

Using consensus methods to develop a Social Prescribing Learning Needs Framework for practitioners in Wales

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Abstract

Aims: Social prescribing is being widely implemented in Wales, but there is no consensus on the necessary learning, training and education needs for people delivering social prescribing. The purpose of the study was to develop an education and training needs conceptual framework for social prescribers in Wales, which could be used by commissioners and providers for the development of social prescribing curricula.

Methods: This study used two consensus methods. First, Group Concept Mapping using Concept Systems Global MaxTM software which identified the important and available learning needs of 18 ($n = 18$) geographically spread social prescribing practitioners. Second, a world café style workshop asked 85 ($n = 85$) social prescribers to identify when training and support would be most appropriate and valuable in developing their role and skills.

Results: A Social Prescribing Learning Needs Framework was developed identifying important learning needs and their availability across a timeline from induction onwards. This was conceptualised from a group concept mapping cluster map and go-zone report. The map comprises five clusters of statements (compassion, interpersonal relationships, socioeconomic disadvantage, networking and monitoring data) from the original 120 statements of learning needs identified by participants. The Go-Zone report displayed how each learning need was rated by participants on scales of importance and availability. A large number of training needs (45%) that were identified as important, are not currently available to social prescribers. All training needs were placed within the first year of the social prescriber working timeline, with 39% placed in an induction period.

Conclusion: The use of two different consensus methods enabled social prescribers geographically spread across Wales to engage with the study. The Social Prescribing Learning Needs Framework will be used to inform the commissioning and decommissioning of training for people delivering social prescribing in Wales.

INTRODUCTION

Social prescribing (SP) is, 'a process to help people make positive changes in their lives and within their communities by linking people to volunteers, activities, voluntary and community groups and public services'.¹ Its purpose is to improve individual well-being and support people to take greater control of their lives by addressing the bio-psychosocial and environmental context.² SP is being widely implemented across Wales. Health and social care is devolved to Welsh

Government (WG), and they have commissioned SP prevention and early intervention service pilots in mental health.³ There are a number of SP models used in Wales. Most include a general practitioner (GP) practice or a community-based support worker having a 'what matters conversation' with individuals, co-producing personal goals and action plans, and connecting people to community resources. Across Wales, the complexity is exacerbated as the different programmes are managed by the health sector,

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social care, or 3rd sector providers. There is limited agreement on SP competency, and training and education needs and provision.

Lifestyle and the physical, economic and social environment are among factors that determine individual health,⁴ and access to and use of healthcare services has less of an impact,⁵ accounting for approximately 10% of population health and well-being.⁶ UK GPs report that 20% of consultations are related to patient psychosocial needs.⁷

Psychosocial needs are psychological, social or emotional needs, which may detrimentally affect health if not met. Time constraints and limited GP knowledge of community resource availability may add additional pressure to caseloads with supporting costs.⁷ SP may help relieve this pressure, expand patient options and support effective health resource use.

Many people in the UK live in situations that have detrimental impacts on their health and wellbeing, for example, poor housing, low self-esteem, social isolation, financial difficulties, poor education, and physical and/or mental health problems. SP acknowledges the importance of these factors and takes a bio-psychosocial approach to addressing individuals' needs.^{2,8} It does so by helping people access non-clinical support through resources available in the voluntary and community sector. Examples of SP schemes include art activities, volunteering, walking groups, museum visits, team sporting events, gardening, cookery and group learning; availability of community resources varies between localities.⁹

In Wales the terms 'social prescriber', 'link worker', 'community connector', 'coordinator' or 'community navigator' are among the terms used to describe the role. In this study, the term social prescriber is used for convenience but also encompasses other terms. The SP role is challenging as it involves a range of cognitive, functional and ethical competencies¹⁰ to help people feel at ease and motivated, and to support people living with anxiety or depression who may have difficulty engaging, or who are lonely and isolated. In addition, social prescribers need sound knowledge of

resource availability in their local practice area, for example, on housing issues and benefits advice.¹¹ Due to the complexity of commissioning arrangements and focus on localism, SP has developed organically in Wales to meet local needs, such that current roles have different skill requirements and employment scales. Consequently, there has been no consensus on the required learning needs to demonstrate competency. The purpose of this study was to develop an education and training needs conceptual framework for SP in Wales, which commissioners and providers could use to develop SP curricula and competency assessment frameworks, regardless of employing authority. This is the first study in the UK that explores the learning needs identified by social prescribers.

METHODS

Setting and design

This sequential mixed-methods study used two different consensus methods – Group Concept Mapping (GCM),¹² and a World Café workshop.¹³ In part 1, GCM and Concept Systems Global Max™ online software were used to help a group of geographically spread (urban, city and rural) social prescribers organise and represent their ideas about their learning needs as opposed to using other workshop type consensus methods such as a Nominal Group technique. GCM involves a facilitator-led three-phase participant process of brainstorming, grouping and rating, followed by structured analysis and interpretation. All completed online to facilitate ease of participation. Part 1 outcomes informed part 2, a World Café workshop where social prescribers identified when training and support would be most appropriate and valuable in developing their role and skills.

