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Developing an Evidence Based Glossary of Terms for Social Prescribing

Draft Report

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Wales School for Social Prescribing Research
PRIME Centre Wales· Public Health Wales
October 2022

Canolfan Datblygu ac Arloesi Gofal Sylfaenol a Chymunedol
Datblygu Gofal Sylfaenol yng Nghymru

Primary and Community Care Development and Innovation Hub
Developing Primary Care in Wales

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Executive Summary

The lack of consistency of social prescribing related language creates confusion for professionals and the public alike, impairing communication between sectors, professionals and with the public. Through consultation, the Wales School for Social Prescribing Research (WSSPR) identified a need for a reference tool to provide a unification of the language associated with social prescribing and committed to the development of a glossary of terms for social prescribing in Wales.

The identification of the terminology associated with social prescribing and the subsequent development of the glossary of terms has been an extensive piece of work that incorporated a scoping review, a group concept mapping study and consultation with social prescribing professionals and PPI members of the WSSPR steering group.

The development of the glossary of terms identified a diversity of terminology associated with the social prescribing process that was larger than anticipated (186 core terms and 236 non-core terms). This has been refined in a usable list of 46 core terms that can be easily navigated and provides definitions for each term, highlight alternative terms and where appropriate highlights the preferred term for different sectors.

Although the terms social prescribing and link worker are the preferred terms within the UK literature, the terms community connection and community connector appear to be the preferred terms used in practise within Wales. It is suggested that the glossary be developed into a digital format that will allow easy dissemination of any future changes as social prescribing terminology inevitably evolves.

Acknowledgments

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Introduction and Background

Social prescribing, defined in Wales as 'connecting citizens to community support to better manage their health and well-being' (Rees et al, 2019) is an umbrella term used to describe a variety of interventions and levels of support that use a person-centred approach to lift-up and empower an individual through engagement in different community based activities (Kimberlee, 2015; SCIE, 2020). Although the term 'prescribing' might imply that the individual is told what they should do, key elements of social prescribing include a 'what matters' conversation and the co-production of goals between the social prescribing practitioner (commonly referred to as a link worker) and the individual (Thomas et al., 2021). Through engagement with this process, aspects such as isolation, weight, health or financial worries can be addressed, thereby providing the individual with increased control over their circumstances and wellbeing (Drinkwater et al., 2019; Wood et al., 2021).

Social prescribing has seen a period of proliferation and development over the last decade (Morse et al., 2022; The King's Fund, 2020), the speed of which has not only outstripped the establishment of suitable measures of efficacy and evaluation, but has also led to a lack of unification of language across sectors and regions (Bertotti et al., 2018; Halder et al., 2021; Morse et al., 2022; Rempel et al., 2017). For example, social prescribing is also known as community referral (All Ireland Social Prescribing Network, 2021; Husk et al., 2016), connector schemes (Tierney et al., 2020), and care navigation (NHS Inform, 2022; Pesut et al., 2017). Social prescribing practitioners may have various titles such as link worker, community connector, well-being advisor, care navigator, or social prescriber (Carnes et al., 2017; Hamilton-West et al., 2019; Tierney et al., 2020; Wallace, Davies, Elliott, et al., 2021; Wallace et al., 2019). The roles undertaken by these practitioners are wide-ranging and variable, with little clarity about which roles undertake which duties (Elliott et al., 2020; Roberts et al., 2021; Wallace, Davies, Elliot, et al., 2021).

The lack of consistency of social prescribing related language creates confusion for professionals and the public alike, impairing communication between sectors, professionals and with the public. Through consultation, the Wales School for Social Prescribing Research (WSSPR) identified a need for a reference tool to provide a unification of the language associated with social prescribing (Wallace et al., 2018, 2021) and committed to the development of a glossary of terms for social prescribing in Wales (Wallace et al., 2018).

> ***"you've had twenty job descriptions or whatever and a lot of different roles come through...if it's that complicated to those that are doing it, the ones sitting on the outside, we stand no chance of knowing"*** **(Member of Public: Wallace et al., 2021)."**

The initial funding for the development of this glossary was through PRIME and Health Care Research Wales. This allowed the development work to begin before WSSPR secured additional support and funding of £25k from Public Health Wales to complete the first version of a glossary of terms for social prescribing. The glossary has already been incorporated into the Welsh Government National Framework for Social Prescribing (WG, 2022). While most glossaries are simply comprised of a list of 25-50 specialist terms (*in preparation*) the complexities of the language associated with social prescribing necessitates a different approach that identifies the terms used within the social prescribing pathway, alternative terms, associated definitions, and contextual information associated with the terms.

This report describes the process of the development of the glossary of terms through the identification and categorisation of the terminology associated with social prescribing.

