Understanding the model of Social Prescribing through interviewing link workers in the role.

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Abstract

The promotion of social prescribing as a solution to support patients presenting in primary care with non-medical needs has been well documented. Despite the inclusion of social prescribing in the NHS long term plan the evidence of social prescribing's effectiveness has been continually questioned (Ayorinde et al., 2024). Previous studies attempting to understand the social prescribing service have cited high variability in the delivery of the service, complex patients referred and link workers recognition that the job advertisement has not matched the requirements of the role (Brunton et al., 2022; Frostick & Bertotti, 2021; Hazeldine et al., 2020; Holding et al., 2020; Rhodes & Bell, 2021; Skivington et al., 2018; Wildman et al., 2019; White et al., 2022). The aim of this study was to gain an insight and understanding of social prescribing through interviews with the link workers tasked with delivery this model of support. The study used a qualitative method to conduct 12 interviews with link workers about their experience and understanding of the social prescribing role. Following these interviews the researcher employed a reflexive thematic analysis to examine the data. From this thematic analysis the researcher constructed 4 theme keys: Don't Judge a Job by its Description, A Silver Bullet, The Wild West of the NHS and An Inconsistent Service. These 4 themes highlighted the challenges in the current model of social prescribing such as the mismatch in the current advertisement of the social prescribing service, as a light touch signposting support versus the reality of the day-to-day job of supporting patients with complex physical and mental health. The lack of framework and formal supervision has created a 'make it up as you go' approach to social prescribing which leads to its high variability and immeasurable nature. While these issues with social prescribing are highlighted the researcher also found aspects of social prescribing which offer great benefits to patients such as the ability to feel heard by a professional and to access support that is truly tailored to their personalised needs. The researcher makes recommendations for how the social prescribing model can be improved to offer a safe and consistent practice while keeping the core principles of social prescribing that offers support to individuals in need.

Contents

1. Chapter 1: Introduction

1.1 Thesis Structure

This thesis has been sectioned into the following chapters:

Chapter 1: Outlines the structure of the thesis, the doctoral descriptors, and the background to the thesis topic.

Chapter 2: Details a literature review of previous research examining the model of social prescribing.

Chapter 3: Denotes the ontological and epistemological approaches that underpinned this thesis study. Additionally, the method employed in the study design is outlined including the ethics, recruitment, data collection and data analysis procedure.

Chapter 4: Discusses the results of the qualitative analysis of the study.

Chapter 5: Presents a discussion of how these results interact with previous research and outlines the implications of this thesis study's findings. Following this the limitations of the study are discussed, and recommendations are made for future practice. Finally, conclusions are drawn from the studies thesis findings.

The thesis is written predominantly in the third person. The use of the first person is adopted in chapter 3 in the researcher's reflexive section during which the researcher reflects on their experience of the conducting the research and how this affected the data interpretation.

1.2 Doctoral Descriptors

The Doctoral Descriptors that the postgraduate researcher must meet are as follows:

· The researcher must have conducted an enquiry leading to the creation and interpretation of new knowledge through original research or other advanced scholarship, shown by satisfying scholarly review by accomplished and recognised scholars in the field.

· The researcher must demonstrate a critical understanding of the current state of knowledge in that field of theory and/or practice.

· The researcher is required to demonstrate the ability to conceptualise, design and implement a project for the generation of new knowledge at the forefront of the

discipline or field of practice including the capacity to adjust the project design in the light of emergent issues and understandings.

· The researcher needs to demonstrate a critical understanding of the methodology of enquiry.

· The researcher has developed independent judgement of issues and ideas in the field of research and / or practice and are able to communicate and justify that judgement to appropriate audiences.

· The researcher can critically reflect on their work and evaluate its strengths and weaknesses including understanding validation procedures.

All the work submitted for this thesis has been produced solely by the researcher and delivers the doctoral descriptors above including the production of an original contribution to knowledge.

1.3 Introduction

"Evidence has shown the potential benefits of approaches like social prescribing, which addresses people's physical and mental wellbeing and has been shown to both improve patients' quality of life and reduce pressure on other NHS services."

- Matt Hancock Health Secretary (Smyth, 2018, p.1)

1.3.1 The evolution of the definition of health

The concept that health encapsulates not simply the absence of illness, but a state of wellbeing, has been well established since the World Health Organisation (WHO) publication of its definition that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in 1948 (Larson, 1996). Despite this recognition of the importance of an individual's wellbeing a universal definition of what wellbeing should encapsulate remains elusive (Placa et al., 2013). Unlike its counterpart health (in which disease eradication or prevention is the clear goal to achieve a state of wellness) wellbeing remains a complex web of social, psychological, and physical health determinants (Simmons & Baldwin, 2021). Attempts

to agree a universal measurement tool for wellbeing similarly remains a point of contention (Cooke et al., 2016). Despite the challenges of defining what it is, the focus on improving wellbeing has taken a prominent position in health care settings of both staff and patients (Robertson & Flint-Taylor, 2010; Lee et al., 2013). For this study the researcher will adopt the definition of wellbeing which describes the concept as an individual's perception of how positive they feel about their overall life (Magyar & Keyes, 2019).

This recognition of the importance of wellbeing in healthcare coincides with a movement away from the biomedical model of health to instead focus on the importance of social determinants (WHO, 2008). This shift has led to the adoption of a biopsychosocial model of health which considers factors that influence a person's health and wellbeing status such as their social connections, psychological status as well as their biological symptomatology (Wade & Halligan, 2017.). The adoption of a wider biopsychosocial model as the new focus of health care was borne out of recognition of the need to consider wider factors outside of pathology or biological symptoms to treat the increasing levels of long-term conditions, improve patient outcomes and reduce health care costs (Wade & Halligan, 2017). This has been particularly prominent in a population that is experiencing increasing levels of loneliness and social isolation both of which have a notable impact on health and wellbeing (Surkalim et al., 2022).

1.3.2 The impact of loneliness

The presentation of patients with loneliness and social isolation is a prominent issue in health care settings and is an increasing problem among the British public with a reported 3.83 million people experiencing loneliness (ONS. 2023; Jovicic et al., 2020; Cross, 2016; Barreto et al., 2021). The NHS defines loneliness as a subjective experience that can be experienced on 3 different forms: emotional loneliness which describes a person who is lacking in emotional attachments, social loneliness which depicts an individual who has an absence of people to experience social interactions with or whom they share hobbies or interests with and existential loneliness which outlines an individual's experience of being surrounded by people you know and yet still feeling

alone (Benson et al., 2021; NHS Choices, n.d.). In contrast, to the subjective nature of loneliness social isolation is defined as an objective absence social contact or a social group (Gardner et al., 2018; National Institute for Health Research, 2014).

The impact of loneliness on health has been noted to have a detrimental effect on our physical and mental health, sleep, cognitive abilities, cardiovascular system, increased risk of dementia, higher medication dependency, high blood pressure and increased mortality risk (Emerson et al., 2021; Park et al., 2020; Surkalim et., 2022; Xia et al., 2018). As such the recognition that interventions to help reduce loneliness are understood to be crucial in improving health outcomes and reducing mortality risk, especially in older adults (Singer, 2018). Research has also noted that individuals experiencing loneliness use a higher rate of primary care resources than the average individual (Sirois et al., 2023). To meet these growing needs of the population, an approach focusing on supporting these social needs is required.

1.3.3 The rise of long-term conditions and social need

Coinciding with this rising social presentation among patients attending Primary Care appointments is the growing population in the United Kingdom (UK) of individuals with long term health conditions and complex multi-morbidities which are further indicative of developing social needs (Valabhji et al., 2024; Baird et al., 2016). Individuals with comorbidities have greater psychological and physical needs as well as experiencing poorer socioeconomic status, poorer health outcomes, higher rates of mortality and require more health care resources for their disease management (Valabhji et al., 2024). As such the treatments available to support this array of needs are required to be equally varied in their options of support available. One suggested avenue to support this assortment of need is the promotion of non-clinical treatments in health care settings.

The benefits of non-clinical solutions such as the promotion of exercise, exposure to green spaces, exposure to music, arts on referral and increased social interaction have been well established in their ability to improve health outcomes (Pang et., 2012; Coventry et al., 2021; De Whitte et al., 2022; Umberson et al., 2010). However, asking GPs to provide this form of non-medical support is not within the scope of their practice

as a medical clinician. The pressures for clinical health professionals in primary care (such as GPs, Nurses, Pharmacists and Health Care Assistants) to have knowledge of these non-medical interventions has been noted as a barrier to promoting these alternatives to medical prescriptions (Baird et al., 2016); particularly due to already increasing prevalence of burnout among doctors and nurses in primary care (Karuna et al., 2022; Perez-Francisco et al., 2020). In response to this increased complexity in patients' needs and the growing impact of social determinants on health, the model of social prescribing emerged to allow for a new type of GP led offer that went beyond medicines (Chatterjee et al., 2018; Vidovic et al., 2021).

1.3.4 The development of social prescribing

Social prescribing aims to provide clinicians and patients with alternative options to improve their overall health and wellbeing and reduce loneliness (Brandling et al., 2009; Reinhardt et al., 2021; Foster et al., 2021). This approach aimed to bridge the gap between primary care and non-statutory community-based services such as art programs, exercise groups, social groups, and signposting to books on wellness (Age UK, 2011; South et al., 2008; Stickley et al., 2012; Vogelpoel et al., 2014; Chatterjee et al., 2018; Younan et al., 2020). Thus, encouraging patients to access non-traditional forms of intervention to improve long term health, decrease experiences of loneliness and promote healthier lifestyles and behaviours (Brandling et al., 2009). This need for an alternative approach was further fuelled by the increasing demand on health care resources with a reported 20% of patients now presenting in primary care settings with social r elated needs (Trojessen, 2016; Kaper & Plunkett, 2015).

1.3.5 What is Social Prescribing

There is no universally agreed definition of what social prescribing is nor is there an agreed measurement to assess its effectiveness (Reihardt et al 2021). Nevertheless, at the core of social prescribing is the aim to support individuals to address their non-medical needs and improve their wellbeing through offering a guided access to non-clinical interventions (Kimberlee, 2015). There is no consistent delivery model of social

prescribing however the different formats of social prescribing have been broken down into 4 types by Kimberlee (2015):

1. Social Prescribing as signposting

In which healthcare professionals' signpost to community-based interventions directly to encourage engagement with non-traditional interventions. Patients are left to their own devices to uptake these suggested resources.

2. Social Prescribing Light

Describes schemes in which patients are referred to community-based interventions aimed at targeting a specific social need. For example, an exercise on prescription programme.

3. Social Prescribing Medium

The introduction of a health facilitator based in practice to offer direct advice and guidance to patients on issues impacting their wellbeing such as exercise and diet.