A study steering group comprised Wales Social Prescribing Research Network members variously employed by Public Health Wales, University of South Wales, Glyndwr University, Betsi Cadwaladr University Health Board, Torfaen County Borough Council and the Wales Council for Voluntary Action (WCVA), the umbrella body for the third sector in Wales. Health Education and

Improvement Wales (HEIW) commissioned the study. HEIW has the lead role for education and training of the Wales healthcare workforce. The steering group supported map interpretation and commented on findings, and was convened on a fortnightly basis.

Ethical approval

Ethics approval was given by the lead university faculty ethics committee for both part 1 and 2, ethics approval numbers are 18ME1001LR and 19ME0204LR, respectively.

Participants

In part 1, 18 participants were recruited from north, south, east and west Wales using purposive sampling through the Wales Social Prescribing Research Network (WSPRN).¹⁴

Part 2 participants were a convenience sample. The research team had permission to present part 1 findings at a conference and conduct a World Café workshop. The conference included 85 invited participants from Wales considered to have SP components in their work role.

Procedure

Part 1 – GCM brainstorming, grouping and rating, November 2018 to March 2019. The three phases of brainstorming, grouping and rating were GCM facilitator led. They comprised three individual 30–40 min online exercises over 9 weeks with emailed prompts, and written visual screen instructions; telephone support was available on request.

An email invitation was sent to the WSPRN membership. Informed consent was gained from interested respondents who then received an online software link and unique username and password. Five demographic questions (see Table 1) were asked prior to brainstorming and used later for data analysis. The facilitator and study steering group developed brainstorming focus prompts and two rating scales. Recognising that some participants may be practitioners and managers, the agreed focus prompts were

To help me in my social prescribing role my learning needs are....

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Table 1

Participant online demographic questions			
Participant question	Option	Frequency	%
In which area do you work?	Torfaen	3	16.67
	Newport	2	11.11
	Caerphilly	1	5.56
	Cardiff	1	5.56
	Carmarthenshire	1	5.56
	Flintshire	1	5.56
	Merthyr Tydfil	1	5.56
	Pembrokeshire	3	16.67
	Powys	2	11.11
	Rhondda Cynon Taf	2	11.11
	Wrexham	1	5.56
	TOTAL	18	100.00
Time in role	Start-up no experience	1	5.56
	Less than 12 months	3	16.67
	13–36 months	11	61.11
	37–72 months	3	16.67
	73 months plus	–	–
	TOTAL	18	100.00
Components of role	Providing information and advice	16	10.60
	Face-to-face support up to 6 weeks	7	4.64
	Coaching	7	4.64
	Motivational interviewing	9	5.96
	Meetings with community assets	11	7.28
	Case management	11	7.28
	Regular feedback to referrer	12	7.95
	Signposting	15	9.93
	‘What matters’ conversation	15	9.93
	Co-produce well-being goals	12	7.95
	Co-produce well-being plan	9	5.96

(Continued)

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Table 1.

Participant online demographic questions			
Participant question	Option	Frequency	%
	Referral to community asset	11	7.28
	Follow up interview	8	5.30
	Other: Raising awareness of role with Primary Care; ASIST interventions; capacity limits follow up options; holistic complementary treatment for chronic pain conditions; support to sector; help people liaise with other service providers; reframing problems and support during periods of life transition; and indicate all the tasks I would expect the connectors would complete.	8	5.30
	TOTAL	151	100.00
Paid or non-paid	Paid	17	94.44
	Non-paid (volunteer)	1	5.56
	TOTAL	18	100.00
Type of organisation	Third sector (charity)	10	55.56
	University Health Board	-	-
	Primary Care (GP) organisation	1	5.56
	Registered social landlord	-	-
	County Borough Council	3	16.67
	Other: private sector; paid by NHS, managed by county council; community interest company; and partnership between NHS Health Board and Third Sector	4	22.22
	TOTAL	18	100.00

ASIST: Applied Suicide Interventions Skills Training; GP: general practitioner; NHS: National Health Service.

To help my staff in their social prescribing roles their learning needs are...

The online Concept Systems Global Max™ software link was open for 2 weeks in December 2018 for participants to generate as many statements as they wanted in response to the focus prompts. Statements were cleaned and duplicates removed in preparation for grouping.