Method & Results

The identification of the terminology associated with social prescribing and the subsequent development of the glossary of terms has been an extensive piece of work that incorporated a scoping review, a group concept mapping study and consultation with social prescribing professionals and members of the public. The method used to identify and classify the terminology associated with social prescribing is explained below and described in Figure 1. It is beyond the scope of this report to intimately describe the breadth of data examined and produced for the development of the glossary but contained within this section is an overview of the methodology and the base results that serve to exemplify the foundation of the development of the glossary of terms.

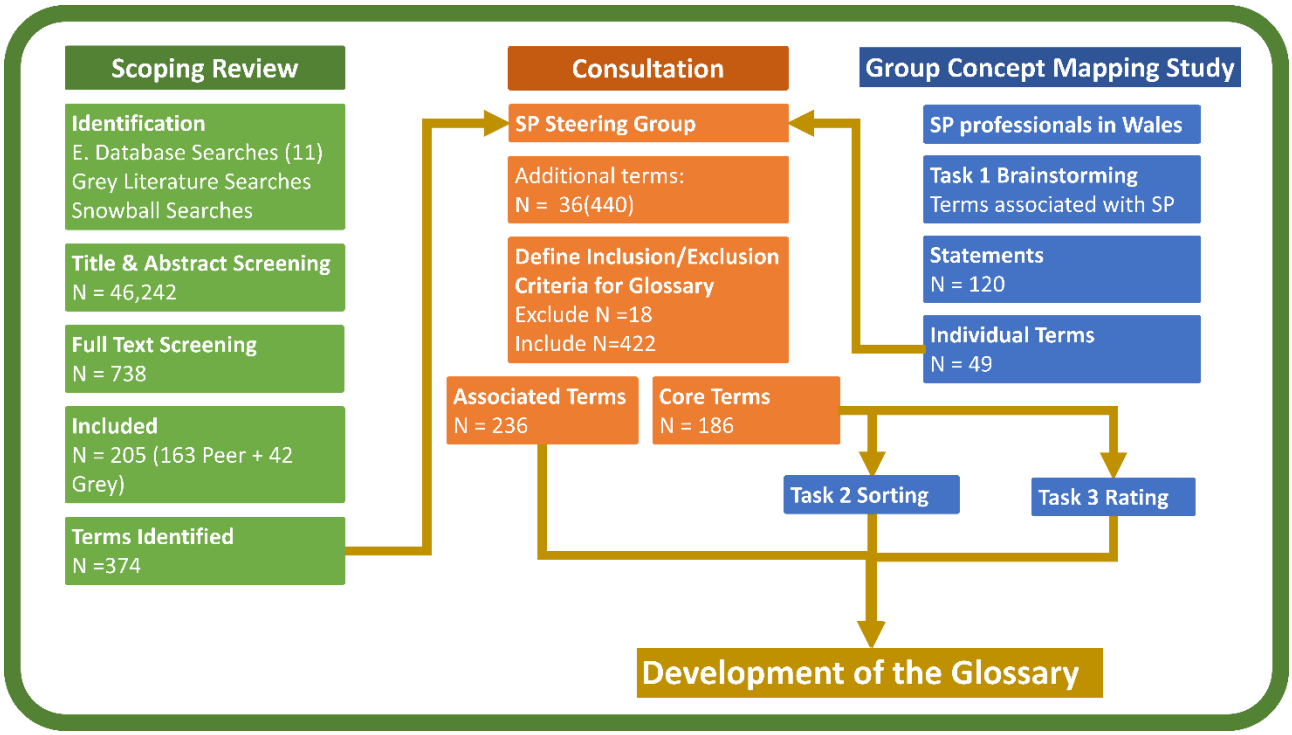


Figure1. Pictorial depiction of the process of identification of social prescribing terminology for inclusion in the glossary of terms.

Scoping Review

The most appropriate form of literature review for this research was identified as a scoping review. A scoping review is more in depth than a traditional literature or narrative review in that the review is systematic and includes steps to increase reliability and reduce error whilst providing transparency and reproducibility (Peters et al., 2015). The scoping process incorporates an analytical reinterpretation of the literature, ensuring that data is extracted and presented in a structured way (Davis et al., 2009; Levac et al., 2010; Peters eta l., 2015) and is most suited to mapping, reporting and discussing the characteristics/concepts within a body of literature (Munn et al., 2018). By comparison, a systematic review would be more suited to the provision of evidence to inform practice or answer a clinically meaningful question (Pearson, 2004). Additionally, a scoping review is able to address a broader topic range than a systematic review, incorporating data from studies of a variety of designs without assessing the quality of the included studies. Whereas a systematic review is more suited to focusing on a well-defined question where appropriate study designs can be identified in advance and the quality of such studies is assessed (Arksey & O'Malley, 2005).

