchasing bilingual systems where Welsh and English are fully integrated – to ensure that Welsh language access could also be overcome as a barrier.

6.110 In terms of the complexity of needs varying from place to place, and between individual groups, organisations also commented on the importance of designing digital strategies at a local community level, as opposed to the national level. It was felt that this could allow organisations to properly tailor their provision to local needs as opposed to having options which may not be suitable prescribed to them.

Workshop Findings

6.111 Workshop feedback centred around awareness of digital exclusion and adaptation of services accordingly. Stakeholders were conscious of the issues surrounding digital exclusion and highlighted the prevalence of digital poverty in Wales – with one stakeholder citing that 13% of the population don't have access to Wi-Fi.

6.112 Additional considerations included being mindful that it can be difficult to access decent support, even for those who do have Wi-Fi access, via mobile and that not everyone has access to a quiet/private space in their homes.

6.113 As such, it was suggested that alternatives need to be in place, sharing that digitisation works well but also a sense that some content works better face-to-face. Stakeholders suggested that it was critical to use digital technologies but not to rely on it to build communities around.

Focus Group Findings

6.114 Focus group discussions covered the topic of accessing services online more generally, to find out what does and does not work for participants.

6.115 Generally, participants spoke positively about the use of digital technology and video calling as an aid for accessibility – when in-person options weren't available. Participants shared that their digital skills developed during the pandemic made participants more confident in accessing and utilising digital technology.

Theme 4 Conclusion

6.116 With regard to Question 7, standardisation of training, evaluation/ reporting and procedures was a common theme which was raised in individual responses, along with organised forms of communication and management with local representation. Organisational responses identified a range of actions at the national level including; the establishment of robust monitoring and evaluation processes, connecting social prescribing to existing health and social care infrastructure, investments in infrastructure, sustainable funding arrangements and training needs. Workshop discussions centred around the themes of accreditation (to ensure trust) and the need for third sector funding.

6.117 Beyond requesting greater local representation at a national level, individual responses to Question 8 also mentioned that funding and provision should be informed by geographic differences and stressed the importance of national frameworks and campaigns. An action proposed by organisational respondents was the need for long-term sustainable funding to ensure services are present at the local level to meet demand. Workshop stakeholders suggested engaging the public in the process and utilising community advocates who can relate the importance of social prescribing to others. All focus groups mentioned the importance of word of mouth in disseminating information within communities.

6.118 Individual respondents shared a number of other directories that they use to gather information in response to Question 9. However, a significant number of people opted for traditional methods of information gathering, such as word of mouth, community networking, and direct engagement with organisations and individuals. Workshop attendees discussed the

importance of social media in sharing events and keeping things more current, but that this was reliant on audiences being ‘social media savvy’ and knowing where to look. The most popular answer from all focus groups except for the group with children and young people mentioned they use local community Facebook pages/groups to keep up to date with community activities.

6.119 In response to Question 10, many individual respondents pointed out that a lack of community transport schemes was hindering access. In terms of access to information, respondents mentioned alternative, more "analogue" information-sharing methods, as well as the value of mentoring services. Workshop attendees mentioned the need to consider practical barriers preventing individuals from accessing services, investigating the reasons attributed to ‘drop-off’ between referrals and take up rates, and the communication methods for reaching different groups varying significantly. Barriers mentioned by focus group respondents fell into four themes: not knowing who to ask, finding it difficult to access information online, not seeing information in the local area and not seeing the benefit in looking for community-based support.

6.120 When asked whether the national framework should contain a set of national standards for community support to help mitigate safeguarding concerns, 38 individual respondents answered 'Yes’, 5 answered 'No’ and 14 answered 'Not sure’. Amongst Organisational responses, 21 respondents answered ‘Yes’, five responded ‘No’ and the remainder did not give a categorical answer. Workshop Stakeholders provided mixed feedback for the question - those who said yes were primarily motivated by safeguarding concerns, those that said no were primarily motivated by the impact this could have on smaller groups and community organisations and those that weren’t sure were cautious of excluding people and felt that groups/organisations may need incentives if they are to resource for further training and adhere to guidelines.

6.121 With regard to Question 12, individual respondents mentioned the need for a robust network of community hubs, libraries and better broadband infrastructure around rural and digitally deprived communities, which

could be alleviated by grants and loans of digital equipment alongside investment in training. Finally, information provided in non-digital formats and relationships fostered through real conversations and partnerships should still be valued. Organisational responses proposed research into barriers associated with access, promotion and funding of digital literacy training, access to devices and extended broadband access and expanding and co-designing the existing digital offer to engage and empower socially isolated and housebound people in online activities. Workshop attendee feedback centred around awareness and adaptation of services especially considering the prevalence of digital poverty in Wales. Digitisation was said to work well but there was also a sense that some content works better face-to-face, especially when building communities.

7. Theme 5 – Sustainability Analysis

Question 13 - What action could we take at a national level to support effective partnership work to secure long term funding arrangements?

Individual Respondents

7.1 Seven respondents believed that partnership working should be better encouraged to maximise funding. It was suggested that this could include:

- Joint consultation events
- The development of liaison networks
- Health boards to advertise partnership opportunities.

7.2 Six respondents stated that an increase in the availability of long-term funding would be beneficial, two of which stated their support for the new Welsh Government 3-year funding. There was however a consideration of ensuring that the funding cycle does not always end at the same time, instead suggesting having overlapping funding streams with different start dates. In addition, less restrictions in the funding currently available was mentioned by two respondents, one of whom stated being able to carry over year-to-year funding would be a positive outcome.

7.3 Six respondents mentioned the use of impact assessments. Through embedding social prescribing across the health sector would also increase understanding due to how the NHS and health sector has a set way of reporting on impact of activities which is not known or understood by organisations outside of the sector. Therefore, it was stated by one participant in relation to an earlier question that this language gap needs to be bridged in order to support effective partnership work.

7.4 Three respondents mentioned that RPBs should use strategic plans, making it a priority for RPBs to implement a full network across their organisations. Some respondents furthered this point, stating that a network for participating organisations could be created for better collaboration.

7.5 A common theme amongst many respondents was an overhaul to funding structure, in this vein; ringfenced funding, individual allocated funding as well as less stand-alone funding pots and overlapping funding were mentioned.

Organisational Respondents

7.6 As was the case with a number of themes in this consultation, respondents felt that collaboration was critical. Modes of collaboration should follow existing best practice and learn from past approaches.

7.7 Linking up with key bodies and agendas (e.g., health, social care, environmental) appropriately was highlighted as important. This includes PSBs, CVC, and town and community councils, as well as multiple government departments both the local and national levels. Developing and supporting effective networks, in which small organisations can have their voices heard equally to large organisations, was mentioned frequently.

7.8 Organisational respondents emphasised that effective partnerships and sustainable funding both require a clear, national commitment from Welsh Government and a clear division of responsibilities between the actors involved.

7.9 One respondent said partnerships should start with a co-produced Memorandum of Understanding, so all expectations are clear on all sides.

7.10 One stakeholder stated that "building effective partnerships needs proactive and ongoing support and incentivisation from the Welsh Government. Partners need to be valued and heard equally", which is inhibited by power differentials between government and organisations of different sizes.

7.11 It was also felt that third sector organisations and other relevant partners should be well-positioned to have voice and resources enough to

influence the commissioning process at a local level and ensure it is inclusive.

7.12 The need to change how organisations are funded in favour of longer-term, core funding was frequently mentioned.

7.13 Many respondents saw Welsh Government as responsible for ensuring that statutory bodies, RPBs, and other relevant actors collaborate to ensure the model is well-funded and in alignment with relevant legislation. Some thought Welsh Government should provide a form of central or cross-departmental funding.

7.14 Short-term funding was roundly criticised. Many respondents asserted that long-term funding must be provided from early-on, though some recommended that frontloading funds might facilitate effective partnership working. Some provided notes of caution about what would happen when the funding expired.

7.15 Recommended funding strategies included giving autonomy to local areas and third sector organisations in how to spend funds, simplifying funding applications, and ensuring grant applications promote collaboration rather than competition - including by encouraging and stating in funding applications that participating organisations should submit joint bids.

7.16 Sustainable funding was linked to a wide range of issues, including organisations' fundamental ability to provide services, perceptions of service quality and referrals.

7.17 One organisation shared that:

> "We are aware that some formal services, such as GPs, can be reluctant to signpost individuals to third sector support due to a lack of confidence in that third sector or community organisation’s continued operation or sustainability. The success of implementing a social prescribing framework therefore hangs on the ability of third and community sector organisation’s ability to continue to deliver their service, and for professionals to have confidence in that service’s ongoing delivery beyond short term funding rounds."

7.18 The effective and strategic use of training and technology could support effective partnership working, robust local communities, and relevant funding.

7.19 Finally, respondents discussed approaches to measuring/monitoring outcomes, pointing to the importance of demonstrating value (and potential savings to the health system – though this was not universally supported) and evaluation in securing further funding and support for the social prescribing model. Some stakeholders shared that similar to funding applications, monitoring and evaluation requirements are important. However, they should be simple and not overly time-consuming given the strain on delivery organisations, especially those which have limited resource.

Workshop Findings

7.20 The most common theme mentioned was the need for central coordination. The main reason for this was to evaluate who is funding what, where and asking for what to avoid duplication or gaps in service. If this is centrally coordinated, some workshop participants felt that the emphasis of social prescribing as an integral pillar in the terms of service operation will lead to its success.

7.21 Also listed as important by workshop attendees and related to central coordination was the need for a partnerships database as it is an issue to keep up-to-date individual organisational links and networks. It was suggested that this needs to be implicit going forward for quality assurance.

7.22 Attendees also mentioned the need to invest and offer people skills and tools, stating “this is not a case of saving the day, but saving the day in five years’ time”. Several workshop attendees reinforced the need for open ended contracts to ensure staff retention.

7.23 Finally, the need to ensure that any funding that is successful matches the increase in demand was mentioned in order to effectively build communities.

Focus Group Findings

7.24 Focus group stakeholders were not asked a question related to this theme.

Question 14 - What actions could we take at a national level to mitigate the impact of the increased demand on local community assets and well-being activities?

Individual Respondents

7.25 The most popular response amongst individual respondents was the feeling that an increase in funding would be needed. This was shared by 18 respondents. Several individual respondents expanded on this, and suggestions were made for funding distribution such as participatory budgeting and inward investment or through a dedicated local authority stream. Three respondents mentioned ring fencing funding for the purposes of social prescribing, as well as mentioning opinions echoed in previous questions that longer term funding would also help mitigate increased demand.

7.26 Five respondents believed data capture and monitoring of use was key to provide responsive services that are demand-led. Related to this, five respondents also thought that staff provision should be monitored to ensure adequate resource to be able to respond to the predicted growth in demand of the services. Similarly, five respondents also mentioned further training opportunities for staff and volunteers.

7.27 Finally, three respondents explicitly mentioned how they believed that services should be joined-up, with the example of the exercise referral scheme highlighted as good-practice.

Organisational Respondents

7.28 The primary themes mentioned by organisational respondents to this question were centred upon resourcing and collaboration.

7.29 In terms of resourcing, respondents frequently mentioned the need for funding for community assets which underpin the social prescribing model. This should ideally be core or longer-term funding to facilitate continuity. One respondent suggested exploring creative ways to champion community assets such as tax relief.

7.30 Many stakeholders believed that funding should be locally managed and flow quickly to grassroots organisations to enable staff retention, scale-up where needed, and sustainable delivery instead of a constant focus on recruitment and funding applications.

7.31 This would promote confidence in the services and is a crucial element of the preventive approach designed to save costs elsewhere in the system.

7.32 Strengthening local systems of governance and oversight with a "whole systems" approach was also seen as key to mitigating the impact of increased demand on local community assets.

7.33 Respondents also mentioned the need for a method of sharing or centralising information about community assets' needs, demand, and availability so that resources can be best deployed locally and across regions. This may entail the pooling of resources or volunteers given the probable shortage of staff (at least initially). Existing bodies such as RPBs and CVCs were mentioned as possible vehicles for coordination of local need.

7.34 There were several mentions of investment in community-led action and devolution of power. This means ensuring the service is co-produced with communities and provides flexibility to them.

7.35 Several responses highlighted that effective support also implies investment in other areas of the system so that social prescribing is not relied upon as the sole solution to complex problems.

7.36 Other ideas included providing more "out of hours" access to activities, allowing groups to limit referrals, and implementing a regular review

process for social prescribing service users to assess who still require "hand-holding" support from the service. One respondent identified the need for supportive exit routes and several challenged the assumption that demand on community assets will increase.

Workshop Findings

7.37 A contrast in the needs identified by larger and smaller organisations highlighted that all organisations need to collaborate and share experiences to avoid duplication.

7.38 Fundamentally, many workshop participants built upon their response to the previous question, stressing that an increased demand means that you need to see increased (long-term) funding, but that this isn't being felt, particularly in the third sector.

7.39 The cost-of-living crisis was mentioned as a challenge for community assets and wellbeing activities meaning that there has been an increase in demand but also a decrease in facilities available. Some participants shared that there needs to be a reappraisal in community funding in response to the cost-of-living crisis.

Focus Group Findings

7.40 Focus Group participants were first asked whether they thought there is a good range of community-based support in their local area, followed by whether they would like to access community-based support.