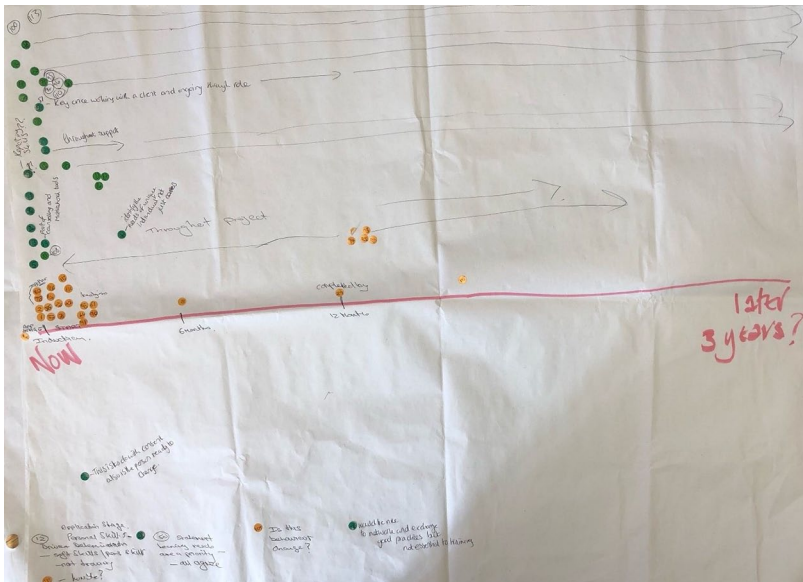
The grouping phase began January 2019 and participants received an email prompt with instructions. Using the online table-top sorting screen,

participants sorted the statements into groups which made sense to the individual using a drag-and-drop technique, and then labelled the individual groups with a label of their own choice. Finally, participants rated the statements against two 5-point Likert-type scales – importance and availability. Data collection ended in February 2019.

Part 2 – World Café workshop. A 1-day World Café workshop took place in a mid-Wales hotel in March 2019, following seven integrated principles^{13,15}:

1. The **context** was set by presenting part 1 findings to participants.
2. The hotel provided a **hospitable space** in which to hold the event using a carousel table configuration for seating. Ice-breaking techniques were used to promote whole group interaction and participants were allocated to one of three roles – flowers, butterflies or bees. Flowers stayed at their table, butterflies moved about the room at any time in any direction, and bees moved clockwise between tables at set time points.
3. Participants **considered their own experience and roles** when reading

Example of a group timeline with training needs identified at different time points over a 3-year period.



into two categories (1) those considered **important** and **available** and (2) those considered **important**, but **not available**.

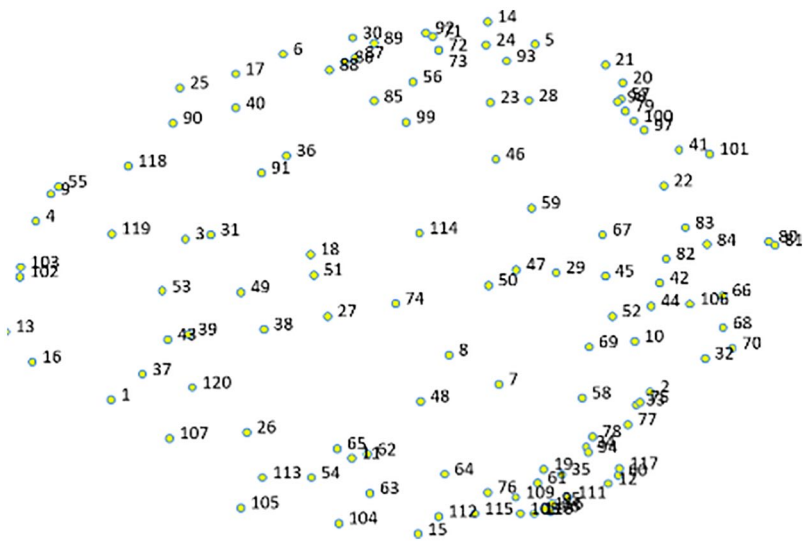
5. Connecting diverse perspectives was challenging. There was some debate about whether SP was the most appropriate term to use. One table felt strongly that their community connector role was not the same as social prescriber and decided not to participate. Although they performed the many aspects of the role including 'a what matters conversation', they perceived the SP role as only existing within primary care. A perspective which is not generally held within the SP community in Wales.

6. Patterns and insights were collected throughout the workshop as participants moved around the room and contributed to the learning needs timelines.

7. It was agreed that the workshop findings (**the harvest**) would be shared via a brief report disseminated by the WSPRN.¹⁴

Figure 2.

A 120 statement point map following multidimensional scaling.



the learning needs from the part 1 findings. They discussed each training need in their group and placed it on a social prescriber training timeline to show when it should be addressed. Groups made their own timelines, so timescales varied according to what each group

decided was appropriate (see Figure 1 for an example).