Our protocol was based on the scoping review methodological framework proposed by Arksey & O'Malley (2005), and employed a five-stage process that reflected a need to identify all relevant literature and generate broad and in-depth results:

1. Identifying the research question
2. Identification of relevant studies
3. Selection of studies/literature
4. Charting the literature and data
5. Collating, summarising and reporting the results

The protocol was preregistered with the Open Science Framework. As is common with scoping reviews, the process was refined as familiarity and an appreciation of the breadth of material was gained. This was an iterative process which required reflexive engagement, along with repetition of many of the stages to ensure a comprehensive review of the relevant literature.

Our research question was “What terminology is associated with social prescribing and the social prescribing pathway?”

Documents were identified via three methods:

1. Peer reviewed journal articles were identified though searches of 11 electronic databases. Peer reviewed articles in academic journals included case studies, editorials, opinion pieces, studies and experiments.
2. Grey literature documents were identified by searching google and local authority, third sector and university websites, third sector websites, as well through recommendations from professionals associated with WSSPR and the social prescribing communities of practise in Wales. Grey literature articles included guidance, reports, working papers, government documents, white papers, and evaluations) and specialist magazine articles (e.g., specific to health or social care).
3. Additional peer and grey documents were identified though ‘snowball searches’ of the reference lists from documents that been identified as relevant.

The selection of documentation for analysis and identification of social prescribing related terminology underwent a two-stage eligibility screening process:

Stage 1 Screening: Titles and abstracts from peer reviewed literature and the title and overview/foreword from grey literature, were screened to determine if the content was relevant to the nature of our search. In total, 46,242 documents underwent stage 1 screening.

Stage 2 Screening: Details of all items identified as potentially relevant during stage 1 screening were recorded in a database. This included items identified during snowball searches. Stage 2 screening involved screening the whole text of each document for social prescribing related terminology. This was defined as terminology that was explicit to, or associated with, social prescribing and the social prescribing pathway. As a quality control measure, 20% of the documents underwent secondary, independent stage 2 screening and charting. Periodic collation and consensus meetings were held. In total, 738 documents underwent stage 2 screening (565 peer reviewed articles and 173 grey literature articles).

Of the documents that underwent stage 2 screening, 205 documents (163 peer reviewed and 42 grey literature documents) were determined as relevant, i.e., to contain social prescribing related terminology. The data from these documents was input into an Excel data charting form. The form was used to record a mixture of general information, document classification information, and terminology and contextual information. Charting the information from the articles identified in our research allowed us to compile a basic numerical analysis of the information collated. For the purposes of this report, the summation and reporting of the results focuses on the number of terms identified and the source of the document (i.e., scientific peer reviewed literature from electronic database searches or grey literature). Additional information, such as the accompanying descriptions of terms and the author perspective of the document (e.g., health, social care) was used to inform development of the glossary.

Consultation

Consultation with members of the PHW social prescribing operational group and WSSPR PPI steering group members helped define the scope of the terms to be included in the glossary, classify the terms that were to be included in the glossary, and identify any potentially missing terms. To be included in the glossary a term had to be either a core social prescribing term or non-core social prescribing term, the definitions and inclusion/exclusion criteria for each are given below:

Scope:

Core Social Prescribing Terms

Definition: A term used in everyday language in social prescribing by social prescribing practitioners, professionals and people who engage with social prescribing, that specifically relates to and/or describes an essential part of the social prescribing process.

Inclusion Criteria: A term that specifically relates to and/or describes an essential part of the social prescribing process. The term is used in communications to improve individual physical, mental and social health and wellbeing throughout the social prescribing process and/or when improving the wider determinants of health for individuals throughout the social prescribing process.

Exclusion Criteria: A term commonly used across health and social care/ statutory/ non-statutory service delivery BUT does not relate to and/or describe a central and/or essential part of the social prescribing process.

Non-Core Social Prescribing Terms

Definition: A term used across health and social care/ statutory/ non-statutory service delivery, that is associated with social prescribing but does not relate to and/or describe an essential part of the social prescribing process.

Inclusion Criteria: A term that is not a core social prescribing term but one that is used in communications to improve individual physical, mental and social health and wellbeing throughout the social prescribing process and/or when improving the wider determinants of health for individuals throughout the social prescribing process.

Exclusion Criteria: The word is a common term used across health and social care/ statutory/ non-statutory service delivery but is one that is not specifically associated with social prescribing.