4. Social Prescribing Holistic

The referral from a GP to an established social prescribing model in which a link worker role exists. This link worker acts as a source of information to support the patients' needs holistically and to provide guided support to community-based interventions that would benefit these needs.

(Kimberlee, 2015)

During its publication in 2015 this holistic model of social prescribing was described as the least generic form of model. Since then, this model of social prescribing has become the most prominent in the delivery of the social prescribing model. Since its initial launch within the NHS social prescribing has been further described as a model that can address a system level need and individual health problems in its ability to provide cost saving resources that support improvement in overall wellbeing (Rempel et al., 2017). Studies have indicated that social prescribing can lead to a reduction in the use of

health care services (Kellezi et al., 2019). However, despite its promotion as a cost-effective solution to meet health care needs studies examining the evidence of social prescribing's cost effectiveness have called for further investigation into the cost analysis (Kiely et al., 2022).

The adoption of the holistic model of social prescribing into primary care has been launched through the Additional Roles Reimbursement Scheme (ARRS) which allows for Primary Care Networks (PCNs) to access NHS funding to support the employment of these positions (Penfold et al., 2023). One of these new ARRS roles which has been adopted by the NHS is a social prescribing link worker (Fisher et al., 2019). Since the roll out of this scheme a reported 1,200 link workers have been employed in a PCN (Primary Care Network) based social prescribing role (Buck & Ewbank, 2020). An estimated 60% of clinical commissioning services have adopted a social prescribing service (Eaton & Gheera, 2020). The NHS Long Term Plan suggests that a goal of over 900,000 people will be eligible for a referral to a social prescribing scheme by 2023/2024 (The NHS Long Term Plan, 2019).

1.3.6 The placement of social prescribing in primary care

The primary care setting is typically the first point of contact for a patient to present with a concern. Overwhelmingly, of all reported health care consultations in the NHS, 90% occur in a primary care setting (Hobbs et al., 2016). A recent analysis of general practice noted the significant and increasing strain on the workforce (BMA, 2024). As the demands on primary care grow so do the financial pressures with budgets reducing and needs increasing (Razai et al. 2023). This growing demand on the healthcare service is evident among primary care teams as workloads expand, expected contacts with patients increase and the complexity of patients' needs grow (Baird et al., 2016). Therefore, the desire to find cost reducing solutions is vital in the NHS as financial pressures are formidable and show no signs of abating (Robertson et al., 2017).

In addition to the increasing challenges of financial pressures on the NHS has been the impact of the period of austerity across the UK. The period of austerity in the UK has been shown to have a detrimental impact on the health and wellbeing of the most

vulnerable individuals in the population (Stuckler et al., 2017). This health poverty has only been exacerbated by the rise of the cost-of-living across the UK which has seen a rise in poverty levels across the population (Francis-Devine et al., 2022). This increase in patient needs in a financially strained health service has led to an uptake of funded opportunities to increase workforces.

One offer presented within primary care was the creation of government grants to employ social prescribing link workers in Primary Care Networks (PCNs) across the UK (Brunton et al., 2022; Moore et al., 2022). This announcement of funded roles available to support the social needs of patients caused a shift in focus away from recognition of the complexity behind the increasing demands of these patients and a lower cost role of a link worker was rolled out. The funding for social prescribing has also been provided by the government with a reported £4.5 million promised to social prescribing services in 2018 (Mahase, 2018). The promotion of social prescribing was advertised as an option to offer support to patients to improve their wellbeing while alleviating pressures on the NHS and social care system (Elston et al., 2019).

Despite the funding made available the delivery of social prescribing has still been impacted by the budget conscious health service in which it operates in (Maughan et al., 2016). The impact of austerity is also evident in the delivery of the social prescribing service as the community resources available for social prescribing link workers to refer in to has reduce as community funding resources receive further budget cuts (Wildman et al., 2019; Fixsen et al., 2020; Skivington et al., 2018; Rimmer, 2020; Bex et al., 2022; Cummins, 2018). Studies investigating the social prescribing services have only just begun to address the impact of the pandemic and cost of living crisis. Both of which have affected the ability of the link workers to promote social prescribing initiatives to a population who are struggling to meet basic needs of food and energy bills while recovering from a period of forced social isolation (Fixsen & Barrett, 2022).

The promotion of social prescribing as a new integral part of the National Health Service (NHS) offering was established in 2019 during the publication of the NHS Long Term Plan (Howarth & Burns, 2019).

1.3.7 Help seeking behaviours.

In considering the impact of the placement of social prescribing in a primary care setting it is also necessary to contemplate help seeking behaviours to understand how this influences the population who are accessing social prescribing support. Previous studies have yet to investigate the demographics of patients who are seeking support from social prescribing services. In an aim to understand which populations may be accessing social prescribing support it is possible to consider previous research into help-seeking attitudes across populations. Studies examining help-seeking behaviours have demonstrated a difference in genders, cultures, and age groups (Fekhih-Romdhane et al., 2023). Research has shown that women, older adults, and those with an increased depth of knowledge and positive attitude towards mental health had a higher likelihood of seeking professional help (Fekhih-Romdhane et al., 2023). Additionally, research has noted the impact of self-stigma in help-seeking behaviours with individuals who had an elevated level of self-stigma displaying a reduced likelihood of reaching out for support (Yu et al., 2023). As such it is necessary to consider the barriers which may influence individuals seeking out social prescribing services. Given the placement of social prescribing in healthcare settings barriers also need to be explored through the lens of health care services.

1.3.8 Barriers in accessing health care.

For the experiences of these populations to be considered it is first necessary to explore the barriers that exist in preventing people from accessing health care. Racism in healthcare has been well documented as a barrier to achieving health equity (Hamed et al., 2022; Sim et al., 2021). Minority populations and vulnerable groups also face barriers which prevent them from accessing healthcare services and engaging with health professionals. Social prescribing link workers being placed in a health care setting then frames them as a health care professional which creates a barrier to accessing support

by existing in this setting. One study which explored the migrant's community experience of social prescribing noted the challenges of this population accessing health care services which often prevented engagement noting concerns implications on their undocumented status and a lack of understanding from the social prescribing link worker into the complexity of the experiences of the migrant as well as a failed understanding from health services of migrants rights to health care (Kellezi et al., 2021). Other studies have similarly noted a lack of cultural, religious and language understanding in social prescribing which creates a non-diverse friendly environment thus creating barriers for global majorities to access social prescribing support (Gupta, 2021). Further critiques of social prescribing have suggested that the placement of social prescribing in a health setting and focus on promoting autonomy in improving health and wellbeing can worsen health inequalities as opposed to tackling them as suggested (Gibson et al., 2021). This argued to be a consequence of social prescribing ignorance of social equity of different groups. As those in marginalised communities do not have the same resources to enable to make change as their unmarginalized counterparts (Gibson et al., 2021).

This recognition of the lack of cultural and ethnic diversity in typical social prescribing services has led to the development of pilot social prescribing schemes designed with a focus on the needs of an ethnic group with the Black Focused Social Prescribing in Canada (Ramirez et al., 2024). This project highlights the importance of social prescribing understanding and celebrating the culture of the community it is aiming to support (Ramirez et al., 2024). For social prescribing to recognise and understand cultures, experiences, barriers, religion, and languages of a diverse population it is necessary for the workforce of social prescribing to reflect this diversity in its rollout of services and in its link worker population. A study exploring the rollout of social prescribing services across the UK noted that services had not been equitably offered across areas of geographical inequality and high diversity population areas (Wilding et al., 2024). For social prescribing to continue to develop and be offered as a resource services first need to capture the demographics of patients who are accessing this support currently. Following this data capture considerations need to be explored to

understand barriers faced by populations who are not currently engaging with social prescribing support to examine how services can be made accessible to all those in need of support.

1.3.9 The impact of increasing deprivation

In examining the barriers that exist for those who may be unable to access social prescribing it is also important to consider the obstructions that may hinder engagement with social prescribing for those who do access the service. Studies attempting to capture the demographics of patient populations referred to social prescribing have noted an inconsistency in data collection among social prescribing and have called for more robust data collection to assess the impact of social prescribing on health inequalities (Khan et al., 2024). Studies evaluating link workers perspectives have noted the increasing challenges in supporting patients in a climate of increasing deprivation (Bickerdike et al., 2017; Chng et al., 2021; Mercer et al., 2017; Pot, 2024; Wildman et al., 2019).The impact of social prescribing on supporting health inequalities is important to consider given the increasing predominance of deprivation and health inequalities across the UK (Case & Kraftman, 2022).

The increasing needs of the population and rise of social challenges has been exacerbated by the impact of the cost-of-living crisis and the covid-19 pandemic. The national impact of the cost-of-living crisis has resulted in the rates of material deprivation to rise significantly in the last 5 years (Cribb et al., 2024). In addition to the impact of the cost-of-living crisis the aftereffects of the period of austerity in the UK and the Covid-19 global pandemic have all had a significant impact on the populations' health and wellbeing with the most vulnerable populations facing the greatest impact (McEachern et al., 2024; Moreas et al., 2024). An estimated 1 in 5 people in the United Kingdon (UK) are living in poverty (Joseph Rowntree Foundation, 2024). As a result, people are facing increased food scarcity, challenges in heating the affordability to heat their homes while the period of austerity also caused unemployment rates to rise, suicide levels to increase, a rise in mortality rates while funding has been cut for social

support services supporting the homelessness and elderly, and overall funding available to health and social services has decreased (Cribb, 2024; Stuckler et al., 2017).

The impact of austerity and the cost-of-living crisis was also noted in the financial pressures experienced by patients who were referred to social prescribing. The increase levels of poverty and social deprivation across the UK meant that some patients were struggling to even afford necessities (McEachern et al., 2024). As such paying for social activities was viewed as a luxury that was not able to be prioritized despite the benefits it may have on wellbeing. When patients did have the financial resource to access support other barriers existed to prevent engagement in social prescribing support.

In areas of both city populations and rural areas transport was often not readily available or was inaccessible for patients. Challenges in accessing suitable transport to prescribed community interventions has been highlighted by previous studies as a barrier to patient engagement with social prescribing (Fixsen & Barrett, 2022; Husk et al., 2024; Pescheny et al., 2018). The difficulties of operating a social prescribing service without community resources such as transport highlighted the dependence of social prescribing on community having an infrastructure to support social initiatives (Holding et al., 2020; Morris et al., 2020). This reliance on community resources was particularly challenging in communities following the period of austerity in which funding to communities and social resources has been reduced (Morris et al., 2020). This was further worsened by the uncertainty of funding available to VCSE organisations and those delivering social prescribing outside of a long term financed structure (Henry, 2024; Wallace et al., 2021). In some services funding to deliver social prescribing services and other community support was offered on a short-term basis. This model of financial support created severe challenges in the delivery of the services as the lack of assurance of future funding opportunities created instability (Rafiei et al., 2024). For social prescribing services to offer long-term effect support investment in community-based resources and stable funding streams for social prescribing is crucial (Polley et al., 2020; Sandhu et al., 2022).