7.41 Participants in all groups shared a range of views on whether there was a good range of community-based support in their local area which was dependent on the region of Wales they lived in. Participants who lived in more urban communities felt that in their areas it was very good, with one Black, Asian and Minority Ethnic participant sharing that they are surrounded by parks and Cardiff football club so there are a lot of facilities, but it would benefit from being more accessible.

7.42 Three older people group participants mentioned that there was a lot going on but getting to know about it is the issue they feel is most important. COVID-19 was also mentioned by several participants as being a factor of the range of community-based support being diminished.

7.43 All participants varied in terms of whether they would like to access community-based support. Generally, participants in the older people group were the most supportive of this and other groups had mixed feelings, listing factors such as barriers of participation (covered in Theme 4) and that they are involved in enough activities already.

Theme 5 Conclusion

7.44 Across all stakeholder groups there was consensus on the need for a strategic overhaul to the funding of social prescribing activities and services. Stakeholders felt that the way funding is currently designed, both in duration and by type, does not meet the requirements of the sector. Another commonly observed comment raised was the lack of cohesion and/or collaboration amongst partners in social prescribing; it was felt that with better collaboration, services could become more effective, avoiding duplication of resources.

7.45 Focus group participants varied in their opinions of the quality of activities that were available and whether they would participate in social prescribing. The range of opinions and views generally echoed the point made by those working in the industry, who stated that social prescribing activities should catered for the individuals and communities involved and not simply be a ‘one size fits all’ approach.

8. Theme 6 – Measurement of Impact Analysis

8.1 N.B. Focus group stakeholders were not asked any questions related to Theme 6.

Question 15 - In your view what are the core things we need to measure to demonstrate the impact of social prescribing?

Individual Respondents

8.2 Individual responses were concerned with the collection of qualitative and a range of quantitative data focused upon the individual, the service and other health services, as well as providing suggestions with how data could be collected.

8.3 To measure the effect of social prescribing on the individual, 19 respondents highlighted the importance of assessing traditionally "more difficult to measure" aspects, such as individual well-being, confidence, life satisfaction, and sense of happiness and belonging. In addition to this data, five respondents encouraged the measurement of individual patterns, such as diet, sleep, weight, BMI, blood pressure and life expectancy.

8.4 With regards to the social prescribing service and community-based support providers, seven respondents mentioned quantitative data, such as the number of referrals into the service, number of referees, number of referrals bounced back, and number of sessions attended by referees.

8.5 Respondents strongly felt that it was important to measure the reduction in the more "traditional" medical interventions. With 13 respondents suggesting measuring, for example, NHS cost reductions, eased demand on health services, medication prescriptions, and hospitalisations.

8.6 As well as these quantitative measures, 17 respondents suggested demonstrating social prescribing through case studies, stories, surveys, and other feedback mechanisms that would highlight the qualitative aspects of social prescribing.

8.7 Respondents also shared several other ideas for what to measure, including employment statistics, social prescribing staff information, community cohesion, and the wider determinants of health. In addition, pre-existing measures were mentioned including; EQ5D5L[11], Patient Centred Assessment Method (PCAM)[12] and the South Wales Social Wellbeing Scale[13]. Four respondents deem it necessary to have consistent and continuous follow-ups for a constant flow of useful data.

Organisational Respondents

8.8 The organisational responses engaged with this question in five ways; outcomes which need to be considered in measuring offering suggestions for measures of qualitative and quantitative data, suggested methods for data collection, issues that may arise, and the existing approaches that may be built upon.

8.9 Respondents suggested that the outcomes that should be captured needed to focus on the long-term effects of the social prescribing framework on statutory partners, referring agencies, community-based support providers, communities, and individuals. These suggestions are outlined in Table 2.

Table 2 – Organisational responses summarised in response to Question 15 - *In your view what are the core things we need to measure to demonstrate the impact of social prescribing?*

Subject	Outcome/Impact
Statutory Partners	Do they know how to refer?
	Are people getting the right community support?
	Are they getting feedback on action taken?
	Is there a reduced demand for statutory services?
Referring agencies	No suggestions
Community-based support providers	Are they getting referrals?
	Are they getting appropriate referrals?

[11] The EQ-5D-5L system is a preferred measure of health-related quality of life in adults.
[12] The Patient Centred Assessment Method is used for action-based biopsychosocial evaluation of patient needs.
[13] The South Wales Social Wellbeing Scale (SWSWBS) has been developed by the Wales School for Social Prescribing Research to evaluate and monitor social prescribing intervention impact in health and care settings.

	Are they able to respond to demand? Do they have waiting lists?
	Have the staff got the skills they need?
Communities	Benefits to participating organisations
Individuals	Measure wellbeing using What Works Wellbeing or the Warwick Edinburgh Mental Wellbeing Scale

8.10 With regard to qualitative data measures, organisational responses expressed a strong preference for measures which focused on the individual including; individual wellbeing, the positive experience of people using recorded stories, testimony and case studies, measuring someone's journey using STAR, increased activation in selfcare. It was also suggested that these measures include the specific effect of social prescribing services in Welsh on Welsh-speakers. Specific suggestions for measures of this qualitative data include;

- Reduced feelings of loneliness
- Reduced feelings of social isolation
- Increased motivation
- Improved self-esteem and confidence
- Improved emotional and mental wellbeing
- Improved relationships and support networks
- Increased motivation to complete everyday tasks.

8.11 Preferred quantitative measures fell into two categories, the effect on the health service and the effect on communities and participants. The focus for those concerned with the health and care services was the reduction of demand on GP practices, reduced need for social care services, changes in attendance and prescription of medication. Suggested measures for the effect on communities and individuals included economic impact, social value measures and social return on investment. In addition to this there were suggestions that the above qualitative measures could be collected and analysed quantitatively. Those suggesting quantitative data were also keen to collect immediate output data on the following:

- Demand (e.g. referrals that convert to attendance)
- Numbers attending/attrition
- Numbers that cannot get on their chosen activity waiting lists
- Ideally clinical markers for cross section of people
- Uptake of social prescribing by people from marginalised groups
- Preferred language
- Number of Welsh Social Prescriptions provided
- Ability of workforce to provide social prescriptions in Welsh.

8.12 Organisational respondents were also able to suggest a number of different data collection methods, models and software. There was a preference for ongoing feedback through regular check-ins, surveys and digital health and wellbeing journals. Although it was stressed that online tools are not accessible to all. It was recommended for evaluation that interviews and focus groups should accompany surveys. Two models were highlighted for use, the Distance Travelled and Most Significant Change. Finally, Elemental was mentioned most frequently as useful software for data collection, alongside PROMS and PREMS.

8.13 Organisations raised a number of issues in relation to measuring the impact of social prescribing. The most frequently mentioned was that any measurement should not be weighed too heavily towards reduced GP visits, rather it should focus on the individuals lived experience. It was pointed out that social prescribing has the potential to increase demand for certain health services as it increases the confidence of participants. The focus here should be on appropriate usage. Beyond this it was stressed that the focus should be on the individual as reporting may be difficult in a standard format for people with ALN for example. Additionally, it was noted that;

- Measurement should not exclude small providers
- Some interventions are long-term/life long and will not have a completion date, and,

- Data management systems must be accessible to all service providers.

8.14 A number of respondents suggested that any framework should build on existing approaches, these have been collated in Table 3.

Table 3 – Existing Approaches cited in response to Question 15 - *In your view what are the core things we need to measure to demonstrate the impact of social prescribing?*

Existing approaches
Social Services National Outcomes Framework
National Academy of Social Prescribing
Developing Evidence Enriched Practice (Deep) by Swansea University
Recovery College Model
Warwick-Edinburgh Mental Wellbeing Scale
Montgomeryshire Wildlife Trust's Wild Skills Wild Spaces
Most Significant Change methodology
University of South Wales - Developing a core minimum dataset for a social prescribing evaluation framework: A Group Concept Mapping Study

Workshop Findings

8.15 Workshop participants consistently mentioned the use of a standardised measure to enable consistency across all areas/geographies to be able to compare across programmes. The introduction of a toolkit aggregating resources already available would be useful to organisations.

8.16 A question was raised about what the baseline is that will be measured against and potential indicators it would be useful to include. COVID-19 was mentioned as a potential difficulty in measuring the baseline.

8.17 The use of case studies to supplement quantitative data was also mentioned repeatedly, ensuring emphasis on the benefits and the value of social prescribing on the individual person.

8.18 Difficulties mentioned were in the amount of feedback that could be obtained from vulnerable individuals and that interventions should be bespoke to each person so would be difficult to capture. A potential solution to this would be to categorise interventions such as employment and social skills.

8.19 Finally, a counterfactual impact assessment would be a useful tool to understand the extent to which any outcomes can be attributed to social prescribing interventions. as well as what externalities will have impacted on its implementation.

Question 16a - Do you have any research or evaluation evidence you'd like to share with us?

8.20 A full list of research and evaluation evidence that was shared in response to this question by stakeholders has been compiled and can be found as Annex C.

Question 16b - Do you have any suggestions on how the implementation of the national framework in Wales can and should be evaluated?

Individual Respondents

8.21 Many respondents referred to answers given in response to Question 15. Those who did respond to Question 16b highlighted the need for effective feedback channels including:

- Feedback from social prescribers through channels such as questionnaires and focus groups
- Feedback from third sector and health professionals
- Feedback from members of the public

8.22 When considering the nature of the evaluation, five respondents suggested a mixed-methods approach, including: "an innovative qualitative evaluation, through film, photography, creative writing, performance..."

8.23 However, it was stressed by respondents that the evaluation of social prescribing activity and its outcomes should not add an additional administrative burden while it should focus on the social return on investment.

Organisational Respondents

8.24 Organisations responded to this question by considering who should be involved in the development of evaluations, what an evaluation framework should look like, what its priorities should be and how it should be carried out.

8.25 The first concern was that stakeholders across the service cycle should be involved in the evaluation framework, including service users, providers, health care professionals; overall, the approach should be multi-professional. This should assist the respondent's suggestion that the framework should be designed to monitor equality, diversity, and inclusion from the outset.

8.26 It was proposed that monitoring and evaluation should be led by a single national body with regional teams. This reflected the desire for consistency across Wales while considering local variation with local intelligence gathering.

8.27 The priorities of an evaluation framework were a crucial factor for responding organisations. As shown throughout the framework, consultation respondents felt that greater clarity was required regarding the service's expectations. In short, what does success look like? Similarly, it was felt that evaluation should consider the impact of social prescribing on early intervention and the financial savings to the NHS.

8.28 Evaluations should also prioritise long-term learning in that they should focus on improving rather than proving. Services should not be required to report and evidence their need for existence, but instead should focus on where they can improve and develop best practice examples. Evaluation should be both proportionate and appropriate. Related to this, a respondent suggested that the sustainability of the sector should be a consideration of the evaluation framework given the reliance upon voluntary and community work, mostly carried out by low paid women.

8.29 Finally, respondents recommended that the evaluation framework should be in place before the Social Prescribing Framework is rolled out. To help

with this, a pilot with a few organisations was recommended to enable a baseline to be considered prior to the rollout, ease of use of the framework, and usefulness of the data collected. It was recommended that Welsh Government work with the Wales School for Social Prescribing Research.

Workshop Findings

8.30 During the workshops sessions, several participants stressed the need for a national evaluation framework which could be centred around the logic model related to national outcomes.

8.31 The inclusion of a core set of outcomes for organisations to be able to compare and be consistent on measuring would also give an indication of quality. Another participant built upon this, outlining the need for flexibility of outcomes that consider local context and available resources.

8.32 A social return on investment metric was mentioned as a useful tool to measure effectiveness of third sector activities.

8.33 Finally, it was mentioned by several workshop participants that user groups should be informing the metrics being used, alongside monitoring effectively and only evaluating 'what needs to be evaluated.'

Theme 6 Conclusion

8.34 In response to Question 15, respondents across all three groups agreed that measuring the impact of social prescribing required a mixture of quantitative and qualitative measures that focussed on the individual, community, and health services.

8.35 It was stressed that this should not be weighted towards the effect on health services, particularly the ability of social prescribing to reduce GP workloads. There were concerns raised about over-evaluation and the impact this might have on both individuals and community providers, with respondents recommending that the framework builds on existing approaches.

8.36 Responses to Question 16b expressed a desire for a consistent national model of evaluation across Wales with built-in flexibility and regional teams to consider regional contexts. In addition, it was important to respondents that any evaluation framework is developed alongside user groups, participants, and providers, and that this evaluation model should be in place before the social prescribing framework is rolled out.

8.37 Finally, it was recommended that the evaluation is both qualitative and quantitative to capture as much data as possible, in particular the experience of the individual and the effect of social prescribing on the community.

9. Theme 7 – Workforce Analysis

9.1 N.B. Focus group stakeholders were not asked any questions related to this theme as this set of questions were targeted at the consultation respondents rather than the priority groups identified.

Question 17a - What are the key knowledge and skills the planned competency framework should cover?

Individual Respondents

9.2 The skills that individual respondents prioritised were communication skills. Eight respondents mentioned the importance of active listening and communication skills more generally– this should be encompassed by general leadership and organisational skills. The importance of a specific communication skill, motivational interviewing, was mentioned by three respondents. Two respondents highlighted the importance of bilingual communication in social prescribing.

9.3 The knowledge that respondents felt should be prioritised in the competency framework focussed on awareness of mental health and wellbeing needs, knowledge of local areas and knowledge of best practice. For awareness of mental health and wellbeing needs, seven respondents highlighted "mental health first aid" - this relates to an understanding and awareness of mental health and well-being, and how to support someone in this regard, should they need it. Five respondents felt that having a good understanding of already existing local networks and communities was important, in addition to acknowledging and implementing local knowledge. Finally, four respondents encouraged looking at best practice elsewhere, such as from England and Scotland – having an example of what has already worked is efficient and useful.