4. Everyone **was encouraged to contribute** to discussions and some participants from part 1 were available to circulate and explain statements as required. Training needs were sorted

ANALYSIS

Part 1 – the online software data analysis followed four steps:

1. Participant demographic responses analysed using descriptive statistics.
2. Similarity matrix created from sorted statements – demonstrates number of participants sorting the statements together.
3. Multidimensional scaling analysis of similarity matrix produces a point map. Each participant statement is allocated a point on a two-dimension (XY) axis (see Figure 2).
4. Ward's algorithm used in hierarchical cluster analysis of statement clusters to produce a cluster map with cluster labels (see Figure 3), cluster rating (Figure 4) and go-zone analysis (Figure 5) to develop final learning needs framework.

Following part 1 data analysis, the study steering group discussed and interpreted

Figure 3.

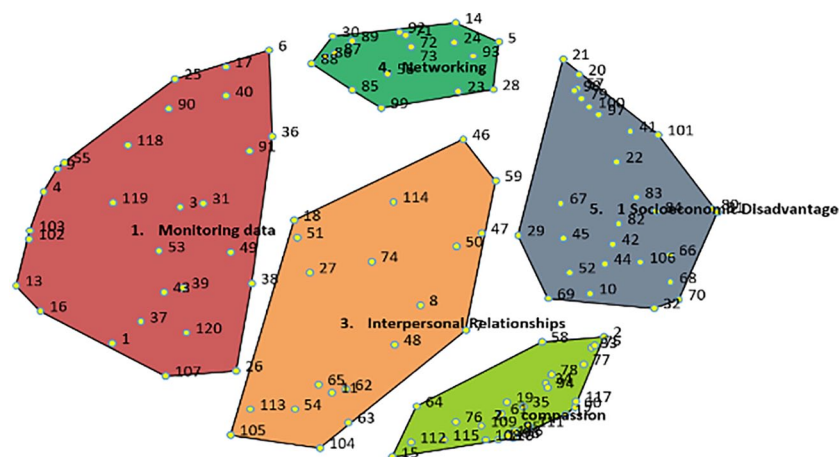
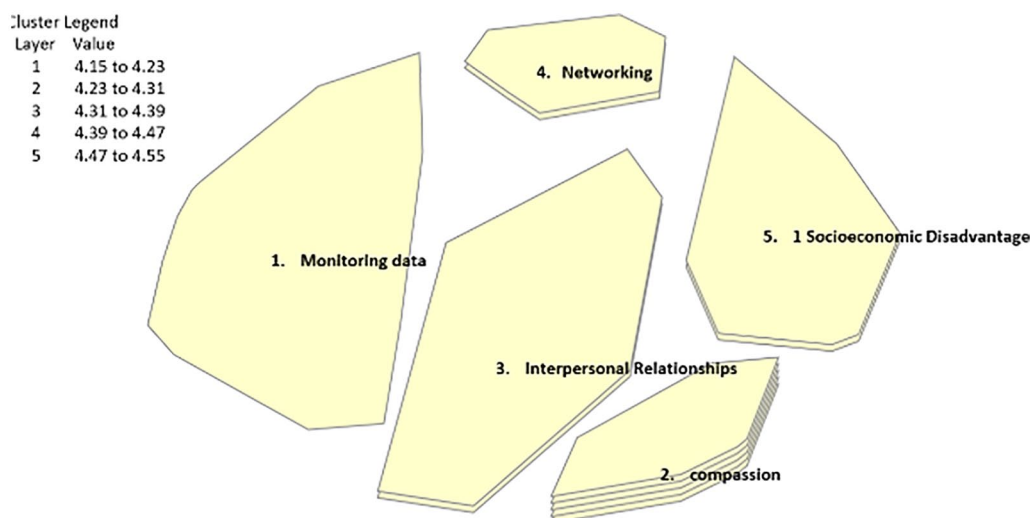
Cluster map with labels from the participant grouping exercise

Figure 4.

Cluster rating map – importance of learning needs

the results, and considered how to proceed in the World Café workshop.

Part 2 – Timelines were analysed and split into five categories; *Induction*, *3 months*, *Year 1*, *Years 2-3* and *ongoing* based on commonly used labels included by each group. Each timeline was analysed individually and statements were separated into the five categories. The modal category for each statement is reported in Table 5; where there was no modal category, all categories are reported. Training needs identified as *ongoing* were asterisked and a main category identified.