When funding has been made available to health resources this has typically focused on interventions which support the biomedical factors of illness which is in contrast with our increased recognition and understanding the importance of the wider determinants of health (Bambra et al., 2010; Jani et al., 2020). This care crisis in the UK has led commissioners to try and develop resources to fill the gaps in services by creating roles to provide support to patients at a lower cost in replacement of funding skilled professionals such as social workers (Holding et al., 2020). This focus on offering budget conscious support services has seen the promotion of social prescribing as a suggested solution to support this increasing social need while simultaneously being a budget friendly solution (Phizackerley, 2019). However, further economic evaluations are required to establish social prescribing cost effectiveness and return on investment (Kiely et al., 2022).

1.3.10 Health Psychology Influences

At the core of the NHS promotion of social prescribing is the desire to deliver personalised care, non-clinical interventions, and the goal to encourage individuals to take more responsibility of their health and illness (de longh et al., 2019). The basis of each of these ideas can be traced back to health psychology theory and models. The goal in health psychology is to gain an insight into individual's social, biological, and psychological characteristics that influence their health behaviours (Divisions of Health Psychology BPS, n.d.). Various models and theories are utilised to achieve this goal such as the Health Belief Model, the Health Locus of Control and Theory of planned behaviour (Skinner et al., 2015; Lau, 1982; Ajzen, 1991). The health belief model considers the ways in which individuals' belief about their health impacts their approach to health and illness (Champion & Skinner, 2008). Similarly, the health locus of control aims to assess how much an individual believes their health is within their own control or if the responsibility lies with others (Wallston & Wallston et al., 2013). Meanwhile the theory of planned behaviour is utilised to elucidate and predict future actions (Ajzen, 2020).

Each of these models can be applied to the social prescribing delivery as the support offered is aimed to be personalised in its approach to support someone's health and

wellbeing journey. Link workers could employ the use of these models to offer these tailored approaches to health care interventions and to help patients better understand their own health behaviours to enable positive change. Another key focus of Health Psychology is to understand the effectiveness of psychosocial interventions (Masterson et al., 2020; Vedel et al., 2020). For social prescribing to be assessed on its effectiveness it is necessary to have a deeper insight into the existing models and theories which may be applied to help understand its potential use (Bhatti et al., 2021). Through the application of a health psychology lens, we can begin to assess ways in which social prescribing may make an impact on an individual's health and wellbeing. By applying health psychology theory to social prescribing, this deeper understanding of its effectiveness may be gained. However, before the 'how it works' of social prescribing is understood, it is first important to understand what it is.

1.3.11 The role of the link worker

Despite the variation in the delivery models of social prescribing most services have adopted the structure of employing a link worker who facilitates the delivery of the social prescribing in practice (Oster et al., 2013). The role of the link worker is to support patients to access non-clinical interventions, promote self-determination in an individual's attitude towards their health and to be an in-house expert on the resources available in the community (Thomson et al., 2015; Brandling & House, 2009). At the same time, eliminating additional pressures on GPs and allowing them to focus on the medical needs of patients (Trojessen, 2016; Thomson et al., 2015; Morse et al., 2022). Furthermore, a report assessing the prominence of patients attending with nonclinical issues at GP appointments found that when patients presented with these issues such as personal relationship challenges, housing, and work-related issues only 31% of GPs felt comfortable offering advice on these topics directly (Kaper & Plunkett, 2015). In the absence of standardised models, it is useful to understand the typical patient pathway of a SP referral.

1.3.12 The Journey

At the beginning of a patient's social prescribing journey an appointment with a link worker is offered during which the patient's wellbeing needs are discussed (Husk et al., 2019). Following this initial appointment the link worker will work collaboratively with the service user to create a tailored personalised plan of what support will be offered to suit their needs (Buck & Euwbank, 2020; Howarth & Burns, 2019). The interventions a link worker may suggest range from promoting visiting green spaces; community exercise groups; social groups; support with benefits and housing; befriending support; volunteering opportunities; mental health support and more (Morse et al., 2022; Kimberlee, 2016). Support is most often initially in a one-to-one format and in some instances link workers may have capacity to attend groups with service users to promote engagement with these suggested interventions (South et al., 2008). Other service styles of social prescribing may involve a combination of a social prescribing link worker and support of a volunteer who engages with the patient to offer additional social support and befriending as part of the social prescribing offer (Oster et al., 2023).

The way in which social prescribing is delivered experienced a shift during the Covid-19 pandemic. The launch of social prescribing as an integral part of the Primary Care contract began at the end of 2019 entering 2020. However, with the enforcement of lockdowns and the need to prevent rather than promote social interaction the landscape on which social prescribing, a community-based project, shifted significantly (Westlake et al., 2022). One study examining the service delivery of social prescribing during covid found that organisations transferred to a primarily telephone-based service in which social prescribing link workers quickly adopted the role of befrienders/experts in support services to meet the ever-developing demands of their patient population (Morris et al., 2022). However, the impact of Covid-19 on the link workers experiences of delivering social prescribing has not yet been examined.

1.3.13 The question of social prescribing's effectiveness

Despite the promotion of social prescribing in the NHS evaluations of social prescribing, services have continuously called for the need for further investigation into its

effectiveness (Ayorinde et al., 2024; Husk et al., 2020; Chatterjee et al., 2018; Bickderdike et al., 2017; Pescheney et al., 2020; Htun et al., 2023; Carnes et al., 2017). Previous studies evaluating the outcomes of social prescribing interventions have highlighted the variability in model of social prescribing which leads to challenges of assessing its impact (Oster, 2023; Calderón-Larrañaga et al., 2022; Bild & Pachana, 2022). Further investigations into social prescribing have called out the lack of evaluation tools used in social prescribing to assess outcomes of the service (Costa et al., 2021; Rempel et al., 2017). The assessments have cited that social prescribing services do not use any consistent models of delivery or evaluation if an evaluation is conducted at all (Elliot et al., 2022). As such the effectiveness of the social prescribing model remains elusive.

Due to the differing models of social prescribing if we are to understand the contribution it can offer to health care services it is necessary to research what it is and how it is being done. To gain this understanding of how social prescribing is operated it is necessary to seek the perspectives of those tasked with delivering these various models of social prescribing. As such this study focuses on understanding the experiences of link workers who are delivering social prescribing to these patients.

A key contributing factor in the challenge to measure the effectiveness of social prescribing is the variability that exists in its delivery. Therefore, to understand what social prescribing offers to patients this study will investigate what link workers who are tasked with delivering the service think they are delivering. This approach of interviewing link workers will allow the researcher to understand what link workers think they are offering under the umbrella of social prescribing while also gaining an insight into the key ingredients of social prescribing that may make it an effective non-medical treatment.

Chapter 2: Literature Review

Ahead of conducting the study the researcher completed a literature review of the previous studies that evaluated social prescribing services. The researcher focused on studies which examined social prescribing models which employed a link worker who

provided one to one support to patients following a referral from a health professional. Studies which utilised a qualitive approach or mixed methods design were included in the analysis. Studies which undertook a purely quantitative analysis were excluded as the review focused on the qualitative research. In examining studies which conducted such evaluations 8 key themes were constructed from the literature which explored both what social prescribing was delivering and the challenges that exist in the model which cause challenges in evaluating its effectiveness of delivery.

These 8 themes as displayed below consisted of: Personalised Care Planning, Duration of Support, The Role of the Link Worker, Complex Cases vs. Unrealistic Expectations, The Emotional Impact of the Role, Social Prescriptions Impact on Health, High Variability and Austerity.

2.1 Personalised Care Planning

Studies examining the delivery of the social prescribing model highlighted the benefits of the model allowing patients to access a type of support that was personalised and tailored to their needs (Carnes et al., 2017; Fixsen et al., 2020; Freichs et al., 2020; Frostlick & Berotti, 2021; Griffiths et al., 2023; Hanlon et al., 2019; Holding et al., 2020; Pescheny et al.., 2018; Moffat et al., 2017; Rhodes & Bell, 2021; Skivington et al., 2018; Wildamn et al., 2019; Wildman et al., 2019; Whitelaw et al., 2016; Woodall et al., 2018). This is consistent with the NHS advertisement of social prescribing that the sessions will allow patients to focus on 'what matters to me' (Griffiths et al., 2023). Patients who accessed social prescribing described being encouraged to find their own motivations for making changes and being supported to access information on support services that suited their needs as opposed to being dictated to (Aughterson, et al., 2020; Griffith et al., 2023; Moffat et al., 2016). This was seen as beneficial in supporting patients with complex health needs as patients were able to offer their own insight into what they felt was a priority (Carnes et al., 2017; Fixsen et al., 2020; Freichs et al., 2020; Frostlick & Berotti, 2021; Griffiths et al., 2023; Hanlon et al., 2019; Holding et al., 2020; Pescheny et al.., 2018; Moffat et al., 2017; Rhodes & Bell, 2021; Skivington et al., 2018; Thompson et al., 2023; Wildamn et al., 2019; Wildman et al., 2019; Whitelaw et al., 2016; Woodall et

al., 2018). This encouraged patients to feel they had autonomy over their health which was not always typical of their previous engagement with other health services.

2.2 Duration of Support

Another novelty experienced by patients was the ability to access long term support from their link workers. The appointments offered by social prescribing link workers was often between 40 minutes to an hour for an initial appointment. Both the link workers providing the social prescribing service and the patients who accessed this support felt that this provision of longer appointments and continued support was a huge benefit of social prescribing that was a typical of other interactions with health professionals in which appointments faced time restrictions (Fixsen at el., 2020).

One key benefit of this lengthened support was that it provided patients with the opportunity to offer a more in-depth insight into the challenges they were struggling with (Scott et al., 2020; White et al., 2022). This was further supported by the ability of link workers to provide follow up sessions of support. In some cases, this support was up to discretion of the link worker and the patient and there was no limit on how many sessions of support could be offered. In other cases, however a more typical structure was applied in which sessions were capped at six to eight follow up sessions.

While this ability to provide more intensive support based on patient need was deemed beneficial it did however demonstrate one of the challenges in social prescribing as the types of cases the link workers were referred were often overly complex. This was exacerbated by the fact that the referrers who sent the link workers these patients often had unrealistic expectations of what could be achieved by the link workers to support these patients.