Organisational Respondents

9.4 Organisational responses offered more detailed suggestions, although again they focused on communication and health knowledge. Relationship building was an additional focus with the ability to sit with individuals during difficult conversations without trying to solve the problem, engage and support people, and assess someone's strengths and needs all highlighted as necessary communication skills. Further specific communication skills included: the importance of "What Matters to You Conversations", motivational interviewing and collaborative planning.

9.5 The focus on health experience was seen through the prism of the importance of person-centred care. Understanding and being comfortable working with people with various health and complex needs, including communication impairments, pain fluctuation, mental health challenges, learning disabilities, and dementia was seen as beneficial. This led to the need for skills to include trauma-informed and ACE-aware practice, counselling and behaviour change techniques, and suicide prevention. Additionally, organisations thought that practice and knowledge of safeguarding was critical.

9.6 Similar to the individual responses, organisations felt that having a deep knowledge of local community assets and relevant policies, understanding how practitioners can enable community development, working across sectors, and evidencing outcomes were all essential for social prescribing. Knowledge of Welsh and linguistic awareness was also highlighted in this context. It was mentioned that the programme should build in time for social prescribers to develop this knowledge, build relationships and become embedded in the community.

Workshop Findings

9.7 Stakeholders emphasised that recruiting based on accreditations and qualifications alone would not be enough, and that communication and other skills are important within social prescribing.

9.8 The concept of ‘cultural competency’ should be included – to ensure that the model is as inclusive as possible, this should cover things like

religious beliefs, trauma, the role of past experiences, the way that neurodivergence might affect the way that information is communicated, to understand how these things shape patient needs.

9.9 Nuanced understandings of this were seen to be particularly important when considering and overcoming misconceptions (i.e., that autistic people would not want to be prescribed social activities). This also applied to overcoming unconscious bias and prejudice – and the need to ensure that activities being prescribed were culturally relevant and provide safe spaces for marginalised groups

9.10 Stakeholders also spoke about standards and values including empathy, collaboration, and person-centred care. Safeguarding and clarity surrounding referral pathways were also a key consideration, mentioned in detail in other themes of the consultation.

Question 17b - How can the planned competency framework best complement existing professional standards?

Individual Respondents

9.11 Five respondents encouraged the use of existing professional standards and measures that can be aligned with where possible. Two respondents pointed out that this could be an opportunity to formalise social prescribing professional standards and ensure quality and governance.

9.12 However, another respondent cautioned against confusing professional standards with social prescribing, as it was "not a registered profession". Furthermore, it was also questioned whether existing professional standards are correctly assessed. If not, aligning them could be a moot point. One respondent cautioned against social prescribing becoming too specialised or "deviating too far" using too-thorough standards – this could result in the core aim of social prescribing getting lost.

Organisational Respondents

9.13 Most frequently mentioned was the need to link the planned competency framework to existing standards wherever possible. Several respondents requested a single set of standards, meaning a new competency framework should encompass existing relevant standards. This may require a mapping of existing professional standards to understand how social prescribing fits in with them.

9.14 The standards mentioned included:

- The Professional Records Standards Body Social Prescribing Standard,
- Professional Standards for Pharmacy Professionals,
- The Social Prescribing Framework for Allied Health Professionals,
- The National Exercise Referral Scheme,
- The Public Health Wales TrACE framework, which is in in development,
- The new HCPC Public Health Standard, and,
- The Framework with Social Care Wales.

9.15 Some respondents cautioned that it may not be a good idea to frame professional standards as essential to the social prescribing framework, as it may lead to a perception that risk is distributed more similarly to a healthcare setting or alternatively, may put some organisations off from participating. One response emphasised that the focus should be on supporting a workforce that is not professionally regulated.

Workshop Findings

9.16 Stakeholders found it more difficult to comment on how the planned framework could best complement existing standards. Some suggested that it would be difficult to say until a final definition of social prescribing had been decided upon – and accordingly, an agreed understanding on the minimum qualifications that anyone involved in social prescribing should hold.

9.17 Stakeholders struggled to suggest specifics but did suggest the Level 4 Diploma in Advice and Guidance (following the emphasis on holding good communication skills). Some stakeholders were also concerned that having qualifications attached to standards could exclude grassroots organisations that provide valuable services.

Question 18 - Are there benefits and/or disadvantages of education and training to underpin the competency framework, that is academically accredited?

Individual Respondents

9.18 Individual responses to this question were mixed to positive with seven responses simply stating that there were benefits and disadvantages, the majority offering benefits, while over a dozen cautioned against underpinning the competency framework with academic accreditations.

9.19 The benefits of this link related to quality of the social prescribing service and the establishment of social prescribing as a career. Nine respondents said that education and training will help to maintain consistency and standards relating to social prescribing and can also add legitimacy/weight to the profession while providing social prescribers with more confidence. Through this training three respondents thought it would help the social prescribing professional to understand their role better and assist with upskilling.

9.20 Three respondents said that education and training would allow people to better understand the social prescriber role, that it would raise awareness about the role, it would assist the status of social prescribing, and people seeking social prescribing would be assured. In short, this link for some was a form of quality assurance.

9.21 Not unrelated, some respondents felt that the link would ensure social prescribing was embedded within health and social care. Four respondents said that education and training can provide professional development pathways and provide formalised career development

routes. Others thought that those who are passionate about social prescribing will welcome the opportunity for further education and training.

9.22 Conversely, a number of respondents felt that the link to education may act as a barrier and make social prescribing more rigid and exclusionary. Five respondents caution that education and training may add too many restrictions/demands and rigidity to social prescribing, feeling that it may become too regimented and exclusionary. Four respondents mentioned that accredited training does not always mean that someone is qualified enough to do the job. Experience and emotional intelligence are just as important. Two respondents suggest "train the trainer" programmes, that sometimes academic situations do not work for everyone. Furthermore, one respondent suggested that there can be training but it does not necessarily have to be academic. Two respondents mentioned that education and training is important, but it could be optional. Mandatory education and training could be a barrier to some. One respondent said it could be a long and costly exercise.

Organisational Respondents

9.23 Organisational respondents identified both benefits and disadvantages. Benefits were identified for the service as a whole, for the social prescriber and for communities. Respondents felt that underpinning the framework with accreditation would add value and acts as a form of quality assurance giving confidence to those referring into the service providing it with a recognised, standardised level of quality. It was felt that the education and training would underpin the ability to implement the framework, provide expertise to communities and allow for greater equality of provision. Finally, organisations felt that education would be important for the development of the future workforce, building a network for workers, while also supporting others to transfer into the workforce, or transfer into other health sector roles building awareness of social prescription across the health service.

9.24 In terms of disadvantages, several respondents indicated academically accredited training could deter some smaller organisations due to the

cost; it could impede recruitment and retention and could over-professionalise the workforce. One organisation was concerned that post-qualification, workers would move on to different, higher paying jobs. The concern that academic qualifications could overshadow important lived experience was also mentioned several times. Any qualifications should recognise soft skills and should not de-value organisations that work on the basis of trust. One respondent said that academic qualifications could effectively be a "tick box exercise" while others said the focus should be on skills and attributes. Any education and training should carefully consider barriers such as cost, time, and existing workload, and should not exclude those currently doing this work. Additionally, a future framework which includes accreditation must consider existing social prescribers pay bands, terms and conditions.

9.25 Ultimately, several respondents recommended that academic accreditation should not be mandatory, with one suggesting minimum quality standards instead, with formal accreditations acting as a bonus. Respondents also cautioned that all training must be quality-assured and accessible at the outset with one respondent pointing to The Personalised Care Institute statement that the link worker role was in its infancy and accreditation should be considered further in its development. Respondents also mentioned the need to determine a list of competencies that are proportional to the size of the organisation and to make the necessary training easily accessible and possibly free, given the time and cost it would otherwise take away from the budgets of third sector organisations.

Workshop Findings

9.26 Stakeholders primarily emphasised the need for long-term funding for organisations in order to deliver this. Limited or time-restricted funding can make it difficult to invest in training opportunities which are of benefit in the long-term, leaving no room for future planning. It will also be essential to consider cost implications, to avoid excluding smaller organisations

altogether. Some also suggested that digital poverty might be a factor, and that we cannot assume all organisations/individuals have the digital resource to participate in this education and training

Question 19 - What other actions could we take at a national level to support the development of the workforce?

Individual Respondents

9.27 Fourteen individual respondents highlighted the important of training or education, particularly training that focussed on the real world, is accessible and considers the mental health and well-being of staff.

9.28 Accessibility considered both the mode of delivery and financial constraints with six respondents mentioning financial support/compensation for time spent training/appropriate remuneration and further funding is a necessary action.

9.29 The form of education/training was also important with a comparison between academic and non-academic opportunities arising. Five respondents mentioned cross-sector collaboration and knowledge sharing. Two respondents highlighted the importance of having informal support forums to confidentially discuss some issues seen in the field. This is an opportunity to "off-load"/share in a safe space and is also a networking opportunity.

9.30 Individual respondents were also keen to see the Welsh Government promoting social prescribing as a career path and raise awareness of the benefits and the good that social prescribing does.

Organisational Respondents

9.31 Many respondents emphasised the value of training, available in English and Welsh, including on coaching, behaviour change, outcomes-focused approaches, and how to support local organisations. Training could be specific to working with particular groups (e.g., young people) and linked

with other workforce development initiatives in different sectors. Any training should be accessible for rural populations.

9.32 Several respondents underscored the need to support those who work in social prescribing to prevent burnout and facilitate retention. This means building in time, funding, and resources for social prescribers to keep up to date with local community assets and build relationships in their communities and ensure they are provided with appropriate supervision and are not made to work over-capacity. National and local practitioner networks for mutual support and development were suggested in several responses. Additionally, several respondents highlighted the fact that many of those who work in this sector are low-paid women or volunteers, so any actions should be sensitive to this.

9.33 Finally, respondents said it was important to work with those already doing this work and to collaborate with health and social services so as not to "reinvent the wheel." Effective support and valuing of this work should also enable social prescribing to be seen as a legitimate career pathway, which several respondents saw as crucial, asking questions about the type of applicants they were expecting at given salary levels.

Workshop Findings

9.34 Stakeholders raised a number of suggestions for supporting development of the workforce including:

- Welsh Government providing training and wellbeing programmes to support the workforce
- Ensuring that staff are trained to a certain calibre/standard, to support happy and safe workspaces
- Ensuring that social prescribers or Link Workers are viewed as valued professionals, and that there are professional development pathways for them
- This should be reinforced by corresponding pay scales and consistent job descriptions of the roles across Wales

- Involving people with lived experience in the design and delivery of workforce developments
- Providing webinars on key issues e.g. safeguarding.

Theme 7 Conclusion

9.35 From analysis across the responses to the consultation it is clear that the core skills within the competency framework, asked within Question 17a, should relate to communication, relation building and an understand of the wider health sector and healthcare needs, and practices when supporting someone living with complex needs. There was a focus on person-centred support, building additional specific skills such as ACE-aware practice, and developing deep knowledge about safeguarding.

9.36 Therefore, respondents to Question 17b as a whole were uncertain how to answer without a clear definition of social prescribing, and clarity on the position of social prescribers in the wider health and social care sector. There were conflicting recommendations for how the competency framework could be linked to existing professional standards, and whether this risked excluding organisations providing valuable services from the framework.

9.37 Overall, Question 18 received a mixed to positive response with respondents emphasising the potential benefits, such as underpinning the new service, quality assurance, career and skills development for the workforce and raising awareness throughout the health service. These were tempered by cautions that accreditation may act as a barrier to those providing valuable services, the cost implications of such an accreditation, and whether accreditations capture everything that is important in the role. Therefore, while education and training were deemed important and beneficial the view was generally expressed that it should also be proportionate and appropriate.

9.38 The responses to Question 19 as a whole focus on three levels of support that can be taken at the national level; the provision of training, which is accessible, affordable, relevant, and proportionate, support for the workforce through funding, wellbeing, and networking, and valuing the

workforce by ensuring there is a career pathway with clear and appropriate salary scales.

10. Theme 8 – Technology Analysis

10.1 N.B. These questions concentrated on the use of technology in relation to specific areas of Social Prescribing covering the referral process, assessment process, access and delivery of community-based support, and management of information/reporting of outputs. These topics were not covered with focus group participants.

Question 20a - What are your current experiences of using digital technology in the following areas of social prescribing? (*Referral process, assessment process, accessing community-based support, delivery of community-based support, management of information and reporting of outputs/outcomes***)**

Individual Respondents

10.2 Individual respondents had varied experience of using digital technology. Whilst many had no relevant experience at all, digital technology was predominantly used for the management of information such as reporting and the referral process through emails and calls.

10.3 Twelve respondents stated that they had limited or no relevant experience with the application of digital technology to social prescribing practices.

10.4 In terms of those that did have experience, five respondents commented on their direct use of digital technology within the referral process, including the use of ‘Referent’, ‘Elemental’ and through emails.

10.5 Eight individuals had experience in the management of information and reporting of outputs/outcomes using online databases. Examples shared included using ‘Elemental’ for recording information, ‘Lamplight’, as well as their own organisations’ management systems.