Terms that were identified from the scoping review and the brainstorming task of the GCM study (described below) were examined to determine whether or not they fell within the scope of the glossary and if so to which category they should be assigned. Following the removal of duplications, 374 individual terms related to social prescribing were identified in the scoping review. Forty-nine terms were identified in the brainstorming task. These terms were combined and after the removal of duplicates 404 terms were fed back for consultation. From consultation an additional 36 potential terms were identified. These 440 terms were then compared against criteria for core and non-core social prescribing terms, which resulted in the exclusion of 18 terms and the allocation of 186 terms as core social prescribing terms and 236 terms as non-core social prescribing terms.

Group Concept Mapping Study

Group concept mapping (GCM) is a mixed-methods consensus-generating approach that combines qualitative data collection approaches with quantitative analysis processes and tools. It proved a means to capture and organise the ideas of a group on any topic of interest and then represent those ideas visually in a series of interrelated maps (Kane & Rosas, 2017; Kane & Trochim, 2007). The results reflect the perceptions and values of the participants and provide results that are immediately usable. The results do not necessarily provide a definitive answer but instead, provide an evidence-based means of facilitating discussion around a topic of interest, in this instance the terminology associated with social prescribing. GCM involves three stages of participant engagement described in the subsections below: 1) a brainstorming activity; 2) a sorting activity; and 3) 2 x rating tasks.

Participants were recruited from social prescribing communities of practice, Connect Wales, research networks associated with WSSPR and through members of the PHW social prescribing operational group. Both purposeful and snowballing (Patton, 2015) methods of recruitment were employed (participants recommending potential participants to us and/or sharing our recruitment invitation). The recruitment invitation included a link to an online consent form, which once completed provided a link to the GCM task(s) using groupwisdom™ software. Participants were able to register on the research software using their email addresses as their username and a unique password of their choosing.

Participants only had access to the online exercises they agreed to complete and were not be able to view other participants data.

Participants were asked four demographic questions that could later be used to help filter, analyse and interpret the data:

1. In which Welsh local authority do you work? (listing a choice of all 22 LAs).
2. Under which category does your current professional role fall?
    - Academic/researcher
    - Social prescribing/community connector professional
    - Health care professional (not SP)
    - Social care professional (not SP)
    - Community or voluntary services professional (not SP)
    - Manager/commissioner/policy maker
3. How long have you been working in/with social prescribing?
    - Start-up/no experience
    - Less than 12 months
    - 13-36 months
    - 37-72 months
    - 73 months plus
4. How would you rate your level of knowledge for social prescribing?
    - Very poor
    - Poor
    - Quite good
    - Very good
    - Extremely good

Brainstorming

Twenty-nine participants completed the brainstorming task. The task used the written prompt "A term or phrase used within the social prescribing pathway is…" for which participants were required to generate statements. Participants produced 120 statements which were subsequently refined to 49 individual terms. These terms were combined with those identified in the scoping review and submitted for consultation.

Sorting

Forty-three participants began the sorting and rating tasks but only 28 participants completed the tasks and produced usable data. The distribution of professional category from those whose data is included can be viewed in Figure 2.

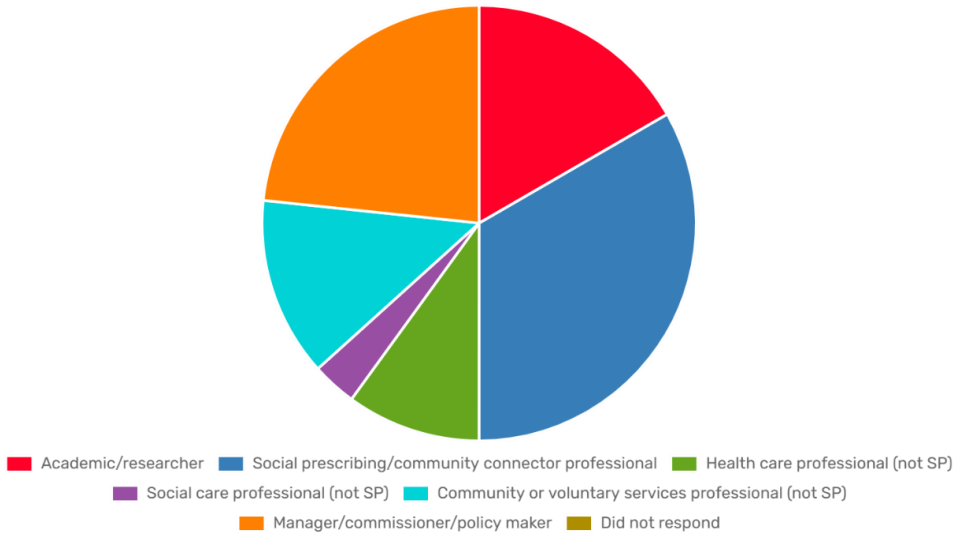


Figure 2. Participant distribution by professional category for data included in analysis

The sorting task used the core terms identified from the scoping review and brainstorming task and refined during consultation. In the sorting task, participants were instructed to sort all 125 terms statements “into piles in a way that makes sense to you” and to “group the statements on how similar in meaning they are to one another by sorting each card into a pile as you create your own version of how these ideas are related”. They were then asked to “give each pile a name that describes its theme or content”.