2.3 Complex Cases & Unrealistic Expectations

In its original design social prescribing was developed as a light touch support for individuals to improve wellbeing by linking patients to community resources (Gibson et al., 2022; Tierney et al., 2020; O'Sullivan et al., 2023). In practice link workers received referrals for patients with much more complex needs than was originally suggested

(Brunton et al., 2022; Hazeldine et al., 2020; Holding et al., 2020; Rhodes & Bell, 2021; Skivington et al., 2018; Wildman et al., 2019; Frostick & Bertotti, 2021; White et al., 2022). These needs ranged from complex mental health needs, difficulties accessing housing and poor financial situations (Augghterson et al., 2020; Ayorinde et al., 2024; Fixsen et al., 2020; Fixsen et al., 2021; Freichs et al., 2020; Moffat et al., 2017; Scott et al., 2020; Skivington et al., 2018, Rhodes & Bell, 2021; Wildman et al., 2019, Wildman et al., 2019; Frostick & Bertotti, 2021; White et al., 2022). In cases in which patients were referred for needs that were expected of social prescribing, such as support with loneliness and social isolation, these patients had often struggled with these challenges for an extended period with no clear solution of support available (Freichs et al., 2020). Social prescribing was seen as an option for health professionals to refer patients to when they had exhausted all other options (Holding et al., 2020).

This use of the social prescribing service to pick up such complex patients was in part due to the high demands on other statutory services such as mental health teams (Griffiths et al., 2023). This overload on other services meant social prescribing link workers began providing support more akin to casework (Skivington et al., 2018, Rhodes & Bell, 2021, Holding et al., 2020; Wildman et al., 2019, Frostick & Bertotti, 2021). Another cause of inappropriate referrals was cited as being due to health professionals lack of understanding of the link worker role (Ayorinde et al., 2024; Brunton et al., 2022; Carnes et al., 2017; Griffiths et al., 2023; Hanlon et al., 2019 Hazeldine et al., 2020; Pollard et al., 2023; Rhodes & Bell, 2021; Scott et al., 2020; White et al., 2022; Frostick & Bertotti, 2021). This was further evident in the referrers lack of explanation to patients about what they were being referred to. This led to difficulties for the link workers in supporting patients as often when the link worker contacted a patient, they were unaware they had been referred for support or were unclear on how the link worker could support them (Ayorinde et al., 2024; Brunton et al., 2022; Pollard et al., 2023).

The link workers recognised that they were not always qualified to offer the level or type of support required by the patient due to the level of complex needs (Brunton et al., 2022; Holding et al., 2018). Despite this display of understanding of their limitations, link

workers still felt a pressure to offer support to these patients to try and offer some form of help to these patients. This led to the social prescribing often having a negative impact on the link workers emotional health (Fixsen et al., 2020).

2.4 The Emotional Impact of the Role

Due to the level of need displayed by the patients referred to social prescribing the link workers often grappled with having to hear distressing accounts from patients about their struggles (Fixsen et al., 2020; Frostlick & Berotti, 2021; Freichs et al., 2020; Holding et al., 2020; Rhodes & Bell, 2021; Skivington et al., 2018; Wildman et al., 2019). The type of individuals who adopted the role of the link worker often had a desire to be helpful and to be supportive to patients in helping to improve these circumstances and reduce this distress (Griffith et al., 2023). However, in several cases a solution to these needs was outside of what the link workers were able to provide (Holding et al., 2020). This led to a feeling of helplessness in the link workers. The impact of working with such emotionally distressing cases was not always evident to link workers immediately but would then arise a later point (Beardmore, 2020; Rhodes & Bell, 2021).

Unlike in other professions with emotionally complex pressures, the link workers delivering social prescribing services often did not receive clinical supervision (Beardmore, 2020; Hazeldine et al., 2020). Instead link workers had to rely on their peers to allow them to access some form of support. In some cases, however even peer support was not available. Additionally, link workers described feeling isolated from the primary care teams in which they worked within (Griffith et al., 2023; Pollard et al., 2023). This was in part due to the lack of understanding about the link worker role (Ayorinde et al., 2024). This isolation was further exacerbated for link workers working in roles without peers and this further unavailability of support led to increasing difficulty in managing the emotional impact of the role. This lack of support provided to link workers was particularly concerning given the importance of the link worker role in the social prescribing service.

2.5 The Role of the Link Worker

The evaluations of the social prescribing services highlighted the importance of the link worker role as being a key in the success of the service (Foster et al., 2020;Fixsen et al., 2020; Freichs et al., 2020; Hanlon et al., 2019; Hazeldine et al., 2020; Holding et al., 2020, Moffat et al., 2017, Pescheney et al., 2018; Pollard et al., 2023; Woodall et al., 2018; Wildman et al., 2019; ; Wildman et al., 2019; Frostick & Bertotti, 2021). The development of the therapeutic relationship between the link worker and the patient led the patients to feel supported and encouraged to engage with support services without the fear of being judged or pressured if the suggested resource was not suitable for their needs. This ability for patients to feedback to their link workers on how they felt about what they were referred onto or signposted to allowed patients to feel they had an input into the form of support they were offered.

In addition to being able to provide feedback to their link workers patients could also request a link worker attend a first session with them to a community group or activity that was prescribed. This supported attendance was seen as very helpful in promoting engagement with the resources the patients were signposted to. By offering to attend the initial session with a patient the barriers which may have prevented their engagement, such as social anxiety and uncertainty of being in a new environment, was reduced (White et al., 2022).

The impact of this therapeutic relationship was found to be influenced by the characteristics of the link worker. The link workers were described as non-judgmental, providing active listening, being empathetic and empowering to the patients (Ayorinde et al., 2024; Moffat et al., 2017, Holding et al., 2020, Woodall et al., 2018, Pescheney et al., 2018, Pollard et al., 2023; Wildman et al., 2019, Hanlon et al., 2019, Wildman et al., 2019, Frostick & Bertotti, 2021, Fixsen et al., 2020, Carnes et al., 2017; Kellezi et al., 2019). This provided a good foundation for the development of a positive relationship between the link worker and the patients. It also encouraged the patients to engage with the resources suggested by the link workers as there was a level of trust in the link workers endorsement of the support services being suggested.

The importance of this relationship could be challenging however as in instances in which the patient did not build a positive therapeutic relationship with their link worker the patient disengaged in the support offered (White et al., 2022). This further highlighted the importance of the relationship between link worker and patient. This influence of the link worker on the patient's engagement with support was also raised as a concern if the link worker left the job role (Beardmore, 2020). This period of transition between link workers leaving a role and a new individual being employed was often poorly managed with the patient simply being discharged from the service (Pollard et al., 2023). This reliance on the personal relationship between a link worker and patient highlighted further concerns around the professional boundaries between link workers and patients.

Additionally, the challenge of maintaining a professional distance when building these relationships was evident in both the patients and link workers descriptions of the relationship. Patients described feeling as though their link worker was more a friend than a health professional (Thompson et al., 2023; Griffith et al., 2023). This was seen as a positive by the patient while link workers conversely recognised the challenges of maintaining a professional distance from their patient. One area in which the link workers struggled was ensuring the patients did not become overly attached to seeing the link worker on a regular basis (Thompson et al., 2023). This was also challenging as several social prescribing models did not provide link workers with a strict guidance on how long they could support a patient for. As such it was up to the link workers to enforce these boundaries.

In cases in which link workers were able to set clear boundaries with their patients, this was often due to the link worker having a previous job role which provided this training. In these instances, in which link workers had received previous training in how to maintain this professional separation between themselves and the patient there was a reduction in the risk of the patient developing dependency (Hazeldine et al., 2020; Griffiths et al., 2023; Pollard et al., 2023; White et al., 2022). This dependency on previous experience was also evident in the lack of formal training structure offered to the link workers (Hazeldine et al., 2020). This lack of formal training plan led to link

workers relying on their previous experience to shape their approaches to the link worker role as no standardised guide of how the role should be operationalised existed. This dependency on previous experience led to an increase in the variability of the support offered by link workers as their previous roles shaped how they felt social prescribing should be delivered (Beardmore, 2020; Brunton et al., 2022; Fixsen et al., 2021; Griffith et al., 2023).

This importance of the link workers knowledge was also evident in the necessity for them to have a detailed awareness of the services available to patients. The link workers were described as having an extensive comprehension of local resources that were available to refer into (Ayorinde et al., 2024; Fixsen et al., 2021). This was highlighted as a positive trait of the link worker role by patients, community stakeholders and managers (Holding et al., 2020; Moffat et al., 2017; Rhodes & Bell, 2021; Skivington et al., 2018; White et al., 2022; Woodall et al., 2018). It was noted that other health professionals did not have the time to maintain such a detailed awareness of the resources available in their communities however, no study seemed to recognise the pressure on link workers to keep up to date with this information (Aughterson et al., 2020).

Link workers were also praised as being able to act as bridge between community services and health care (Aughterson et al., 2020). Primary care services were often seen as an impenetrable organisation which community teams were unable to access to promote the services they offered. The placement of a link worker in these organisations allowed the community stakeholders to gain unprecedented access to these health organisations and created opportunities for shared working that was previously challenging (Howarth et al., 2023). There was again a lack of contingency planning however if the link worker were to leave the role on how this would impact this relationship.

2.6 The Impact of Social Prescription on Health

During the evaluation of social prescribing previous studies reported positive outcomes for patients who received support from link workers in both physical and mental health (Carnes et al., 2017; Foster et al., 2020; Freichs et al., 2020; Kellezi et al., 2019; Moffat et

al., 2017; Thompson et al., 2023; Wildman et al., 2019; Woodall et al., 2018). Patients reported having met personal targets and health goals, improved confidence in their ability to self-manage long term health conditions, increased self-esteem and self-efficacy (Moffat et al., 2017; Thompson et al., 2023). Despite this positive feedback the benefits described by patients did not necessarily align with standard measurements of success for health interventions. For instance, the engagement with a link worker did not necessarily translate into fewer GP appointments for these patients. In contrast, some patients reported an increased engagement with other health professionals as they were now ready to seek support for their health needs which required medical intervention (Ayorinde et al., 2024).

The impact the link workers had on patients was varied in the level of impact. This variability was also noted in the delivery of the social prescribing service overall.

2.7 High Variability

The variability of the social prescribing service was first prominent in the range of titles used to denote the link work title. The denominations ranged from Community Navigators to Social Prescribers, Link Workers etc. Services also ranged from the number of sessions available to patients from some offering unlimited sessions to others having a cap at six sessions. Similarly, there was no consistency across the services referral criteria to enable patients to access the social prescribing. Some services imposed a strict referral basis while others had no boundaries for what type of patients could be referred.

The role of the link worker was also lacking a defined structure or template for how it should be placed within the primary care team structure (Ayorinde et al., 2024; Carnes et al., 2017; Fixsen et al., 2021; Moffat et al., 2017; Skivington et al., 2018; Rhodes & Bell, 2021; Wildman et al., 2019, Frostick & Bertotti, 2021). The lack of a formalised structure created added pressure on the link worker with some expected to source their own referrals and having to invest time in 'selling' the social prescribing service to health professionals to promote referrals to the service (Fixsen et al., 20202; Griffith et al., 2022; Pollard et al., 2023; Wildman et al., 2019). The absence of a defined structure of

the role further emphasised other health professionals poor understanding of the social prescribing service (Ayorinde et al., 2024). This led to referrers having a poor understanding of what level of support link workers were able to offer patients which then transferred to patients also lacking in knowledge of what link workers could provide and what was out of their remit to offer (Rhodes & Bell, 2020).