10.6 Two individuals had experience in the delivery of community-based support through a mixture of in-person and digital approaches. Two also shared experiences of accessing community-based support through social media.

10.7 Three respondents had experience in using digital technology in all listed areas of Social Prescribing.

Organisational Respondents

10.8 Organisations shared that the use of digital referrals were generally helpful. That said, they are complemented by trust and effective working relationships between referees and third sector services.

- *Referrals*

10.9 Some respondents shared examples of their own digital referral processes, for example Montgomeryshire Wildlife Trust who has just recently developed an online referral process through their website, and is about to go live. The organisation expects this to make it much easier for the team to manage referrals, in contrast to the manual alternative of sending multiple emails back and forth. Similarly, Credu shared that they operate with an online referral form.

10.10 Crucially, organisations emphasised the need to ensure that different referral processes can be aligned. This was evidenced through examples organisations shared of Social Prescribers based in GP surgeries having different referral processes than those who are based in the community. Some organisation responses reflected this directly, sharing that their experience had only ever been via telephone or physical referral documents. It was suggested that the various systems and processes should be linked as traditional methods will still need to be used, in order to cater for those who digitally excluded.

10.11 In this context, Elemental was mentioned again – with organisations discussing how the platform enables the receipt of referrals from multi-sector agencies (including GPs, mental health professionals, social care,

link-workers, and self-referrals). Multiple references were made again to the simplicity that the platform enables, and responses indicated a general level of support for a universal style system which streamlines the process.

- *Assessment*

10.12 Elemental was also praised in terms of its ability to manage and record the assessment process. One organisation also noted that whilst successful projects standardise assessment progress in accordance to their own unique community, technology can be used and applied to reflect these differences in approach.

10.13 By contrast, one organisation commented that the assessment process should always be handled face-to-face.

- *Access*

10.14 In terms of access, organisations shared experience of linking individuals to appropriate support via the 'Connect' platforms. In this context, the use of Elemental was also directly linked to efficiency and freeing up time for link workers – enabling them to provide more capacity for patients.

- *Delivery*

10.15 In terms of delivery, organisations shared that digital technology had been beneficial in their experience, such as in the provision of chatrooms and forums for sharing good practice and opening up peer support. These had led to the creation of online communities of practice.

10.16 In addition, one organisation shared that a new service developed by Access enables individuals to communicate with their own dedicated member of the implementation team who helps populate their DOS and enable regular health checks.

10.17 Another platform highlighted was 'Insight', Innovate Trust's free community app for adults with disabilities across the UK. The organisation shared that it has a large membership base and aims to be the 'go to' hub for online and in-person activities where people can interact in a friendly online space.

- *Management of information/reporting*

10.18 Organisations reported that 'most' Carers Trust Network partners and some CVCs use local CRM systems to capture outcomes. One example shared was 'Charity Log'. In addition to this, organisations shared that Health Boards are investing in CRM programmes too, drawing attention to Hywel Dda University Health Board's investment in Access, to provide better connections between link workers and multiple service providers.

10.19 Specifically, Elemental was reported as helpful in terms of its tracking of outputs – which could provide the kind of quantitative data that many professionals commented would be desirable for demonstrating the value of social prescribing.

10.20 One organisation also detailed that the use of digital technology in terms of gaining participant feedback through the distribution of surveys and activity monitoring forms had been helpful for the evaluation process.

Additional Considerations

10.21 Some organisations provided far greater detail on the potential/perceived advantages and weaknesses of using digital technology to support these areas, rather than commenting on their own experiences.

10.22 Generally, organisations demonstrated a lot of positive sentiment around the benefits that digital technology could bring to the social prescribing process. These included:

- Enabling greater efficiency
- Enabling a wider reach for services
- Access to different systems and sources of information
- Helping people to be better connected in rural communities
- Helping to capture the community-based support elements of social prescribing.

10.23 On the other hand, some used this space to express caution, though these comments related to perceived flaws in the current process – through which digital platforms and records can often be disjointed. This

was highlighted by one organisation drawing attention to the fact that the third sector's lack of access to NHS platforms can be a barrier to effective joint working. Additionally, it was noted that the use of multiple platforms/duplication of digital records could be unhelpful, as it still results in patients needing to repeat their experiences many times.

10.24 Where used effectively however (in platforms where a patient's journey could be shared), the organisation suggested that this could not only reduce time but also trauma, alleviating the need for people to revisit the same difficult experiences over and over.

Workshop Findings

10.25 Professional stakeholders in workshops discussed their experiences of their workload being 'moved online'. A minority of stakeholders suggested that this could be overwhelming, illustrated by one participant for example, who described being 'catapulted into digital-focused work'. There was some feeling that this resulted in the need for more skills and services in order to deliver social prescribing, i.e. the need to be "both an IT-helpdesk as well as a dietitian".

- *Referrals*

10.26 Workshop attendees reinforced the importance of a person-centred approach to the referral process, utilising digital technology when appropriate but not being too prescriptive in terms of what the service should include. Ultimately, it was felt that this should be driven by what the individual wants and needs, and that a hybrid approach is most suitable.

- *Delivery*

10.27 COVID-19 was cited as providing an opportunity for pivoting the delivery of community-based support online. Stakeholders shared that there has been progress in the 60+ age group and in care homes where sport activities are conducted in a home setting. It was however reinforced that

face-to-face delivery of community-based support is still the preference where possible.

10.28 An example was also shared of a digital volunteering project, which involved setting up and inputting crowd-sourcing information for fundraising. This was highlighted to demonstrate the possibilities that online delivery can open up in terms of being able to create new opportunities for those who are house-bound to make meaningful contributions to volunteering.

- *Management and reporting*

10.29 In one workshop session, stakeholders discussed the difficulties of keeping track of multiple Excel spreadsheets for example when documenting and managing information – for this reason the use of specialist platforms were thought to be essential.

10.30 The software Elemental was listed by some stakeholders as being their preferred system due to the ease of use of recruiting, referring, monitoring and reporting information. A feature where participants can also access the system was thought to be desirable. Some stakeholders however did indicate concerns around using this in relation to cost, with one individual sharing that they would use it if their organisation were able to afford it.

Question 20b - How could the use of digital technology enhance delivery of social prescribing in these areas? (*Referral process, assessment process, accessing community-based support, delivery of community-based support, management of information and reporting of outputs/outcomes***)**

Individual Respondents

10.31 Individual respondents mentioned a range of ways in which digital technology could improve mostly the delivery of community-based support. Themes that appeared consistently was the ability to standardise processes, communicate more easily and provide improved support to those with mobility issues.

10.32 As direct experiences were limited in response to the previous question, perceptions for ways that digital technology could support the five areas further reinforced organisational responses in relation to positives and negatives.

10.33 To summarise individual responses, the most common view (shared by six respondents) was that digital technology could enhance delivery of community-based support through an online database or directory.

10.34 Four respondents thought that digital technology could enhance access to community-based support through better linkages with GP surgeries and partners, and improving access for those with mobility issues.

10.35 Two respondents commented that digital communication could enhance the referral process through enabling standardised referral methods. Two respondents also believed that it could support the management of information through standardised reporting and information sharing.

10.36 One respondent mentioned the possibility of assessment data gathering in order to measure impact.

Organisational Respondents

- *Referrals*

10.37 In terms of referrals specifically, participants commented that digital technology could enhance the process in the following ways:

- Creating a single point of contact for referrals
- Providing availability 24/7
- Saving confusion for self-referrers
- Streamlining to ensure greater data protection, with all information stored securely in one place
- Speeding up and simplifying the process
- Promoting greater awareness and access to support services that are available.

- *Assessment process*

10.38 Similarly, organisations felt that digital technology could simplify the assessment process, “when made easy with as few click-throughs as possible”. Consequently, it was also hoped that technology could help to cut down on bureaucracy, which would be advantageous for both staff and patients.

10.39 One organisation also suggested possibilities for using digital technology in different ways. For example, the use of digital tablets during consultation to support practitioners when talking through what is available with patients and encouraging engagement with social prescribing.

10.40 Consistency was noted again in relation to assessment, with organisations describing the potential for the auto-grading of assessments which would offer a standardised approach to the process.

- *Access*

10.41 Comments around access from organisations linked back to earlier emphasis on the value of a centralised online directory.

10.42 Opportunities to provide direct access, in terms of communication (i.e. ‘chat to an advisor’) functions were also suggested to be a beneficial avenue to explore. This response also discussed the opportunity it may provide to offer a more-rounded level of support, for example through self-directed objectives and goals, and other support tools.

10.43 Finally, some organisations also shared the creative ways in which technology can be used to support access for some service users which would otherwise not be possible. For example, the RSPB in England has a live stream bird feeder in some places, which is viewed by people living in care homes. Whilst multiple organisations and stakeholders emphasise that virtual activities should not become a replacement, they do cite several opportunities for virtual activities to complement other services.

- *Delivery*

10.44 The above sentiment was echoed in relation to delivery. A new suggestion in relation to this question was the use of technology to map

out community-based support across Wales, identifying unmet needs or gaps. This would inform 'intelligence-based' commissioning for future services.

- *Management of information and reporting of outputs/outcomes*

10.45 The majority of suggestions around enhancement for management and reporting processes were focused upon the centralisation of booking management, the patient journey, and data collection.

10.46 If done properly, organisations felt that this would have a great potential to enhance reporting of outcomes, which have typically not been handled in any one unified way. Suggestions around this included the integration of a key indicator dashboard, online surveys to evaluate services, and development of an Audit+ module to support data collection.

Workshop Findings

- *Referrals*

10.47 Some stakeholders expressed concerns around practicalities – for example, the reality that traditional pen and paper methods are still heavily relied upon in GP settings, making the transition to digital methods a substantial switch that shouldn't be under-estimated

10.48 Some stakeholders raised the suggestion of the NHS App being used as a portal for referrals/self-referral.

- *Access*

10.49 In terms of promoting access to community-based support, multiple stakeholders suggested that further investment would be needed in digital infrastructure for community and public spaces.

10.50 The benefits of using digital technology were recognised as valuable for those who have extreme social anxiety.

- *Delivery*

10.51 Stakeholders across the workshops felt that there was a place for digital technology to enhance delivery, but that it should be viewed as an option to complement services – as opposed to the norm/standard practice.

10.52 A number of stakeholders were conscious of digital exclusion and highlighted that digital platforms can be exclusionary unless the right support is in place.

10.53 Stakeholders referenced specific examples of designated digital social prescribers, whose job was to advocate and build competencies in digital skills – drawing on knowledge of this being supported in Scotland.

- *Management of information and reporting of outputs/outcomes*

10.54 In order to monitor outcomes, stakeholders felt that there should be more efforts to establish agreement of core/expected outcomes – this was also emphasised in relation to cost. They felt that if platforms for monitoring and administering services are to require investment, and payment is provided by the health board, then there needs to be a wider consensus on what is being used and why.

10.55 Finally, stakeholders suggested benefits that would be associated with a central database for managing information, including removing pressure from smaller organisations to give reports, and being able to indicate which activities and services are actually being used by individuals.

Theme 8 Conclusions

10.56 Individual respondents had a varying experience of using digital technology. Whilst many had no relevant experience at all, digital technology was predominantly used for the management of information such as reporting and the referral process through e-mails and calls. Organisational responses demonstrated a wealth of experience in utilising digital technology for these areas in wide and varied ways. They particularly highlighted the role of the pandemic in transforming usage, and the role that technology had played in increasing access. However, this was tempered by those who lacked experience, and many cautioned

against a reliance on technology due to the digital divide in service provision. Workshop stakeholders shared examples of the ways in which digital delivery had been able to engage and reach groups that otherwise would have been excluded from support (particularly in relation to the restrictions imposed by the pandemic).

10.57 Individual respondents mentioned a range of ways in which digital technology could improve, mostly the delivery of community-based support. Themes that appeared consistently were the ability to standardise processes, communicate more easily and provide improved support to those with mobility issues. Organisational responses included suggestions for the use of digital technology across each of these areas. There was a particular focus on the referral process with the hope that this would increase the speed and ease of referrals, as well as the access to information. Management of information and reporting of outputs featured prominently, as respondents offered suggested features for a reporting system such as an online portal to upload evidence and stories. Again, this was tempered by the issue of accessibility. Workshop stakeholders highlighted that digital delivery presents valuable opportunities for those who are particularly limited by conditions such as extreme social anxiety, or those who are housebound or face multiple barriers to engaging in a face-to-face setting.

11. Theme 9 – Welsh Language Analysis

11.1 N.B. Focus group stakeholders were not asked any questions related to this theme.

Question 21a - We would like to know your views on the effects that the introduction of a national framework for social prescribing would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be?

Individual Respondents

11.2 Five respondents did not believe there would be any notable effect on the Welsh language.

11.3 Four respondents raised concerns around catering for a varying Welsh dialect in all regions as the level of proficiency is different for all.

11.4 Two respondents mentioned the increased resource associated with additional language provision such as training, funding and individuals to deliver:

> "It should go without saying that all social prescribing services, including a national framework etc. should be equally available in English and Welsh. This will have a positive impact in ensuring no inequalities and also in terms of providing services to those who speak Welsh as a first language."

> "Delivering anything in Welsh is a challenge and expensive, I'm a proud Welsh person and don't want to see the language go, but it’s crazy the situation we are in with the Welsh Language Act."

Organisational Respondents

11.5 Three organisations did not believe that it would impact upon opportunities to use the Welsh language, and two organisations were unsure or didn't know if it would have an impact.