RESULTS

Participant demographics

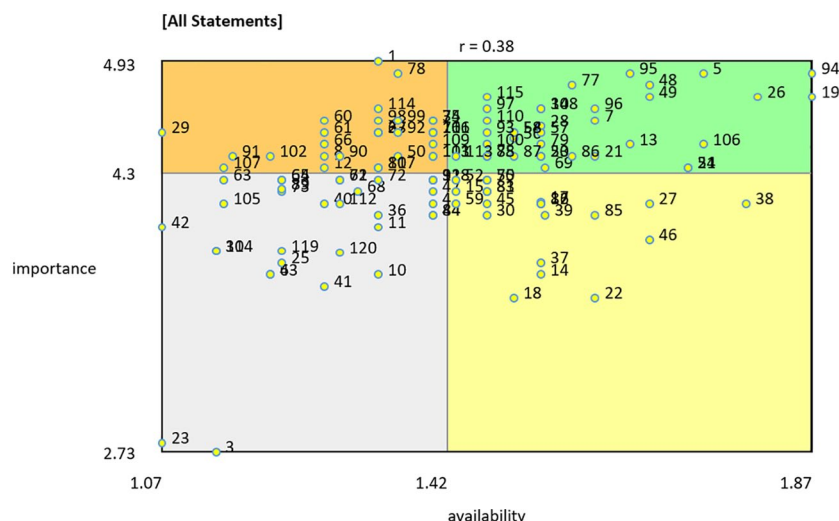
Table 1 presents responses to the five demographic questions. It demonstrates that participants worked across 11 of the 22 local authorities found in north, south, east and west Wales. The majority (61%) had 13–36 months experience in a SP role, although experience ranged from ‘Start-up no experience’ to 37–72 months. Fifty-five per cent were employed by third-sector organisations, and only one was a volunteer. Participants identified their main role components as providing information

and advice (10.6%), signposting (9.9%), having ‘What Matters’ conversations (9.9%), providing regular feedback to referrers (7.95%), co-producing well-being goals (7.97%), referring to community assets (7.28%), meetings with community assets (7.28%), and case management (7.28%).

Part 1 – Generating and mapping social prescriber learning needs using GCM

Participants identified 89 statements in the brainstorming exercise. Some were

Figure 5.

Go-Zone report showing learning need rated in relation to importance and availability.

multiple statements which were reframed, for example, No.69 'to understand the aims of SP for the patients. Supervision and 1:1 is essential to identify learning needs. What services are available. How services are evaluated'. This was reframed as four learning needs statements – understanding patient aims, supervision availability, service availability and service evaluation. After cleaning and duplication removal, 120 statements of individual learning needs remained.

GCM software generated a point map (Figure 2) showing the 120 statements with a final stress value of 0.3402 after 10 iterations. The acceptable range is 0.205–0.365, and this is considered similar to reliability. The stress value is at the higher end of the range, but implies a good relationship between data input, similarity matrix (developed from the grouping task) and distance on the map.¹²

The SP learning needs cluster map comprises five statement clusters from 120 statements – Compassion, Interpersonal Relationships, Socioeconomic Disadvantage, Networking, and Monitoring Data (Figure 3). The distance between clusters represents their conceptual relationship, for example, Compassion is closer in

relationship to Interpersonal Relationships and Socioeconomic Disadvantage than it is to Monitoring Data and Networking. Cluster labels are generated from the participant grouping and labelling exercise. Table 2 shows the distribution of the number of statements across the five clusters. Socioeconomic Disadvantage has the most statements ($n=28$) and includes poverty, inequalities, finance and housing. Networking has the least statements ($n=18$) and includes supply chain management, co-operation, integration and partnership arrangements. Table 2 also gives the average rating of importance and availability of training for each cluster. It shows that the 'Compassion' cluster on average was rated most important (4.55) and training was most available (1.45); while 'Monitoring data' was the least important (4.15) and training least available (1.38).

Statement placement in a cluster originates from participants' grouping and rating of each statement. Examples of statements within each of the clusters can be seen in Table 3. For example, statement 20, 'an in-depth knowledge of the services available in the area (place in which my work is based) so that I can refer people accurately in to the service if required', is in Socioeconomic

Disadvantage because most participants placed it there.

The cluster-rating map (see Figure 4) shows participants rated Compassion as the most important SP learning need (average rating 4.55), and the most available training (average rating 1.45). Monitoring Data was rated least important (average 4.15) and least available training (average rating 1.38; see Table 2).

The Go-Zone report (Figure 5) shows learning needs above or below the mean across two rating criteria – importance, availability. Statements above the importance mean (4.3) were rated most important and located in orange and green zones. Statements above the availability mean (1.42) are learning needs with most available training to participants and located in green and yellow zones. Figure 5 shows green zone learning needs are most important and training is most available. Orange zone learning needs are most important but training is not/least available. Yellow zone learning needs are least important but training is available. Grey zone learning needs are least important and training is not/least available.

Part 2 – World Café identifying timeliness of training delivery

The 85 participants worked in seven groups and identified timelines and time scales, ranging from 12 months to 3 years. Each timeline was analysed individually and statements were separated into the five categories *Induction, 3 months, Year 1, Years 2-3, Ongoing*. The most commonly identified category became the main category and reported below in Table 4. Where there was no commonly identified category we have stated all the categories used for that training need. This leaves it open for individuals to decide for themselves when to address this training need based on local context and contingencies.