For social prescribing to be effectively evaluated there needs to be a clear definition of the parameters of the role. It also needs to reach a level of consistency in its delivery model for it to be considered an intervention. However, it is important to note that a level of variability will continue to exist in social prescribing as it relies on the community resources in which it is being delivered within (Ayorinde et al., 2024). This has reliance on community resources is challenging due to the socioeconomic climate of non-statutory services and community initiatives. This impact was explored in the last theme found in this systematic review. The impact of austerity.

2.8 Austerity

As previously noted, the referral criteria for link workers were often unstandardised resulting in patients being referred who displayed highly complex needs more suited to a specialist service. This inappropriate use of social prescribing was also the result of the surmounting pressures on statutory mental health and social care services which has led to an overflow of patients who require support without the resources available to meet this level of need (Cummins, 2018) (Beardmore, 2020; Griffiths et al., 2023; Skivington et al., 2018; Rhodes & Bell, 2021; Holding et al., 2020; Wildman et al., 2019; Wildman et al., 2019; Fixsen et al., 20202). The budget cuts placed on these services due to austerity in the United Kingdom has caused a substantial impact on the support available while the health needs of the population continue to become more complex combined with increased frailty, higher mortality rates, an increase in food scarcity and increasing poverty levels across the population (Hovland, 2024; Jenkins et al., 2021; Pugh et al., 2024; Vera-Toscano et al., 2024).

The impact of the rising poverty levels in the UK was recognised by link workers and impacted their ability to offer support to patients who were referred to the social

prescribing services. This impact was seen in both the complexity of the health needs patients presented with and the challenge in offering patients the opportunity to engage with a community group when they were unable to afford necessities such a food (Fixsen et al., 2020; Pollard et al., 2023; Wildman et al., 2019). Link workers had to adjust their focus of support to help patients to meet these basic needs. Further challenges arose when link workers were unable to offer solutions to support with these needs such as the lack of housing provisions available to patients.

In addition to the individual needs of the patients', stakeholders and link workers were cognizant of the impact of the budget cuts on support services for the link workers to refer into and how this impacted their ability to offer effective support to patients (Aughterson et al., 2020; Griffith et al., 2023; Holding et al., 2020; Rhodes & Bell, 2021; Skivington et al., 2018; Wildman et al., 2019; Wildman et al., 2019; Fixsen et al., 20202). For social prescribing to be an effective initiative it was evident that there needed to be services available for link workers to refer their patients into (Griffith et al., 2023). Additionally, these services needed to accessible for patients to access in both their transport accessibility and affordability to allow the patient to remain engaged (Aughterson et al., 2020; Foster et al., 2020; Fixsen et al., 2020; Hazeldine et al., 2020; Holding et al., 2020; Griffiths et al., 2023 ;Rhodes & Bell, 2021; Skivington et al., 2018; Thompson et al., 2023; Wildman et al., 2019; Wildman et al., 2019). There was also rising concern that the increasing demand on community groups may also lead to a flooding of these services which would negatively affect the quality of support received by patients (Brunton et al., 2022; Pollard et al., 2023; Skivington et al., 2018). In areas in which the community resources were not able to meet the demands of the referring numbers this led to a breakdown in the relationship between the social prescribing service and the community and resulted in patients becoming frustrated by the service (Brunton et al., 2022). For social prescribing to continue there needs to be an equal investment in communities in which it is delivered in.

Following the completion of the literature review the researcher began planning the methodology for the research study for this thesis. The literature review acted as a

foundational basis for the aims of this study and allowed the researcher to form a research question to further examine the themes that were constructed. The details of this study's methodology are outlined in the following methodology chapter.

Chapter 3: Methodology Chapter

3.1 Introduction

The research aimed to understand how social prescribing is experienced by link workers working in the role and operating the service. Previous studies examining social prescribing have noted a wide variety in the service delivery of social prescribing across different areas of the UK (United Kingdom) (Brown et al., 2021; Hazeldine et al., 2021; Reinhardt et al., 2021). This variability across service delivery of social prescribing has been in part attributed to the differences in geographic locations in which services are based and the influence of the socioeconomic status, availability of services and transport links in the area (Bickerdike et al., 2017). Despite this recognition of the factors impacting the delivery of the social prescribing service previous studies have yet to examine and compare this impact of difference across geographical locations in one study. Additionally, no previous studies have intentionally recruited link workers from varying backgrounds and sectors to compare how these differences affect the link workers understanding of the social prescribing model. As such this study aimed to take an innovative approach to the research to examine how link workers from a variety of backgrounds experience social prescribing from a range of geographic and socioeconomic locations. This allowed the researcher to examine how these factors affected the link workers understanding of social prescribing and in turn allowed the researcher to understand how this impacted the operationalization of the social prescribing service.

To capture the experiences of link workers the researcher employed a qualitative approach. The use of a qualitative method allowed the researcher to capture a rich and highly contextualized account of the experiences of the link workers (Willig & Rogers,

2017). As the researcher's aim was to find commonalities in the experiences of the link workers a reflexive thematic analysis approach was taken to the study (Braun & Clarke, 2022). This allowed the researcher to analyse the experiences of the link workers and shape common themes in their individual experiences and approaches to social prescribing.

3.2 Theoretical standpoint

The researcher adopted a reflexive thematic analysis of their epistemological and ontological positioning in this study (Mills et al., 2006). The use of theoretical reflexive thematic analysis allowed the researcher to generate theories from the data as opposed to beginning the study with a predetermined hypothesis (Braun & Clarke, 2024). The combination of theoretical thematic analysis and constructivism further allowed the researcher to acknowledge the existence of a common reality but to allow for an understanding that the experience of this reality is subjective (Mills et al., 2006).

The constructivism approach was deemed appropriate for the study as social prescribing is a social construct which is impacted by the social setting and by the individuals who are enacting it (Caledrón-Larrañaga et al., 2022). Therefore, it requires an approach that allows for the recognition that all social phenomena are derived from the interactions between individuals and filtered through the culture, economic landscape, and power dynamics in which these interactions occur (Burr, 2015).

3.3 Method

3.3.1 Procedure

3.3.2 Participants

18 participants registered their interest in the study at the various stages of recruitment. However, only 12 participants reached the interview stage. The participants interviewed for the study were all Caucasian females. The ages of participants ranged from aged 25-63 years old.

Once a participant registered their interest, the researcher would resend the participation information sheet (appendix A) and consent form (appendix B) and suggest an interview time and date. Once this was scheduled the participant was sent a Teams calendar invitation for the interview and asked to return to the consent form with a digital signature. If a participant did not respond to the invitation to schedule an interview, the researcher sent one follow-up email asking if they were still interested. If no response was received the researcher did not make further contact.

3.3.3 Public Patient Involvement

Before the official recruitment of research participants, the researcher interviewed an SP (Social Prescriber) from Swindon. This allowed the researcher to trial some interview questions and to receive feedback regarding the proposed interview topics. The data from this pilot interview was not used as part of the final data set.

3.3.4 Ethics

Approval for the study was sought from the Ethics Committee of Health and Social Sciences at the University of West England (UWE). The Ethics Committee provided approval after requesting some additional information and clarification (appendix D & E). The researcher also completed an assessment to determine if National Health Service (NHS) Ethics Committee approval was required for the study. This assessment was conducted using the Health Research Authority Research Tool. As the study did not include NHS patients, it was determined to not require NHS Ethics Committee approval.

3.3.5 Confidentiality and Data Storage

A data management plan was created and approved by the Ethics Committee of Health and Social Sciences at the UWE. Each participant was assigned a participant number. All information confidential information collected such as the names and contact details and participant number of participants was stored within a separate password protected and encrypted file on my 'Microsoft OneDrive for Business' account (UWE

OneDrive) provided by the UWE. The passwords were unique and known only to the researcher, Director of Studies (DoS) and second supervisor.

All the raw recordings of the interviews were stored in the UWE OneDrive. The interviews were saved under the participants assigned number and all names and personal information and identifiable information was redacted during the transcription of the data.

3.3.6 Sampling and recruitment

The findings of previous research suggested that the setting in which social prescribing was operating impacted how the social prescribing service was delivered (Bickerdike et al., 2017). The original matrix designed by the researcher ahead of data collection included geographical qualities of rural and city areas, areas of deprivation vs areas of affluence. These factors were selected following a systematic review of the literature on social prescribing which highlighted differences between social prescribing services in rural areas vs urban areas, the impact of deprivation and austerity on the social prescribing (Fixsen et al., 2020); Jones et al., 2016; Matthey's et al., 2017; Bickerdike et al., 2017; Skivington et al., 2017). Originally 4 geographic locations were selected as the basis of the purposive sampling with the aim to recruit 3 participants from each area (Campbell et al., 2020). This number was selected to meet the guidelines of participants for doctoral research in a qualitative study of a recommended sample size of 12-15 (Terry et al., 2019).

The geographic locations selected consisted of Bath, Hull, Wiltshire, and Bristol. Bath is an affluent area ranked 238th in UK (United Kingdom) for deprivation with a population of 6.7% classed as income deprived. In comparison Hull is ranked at 6th most deprived area in the UK with a reported 22.7% of its population being ranked as income deprived in 2019. Wiltshire was chosen as it is a vast rural area encompassing a range of towns and villages. Bristol was selected for its city status and ranking of 92nd deprived area. As recruitment continued the locations expanded to include surrounding counties of Wiltshire which were also rural areas including Buckinghamshire and Oxfordshire.

As the researcher began data collection new factors were established that influenced the experience of the link worker and their perception of social prescribing these were then added to the matrix. These additional criteria included: length of service in job role and employment structure (appendix G). The matrix was then adapted to include these additional criteria.

The sample of the link workers recruited in the first stage for the study were homogenous and consisted of Caucasian women ranging in ages from early 20s to mid-60s. Due to this homogony of the sample the researcher then considered the need to capture a wider representative sample population of link workers to include perspectives of others outside of Caucasian cis gendered women. The researcher tried to recruit participants from underrepresented groups in social prescribing. The researcher posted an advertisement on the Social Prescribing Collaboration platform requesting sign up from participants in underrepresented groups. Unfortunately, this did not lead to any participation from minority backgrounds.

Recruitment was carried out in several stages across December of 2023 to October 2024.

Stage 1: the researcher posted a message inviting participants to be interviewed on a message board during an online seminar for link workers. This resulted in the recruitment of 2 participants for the study.