11.6 Two organisations felt that it was possible that social prescribing could increase opportunities for people to use the Welsh language if it is ensured that prescriptions are available in Welsh.

11.7 One organisation felt that it would depend on the setting and group. For example, in Carmarthen or Ceredigion, they felt that it may improve opportunities, whereas in communities where there are now a smaller proportion of Welsh speakers such as Pembrokeshire, there will likely be less of an impact.

11.8 Several respondents mentioned the need to accommodate for other languages, and that there are currently fewer opportunities for this to be done.

11.9 A number of respondents also mentioned that the framework should be used to provide baseline for provision of services in Welsh in all areas of Wales, with gaps in the framework regarding the use of the Welsh language needing to be addressed in order to increase opportunities for use.

11.10 Another organisation felt that a national focus on social prescribing would perhaps strengthen opportunities for the Welsh Language at a community level. They felt there are currently gaps and weaknesses related to Welsh Language Standards which reduce the rights of individuals to receive face-to-face services through Welsh. Two respondents shared:

> "The Welsh language and the planning of services through the Welsh language should be absolutely central to any such framework rather than relying on external bodies or individuals to correct these weaknesses".

> "There will be no impact on the Welsh language provision within social prescribing if appropriate attention is not given to the Welsh language in all aspects of the national framework."

Question 21a(b) How could positive effects be increased, or negative effects be mitigated?

*Individual Respo*nses

11.11 Some respondents believed that there should always be choice given to the individual on engaging in activities in either Welsh or English and the freedom to be able to access services bilingually.

11.12 Six respondents mentioned the development of a set of standards within the social prescribing service to encourage bilingualism as a core provision, not an extra option.

11.13 One individual raised the point that if Welsh is catered for, other languages should also be considered.

Organisational Responses

11.14 Respondents were concerned that the framework does not currently reference the 'Active Offer' (to provide services in Welsh without someone having to ask).

11.15 Involving Welsh speaking citizens from the outset was mentioned as essential to improving social prescribing opportunities through the medium of Welsh. This could be done through a community-based needs assessment approach.

11.16 It should also be noted that some organisations felt that not all programmes should be required to be available in Welsh depending on the context of the local area.

11.17 With a consistent national training pathway for social prescribers, it was suggested that the Welsh Government should consider education opportunities for social prescribers to learn the Welsh language as part of this training. It was suggested that the promotion of the Welsh Language could be achieved through upskilling staff through incentives such as free lessons as well as the production of bilingual material.

11.18 Funding was a concern, and resource in order to translate documents and other key information into Welsh and other languages was mentioned.

11.19 Recruiting a workforce that is bilingual in both English and Welsh was raised. This ensures individuals accessing social prescribing services can communicate in their language of choice.

11.20 As well as the workforce, ensuring other resources such as directories, training materials and support guidance is available dual language as well as ensuring technology can cope with a mixed use of language (often referred to as “Wenglish”) was mentioned.

11.21 Ringfenced funding was proposed to mitigate that in some parts of Wales, Welsh is not widely spoken and bilingualism will increase costs and delay service provision.

11.22 Several answers mentioned activities and services, these included:

- Ensuring that Welsh language activities were available as a provision (mentioned by two respondents)
- Considering the resource of Welsh language that is available when commissioning
- That the national framework specify support must be available through the medium of Welsh. Health board and local authority market stability reports were mentioned as ways to ensure that there is a sufficient supply of Welsh-language services to deliver this service. The Commissioner expects, as a minimum, older people being able to receive support in the language of their choice
- The Active Offer of Welsh in service provision where possible was also brought up by this group, particularly ensuring it is available in certain parts of Wales (For example in West Wales and North Wales) and to certain groups such as older people and children and young people.

11.23 Another common theme raised was communications. Three respondents stressed that communications should be made bilingual at all times. Furthering this point, one organisation suggested that to avoid duplication of services purely for language, priority should be given to bilingual

communications in order to attract native Welsh speakers into the system/framework.

Workshop Responses

11.24 Workshop stakeholders emphasised the importance of ensuring that information around services and activities are recorded properly. Consequently, those making referrals can understand and easily identify which services are available to access in Welsh.

11.25 Stakeholders recognised that there will likely be fewer services available in Welsh and that it may be challenging to for smaller organisations to provide the 'active offer' whilst operating in areas where Welsh language resources are scarce.

11.26 It was felt however that social prescribing services should operate as equitably as possible in terms of language provision.

Question 21b - Please also explain how you believe the proposed a national framework for social prescribing could be formulated or changed so as to have positive effects or increased positive effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.

Individual Respondents

11.27 It was felt by some individual respondents that a Welsh service should be automatic rather than a request (the implementation of the ‘active offer’ within the social prescribing setting). To supplement this, a suggestion was made that the framework could include training in order to teach those who currently do not have Welsh language skills basic language required to at least refer people to information in their preferred language.

11.28 All resources such as paperwork, training and digital infrastructure should be readily available for staff and members of the public bilingually.

11.29 As well as the above, a respondent also mentioned ensuring community support activities can be provided bilingually.

11.30 One respondent shared:

> "Social prescribing is connecting citizens to community support to better manage their health and well-being. This could have a very positive effect on the Welsh language as people will have the opportunity to meet and speak [with] others through the medium of Welsh."

Organisational Respondents

11.31 The ‘active offer’ was again raised by several organisational respondents:

- In order to deliver the 'active offer' and refer people to Welsh medium provision, users, professionals and organizations must be aware of the local provision available in Welsh and be able to access it
- There should be support in place to ensure a range of activities can be provided through the medium of Welsh wherever the participant lives
- The language in which the service will or can be provided should be clearly marked within the directory.

11.32 Training was also raised by organisational respondents, this included:

- Training delivery staff in the Welsh language so that they are able to deliver sessions (or parts of sessions) in Welsh as well as sharing information about the cultural or historical meaning behind Welsh names (such as place or species names)
- The importance of bilingualism as a core competency was raised. The point was made in relation to knowledge and skills but is relevant in this context.

11.33 A theme of choice was raised in this question, answers included:

- Adult Learning Wales continuously work with learners whose first language is neither English nor Welsh and adapt all work according to choice, stating: “we see no adverse effects in embracing other languages, only enhancement of the understanding of and compassion for people.”
- There should be a clear choice given to individuals on whether they wish to access services in Welsh, English or another language and be triaged appropriately with no discrimination, that “Language of choice should be a given whilst still acknowledging constraints”.

11.34 One respondent believed that there should be an improvement in the existing evidence base with a focus on social prescribing through the medium of Welsh.

11.35 One respondent noted that the use of bilingual publicity material could be in itself a method of communicating and a teaching method for the Welsh language.

11.36 The Welsh Language Commissioner shared that: “After considering this consultation document, the Welsh Language Commissioner is considering the Welsh Ministers' compliance with the Welsh language standards, and it is possible that further correspondence will follow from in this regard.”

Workshop Findings

11.37 Workshop attendees stressed the importance of ensuring equitable access to social prescribing services in the Welsh Language where requested.

11.38 Workshop attendees who have experience of delivering groups in both English and Welsh mentioned that only a small number of community groups operate in Welsh in certain areas, therefore ensuring that resources are used as effectively as possible is necessary.

11.39 It was also mentioned how small community groups can’t be mandated to deliver activities bilingually, therefore a way to record in a central

database whether activities are provided primarily in Welsh or English would enable Welsh speaking groups to be easily identified and filtered.

Theme 9 Conclusions

11.40 There was a mixed response to if and to what extent there would be an impact on the Welsh language with the introduction of the national framework. Caveats to this included the diversity of use in Welsh language across the country, meaning impacts could never be equal in every community or setting.

11.41 The 'active offer' was mentioned several times, whilst there were acknowledgements of difficulties in mandating Welsh within community groups, remedies such as training and other additional resources were mentioned. It was felt that implementing the active offer would be easier if resources such as databases, literature, marketing and paperwork were consistently available through the Welsh language as this could also be a learning opportunity.

11.42 Though there was a general support for further use of the Welsh language, there continue to be concerns from many respondents as to how this additional workload would be resourced. This was especially prevalent when considering the geographical differences in levels of Welsh resource available and the percentage of a population that speaks Welsh which vary in each community. Requests for additional resource in order to support the Welsh language such as training, funding, a labelled directory and workforce were brought up continually as something which could have an impact.

Ensuring the service also remained diverse and inclusive by supporting other languages was also repeatedly mentioned, in order to maximise inclusion and reduce barriers to participation.

12. Final Comments Analysis

Question 22 - We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Individual Respondents

12.1 Limited comments were received by individual respondents to this question. Of those who did reply, two individuals said that social prescribers need to be properly embedded and linked to NHS services if based in the third sector, and that sustainability of GP services must be considered.

12.2 It was mentioned that a standard should be identified that can be continually assessed by a “certified commercial company”.

12.3 One respondent mentioned that patience, mutual respect, trust and adequate funding are key to a successful programme.

12.4 There was a suggestion that social prescribers should be located within the community in order to truly understand the needs of those in the area.

12.5 Similarly, cultural competency and inclusion was mentioned as something not addressed in the questions asked.

Organisational Respondents

12.6 Due to the nature of the organisational responses, where the majority of responses were not provided in a consistent format, the responses were mapped into the consultation questions where possible. With regard to this question, where comments were made which do not fit into the consultation, these responses have been structured into specific themes below.

12.7 Several respondents mentioned accessibility in their responses. These included:

- Ensuring the service is accessible at various times and through various channels to people with diverse accessibility needs, both to ensure equity and not further disenfranchise those most in need.
- Encouragement for the reference in the draft document to accessibility as knowing about and physically getting to community based support, as well as being accessible to those with additional requirements.
- Helpful to afford greater consideration to the role that transport, and especially community transport, plays in achieving access to social prescribing.
- Should be a greater emphasis placed on social or practical social schemes such as talking groups, befriending services, or practical help such as assistance with cooking, shopping or cleaning. Social prescribing should not exclusively be 'exercise prescribing'.

12.8 There was concern raised surrounding potential duplication, this was:

- Emphasising the importance and value of local differences and variations across Wales in relation to the delivery of social prescribing functions / roles / services. Whilst a framework will offer an umbrella by which good practice and learning can be achieved, there is a desire that it not to duplicate requirements upon local provision, or take away from actual delivery on the ground by using a blanket approach to provision.
- Concern that by expanding the referral options into Social Prescribing it will in turn create large waiting lists and duplication.
- Concerned surrounding the amount of potential referral routes outlined within the document into social prescribing. "We strongly believe that social prescribing should be aligned with clusters in line with ACD programme currently being implemented across Wales".
- The National Pensioners Convention (NPC) Wales provided a key quote with regard to potential duplication:

  "It seems to us that the best way forward is to continue the work that is being done by Health Boards and Local Authorities, learning

from the experience of the COVID-19 pandemic, to work together more effectively as they are doing. They are the key services and, more importantly are local."

12.9 Resources was brought up by several organisations, this included:

- One of the most important resources needed to get social prescribing right is dedicated roles with time focused on *building relationships*.
- More accurate, and detailed databases as "existing databases detailing community assets are often unreliable, incomplete, and/or not used effectively."
- Training was again mentioned, but with a focus on training to identify and overcome unconscious biases, as well as social model training designed and delivered by people with protected characteristics and/or particular needs to better understand people's individual circumstances and requirements.

12.10 Many organisations mentioned support for community organisations, this included:

- It was mentioned several times that the model as it stands tends to favour larger, well-known, well-funded organisation.
- Small organisations wishing to provide services but there is a lack of funding.
- Repeatedly brought up was support from the third sector for this issue has not received resources historically, therefore future plans should include current provision and support for this sector.
- Similarly, including local, key stakeholders in order to have an overview of what is already being done.
- Ensuring grassroots organisations led by/for marginalised people are included. With traditional routes of engagement, stakeholders shared that they are often exclusionary and require organisations to have sufficient capacity, resourcing, and few accessibility requirements to participate.

12.11 Funding was again brought up by several respondents,

- Two respondents raised the limited duration of funding results in a risk of losing skilled social prescribers or generally a failure to recruit quality candidates.
- It was shared that similarly, long-term sustainable funding would benefit Green Health providers who could deliver green social prescribing. They stated that this is why a funded and approved provider model with standards and a framework is proposed by the Welsh Wildlife Trusts.
- Several members also questioned how this framework will be resourced. It is felt the scale of need is likely to be higher than funding currently allocated through the RPBs.
- Audit Wales provided a key quote with regard to funding:

  > "While individual social prescribing projects tend to be relatively low-cost, it is important to be able to identify the total cumulative expenditure on social prescribing and to consider the opportunity costs. We recognise that it will be difficult to identify total spend as it comes from many parts of the public sector, the third sector and community groups. Also, some social prescribing projects depend heavily on volunteers. However, it would be helpful to understand the full cost of social prescribing, including direct costs, opportunity costs and the cost of the growing social prescriber workforce."

12.12 The priorities of the framework was also raised, with respondents believing there should be a particular focus on the following:

- Two organisations felt that there should be a focus on prevention.
- Four organisations felt outdoors and nature-based interventions should be prioritized, with an explicit outcome being to improve connection to nature for the sake of planetary health and prevention of illness.
- Community cohesion and engagement was again mentioned as a priority when planning service response.