The groupwisdom™ software applied a multidimensional scaling algorithm to the data to plot points that represent the proximity of terms by how frequently they were sorted together

by participants. Those that were frequently sorted appear closer together and items not frequently sorted together are plotted further from each other. The multidimensional scaling produces a point map with each point on the map representing one of the 125 core terms. The dataset had a final stress value of 0.1614. The stress value is considered to be similar to reliability. In typical projects, stress values from .10 to .35 yield results that are interpretable (Kane & Rosas, 2017).

The software then uses these points to generated a number of cluster maps that gather the terms together into similar clusters. The position of the points does not change in relation to each other, but different boundaries are drawn around the points. The software gave options of 4 – 15 cluster solutions but the terms were determined to be most effectively grouped into six clusters (see Figure 3). The conceptual relationship between clusters is shown by the distance between them. The closer the clusters, the stronger relationship they have. Automatic cluster labels were generated by the software based on cluster labels given by participants. However, it for several clusters it was not felt that these provided accurate descriptions of the cluster content. Based on the content of priority statement content within each cluster, the final cluster labels produced were:

- Roles in social prescribing
- Environmental & arts social prescribing assets
- Connecting to the community
- Principles underpinning social prescribing systems
- Names for social prescribing systems
- Related/complimentary partners, schemes & activities

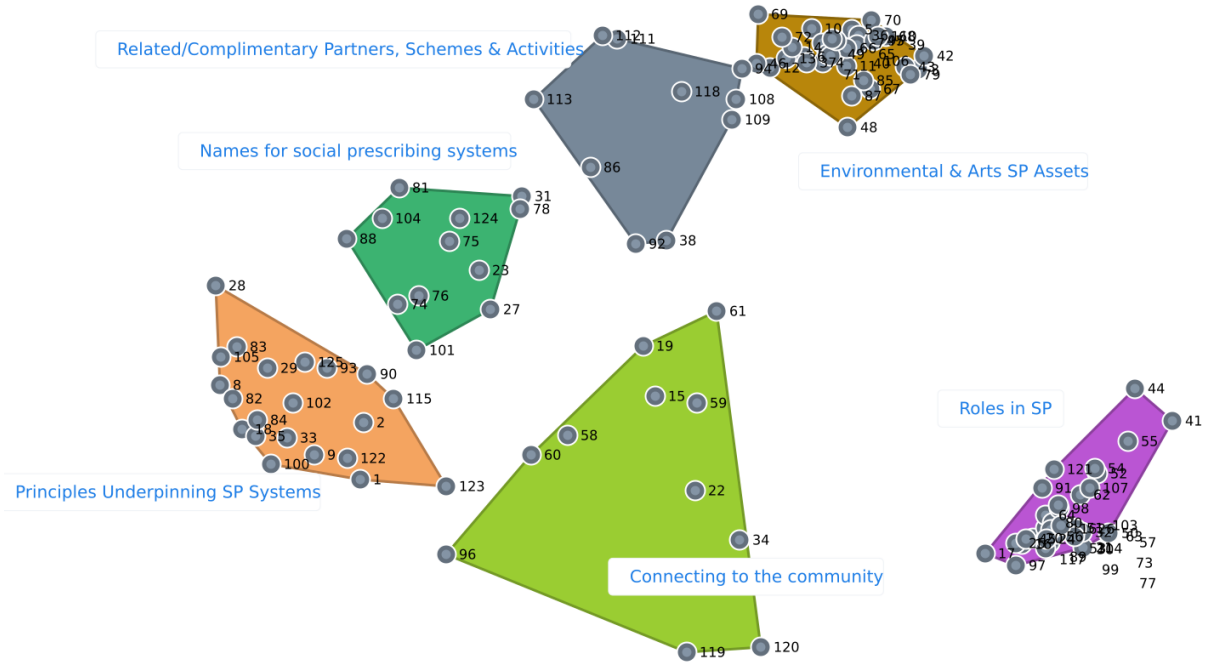


Figure 3. Cluster and point map of core social prescribing terms.