Five groups (71%) included an induction/pre-employment section for training before starting SP work and 26 training needs were located here; 23 training needs were identified for the first 3 months, 28 in year 1, and no training needs in years 2–3. Most training needs

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Table 2

Social prescribing learning needs using a cluster of five

Construct	Compassion	Interpersonal relationships	Socioeconomic disadvantage	Networking	Monitoring data
Number of statements	26	20	28	18	28
Average rating of important learning needs	4.55	4.28	4.27	4.27	4.15
Average rating of availability of training	1.45	1.41	1.42	1.44	1.38

Table 3

Statement examples for SP learning needs clusters

Construct	Example of statements included
Compassion	12. Has the drive and tenacity to see changes through for people 15. Understanding people will not change to help themselves until they are ready to help themselves
Interpersonal relationships	7. Understanding the needs of Carers 11. To understand how wider family and other relationships impact on circumstances
Socioeconomic disadvantage	20. An in-depth knowledge of the services available in the area (place in which my work is based) so that I can refer people accurately in to the service if required 81. Understand the impact of poverty
Networking	5. To have knowledge of other social prescribing projects in the area and how to signpost patients on. 30. Sharing information across sectors
Monitoring data	1. Protocols for dealing with challenging situations within the GP surgery, for example, aggressive behaviour, suggested suicide attempt, etc. 4. To have a greater understanding of how to measure 'success' of my project

SP: social prescribing; GP: general practitioner.

Table 4.

Training need categorisation based on availability and timeliness

	Available	Not available
Induction	14	12
3 months	19	9
Year 1	14	13

(86%) were identified as ongoing by at least one group. Training needs were divided based on availability and timeliness (see Tables 4 and 5).

This allowed us to identify when an individual learning need was most needed (timeliness) and their individual availability. Table 5 shows important

training needs, timeliness (from induction to 1 year in role), training availability (green available, orange unavailable), and cluster categorisation. For example, statement 2 'counselling skills and motivational tools' is identified as an important learning need, but training is not readily available. Participants identified that this should be available at induction. This training need was identified as important within the cluster of training needs called 'compassion'.

Participants identified 26 learning needs for induction or year 1; 17 learning needs were located in the Compassion cluster, of which 10 do not have training

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Table 5

Important training needs, timeliness categorisation and availability categorisation

No.	Availability	Timeliness		Training need	Cluster
1	Not available	Induction		Protocols for dealing with challenging situations within the GP surgery, e.g. aggressive behaviour, suggested suicide attempt etc.	Monitoring data
2				Counselling skills and motivational tools	Compassion
12				Has the drive and tenacity to see changes through for people	Compassion
35				Offering personalised support	Compassion
60				Being able to deal with loneliness	Compassion
74			*	Professional boundaries	Interpersonal relationships
111				Being able to remain humble	Compassion
116				Building rapport	Compassion
117				How to offer or provide solutions	Compassion
19	Available		*	A good understanding of listening effectively when asking people what matters to them	Compassion
34			*	To help people to connect and socialise	Compassion
49				Coaching, mentoring and support is key to staff feeling supported	Monitoring data
94			*	Listening skills	Compassion
95			*	Acting with care and compassion	Compassion
96			*	Being non-judgmental	Compassion
106			*	To understand the Social Service and Well Being Act (Wales)	Socioeconomic disadvantage
108			*	To ask and understand what matters to people	Compassion
110			*	Acknowledging empathy for other	Compassion
8	Not available	Induction/3 months		Having an awareness of the impact on mental health of long term unemployment or never having worked	Interpersonal relationships
61				Being able to deal with isolation	Compassion
102			*	How to measure and plot people's improvement in health	Monitoring data
51	Available		*	Supervision and 1:1 is essential to identify learning needs	Interpersonal relationships
79			*	Know where to find support for community groups to establish themselves	Socioeconomic disadvantage

(Continued)

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Table 5.

Important training needs, timeliness categorisation and availability categorisation

No.	Availability	Timeliness		Training need	Cluster
76	Not available	Induction/3 months/ Year 1		To understand behaviour change	Compassion
33	Not available	Induction/Year 1		To enhance engagement skills	Compassion
48	Available		*	Autonomy, trust, flexibility and confidentiality are key areas of staff skills	Interpersonal relationships
66	Not available	3 months		Staff awareness and understanding of complex issues	Socioeconomic disadvantage
78			*	To build the skills to support people	Compassion
80			*	Understand health inequalities	Socioeconomic disadvantage
109			*	Professional-interpersonal relationship (e.g. understanding people often are unable to apply to their lives what they have been told they need to do)	Compassion
7	Available		*	Understanding the needs of Carers	Interpersonal relationships
13			*	Keeping good work logs of support for those referred in and out of our service	Monitoring data
24			*	The opportunity to network with other social prescribers across Wales	Networking
28				The ability and confidence to successfully network within the community, with colleagues and partners	Networking
69			*	Knowledge and skills base takes into account mental health	Socioeconomic disadvantage
75			*	Coaching skills	Compassion
77			*	To understand motivation and have the skills to motivate	Compassion
86			*	The ability to promote the role with professionals in health	Networking
87			*	The ability to promote the role with professionals in social care	Networking
88			*	The ability to promote the role with professionals in housing	Networking
115			*	The process of discovering what matters to people and developing goals	Compassion
92	Not available	3 months/Year 1	*	Able to work in partnership with local providers	Networking
20	Available		*	An in depth knowledge of the services available in the area (place in which work is based) so that people can be referred accurately in to the service if required	Socioeconomic disadvantage

(Continued)

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Table 5.