12.13 Better clarity concerning particular elements of the framework was requested, this included:

- Confusion regarding references to mental health services being put under the third sector: “We assume you’re referring to third sector organisations and not secondary care, but it would be helpful for you to clarify that CMHTs would access in the same way as a GP”.
- A better understanding of what the service might look like for particular sub-sections of the population such as children and young people
- An explanation of how RPBs would fit into the framework and their specific roles.
- A distinction between “Social Prescribing” and “Signposting”.

12.14 One organisation stressed the need for tailoring to cater for different groups or sub sections of the population including older people “it’s very generic.”

12.15 The range of potential beneficiaries of social prescribing were described, these were:

- One organisation mentioned that most people think those with mild to moderate mental health difficulties, the elderly, isolated and carers are those most likely to engage with and benefit from social prescribing.
- One respondent said that anyone should be able to access the service, including those with severe and complex mental health and learning difficulties.
- There was concern raised surrounding access for ethnic minorities and those with severe financial constraints that may not have appropriate transport modes to access services. Others had concerns with reference to suitability for those with acute serious mental illness, substance abuse and neurodiversity.
- One respondent raised the issue that if delivered incorrectly, it could be damaging.

12.16 Respondents felt that there should be an awareness of things that previously, have not worked well. This included:

- Poor communications loop which results in unclear outcomes. To avoid this participants suggested the use of “Information Sharing Protocols” which are currently not in use.
- Limited options in the community to meet an individuals need, services instead to be built around current “gaps” in the community.
- Short term funding resulting in an abrupt end to a service and inequitable provision across a particular county with the example given in this context being Gwent.
- Generic or superficial social prescription that doesn’t take the needs of the individual into account (e.g., high anxiety levels, transport difficulties in accessing services/support), resulting in an ineffective service.
- Inadequate support for staff including a lack of training, and support with supervision or case management.
- Risk relating to individuals and risk assessments being an exclusion factor for support. It’s proposed that sharing risk assessments for people already within the systems of support such as mental health and/or learning disabilities would be beneficial.
- Currently, social prescribing is used to support those at crisis point, instead the service should be shaped to better focus on earlier intervention.

Workshop Findings

12.17 Stakeholders reiterated a range of issues that they felt would be important for further consideration. These included further thought and detail to be provided around the ways that social prescribing could be used to support young people (including young parents for example) and support general wellbeing.

12.18 Concerns surrounding terminology were raised once again in response to this question, with stakeholders suggesting that the language should be guided by those who use the services, “ask people how they would describe it”.

12.19 Stakeholders emphasised the importance of making sure social prescribing is properly integrated into the community, with local initiatives and activities are known about and are easy to access.

12.20 Finally, stakeholders drew attention to the fact that whilst efforts have been directed to raising awareness, equal emphasis must be placed on services themselves ‘which are already creaking’ if the model is to have any tangible impact.

Focus Group Findings

12.21 All thoughts shared during the focus groups with individuals from priority areas have been integrated into the main consultation questions.

Annex A – Consultation Questions

Your name:
Organisation (if applicable):
Email / telephone number:
Your address:

Is your response from the view point of:

A member of the public	
Provider of community support / well-being activity	
Provider of a social prescribing service	
Referral organisation	
A commissioning organisation/ funder	

1a	Do you think the model captures an appropriate vision of social prescribing within Wales? Yes / No
1b	If not, why not? Is there anything missing / not appropriate?
2a	What is your view of the language/terminology used in the model and supportive narrative? This may include the language and terminology used in both English and, if appropriate, Welsh.
2b	Do you have any suggestions on alternative language / terminology? This may include the language and terminology used in both English and, if appropriate, Welsh.
3	How do we at a national level develop a common understanding of the language/terminology used to describe social prescribing for both professionals and members of the public alike? This may include the language and terminology used in both English and, if appropriate, Welsh.
4a	What actions could we take at a national level to help professionals (from healthcare, statutory and third sector organisations) know about, recognise the value of and be confident in referring people to a social prescribing service?
4b	In the case of self referrals, what actions could we take at a national level to help members of the public know about, recognise the value of and be confident in contacting a social prescribing service?
4c	In the case of targeted referrals, what actions could we take at a national level to help organisations identify specific populations/groups of people who might benefit from contacting a social prescribing service?

5	What actions could we take at a national level to support organisations/groups offering community based support to engage with social prescribing services?
6a	What actions could we take at a national level to minimise inappropriate referrals into a social prescribing service?
6b	What actions could we take at a national level to minimise inappropriate referrals from a social prescribing service into community based support
7	Which actions could be taken at a national level to support strong leadership and effective governance arrangements?
8	What actions could we take at a national level to support the commissioning process and help engage the public in developing a local level model which meets the needs of their community?
9a	Do the current online directories and sources of information provide you (in an easily accessible format) with the all the information you need to make decisions on the appropriateness and availability of community based support?
9b	Are there other online directories / sources of information you use?
9c	What are the key features you think online directories should provide to help people access community based support?
10a	What actions could we take at a national level to help address the barriers to access?
10b	What actions could we take at a national level to help address barriers to access faced by more vulnerable and disadvantaged groups?
11a	Should the national framework contain a set of national standards for community support to help mitigate safeguarding concerns? Yes / No / Not sure
11b	If yes, what are the key things the national standards for community support should cover?
11c	If no or not sure, what are your main concerns around the introduction of national standards for community based support and how might these be addressed?
12	What actions could we take at a national level to help overcome barriers to using digital technology for community based support?
13	What action could we take at a national level to support effective partnership work to secure long term funding arrangements?
14	What actions could we take at a national level to mitigate the impact of the increased demand on local community assets and well-being activities?

15	In your view what are the core things we need to measure to demonstrate the impact of social prescribing?
16a	Do you have any research or evaluation evidence you'd like to share with us
16b	Do you have any suggestions on how the implementation of the national framework in Wales can and should be evaluated
17a	What are the key knowledge and skills the planned competency framework should cover?
17b	How can the planned competency framework best complement existing professional standards?
18	Are there benefits and/or disadvantages of education and training to underpin the competency framework, that is academically accredited?
19	What other actions could we take at a national level to support the development of the workforce?
20a	What are your current experiences of using digital technology in the following areas of social prescribing? • Referral process • Assessment process • Accessing community based support • Delivery of community based support • Management of information and reporting of outputs / outcomes
20b	How could the use of digital technology enhance delivery of social prescribing in the following areas? • Referral process • Assessment process • Accessing community based support • Delivery of community based support • Management of information and reporting of outputs / outcomes
21a	We would like to know your views on the effects that the introduction of a national framework for social prescribing would have on the Welsh language, specifically on opportunities for people to use Welsh and on treating the Welsh language no less favourably than English. What effects do you think there would be? How could positive effects be increased, or negative effects be mitigated?
21b	Please also explain how you believe the proposed a national framework for social prescribing could be formulated or changed so as to have positive effects or increased positive effects on

	opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language, and no adverse effects on opportunities for people to use the Welsh language and on treating the Welsh language no less favourably than the English language.
22	We have asked a number of specific questions. If you have any related issues which we have not specifically addressed, please use this space to report them:

Annex B – Focus Group Questions

A clear model for social prescribing in Wales		
1	Before today, had you heard about 'social prescribing'?	Yes / No
2	Does the social prescribing service model for Wales (the video) explain clearly what it is?	Yes / No
3	Is there anything that we can do to make the model easier to understand?	
4	Are there any words or expressions in how we explained the model, which were difficult to understand or confusing?	
5	Do you have any ideas about how we can show people the benefits of social prescribing?	
A local social prescribing service for you		
There are social prescribing services in some parts of Wales already. If there is one near you, you might know it as a "community connector service" or a "wellbeing service".		
6	Now that you've watched the video about what social prescribing is, what do you think would make a good social prescribing service for you?	• Someone who gets to know me and what's important to me • Information about what community based support is available locally (signposting) • Hands-on support to access community groups and activities • Other
7	What are the best ways for us to tell you about your local social prescribing service?	• Social media (for example Facebook, Twitter) • A social prescribing service website • Word of mouth through people you know (friends or family) • Information from professionals who know you (health professionals like your GP or nurse, council professionals like housing officers or social workers, local services or groups, etc.)

		• Adverts in local community centres, libraries, leisure centres, doctors surgeries, etc • Other
Knowing what community based support is available to you		
8	How well do you know what community based support (groups and activities) is available locally?	• All of it • Most of it • Some of it • A little bit of it • None of it
9	How do you currently find out about what community based support is available locally?	• Social media (for example Facebook, Twitter) • A social prescribing service website • Word of mouth through people you know (friends or family) • Information from professionals who know you (health professionals like your GP or nurse, council professionals like housing officers or social workers, local services or groups, etc.) • Adverts in local community centres, libraries, leisure centres, doctors surgeries, etc • Other
10	If online – what website do you use?	• DEWIS • INFOENGINE • Facebook • Google • NHS website • Council website • Charity website • Other
11	Do any of these get in the way of you finding out about what community based support is available locally	• Don't know who to ask • Find it difficult to access information online • Haven't seen any information in the local area • Don't see the benefit in looking for community based support • Other
Barriers to accessing community based support		
12	Do you think there is a good range of community based	• Yes, there is lots going on • There's a limited range No, there's very little going in • I'm not aware of what is available

	support available in your local area?	
13	Would you like to access community based support (groups and activities)?	• Yes, I currently take part in groups and activities and this helps my wellbeing Yes (I don't take part in any groups or activities at the moment) • No
14	What is currently stopping you accessing community based support in your local area?	• Don't know about the support available for me • Worried about meeting new people • Health concerns • Don't have time • Caring responsibilities • Not able to get transport to location • Don't see the value in attending • Other
15	What would help you to access community based support?	• Being able to get there • Having access to technology • Knowing people involved were sympathetic to my health needs • Meeting people who were in a similar circumstance to me • Having someone to go with me until I made new friends • An understanding of the benefits to my well-being • Other
16	Would it help you to access community based support if you knew it was, for example, dementia friendly, autism friendly, accessible for people with hearing/sight loss, etc?	• Yes • No

Annex C Responses to Question 16a

Question 16a: Do you have any research or evaluation evidence you'd like to share with us?		
Individual Responses		
Resource	**Link**	**Description**
Local Area Connection (LAC)	https://inclusiveneighbourhoods.co.uk/power-and-connection/	15 independent academic carried out regarding LAC and inclusive neighbourhoods
The Arts and well-being	https://wahwn.cymru/knowledge-bank	A Knowledge Bank website with a wide range of evidence of benefits of the arts, and its role in health and well-being. Specific details below
WAHWN film	https://wahwn.cymru/knowledge-bank/how-the-arts-in-wales-are-supporting-mental-health-and-well-being-during-covid-19	How the arts in Wales are supporting mental health and well-being during Covid-19
HARP - Health Arts Research People	https://healthartsresearch.wales/news-jobs-opportunities/wales-arts-and-health-organisations-call-for-arts-play-leading-role	Wales' arts and health organisations call for arts to play leading role in 'A Healthier Wales'
Creative Health: how arts, creativity and social prescribing support health equity	https://www.ucl.ac.uk/ucl-east/news/2021/jan/virtual-lecture-creative-health-how-arts-creativity-and-social-prescribing-support	Bridging the gap between diverse service users, service providers and policy makers engaged in social prescribing in Wales.
Creative Health: The Arts for Health and Wellbeing	https://www.culturehealthandwellbeing.org.uk/appg-inquiry/Publications/Creative_Health_The_Short_Report.pdf	A short report on how the arts contributes to health and well-being
Links to existing evidence - arts and health	https://healthartsresearch.wales/sites/default/files/2022-05/HARP%20-%20Links%20to%20existing%20evidence.pdf	More links to resources that bridge the gap between the arts and well-being
Evidence for Health Through Arts	https://padlet.com/drcathjenkins/sp9mv26se2mnt041	The early stages of the development of a new Arts in Health Research and Innovation Group within Hywel Dda health-board that the respondent is happy to share

England Health Report – Supporting Integrated Care Through Leisure & Culture	https://communityleisureuk.org/work/health-wellbeing/	A report produced in collaboration with the Welsh NHS Confederation to understand the impact of charitable leisure and culture trusts on community health and wellbeing and reducing pressures on the NHS
Social Prescribing of sport, exercise, and physical activity	https://sp-bpr-en-prod-cdnep.azureedge.net/published/HS/2019/12/4/Social-Prescribing--physical-activity-is-an-investment--not-a-cost/HSS052019R14.pdf	The Scottish Parliament's Health and Sport Committee produced a report on Social Prescribing: physical activity is an investment, not a cost that is worth reading
Salford Social Prescribing Hub	https://hub.salford.ac.uk/ssph/	Would recommend a revisit/review of Salford Social Prescribing hub model and application, regarding a mechanism to operationalisation of the framework
Impact of volunteering	https://static1.squarespace.com/static/60773266d31a1f2f300e02ef/t/623c84c9a9fa197ea40f460c/1648133323300/Williams_The_Impact_of_Volunteering_in_Archives_2018.pdf	Not Wales specific but there is the potential to introduce the collection of meaningful evaluation for volunteering in the archives sector - UK and Ireland based report that might be useful
WHO report on evidence on the role of the arts in improving health and well-being	https://apps.who.int/iris/handle/10665/329834	Growing body of evidence demonstrating the health and wellbeing benefits of engaging in creative and cultural activities
Published research articles about arts and health	https://healthartsresearch.wales/harp/resources/existing-evidence	Partnership Programme with Nesta and Cardiff University review of literature
Arts and Health in Wales: A Mapping study of current activity	https://arts.wales/sites/default/files/2019-02/Arts_and_Health_Volume_1_0.pdf	Arts and Health in Wales: A Mapping study of current activity

Workshop Responses		
Resource	**Link**	**Description**
	N/A	we have an established clinical and academic research programme and have been through all measures to identify which are most effective/accurate. It's telling stories that bring people in. What we find is that many of the measures are not inclusive – eg for those with literacy or language issues.
	N/A	School sport service survey. Welsh schools survey.
	N/A	There has been an 'Enabling the Environmental Sector review' carried out by the Green Recovery group led by the Welsh Government / NRW Green Recovery Group. Not just funding but structural issues too so may well have lessons for broader sectors that could be incorporated.