Rating

In the rating activity participants were asked to rate all 125 terms against two, four-point Likert scales, for usefulness and relevance. In the usefulness rating task participants were asked to “rate the usefulness of this term in your everyday practise” from “not at all, I never use it” to “extremely useful, I use it very frequently”. In the relevance rating task participants were asked to “rate how relevant you think the term is to social prescribing” from to “has nothing to do with social prescribing” to “It is central to the social prescribing process”. Twenty-nine participants completed the rating task.

Pattern matching of the research priority statement clusters allowed us to view these clusters in order of usefulness and relevance. A relative pattern match (Figure 4) presents the cluster averages within the range of ratings for each scale, rather than on a fixed, absolute scale. The relative pattern match enables the researcher to compare multiple measurements to establish a trend (Kamat, 2019). As the rating scales measure different concepts (i.e. usefulness and relevance), it can be more useful to compare the ranking of clusters on the different scales, as opposed to the absolute numbers, which may not be directly comparable.

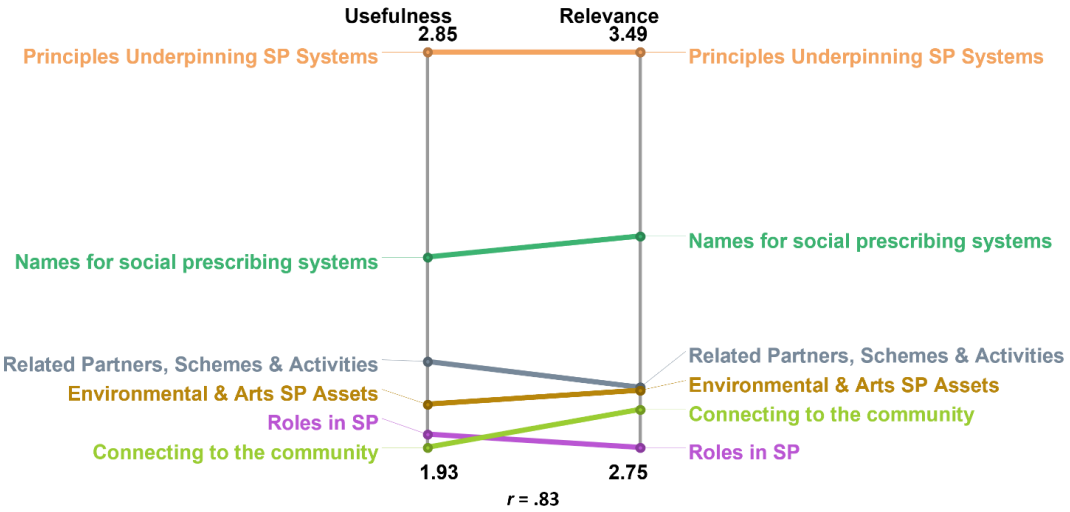


Figure 4. Relative pattern match of

Go-zone analysis (Figure 5) also allowed us to identify individual statements by their average ratings of usefulness and relevance, the top 10 of which are displayed in Table 1. The Go-Zone is split into four quadrants based on the average rating for all statements for each of the two scales. The green and grey quadrants represent linear agreement of the two scales, i.e. a statement rated as high in usefulness and high in relevance will be in the green quadrant and a statement rated as low in usefulness and low in relevance will be in the grey quadrant. The orange and yellow quadrants represent divergence between the two scales, i.e. orange represents high relevance but low usefulness and yellow represents low relevance and high usefulness.

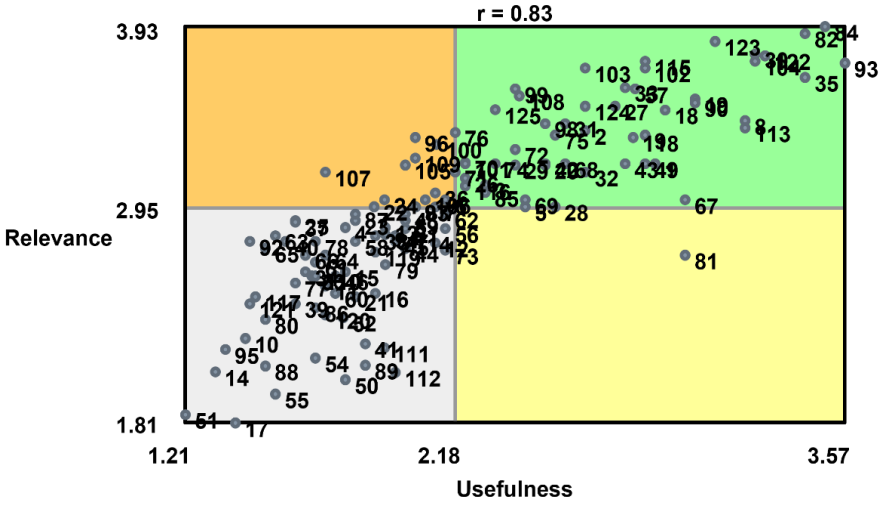


Figure 5. Go Zone analysis of all terms.