Important training needs, timeliness categorisation and availability categorisation					
No.	Availability	Timeliness		Training need	Cluster
21			*	An in depth knowledge of the groups delivering activities and services in given area (place) of work. Including who to contact within the group to make individual referrals to.	Socioeconomic disadvantage
26			*	Mental health awareness and mental health first aid training	Monitoring data
53			*	Reporting skills and processes	Monitoring data
57				What services are available	Socioeconomic disadvantage
58			*	To have the knowledge and confidence to be able to give people the necessary help, advice and support to complain about ill treatment	Compassion
29	Not available	Year 1	*	An accredited course, so Connectors are seen as 'qualified' to offer social prescribing	Socioeconomic disadvantage
50			*	Learning needs are a priority	Interpersonal relationships
67			*	Keep knowledge up to date	Socioeconomic disadvantage
90			*	To know when and how to challenge poor services	Monitoring data
91			*	To know when and how to help improve services	Monitoring data
98			*	A good knowledge of where the gaps in services are	Socioeconomic disadvantage
99			*	A good knowledge of where needs are not being met	Networking
101				Knowledge around social issues affecting their communities	Socioeconomic disadvantage
103			*	How to measure and plot people's improvement in wellbeing	Monitoring data
107				To use policy to empower people to take control over what they need	Monitoring data
114			*	To generate confidence between referrer, activity provider and recipient to provide a quality seamless service	Interpersonal relationships
5	Available		*	To have knowledge of other social prescribing projects in the area and how to signpost patients on	Networking
54				How to convince patients to engage with social prescribing	Interpersonal relationships
56				How to refer patients to services	Networking

(Continued)

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Table 5.

Important training needs, timeliness categorisation and availability categorisation

No.	Availability	Timeliness		Training need	Cluster
93			*	Building trusting relationships with people delivering groups, activities and services in the areas of work	Networking
97				A good knowledge of the services and support available	Socioeconomic disadvantage
100			*	Knowledge around health issues affecting their communities	Socioeconomic disadvantage
113			*	Having the ability to balance work and home life	Interpersonal relationships

GP: general practitioner.

Key: Green – available training needs. Orange – unavailable training needs. Number = training need statement number. Cluster = map label identified via Group Concept Mapping. * = ongoing training need.

readily available, for example, behavioural change, motivational and coaching tools. Participants identified 18 learning needs for year 1 drawn from Interpersonal Relationships ($n=4$), Socio-economic Disadvantage ($n=6$), Networking ($n=4$) and Monitoring Data ($n=4$). Thirty training needs (45%) were identified as important, not currently available to social prescribers, and placed on the year 1 SP working timeline.

DISCUSSION

The learning needs identified in this study reflect the bio-psychosocial and environmental context of the developing SP role² and provide the basis for establishing a competency framework for education, training and assessment¹⁰ and supporting outcome evaluation.¹⁶ However, it should be noted that some of the learning needs required by social prescribers will originate from the need to manage the type of referrals received, for example, managing loneliness, anxiety and depression as opposed to socio-economic issues.² A total of 45 learning needs were identified as 'ongoing' for social prescribers. This suggests that the parameters for a SP career pathway is emerging and a possible competency framework to distinguish progression from basic know-how to more advanced, mature or

complex understanding and execution of SP knowledge and skills. It highlights a SP training provision gap which may limit skill development to:

- Empower others to take ownership of their health and wellbeing;
- Ensure their personal resilience in performing the role.

There are a number of key points which arise from this study. First, the five clusters of SP learning needs have been identified by practitioners from geographically diverse practitioners across Wales as Compassion, Interpersonal Relationships, Socioeconomic Disadvantage, Networking, and Monitoring Data. They include 120 statements of learning needs, and the cluster map could be used to identify cognitive, functional and ethical competency for SP, and consequently organise learning and assessment for social prescribers. These statements could be mapped to previously developed training and development schemes to ensure that learning needs are being met.

Second, the statements included in the clusters have been rated for importance and availability, identifying the most important. This highlights a SP training provision gap that may limit skill development to help others take

ownership of their health and wellbeing; and role holder's personal resilience. This offers education commissioners an opportunity to target funding, and discuss opportunities to decommission available learning not rated as important. It also allows employers to develop evidence-based job roles, competencies and move towards a consensus-based service provision.