	N/A	use two models that are publicly available to use - wenwebs (mental wellbeing) and susubs (social wellbeing)
	https://stratahealth.com/	The digital company Strata I work for develops and links with national and local directories and matches criteria and automates referral
	N/A	better information project in advice sphere. Looked across 300 clinics on Law Works network, following up with clients who received advice. Will be doing interviews and questionnaire centring on wellbeing.
	N/A	provider POV collects stats on this type of thing. Hours involved, number of people involved. But qual more valuable here. Important to create statistical framework around it but can gain a lot from qual feedback.
	http://www.brightlifecheshire.org.uk/key-learning/capturing-impact/	There is also work that has been undertaken in conjunction between Bright Life and Chester University -
Wellbeing guidance. Available at Wellbeing guidance | The National Lottery Heritage Fund		Wellbeing Guidancevii for the UK heritage sector including recommendations on the primary roles of safeguarding, using robust evaluation methods, the integration of inclusive practice and wellbeing across the heritage sector.

Organisational Responses				
Type	**Aim**	**Resource**	**Link**	**Description**
Frameworks / Models				
Frame works / Models	Framework Development	Wild Skills Wild Spaces (WSWS)	https://www.montwt.co.uk/WSWS	Montgomeryshire Wildlife Trust's Wild Skills Wild Spaces evaluation is being undertaken by a team of 5 at Cardiff Met University led by Professor Diane Crone, with the objective of introducing standards and a framework to help influence WG social policy. I.e The need for long-term sustainable investment in the preventative care model
	Evaluation Model	The Recovery College model	https://newhorizons-mentalhealth.org.uk/courses/	The Recovery College model has been used by New Horizons Mental Health Charity for some time. Cardiff and Vale College and Cym Taf Morgannwg have both used the Recovery College model
	Evaluation Model	The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)	https://www.healthscotland.scot/health-topics/mental-health-and-wellbeing/wemwbs#:~:text=The%20Warwick%2DEdinburgh%20Mental%20	Warwick – Edinburgh Mental Wellbeing Scale as evidenced by Warwick Medical School has both a 7 item scale which is shorter and more concise and a 14 item scale for more in depth picture of mental wellbeing

			Well,mental%20health%20indicators%20for%20adults.	
	Dataset	Developing a core minimum dataset for a social prescribing evaluation framework	carolyn.wallace@southwales.ac.uk Mark.llewellyn@southwales.ac.uk Sophie.randall@southwales.ac.uk Contact for details	University of South Wales - Developing a core minimum dataset for a social prescribing evaluation framework: A Group Concept Mapping Study
	Framework Development	Supporting development of community resourcefulness	https://socialcare.wales/cms-assets/documents/Community-resilience.pdf	The RCP in conjunction with Social Care Wales has developed a Working with Communities Framework which has been tested with local communities and revised accordingly
	Framework Development	British red Cross and Co-op - Social Prescribing	https://www.redcross.org.uk/-/media/documents/about-us/research-publications/health-and-social-care/fulfilling-the-promise-social-prescribing-and-loneliness.pdf	Fulfilling the promise: How Social Prescribing can most effectively tackle loneliness: Produced in collaboration with Kaleidoscope Health and Care, this report is based on Community Connector services in England and offers an up-close examination of how social prescribing models can best be designed to tackle loneliness effectively.
	Evaluation Model	The Healthy Disability Pathway	https://www.hdapathway.co.uk/	The Healthy Disability Pathway - developed from a pilot project which was well evaluated, could be a model for how evaluation can lead to change and funding for a national initiative
	Evaluation Model	Social Value Cymru	https://mantellgwynedd.com/eng/social-value-cymru.html	Mantel Gwynedd have undertaken work to evaluate their services using a social value model
	Framework Development	Royal Society of Public Health	https://www.rsph.org.uk/about-us/news/launch-of-new-social-prescribing%02framework-for-allied-health-professionals.html	The Royal Society Of Public Health have worked collaboratively w/ Public Health England and NHS Improvement to develop a framework to support AHPs to increase their social prescribing and to create a vision of social prescribing for AHPs
Public/Third Sector Research				
Public/ Third Sector	Efficacy Measurement	The Work Foundation	www.theworkfoundation.com.	Steadman, K., Thomas, R., Donnaloja, V., 2017. Social Prescribing. A pathway to work? Work Foundation www.theworkfoundation.com. The OPM Group, 2013 http://www.opm.co.uk/blog/social-prescribing-offers-a-

Research				model-to-prevent-ill-health-but-shared-decision-making-could-be-the-mechanism-that-makes-it-happen
	Evidence base	The OPM Group	http://www.opm.co.uk/blog/social-prescribing-offers-a-model-to-prevent-ill-health-but-shared-decision-making-could-be-the-mechanism-that-makes-it-happen	Evidence for shared decision making
	Evidence base	University of South Wales		Rees S, Thomas S, Elliott M, Wallace C, 2019. Creating community assets/social capital within the context of social prescribing. Findings from the workshop held 17/7/2019. WCVA, Cwm Taf Morgannwg University Health Board, University of South Wales.
	Health Inequalitys	Chartered Society of Physiotherapy	https://www.csp.org.uk/system/files/publication_files/001994_Easing%20the%20pain_Mobile%20download_Final8_0.pdf	Addressing inequality in health care is a key plank of Health policy commitments for both the Welsh Government and the CSP. We would like to highlight our report, “easing the pain” on our research in this area
	Evidence base	Public Health Wales	https://www.wales.nhs.uk/news/45383	Price, S., Hookway, A., King, S., 2017. Social prescribing evidence map: technical report. Public Health Wales Observatory. Primary & Community Care Development and Innovation Hub. Public Health Wales NHS Trust.
	Service Evaluation	Cwmtawe cluster of GP	Available on Request	We have an independent evaluation of our Cwmtawe Social Prescribing Service that can be shared.
	Evidence base	Richmond Group of Charities- Summary of Learning on Social prescribing	https://richmondgroupofcharities.org.uk/sites/default/files/field/image/final_for_website_-_dtrt_-_summary_of_learning_about_social_prescribing.pdf	This work provides useful insights and evidence for some of the uses of social prescribing, as well as the potential benefits to individuals, communities and health systems, including: services tailored to the individual, strong personal relationships, support for emotional and social needs, empowering people to make changes in their own lives and that social prescribing feels positive and solution focused. The research outlines the role of social prescribing in supporting health services as they deal with wider challenges
	Programme Evaluation	British red Cross and Co-op - Connecting Communities	https://www.scie.org.uk/prevention/research-practice/getdetailedresultbyid?id=a110f00000NXwDYAA1	In 2018, the British Red Cross and Co-op conducted a UK-wide learning programme to explore Community Connector-like services (or ‘link worker schemes’). This programme brought together more than 50 ‘connector’ schemes across four learning events, as well as policy makers, commissioners and others.
	Challenges and Solutions	British Red Cross	https://www.redcross.org.uk/-/media/documents/about-us/research-	Examining the current challenges and potential solutions present in existing literature: This literature review explores the existing evidence on the impact of the link worker model on loneliness and adds to our growing evidence on the benefits and challenges of the social prescribing link model

			publications/health-and-social-care/the-social-prescribing-link-worker-model.pdf	
	Challenges and Solutions	[i] National Voices (2020) Rolling Out Social Prescribing	https://www.nationalvoices.org.uk/publications/our-publications/rolling-out-social-prescribing	National Voices: 'Rolling Out Social Prescribing' This England focussed research outlines some of the potential limitations and challenges for social prescribing, the potential benefits and provides examples of good practice.[i] The work notes concerns regarding the significant challenges posed for social prescribing by health inequalities. The research recommends that social prescribing bodies should communicate the vision and purpose of social prescribing in creative and engaging ways, working with GPs, practice managers and link workers to help them make the case for social prescribing as a key component of effective primary care.
Nature/Green/Blue Social Prescribing				
Nature/ Green/ Blue Social Prescribing	Efficacy Measurement	Biodiversity and positive emotions in humans	https://link.springer.com/article/10.1007/s11252-020-00929-z	Where the wild things are! Do urban green spaces with greater avian biodiversity promote more positive emotions in humans?
	Efficacy Measurement	Nature Well-being Prescribing Pilot	https://www.cwtsh.wales/_files/ugd/55c76d_4f8c959c37cd4eabac540897e92d780e.pdf	Exploring the benefits that nature / green prescribing can provide
	Barriers	The Outdoor Recreation survey	https://naturalresources.wales/evidence-and-data/research-and-reports/national-survey-for-wales/?lang=en	The latest results for the National Survey for Wales are available via the ONS - includes information on perceived barriers to using the outdoors, motivations and benefits to health
	Efficacy Measurement	The direct and indirect contribution made by The Wildlife Trusts to the health and wellbeing of local people	https://www.wildlifetrusts.org/sites/default/files/2018-05/r2_contribution_of_the_wildlife_trusts_to_local_people.pdf	Royal Society of Wildlife Trusts and the University of Essex report 'The direct and indirect contribution made by The Wildlife Trusts to the health and wellbeing of local people'
	Efficacy Measurement	Gardens and health: Implications for policy and practice	https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Gardens_and_health.pdf	The National Gardens Scheme commissioned The King's Fund to write an independent report on the benefits of gardens and gardening on health
	Efficacy Measurement	Mental Health Foundation: Blue Prescribing Project 33	https://www.mentalhealth.org.uk/our-work/research/coronaviru	Mental Health Foundation conducted research on the mental health impacts of the coronavirus pandemic. This found that spending time outdoors was one of the most popular coping mechanisms to deal with the impact of thepandemic and its

			s-mental-health-pandemic-study/wave-10-summary	restrictions: 42% agreed that being able to visit green space, and 59% reported that going outside for a walk helped them cope with the stress of the pandemic
	Project Evaluation		https://www.mentalhealth.org.uk/our-work/programmes/programmes-adults/blue-prescribing-project	At the Mental Health Foundation, we have delivered a community programme called the Blue Prescribing Project 33. This project has supported vulnerable single parents, people with long term-health conditions, people recovering from long COVID-19 and vulnerable diverse groups, to engage in activities around wetland spaces with a peer support focus. Our interim evaluation has found that the programme helped participants to be more confident and empowered to manage their own mental wellbeing. Participants reported that being in the wetlands provided unique benefits, such as providing a haven to escape from day-to-day concerns and the space to connect with others, adding to the evidence base on the benefits of nature.
	Project Resource	Coed Lleol	https://www.smallwoods.org.uk/assets/Uploads/Coedlleol-/Research/Newsletters/RESEARCH-QUARTERLY-OCT19.pdf	Our successes have centred on establishing working networks and codes of best-practice for social prescribing to outdoor health and wellbeing in new areas
	Project example	West Wales Walking for Wellbeing	https://westwaleswalkingforwellbeing.org.uk/	A Healthy and Active funded project providing walking activity in West Wales
	Efficacy Measurement	ParkRun	https://bjgp.org/content/72/722/414	There has been significant research about health and wellbeing benefits of parkrun.
	Project Example	Paths for All	https://www.pathsforall.org.uk/walking-for-health/health-walks	As highlighted above the work of Paths for All in Scotland (Health Walks | Paths for All) provides a useful example for one area of activity.
Academic				
Academic	System evaluation		https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/realist-evaluation-of-social-prescribing-an-exploration-into-the-context-and-mechanisms-underpinning-a-pathway-linking-primary-care-with-	Bertotti, M., Frostick, C., Hutt, P., Sohanpal, R., and Carnes, D (2018). A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. Primary health care research & development 19 (3), 232-245, 2018.

			the-voluntary-sector/6364CA4AA88B6F287CEE1F80B3457087	
	Efficacy Measurement		https://pubmed.ncbi.nlm.nih.gov/29258514/	Carnes, D., Sohanpal, R., Frostick, C., Hull, S., Mathur, R., Netuveli, G., Tong, J., Hutt, P. and Bertotti, M., (2017). The impact of a social prescribing service on patients in primary care: a mixed methods evaluation. BMC health services research, 17(835), p.1-9. DOI 10.1186/s12913-017-2778-y
	Overview		https://uwe-repository.worktribe.com/output/840167/what-is-social-prescribing	Kimberlee, R (2015). What is social prescribing? Advances in Social Sciences Research Journal, Volume 2, No 1
	Health Inequality		https://policycommons.net/artifacts/1618576/fair-society-healthy-lives-full-report-pdf/2308503/	Marmot, M (2010). Fair Society, Healthy Lives: The Marmot Review: Strategic review of health inequalities in England
	Barriers to delivery		https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-2893-4	Pescheny, J.V.,Pappas Y., and Randhawa, G (2018). Facilitators and barriers of implementing and delivering social prescribing services: a systematic review. BMC Health Services Research 18 (1), 1-14, 2018
	Efficacy Measurement		https://westminsterresearch.westminster.ac.uk/item/q1455/a-review-of-the-evidence-assessing-impact-of-social-prescribing-on-healthcare-demand-and-cost-implications	Polley, M et al (2017). Review of evidence assessing impact of social prescribing on healthcare demand and cost implications. Report. https://www.westminster.ac.uk/file/107671/download
	Literature Review		http://www.wsspr.wales/resources/Roberts%20et%20al%20systematic%20review%20executive%20summary.pdf	Roberts, T., Erwin, C., Pontin, D., Williams, M., Wallace, C., under review. Social prescribing and complexity theory: A systematic review
	Efficacy Measurement		https://www.bmj.com/content/352/bmj.i1436	Torjesen, I (2016) Social prescribing could help alleviate pressure on GP's, BMJ 352; 1436
	Evidence base		https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6301369/	Husk K, Elston J, Gradinger F, Callaghan L, Asthana S. Social prescribing: where is the evidence? Br J Gen Pract. 2019 Jan;69(678):6-7. doi: 10.3399/bjgp19X700325. PMID: 30591594; PMCID: PMC6301369.