Table 1. Top ten terms by average scores for usefulness and relevance.

Usefulness	Relevance
Signposting	Person-Centred / Person Led
Person-Centred / Person Led	Person Centred Approach / Intervention
Person Centred Approach / Intervention	What Matters to me Conversation
Co-production	Connector / Community Connector
What Matters Conversation	What Matters Conversation
Connector / Community Connector	Social Prescribing Service / Intervention / Scheme
Social Prescribing Service / Intervention / Scheme	Well-being Conversation
Asset Based Approach	Signposting
Voluntary and Community Service Organisations (VCSOs)	Social Prescribing Pathway
What Matters to me Conversation	Social Prescribing Practitioner

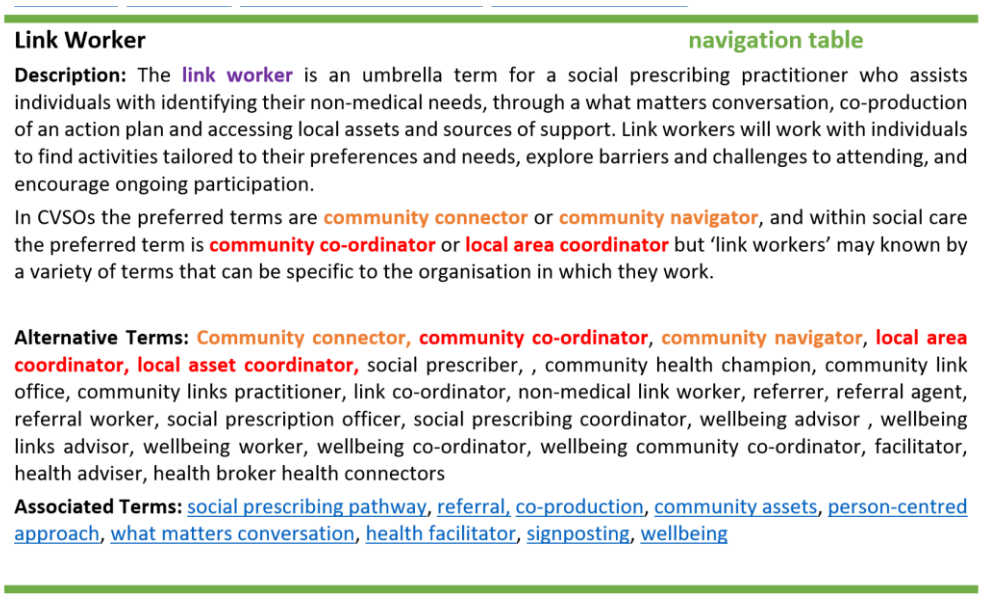
Developing the Glossary

Research by USW (in preparation) shows that most glossary of terms are between 25 - 50 words in length and are predominantly limited to a list of specialist words with no description. The original list of 184 core terms that was identified in this research was therefore considered too cumbersome for everyday use. Data from the scoping review and GCM combined indicates that many of the terms identified relate to a few specific aspects associated with social prescribing and/or are alternative and often less commonly used terms used to describe the same principles or process. For example, 37 terms were included in the cluster 'roles in social prescribing' and 12 terms were included in the 'Names for social prescribing systems' cluster. Likewise, there were 22 terms which were included in the cluster 'Principles underpinning social prescribing systems' which were collectively identified as the most useful in every day practise and the most relevant to social prescribing practise. However, these could not be described as 22 separate principles, as several were alternative terms for the same process or principle. For example, 'what matters conversation' and 'compassionate conversation'.

With the aim of facilitating standardisation of the language associated with social prescribing, where there were multiple terms the glossary needed to identify the preferred term for use across the board as well as inform the user about the alternative terms in use and if possible highlight the preferred term for use in each sector. Examination of the descriptions identified through the scoping review, alongside the categorisation and ratings of terms from the GCM facilitated this process. Using this method we were able to produce a list of 48 preferred core terms that form the basis of the working glossary. For clarity, we will refer to this list as the 'core glossary'. These terms can easily be navigated via the use of a core terms navigation table. Within the core glossary, the preferred term for use across sectors and profession was displayed on the left in large black writing (Figure 6).

Where relevant, identification of the preferred term for use in each sector was further aided by filtering the ratings by cluster and/or profession to help identify the terms that are most useful and relevant collectively and, to the extent that the data allowed, by sector. This

enabled us to include lists of alternative terms if required and, where appropriate, identify the preferred terms used by individual sectors though the use of a simple colour key. For example, the term **link worker** was most highly rated on both scales by health workers, whereas the term **community connector** was most highly rated on both scales by social prescribing professionals who worked within CVSOs, and the term **community co-ordinator** was most highly rated on both scales by social care professionals (see Figure 6).