Stage 2: The researcher attended a social prescribing conference day for the social prescribing across the BSW area (Bath, Swindon, and Wiltshire). The researcher advertised the research project and had individuals register their interest in participating in the study. The researcher then contacted the individuals after the event to provide more information and schedule interviews. This led to 4 participants.

Stage 3: The researcher contacted the regional social prescribing leads for Hull, Bath, Bristol and Wiltshire to request the invitation to be shared among link workers working in these locations. This resulted in a further 4 participants being recruited.

Stage 4: The researcher posted the message on the Future NHS social prescribing collaboration platform. This step was repeated 3 times at various stages. This led to the recruitment of 2 participants.

Participant Number	Age range (years)	Length of service (range in years)	Location Type
1	21-30	1-2	Wiltshire & Surrounding County
2	31-40	0-1	Hull
3	41-50	4-6	Bath
4	41-50	4-6	Bath
5	31-40	1-2	Bath
6	41-50	1-2	Hull
7	21-30	1-2	Wiltshire
8	51-60	0-1	Hull
9	61-65	3-4	Wiltshire
10	31-40	0-1	Bristol
11	41-50	1-2	Wiltshire
12	61-65	1-2	Wiltshire & Surrounding County

Table 1 Participant Matrix

3.3.7 Data Collection

Interviews were conducted over Microsoft Teams with link workers. The interviews were recorded via Microsoft Teams with the transcription recorded through this platform. The researcher then rewatched the interviews and edited the transcript as necessary to accurately record the interview data. The researcher used each interview to then adapt

the research questions for future interviews. This allowed the researcher to explore themes that had arisen in the data collection with future participants and to assess if these themes were common among the participants. The researcher used a semi-structured approach to the interviews, with each interview beginning with the researcher asking what the link worker thought social prescribing was.

3.3.8 Data Analysis

To analyse the data the researcher adopted a reflexive thematic approach. In adopting this approach to the data analysis, the researcher conducted the following steps during analysis of the data in line with the recommendations of reflexive thematic analysis outlined by Bran and Clarke (2016).

The first stage of the analysis involved the familiarisation of the data set. This was achieved by the researcher reading through the transcriptions of the interviews and rewatching the videos of the interviews with participants. During this initial familiarisation stage, the researcher kept a research journal to collate rough notes of topics of interest in the data. These notes were not structured and allowed the researcher to capture first thoughts and concepts that they noticed.

Each interview transcript was individually reviewed and concepts that were noticed by the researcher were recorded in the research journal. The researcher did not move on to the next transcript until each transcript was reviewed individually and notes were made. In addition to recording things that the researcher noticed during this phase of analysis the researcher used prompts in the research journal to facilitate reflection. These included questions such as ‘why are the participants making sense of this topic in this way?’ ‘What are the assumptions underlying their account’ ‘how would I experience what they are describing’ (Braun & Clarke, 2016).

The use of reflection allowed the researcher to conceptualise how their own experiences influenced what was being noticed in the analysis of the data set as well as the influence

of having a prior understanding of previous literature analysing the experiences of link workers in the social prescribing role.

Following this period of familiarisation of the data set the researcher began to engage in a complete coding approach. This involved coding any data which was relevant to the research question. The researcher titled codes that would capture the analytic content of the data that allowed the researcher to understand what the code was cataloguing without the data being present (Braun & Clarke, 2016). Using codes which were descriptive in nature allowed the researcher to review these codes and to adjust as necessary. The coding of the data was conducted by using printed copies of the transcripts on which the researcher made notes in the margins of the codes applied to the relevant sections of data. These coded data was then transferred to one document to organise the data under each code.

The researcher was flexible in their approach to coding and adjusted the codes used as the analysis of the data continued. In some instances, this involved merging codes that overlapped or recoding data with a new code to allow to better capture the nuances in the data. Once the initial sets of codes were confirmed the researcher began organising this data into themes (appendix C).

Once coding was completed the researcher began mapping themes and shaping the relationships between the codes, sub themes and overarching themes in the data. The researcher mapped these themes by first clustering codes which were similar. The development of the overarching themes and sub themes in the data underwent several revisions before the final themes and sub themes were captured. During each revision of the themes the researcher reflected on their own understanding of the themes and influence on the how they shaped the data set. The researcher then began the writing up of their analysis of the data. Once the write up first draft was completed a further review of the themes was undertaken. The ultimate structure of the themes was established by applying the analysis that for a theme to be established it had to have a concept that was

central in its organisation of the data. The final set of themes included 4 primary themes and 8 subthemes.

3.4 The Researcher

As the researcher of this study, I had a close connection to the topic and the data I was collecting. In my daily role, I am employed as a Social Prescriber in the Swindon area. When considering if I should reveal my identity to my participants, I considered the impact of choosing to be transparent about my identity as a social prescriber vs keeping this information private. I recognised the decision would impact several areas of the research such as the ethics of the study, recruitment procedures, data collection and analysis as well as the rapport with the participants.

A constructivist approach to qualitative research highlights the importance of reciprocity between the researcher and the participants (Mills et al., 2006). Further arguments have also been made regarding a participant's ability to provide informed consent if they are unaware of the full details surrounding the study (Miller & Bell, 2012). In considering these implications I decided it was important to be honest with my participants about my status as a link worker. This ensured participants could make an informed decision to speak to me about their own experiences. I was conscious that revealing my identity would allow me to build an easier rapport with my participants. This in turn had additional ethical implications as I was, in some capacity, using my shared experience to build a closer relationship with my participants to hopefully encourage them to be more open about their experiences and to benefit from my data collection (Duncombe & Jessop, 2012). To balance this ethical impact, I offered the participants of the study the opportunity to review the transcripts of their interviews and remove any information that they did not feel comfortable having included in the analysis.

Due to my status as a link worker, I had an insider status as a researcher. Insider research is defined as someone who conducts a research study within a community, social group, or organization in which they themselves are a member (Greene, 2014).

The position of an insider research has been suggested to potentially cause the researcher an increased level of challenge in methodological and ethical consideration such as having a perceived bias (Greene, 2014; Bulk & Collins, 2023). Further arguments have suggested that an 'outside' researcher will be able to maintain a 'birds eye view' that an insider researcher may lack (Kersetter, 2012). While I remained aware of these arguments, I was conscious that I was not striving to deliver an unbiased approach to the research. Instead, I was conscious of prioritizing my reflexivity and transparency in my approach (Galdas, 2017).

Furthermore, the benefits of being an insider researcher have been endorsed as offering the researcher an opportunity to have a deeper understanding of the experiences of the participants s (Kersetter, 2012). The benefits of being an insider researcher have further been argued to include being able to build rapport with more ease with the ability to use this rapport to capture a richer data set from their participants (Kersetter, 2012; Asselin, 2003). Conversely, insider researchers have been warned against pitfalls that may be associated with this insider status. Asselin (2003) raises the importance of the insider not assuming a shared understanding when examining the participants' experience. In instances in which a researcher assumes this perceived understanding this can cause the researcher to fail to ask critical follow up questions which would allow the participant to expand on their experience.

My own experience as an insider researcher reflected these descriptors. The rapport with my participants was built with ease which led to participants being open with me about their experiences. However, in the initial stages of the interviews I struggled to ask the appropriate follow-up questions due to my own assumptions that I understood the experience of my participants. This recognition of my assumptions became apparent to me when reviewing the transcripts of the first set of interviews. On reading back these interactions I recognised points at which someone without my 'insider' status would have asked a follow up to allow the participant to expand more on their experience (Asselin, 2003). To balance this effect in my future interviews I began to keep a research diary to allow me to reflect on how my experiences were shaping the interview questions

and to allow me to be more focused on using the template of the previous interviews I had conducted to formulate future questions rather than my own experiences in the social prescribing role (Nadin & Cassell, 2006). It has been widely accepted that research cannot be conducted in a vacuum and that by its nature it is subjective as such the use of a research diary has been promoted to help understand these influences (Nadin & Cassell, 2006).

The influence of my insider status also impacted my analysis of the data in the study. As I began my analysis of the data, I established several codes and subsequent themes and subthemes in the data. As I began titling these codes and themes my own experience of the working as a link worker and my dual role as a doctoral student led me to develop titles that both captured the experiences of the participants in the study and to attempt to create provocative titles that engaged the reader. My desire to make the titles of these themes both accurate in their representations of the data and engaging to reader was fuelled by my desire to both write an interesting thesis but also to represent the challenges faced by link workers who are tasked with delivering social prescribing. The drive to represent the experiences of the link worker participants in the study was powered by my desire to conduct an effective thematic analysis but also to provide an overarching account from a group of professionals of which I am a part of. My own experiences of the challenges of the social prescribing link worker role were often reflected in the accounts of the participants in the study. As such I had to be conscious of ensuring I did not allow my own experiences to shape or overtake the narrative that was derived from my analysis of the data. The importance of researchers identifying their standpoint and acknowledging how this influences the interpretations of the data has been noted as a key component in reflexive thematic analysis (Braun & Clarke, 2019). To ensure I remained cognisant of the influence of my own experience as a link worker I further utilised a research journal and engaged in discussion with my supervisors. I found discussing my shaping of the themes in my data analysis with my supervisors very helpful in offering helping me to shift my focus to that of a researcher rather than a link worker who was empathising with their fellow peers. Through these supervision sessions

I was able to explore why I had decided on certain titles and was provided the opportunity to analyse my choice of language and descriptors to represent the data. This allowed me to consider these influences in more detail and offer a deeper analytic observation to my data to ensure that my titles accurately reflected the experience of the participants in the study rather than my own experience. The benefit of having access to high quality supervision has been noted by Braun and Clarke as being key in the development of an effective thematic analysis (Braun & Clarke, 2019).