	Efficacy Measurement		https://www.sciencedirect.com/science/article/pii/S0277953621003695	Kate Gibson, Tessa M. Pollard, Suzanne Moffatt, Social prescribing and classed inequality: A journey of upward health mobility?, Social Science & Medicine, Volume 280, 2021, https://doi.org/10.1016/j.socscimed.2021.114037.
Elderly				
Elderly	Guidance	Big Lottery Fund		Hall Aitken (Big Lottery Fund), 'Social Prescribing and Older People: A Guide to Developing Projects', (November 2014)
	Critical review	Academic	https://pubmed.ncbi.nlm.nih.gov/32080727/	Hamilton-West, K., Milne, A., & Hotham, S. (2020). New horizons in supporting older people's health and wellbeing: is social prescribing a way forward? Age and Ageing, 49(3), 319–326. https://doi.org/10.1093/AGEING/AFAA016
	Programme Evaluation	Ecorys & Community Fund	https://www.tnlcommunityfund.org.uk/media/documents/ageing-better/Ageing-Better-Social-Prescribing-evaluation-report.pdf?mtime=20220419144739&focal=none	Ageing Better: Supporting meaningful connections through social prescribing (March 2022) England Focused. Ageing Better was a £87 million, seven-year programme funded by The National Lottery Community Fund. The programme aimed to enhance the lives of people over 50 by addressing social isolation and loneliness, improving social connections, and enabling people over 50 to be more engaged in the design of services for their communities.
				Wales has an aging population, which also makes up 45% of the population that is living alone 28. Research has demonstrated that older people experiencing social isolation and mild-to-moderate mental health problems have reported improvement following social prescribing projects, including increased self-esteem, improved mental wellbeing, reduced loneliness and reduced health service use 35.
				Our programmes at the Mental Health Foundation further illustrate that older people benefit from community support. Working in partnership with housing associations in South East Wales, we ran a programme called Standing Together Cymru to support people in later life communities. Under this programme, individuals engaged in 'getting- to- know- you' activities and sessions built on conversations or topics of interest that were decided on in consultation with the group. Our evaluation found that access to peer support reduced isolation and loneliness and improved the wellbeing of older people in extra-housing schemes in Wales 28. Participants felt more socially connected and viewed the groups as an opportunity to make new friends, which fostered a sense of belonging 28.
				Additionally, we ran a participatory peer support programme called 'Creating Communities' for older people living in extra-care, supported and retirement housing in London. In this project, individuals attended group sessions focused on creative activities and access to the outdoors (e.g.: painting, musical

				workshops and gardening). All of these are social prescribing initiatives. Our project evaluation found this programme had positive effects on older adults' wellbeing by: giving them something to look forward to in their routine, building self-confidence, and increasing opportunity for social connection, all of which are known to support people's mental health.
Familes				
Families	Programme Evaluation		Mental Health Foundation. (n.d.). Creating Connections Impact Report 2014 - 2016 . https://www.mentalhealth.org.uk/explore-mental-health/publications/creating-connections-impact-report-2014-2016	Single parents are at a higher risk of experiencing mental ill-health and can benefit from community support. At the Mental Health Foundation, we ran a programme called Creating Connections which provided peer support for single parents in Wales. The evaluation of this programme found a significant increase in the wellbeing of single parents, from baseline to six months later 40. Single parents reported that attending Creating Connections increased their confidence, and they valued sharing experiences and making friends so that they felt less lonely and isolated 40
Children and Young People				
Children and Young People	Toolkit	RCPCH	https://www.rcpch.ac.uk/key-topics/child-health-inequalities	The RCPCH has recently published 'Child poverty and health inequalities in the UK - a toolkit for paediatricians' to support members in working to reduce health inequalities in childhood locally. 1
	Policy Briefing	Mental Health Foundation	https://www.mentalhealth.org.uk/sites/default/files/2022-06/MHAW22-Loneliness-England-Policy-Briefing.pdf	Although research on the role of social prescribing to improve the mental health and wellbeing of children and young people is limited 36, in a study by the National Children's Bureau, young people reported that a personalised care model utilising social prescribing had a significant and positive impact on their lives, mental health and wellbeing. A personalised care model utilising social prescribing approaches was reported as particularly effective by disadvantaged young people (specifically those experiencing social inequality) 37. This study highlighted that young people valued: a consistent and caring approach from services where their voices could be heard, the flexible nature of the support and the fact that it could be tailored to their specific needs - to take into account individuals' lived experiences and challenges 37. Young people are particularly vulnerable to loneliness. Our Mental Health Awareness Week 2022 research found that 10% of UK 18-24 year olds (the youngest age group surveyed) were 'often' or 'always' lonely compared to the population as a whole (7%)38. Loneliness in young people is not a new phenomenon and was not created by the Covid-19 pandemic, however Covid-19 has greatly exacerbated it. Our research on the mental health impacts of the

				coronavirus pandemic consistently found across multiple timepoints, that loneliness was a particular issue for young people during the pandemic 39. We also found that the most widely reported action that young people across the UK felt had helped them with their mental health when they were feeling lonely was 'getting out of the house' 38. As we build back from the pandemic, social prescribing is an important mechanism by which we can work towards tackling loneliness in young people.
	Programme Evaluation		https://www.ncb.org.uk/sites/default/files/uploads/files/Personalised%20Care%20NCB%20report%20Final%20Nov.pdf	https://www.ncb.org.uk/sites/default/files/uploads/files/Personalised%20Care%20NCB%20report%20Final%20Nov.pdf Pain, S. (2021). Making a Difference to Young People's Lives Through Personalised care: Mental Health Inequalities and Social Deprivation.
	Evidence base		https://static1.squarespace.com/static/5f020c49b484e47001f2bb5b/t/60ba5655cefb6743335f1d4a/1622824535346/walesyouthsocialprescribingarapidreview_2021.pdf	in one survey1 94% of respondents agreed children and young people should have the same access as adults to social prescribing and 68% of respondents agreed this is distinct from adult social prescribing.
	Literature Review		https://static1.squarespace.com/static/5f020c49b484e47001f2bb5b/t/60ba5655cefb6743335f1d4a/1622824535346/walesyouthsocialprescribingarapidreview_2021.pdf https://repository.uel.ac.uk/item/88x15	A literature review10 of social prescribing in Wales highlights how children and young people appreciate services tailoring social prescribing to their specific needs. For example, in one study11 a child raised accessibility as an issue in social prescribing due to transport issues.
	Guidance	Commissioner for Children and Young People	https://www.childcomwales.org.uk/publications/no-wrong-door-bringing-services-together-to-meet-childrens-needs/; https://www.childcomwales.org.uk/wp-content/uploads/2022/02/No-Wrong-Door-Report-February-2022.pdf	The Commissioner's office has published two reports12 relating to the principle of a 'no wrong door' approach to mental health and wellbeing, working with Regional Partnership Boards (RPBs) to ensure services are co-ordinated in supporting children and families when they reach out for help. This approach has been taken forward through the publication of the NEST / NYTH framework.

	Programme Reviews	Hilltop Digital Labs	https://hdlabs.co.uk/wp-content/uploads/2022/11/Westminster-to-NW-Wales.pdf	'From Westminster to North West Wales' Lessons learned in translating a digital social prescribing solution for young people with mental health problems
Specific Health Conditions				
Specific health conditions	Guidance	ARMA (2022) Social Prescribing and Musculoskeletal conditions:	http://arma.uk.net/wp-content/uploads/2022/02/ARMA_Social-Prescribing-Resource_v05.pdf	· Arthritis and MSK Alliance (ARMA): 'Social Prescribing and Musculoskeletal Conditions – A guide for link workers and social prescribing services'. [i] A useful resource on social prescribing specifically in relation to people living with arthritis and MSK conditions, covering issues including mental health, employment and physical activity on the lives of people with MSK conditions.[ii]
	Efficacy Measurement		https://pubmed.ncbi.nlm.nih.gov/28153817/	Pilkington, K., Loef, M.,Polley, M., (2017) Searching for Real-World Effectiveness of Health Care Innovations: Scoping Study of Social Prescribing for Diabetes. J Med Internet Res;19(2):e20
Welsh				
Welsh	The Welsh Language in Legislation	Frameworks and Legislation	N/A Several	Mesur y Gymraeg (Cymru) 2011 Deddf Gwasanaethau Cymdeithasol a Llesiant (Cymru) 2014 Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 Symud Cymru Ymlaen: Y Rhaglen Lywodraethu 2016-2021 a Ffyniant i Bawb – y strategaeth genedlaethol (LLC, 2017) Fframwaith Strategol Mwy na geiriau (LLC, 2012) Stratgaeth Cymraeg 2050: Miliwn o siaradwyr (LLC, 2017) Cymru Iachach: ein Cynllun Iechyd a Gofal Cymdeithasol (LLC, 2018)
	Welsh in the Health Sector (Nature and environment)	Welsh Language Board	http://www.wales.nhs.uk/sites3/documents/415/Cymraeg-mewn-gwas-iechyd.pdf	Misell, A. (2000) Y Gymraeg yn y Gwasanaeth Iechyd: Ehangder, Natur a Digonolrwydd Darpariaeth Gymraeg yn y Gwasanaeth iechyd Gwladol yng Nghymru. Caerdydd: Cyngor Defnyddwyr Cymru
	Welsh and Mental Health	Academic	https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1440-0979.2004.00337.x	Madoc-Jones. I. (2004) Linguistic sensitivity, indigenous peoples and the mental health system in Wales. International Journal of Mental Health Nursing 13:216-224.
	Welsh in Third Sector	Academic	https://www.ingentaconnect.com/content/uwp/cowa/2010/00000023/00000001/art00013	Prys, C. (2010) The Use of Welsh in the Third Sector in Wales. Contemporary Wales, 23 (1):184-200.
	Welsh in the Health Sector	Welsh Government	https://www.iaith.cymru/uploads/general-uploads/profiad_siaradwyr_cymraeg_or_gwasanaethau_iechyd_a_gofal.pdf	Iaith (2012) Profiad Siaradwyr Cymraeg o'r Gwasanaethau Iechyd a Gofal. Caerdydd: Cyngor Gofal a Llywodraeth Cymru.

	Welsh in Care	Academic	https://pubmed.ncbi.nlm.nih.gov/30484003/	Martin, C., Woods, B. a Williams, S. (2018) Language and culture in the caregiving of people with dementia in care homes – what are the implications for well-being? A scoping review with a Welsh perspective. Journal of Cross-Cultural Gerontology.
	Welsh in the Heath sector	Academic	https://cronfa.swan.ac.uk/Record/cronfa12667	Owen, H.D. a Morris, S. (2012) Effaith iaith ar adsefydlu corfforol: Astudiaeth o ddylanwad iaith ar effeithiolrwydd therapi mewn cymuned Cymraeg. Gwerddon 10 – 11:83-112.
	Welsh in Health and Care	Framework	http://www.wales.nhs.uk/sites3/documents/415/WEB%20-%2016184_Narrative_w_WEB.pdf	Llywodraeth Cymru (2012) Mwy na geiriau: Fframwaith Strategol ar gyfer Gwasanaethau Cymraeg mewn Iechyd, Gwasanaethau Cymdeithasol a Gofal Cymdeithasol. Caerdydd: Llywodraeth Cymru.
	Welsh in Health and Care	Welsh Language Commissioner	Link is not currently available on commissioner website	Comisiynydd y Gymraeg (2014) Fy Iaith: Fy Iechyd. Ymholiad i'r Gymraeg mewn Gofal Sylfaenol. Caerdydd: Comisiynydd y Gymraeg. http://www.comisiynyddygymraeg.cymru/Cymraeg/Rhestr%20Cyhoeddiadau/Adroddiad%20Llawn%20Ymholiad%20Iechyd.pdf
	Welsh in Care	Report	https://www.comisiynyddygymraeg.cymru/media/h0knbvow/final-reportwlc.pdf	Alzheimer's Society Cymru / Comisiynydd y Gymraeg (2018) Gofal Dementia Siaradwyr Cymraeg. Caerdydd: Alzheimer's Society Cymru / Comisiynydd y Gymraeg.
	Welsh and Mental Health	Article	https://golwg360.cymru/gwerddon/534234-iechyd-meddwl-gymraeg-maen-amser-deffro	Hughes, S.A. (2018) Iechyd meddwl a'r Gymraeg: mae'n amser deffro. Gwerddon Fach 28/11/2018.