Link Worker navigation table

Description: The **link worker** is an umbrella term for a social prescribing practitioner who assists individuals with identifying their non-medical needs, through a what matters conversation, co-production of an action plan and accessing local assets and sources of support. Link workers will work with individuals to find activities tailored to their preferences and needs, explore barriers and challenges to attending, and encourage ongoing participation.

In CVSOs the preferred terms are **community connector** or **community navigator**, and within social care the preferred term is **community co-ordinator** or **local area coordinator** but 'link workers' may known by a variety of terms that can be specific to the organisation in which they work.

Alternative Terms: **Community connector, community co-ordinator, community navigator, local area coordinator, local asset coordinator,** social prescriber, , community health champion, community link office, community links practitioner, link co-ordinator, non-medical link worker, referrer, referral agent, referral worker, social prescription officer, social prescribing coordinator, wellbeing advisor , wellbeing links advisor, wellbeing worker, wellbeing co-ordinator, wellbeing community co-ordinator, facilitator, health adviser, health broker health connectors

Associated Terms: social prescribing pathway, referral, co-production, community assets, person-centred approach, what matters conversation, health facilitator, signposting, wellbeing

Figure 6. glossary example of a preferred core term with accompanying description, alternative terms with the preferred terms by sectors colour coloured, and associated terms listed.

Clusters 'Roles in social prescribing', 'Names for social prescribing systems', and 'Environmental and arts social prescribing assets' had comparatively high concentrations of terms, a large number of which could be described as alternative terms for the same process or principle. However, evidence from the scoping review indicates that many of these terms are seemingly used interchangeably with little standardisation across and within specific services making subcategorization within the glossary difficult. For example, green prescribing and green health referral.

To facilitate comprehension of the language surrounding social prescribing, within the core glossary we included a subcategory of terms associated with our preferred core term. Individual examination of these preferred terms using the GCM software allowed us to identify the closest and most frequently used terms that were grouped with them. We used this as basis from which to produce the lists of associated terms (Figure 6). To further aid

comprehension of the language surrounding social prescribing the glossary contains A-Z lists of core and non-core social prescribing terms. The A-Z list of core social prescribing terms links directly to the appropriate section of the core glossary.

Conclusions

Prior to commencing this research it was known that the lack of consistency of social prescribing related language created confusion for professionals and the public alike, impairing communication between sectors, professionals and with the public. However, the development of the glossary of terms has identified a diversity of terminology associated with the social prescribing process that was larger than anticipated (186 core terms and 236 non-core terms).

In an effort to produce a usable glossary (annex 1) that aims to inform as well as standardise the terminology associated with social prescribing the focus was on consolidating and clarifying the core social prescribing terms. The result is a list of 46 preferred terms that can be easily navigated and provides definitions for each term, highlight alternative terms and where appropriate highlights the preferred term for different sectors. Additionally, to facilitate comprehension of the language surrounding social prescribing, within the core glossary each preferred core term had an accompanying associated terms subcategory.

Evidence from the scoping review indicates that many of the terms identified are seemingly used interchangeably with little standardisation across and within specific services. The limits of our data therefore have made subcategorising terms for social prescribing professions and terms used to describe the process of social prescribing difficult. Moving forward, testing and refinement of the glossary will inevitably be required and provides an opportunity to clarify subcategories of terms associated with these areas. This would ideally be accompanied by a short study that focuses these specific areas. However, it should be acknowledged that due to the differences in the use of terminology across sectors and professions it is unlikely that distinctions will be made that will accurately reflect all uses of some terms.

In line with the consultation document for the Welsh Governments national framework for social prescribing (WG, 2022), the glossary uses the preferred terms of ‘social prescribing’ and ‘link worker’. However, the research indicates that the terms community connection and community connector were rated more highly by social prescribing professionals. This may be a representation of the demographic of the participants, which was largely from the third sector, but as social prescribing within Wales is predominantly concentrated within the third sector an argument could be made that terminology of the glossary should reflect the majority of those who use it rather than follow the healthcare dominated terminology with the literature. The launch of the glossary and the nations framework might be an opportune moment to embrace the term community connection as the preferred umbrella term and further standardise terminology associated with process. For example, the preferred term for art on prescription could become art referral, which would be in line with exercise referral as the identified preferred term. Such changes could easily be made to the existing draft glossary and incorporated into the a digital glossary, which would allow these and future changes to be quickly disseminated to public and professionals, as well as the easy collection of feedback as the language surrounding social prescribing inevitably evolves.

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