Finally, social prescribers consider it important to have induction training before starting their role. They identify some key competencies and skills needed before providing the service to ensure safety of provision. The majority of training needs are identified as ongoing. Social prescribers indicate that a single training session is unlikely to meet these needs. They indicate that ongoing training should be available to meet developing needs and develop their competency to manage complex and challenging caseloads.

Recommendations

- Findings to inform education and training commissioning for SP.
- Findings to inform programme commissioning intent and support commissioners in setting achievable outcome goals.
- Education and training providers to use the learning needs clusters to organise future curriculum

Using consensus methods to develop a Social Prescribing Learning Needs Framework for practitioners in Wales

development and competency assessment. The learning needs identified as 'important' to be used as topic titles.

- Future research to evaluate the education and training implementation, focusing on training needs timeliness, and evaluate whether perceptions correspond to social prescriber training experience.
- Future research to investigate the social prescribers' preferred education and training delivery format, for example, online training and formal induction, and to identify how to meet these training needs more effectively and efficiently.
- Future research to explore scope of different roles that have emerged within SP and in connecting people to community assets, that is, social

prescriber, community connector, link worker, community navigator; and to identify associated educational and training requirements and competencies for practice.

CONCLUSION

This is the first UK study to explore the learning needs identified by social prescribers. Using two different consensus methods allowed geographically dispersed social prescribers to engage with the study. The Social Prescribing Learning Needs Framework will be used to inform the commissioning and decommissioning of education and training for people delivering SP in Wales. Future research might wish to evaluate the implementation of training, focus on

training needs timeliness and investigate the preferred format in which social prescribers wish to receive this training.

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References

1. Thomas S, Day G, James S *et al*. Social prescribing concept paper. Unpublished, Cwm Taf University Health Board, Cwm Taf Public Health Team, Interlink, VAMT, 2019, p. 5.
2. Moffatt S, Steer M, Lawson S *et al*. Link worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ Open* 2017;**7**(7):e015203.
3. Welsh Government. Taking Wales Forward 2016–2021, 2016. Available online at: <https://gov.wales/taking-wales-forward>. (last accessed 30 July 2019).
4. Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm: Institute for Future Studies; 1991.
5. World Health Organization. The determinants of health, 2019. Available online at: <https://www.who.int/hia/evidence/doh/en/>. (last accessed 24 April 2019).
6. McGovern L, Miller G, Hughes-Cromwick P. The relative contribution of multiple determinants to health. Health Affairs Health Policy Briefs, 21 August 2014. Available online at: https://www.healthaffairs.org/doi/10.1377/hpb20140821.404487/full/healthpolicybrief_123.pdf
7. Zantinge EM, Verhaak PF, Kerssens JJ *et al*. The workload of GPs: consultations of patients with psychological and somatic problems compared. *Br J Gen Pract* 2005;**55**(517):609–14.
8. The Kings Fund. What is social prescribing? 2017. Available online at: <https://www.kingsfund.org.uk/publications/social-prescribing>. (last accessed 30 July 2019).
9. Social Prescribing Network. Report of the annual social prescribing network conference, 2016. Available online at: <http://www.artshealthresources.org.uk/docs/report-of-the-inaugural-social-prescribing-network-conference/>. (last accessed 13 December 2019).
10. Weeks K, Coben D, Lum G *et al*. Developing nursing competence: future proofing nurses for the changing practice requirements of 21st century healthcare. *Nurse Educ Pract* 2017;**27**:A3–4.
11. Polley M, Fleming J, Anfilogoff T *et al*. Making sense of social prescribing, 2017. Available online at: <http://eprints.uwe.ac.uk/33145/1/Making-sense-of-social-prescribing-2017-PRINT.pdf>. (last accessed 30 July 2019).
12. Kane M, Trochim WMK. *Concept mapping for planning and evaluation* (Applied Social Research Methods Series), vol. 50. Thousand Oaks, CA: Sage; 2007.
13. MacFarlane A, Galvin R, O'Sullivan M *et al*. Participatory methods for research prioritization in primary care: an analysis of the World Café approach in Ireland and the USA. *Fam Pract* 2017;**34**(3):278–84.
14. Welsh Council for Voluntary Action. The all Wales Social Prescribing Research Network (WSPRN), 2018. Available online at: [https://www.wcva.org.uk/what-we-do/the-social-services-and-wellbeing-\(wales\)-act-the-role-of-the-sector/wales-social-prescribing-research-network](https://www.wcva.org.uk/what-we-do/the-social-services-and-wellbeing-(wales)-act-the-role-of-the-sector/wales-social-prescribing-research-network). (last accessed 30 July 2019).
15. Brown J, Isaacs D. *The World Café: shaping our futures through conversations that matter*. 1st edn. San Francisco, CA: Berrett-Koehler Publishers; 2005.
16. Husk K, Elston J, Gradinger F *et al*. Social prescribing: where is the evidence? *Br J Gen Pract* 2019;**69**(678):6–7.