Chapter 4: Results

4.1 Overview Map of Themes

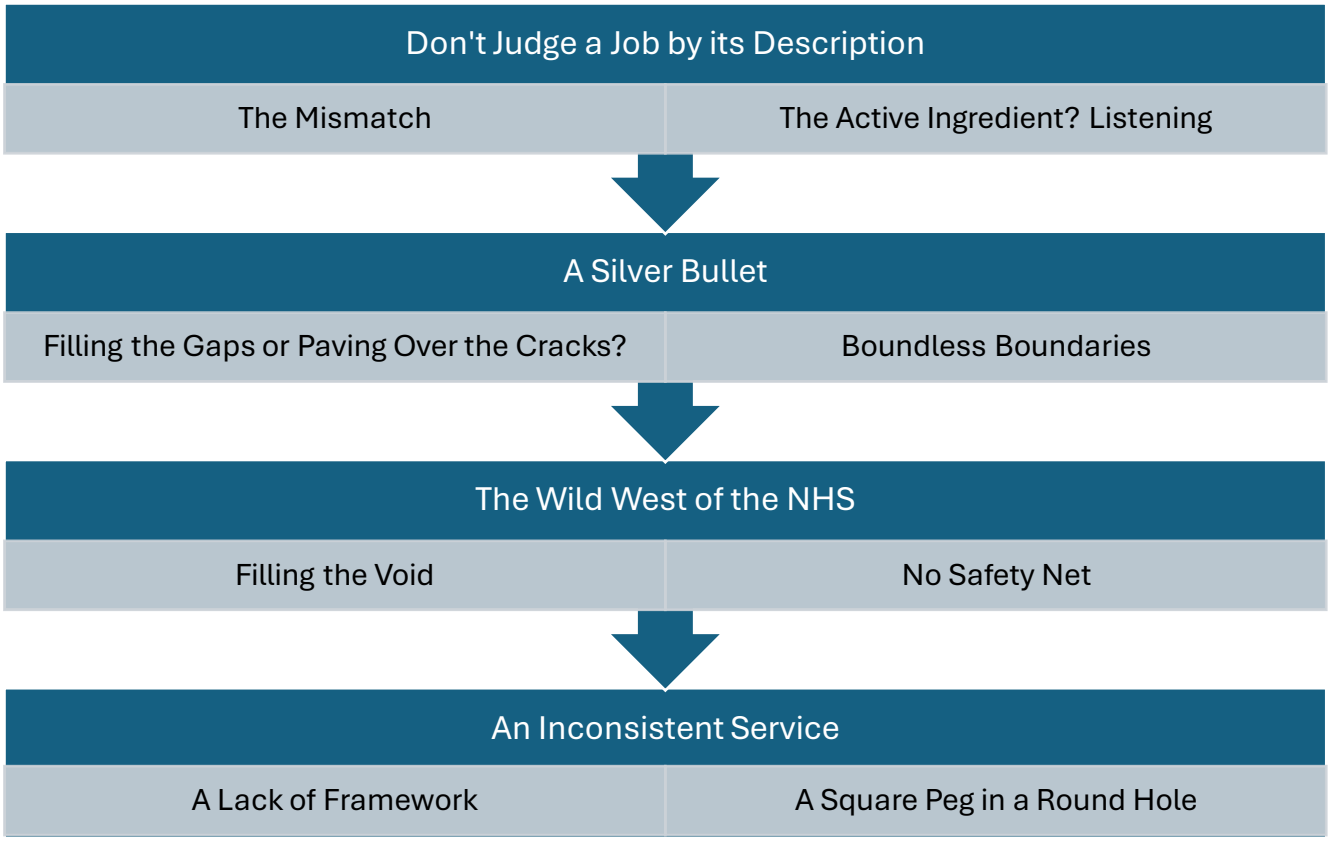

Figure 1 Overview Map of Themes

Throughout the thematic analysis of the interviews with 12 participants in this study 4 key themes were constructed which aimed to capture link workers own understanding of what social prescribing is and how it is operationalised. These themes were entitled: *Do not Judge a Job by its Description*, *A Silver Bullet*, *The Wild West of the NHS*, and *An Inconsistent Service*. Throughout this results section, the researcher will explore how these themes were assembled to highlight social prescribing's challenges and successes. Each theme will be presented including description of sub themes and illustration with quotes. Each section will summarise the findings.

4.2 Theme 1: Don't Judge a Job by its Description.

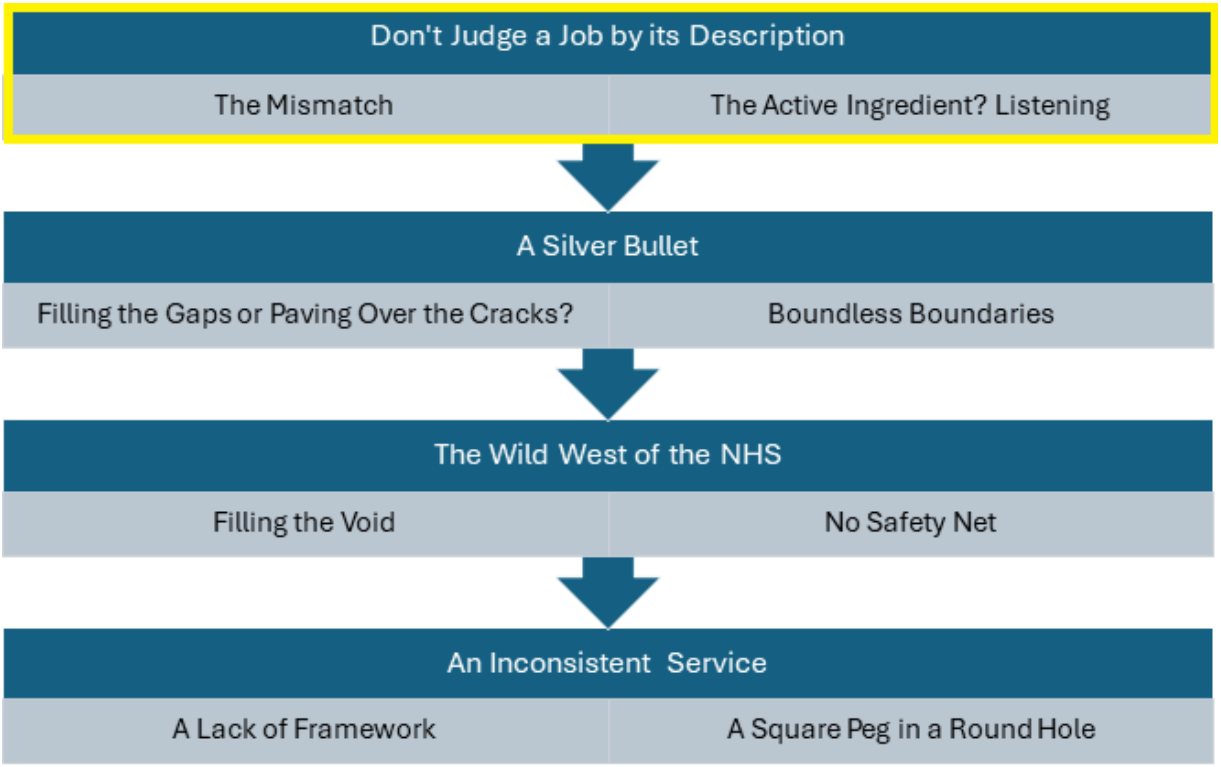

Figure 2 Theme 1 - Don't Judge a Job by its Description

4.2.1 The Mismatch

The first theme that was produced from the thematic analysis of the interviews was the link workers experience that job did not match the description of the role. This was

explored through the subtheme of 'The Mismatch'. The link workers were consistent in their characterisation of what social prescribing offered to patients highlighting their ability to provide patients with connection to the community and offering a holistic approach to support.

"We link [patients] in with social prescribing because we know holistically, in people's everyday lives that there are non-medical concerns and that's where us as social prescribers were able to link people" (P10, Female)

"First and foremost, social prescribing is a signposting and referral service for people who have... Problems that could affect their lifestyle and wellbeing" (P1, Female)

"a holistic view... looking at the mind, the body and the social aspect of people's lives" (P12, Female)

Despite this surface level presentation of the role of social prescribing, the link workers did not always feel that the view of social prescribing on a national level was consistent with the reality of their day-to-day role. The National Academy of Social Prescribing describes social prescribing as a resource that helps people to connect to non-medical support to address their issues or current unmet needs through support to access community resource such as befriending group, supporting connections to community projects such as art groups, signposting to debt support or referring to exercise programs (Social Prescribing Academy, n.d.). Similarly, the NHS description of social prescribing depicts a service that enables people to connect with resources, activities and groups in their community (NHS England, n.d.). One link worker described the National Academy of Social Prescribing webinars as not being reflective of the variation in referral types received into their service.

"When you go to the [national academy] webinars a lot of its you're dealing with lonely people and so you're there to speak to them, tell them about local groups and support home care support and then you discharge them. And I've learned in the last seven months, it's much more varied than that". (P2, Female)

Another link worker described feeling the understanding of the complexity and intensity of the role was lacking in relation to the challenges link workers were facing in delivering the role.

"it's lacking……when we have our network meeting……everybody has different issues and their own challenges in different ways" (P8, Female)

Participants in this study experienced the mismatch in the understanding of the social prescribing service from their employers.

"no one really knows what I do, no one knows the job role, not even the people that interviewed me when I asked them what a day-to-day life of a social prescriber was. They couldn't give me an answer" (P1, Female)

This lack of understanding of the link worker role seemed to reflect a lack of understanding of social prescribing itself. Most of the link workers reported referrals often being inappropriate in nature and requiring push back from the link workers to referrers. This demonstrated the mismatch in social prescribing between what was considered as the national service delivery for social prescribing and the local operationalisation of social prescribing in some areas.

"We've had to keep reminding… the GPs and the referrers… it's a short-term service and whilst we'd love to support people for a longer duration, we have to have people that are willing to engage in change as well" (P7, Female)

"They're quite complex. They've got often quite multiple things going on, not just…physically and mentally, but also housing situation, financial situation and… that kind of thing. But I do get some random ones like the other day, I had someone who's got some issues with the pigeons at the house." (P5, Female)

The link workers felt the referrals they received were problematic as they seemed beyond the remit of the link worker role. Other referrals reported by link workers in this study, were inappropriate in that the reason for referral was vague. In instances in which referrals were received from health professionals link workers on occasion had to

investigate to understand what the reason behind the referral was. This was described by one link worker as the ‘Sherlock Holmes’ portion of their role.

“I call it the Sherlock Holmes bit. Sometimes you have to look on the notes, which again I did look on the notes…. look at referrals. Look at correspondence to try and pull together a picture of what's happening for this person to see what you can help them with.” (P8, Female)

Following this investigation to establish the reason for the referral the link workers would then typically offer a first assessment session with a patient to explore what forms of support could be offered. This assessment however was often more revealing than originally expected. This was highlighted in the code entitled ‘The Iceberg Effect’.

This highlighted the challenge of the social prescribing link worker role in that the patient's complex needs were not always evident by the referral received into the service. Upon talking to a link worker, patients would often reveal several other complicated needs which were under the surface of their original referring need. This further highlighted the discrepancy in understanding between the referrers and the link workers enacting the social prescribing role.

“People were disclosing things. You know ladies in their 70s, eighties. Who lost a baby. In early 20s and it, you know, the attitude then that's just how life was, and you just got on with it. And they'll break down in tears…. No one else knows. None of my friends. I've never talked to anyone about this. Actually, these deep things that people have just shut away suddenly come out when they feel someone is really hearing them…..that can be very powerful for beginning to help them to access additional help because they feel they've been heard and sometimes they say that was enough just to be heard once, but generally it's a starting block for moving forward” (P3, Female)

On discussions with link workers patients would reveal a depth of challenging needs. The implications of uncovering these deeper needs were that the light touch support link workers were tasked to provide was frequently not an option when working with patients with complex needs such as:

“Housing issues” (P10, Female)

“Mental health issues” (P5, Female)

“People are just on the poverty line” (P6, Female)

“Homeless, living in a caravan in that friends shed.” (P2, Female)

“90% of the people… have mental health needs” (P4, Female)

“Patients with severe mental health problems and highly suicidal…and incredibly stuck, and particularly post pandemic.” (P3, Female)

“Safeguarding issues…personal neglect…abuse” (P1, Female)

“I've got a man…that's homeless, living in a tent and. I've got a man who had a stroke and lost his wife in the same year…. a lady that's struggling with her own mental health and her own physical health and looking after her husband just got dementia” (P8, Female)

Often the complexity of the needs the patients presented was not due to the seriousness of the issue but the state of entanglement of a patients housing, past trauma, physical health, mental health, social isolation, and financial status. The enmeshment of these issues meant the support required to aid these patients was wide ranging and required a more specialist support outside of the remit of social prescribing. This was perhaps due to social prescribing being delivered in a medical setting in which the focus is often on identifying one cause of the problem or illness as opposed to taking a holistic approach to the patient.

“The majority are those with more complex cases. So, there could be feeling lonely and isolated, but that's affected by the fact they've recently been bereaved. So, they've got no motivation to go and do anything about it. On top of that, with the bereavement, they've sat down and done nothing and put on loads of weight. So, they haven't got the energy to be able to and do anything physically or motivate themselves…and the three issues are all complex and all affect each other.” (P12, Female)

This again highlighted the discrepancy between the job description and the reality of offering social prescribing. The link workers in charge of operationalising the social prescribing service were not being asked to support patients who required a light touch support for a short period of time. This mismatch between the role and iceberg nature of the patient's needs, in which most of the issues were hidden under the surface, led to the link workers also adjusting the length of support they offered to patients.

"It will vary between different patients. For some it's like a one-off signposting if they can engage… but generally… I'll have sort of 45 minutes with the person initially and for some people I will continue a couple of longer sessions" (P7, Female)

"More complex…people that I've kept on a bit longer for a couple of months" (P2, Female)

This was in perhaps in part due to the link worker characteristics of being caring individuals who often wanted to find a way to be helpful to patients.

The complexity of the needs of the patient were also compounded by other barriers to the engagement in support. This study examined different geographical areas and found that one key challenge faced by the link workers was the lack of transport available to help patients access resources they were signposted to.

"Transport and is definitely in an issue." (P6, Female)

"There isn't the transport anymore. And then now there's like another company, the Big Lemon or something that is sort of like picking up that, but then it feels a bit complex. Like, where do they pick people up from…it's quite confusing when I'm looking at it, let alone if I'm referring to somebody who's, you know, got other issues going on." (P10, Female)

"We do struggle with transport here" (P9, Female)

In addition to challenges with transport some patients physical and mental health acted as a barrier which prevented link workers from providing support.

“If it's…your physical or your mental health won't let you out of the house. Then there's nothing I can do from a so because the whole point of social prescribing is to signpost you to places.” (P11, Female)

“it's such a legacy and mental health deterioration and people have just feel they've lost out on so much, so many elderly people who…were going out and about regularly and post the lockdowns, they'd lost their ability to get out and to do what they used to do…. because they hadn't for so long and now, they're physically not able to do it and there's a lot of sadness around that and frustration still, yes and……still a lot of worry…. about catching COVID and the impact.” (P3, Female)

“We do have a large older people's you know population……who are….in need of….social interaction but…can't get out or they the ones that we might go with them too are too noisy for them because of their hearing. So that that can be a bit of a……problem for them.” (P9, Female)

In low socioeconomic areas, a barrier for engagement in social prescribing was financial resources. Patients who were unable to afford basic resources such as food or rent would then not be able to engage with wellbeing support.

“Financial is taking a big impact…people aren't gonna want to…engage in those…well-being activities when they……can't afford food and… they're struggling…. It might be their social situation at home. They want to move out, but they can't afford to. So, they're stuck in an unsupportive environment” (P7, Female)

“Definitely money……I think being….socially deprived….the impact of deprivation is more ill health” (P6, Female)

In addition to the complex cases the link workers dealt with explored in theme 1 they also had to manage the barriers patients experienced in engaging with support. These barriers included difficulty accessing transport, challenges in patients physical and mental that prevented them from engaging and financial barriers that caused them to have more pressing needs than engaging with wellbeing support.

4.2.2 The Active Ingredient? Listening

Despite the mismatch in understanding of the link worker role and the high level of complex needs of the patients the link workers all felt they provided an important service to patients by giving an opportunity for them to be listened to. The link workers conceptualised the ability to provide patients time to be heard as a distinct of benefit of social prescribing.

"I think is probably half of our job is to sort of being a good listener." (P4, Female)

"Where a doctor's got 5 or 10 minutes, and they are there for medical needs. I use volunteers who have got the time" (P12, Female)

"[the patients] have always appreciated mainly being listened to and someone taking interest in them and having it time for an extended conversation." (P3, Female)

"a lot of its patients just want to be listened to. And need to know they've been heard, and once they've been heard, they're more likely to…. Start putting things in place that maybe I haven't even suggested, but they're thinking about themselves. So, um It's not about signposting and referral" (P1, Female)

This practice of allowing patients the opportunity to feel heard offered a form of support akin to motivational interviewing in which the link workers supported patients to find their own solutions through a guided conversation.

"We very much sit back with all the information now, much more coaching, motivation and interviewing. Much more getting them to come up, you know, helping them to identify the problems." (P3, Female)

The perception of the social prescribing role was mismatched with the reality of the role link workers were tasked with delivering. While all the link workers viewed the purpose of social prescribing as offering a form of holistic support to support wellbeing, the cases they received referrals for often required a much more intensive form of support. The scope of the patient's needs was often revealed due to the time and active listening the link workers provided to patients. The ability to offer patients the chance to be listened

to and feel heard was seen as a key aspect of the service social prescribing link workers were delivering. The discrepancy between the advertisement of social prescribing and the day-to-day operational pressures of the job held an added complexity when combined with the barriers patients faced in engaging with support.

For social prescribing to be effectively evaluated these factors need to be taken into consideration. Despite these challenges faced by link workers the role of social prescribing was seen by other professionals often as a cure all for their patient needs. This was further explored in the next theme 'A Silver Bullet'.

4.3 Theme 2: A Silver Bullet

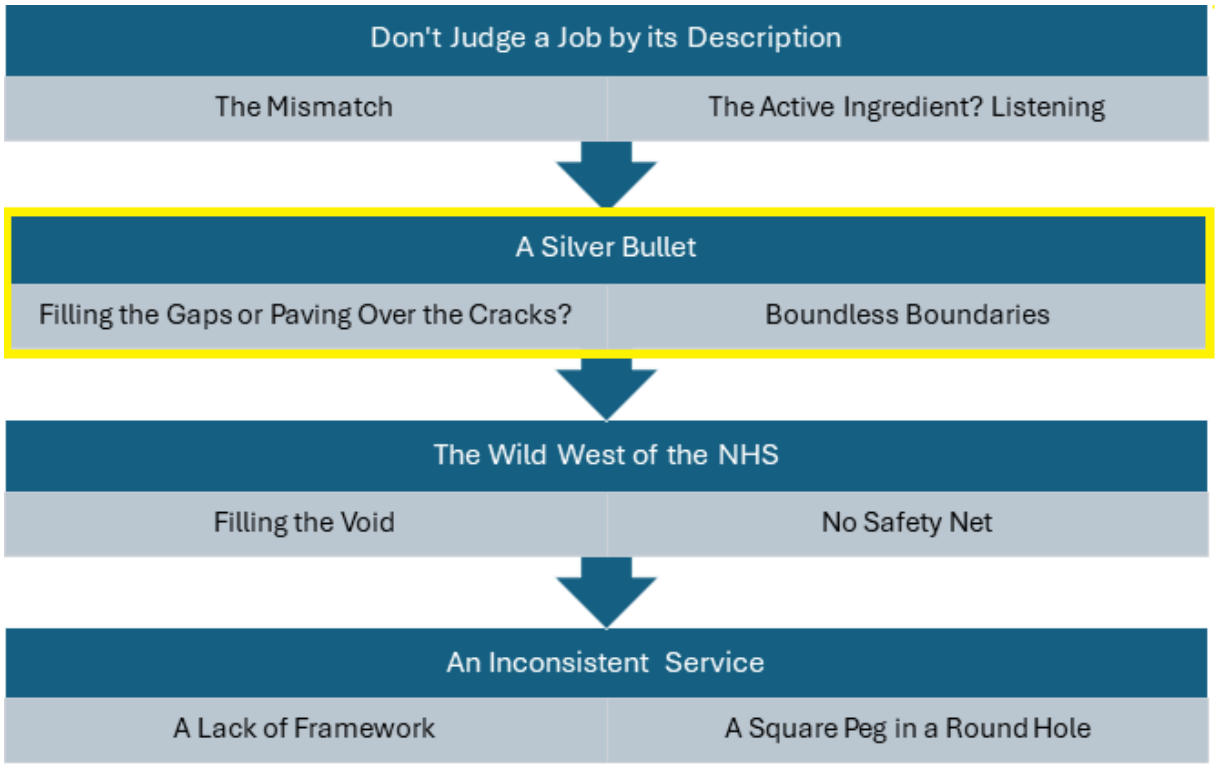

Figure 3: Theme 2 A Silver Bullet

This theme extends link workers perception of how health professionals they work for see social prescribing. They commonly spoke of professionals, seeming to see referral as providing a solution to all a patient's problems. The link workers described the GPs'

desire to offer the patient some form of solution when they are presented at an appointment with highly complex social needs. This ability to refer to a link worker allowed the GPs to offer an intervention consistent with process driven, medical approach in which they refer patients with complex medical presentation on for further testing or to a specialist service.

"Obviously GPs are trying to help people, aren't they? So that's sort of what a lot of the time, I think maybe it's like, oh well, I've referred them somewhere and maybe they can help.... it's like a bit of a silver bullet" (P10, Female)

The use of the social prescribing service to meet these complex needs of the patient seemed to be in response to the over stretched nature of the primary care, mental health, and social services.

"I do see a lot of patients where they could almost do with that one-to-one support worker.... social care is just in crisis, so really long waits for social care packages...I've had patient where social care of agreed a package of care....and there's just no care providers that have taken it up. So, then that patient isn't getting the care they need" (P4, Female)

"Statutory services...things like social care.... they're really stretched" (P6, Female)

4.3.1 Filling the Gaps or Paving over the Cracks?

This pressure on statutory services caused cracks in the system which left patients without a resource to access thus leading the cases being picked up by social prescribing to offer some form of support. However, it was unclear if by providing this form of interim support if social prescribing was filling the gaps left by overstretched statutory services or paving over cracks in a system that is broken.

One link worker described the referral criteria of mental health teams which resulted in patients having no other resources available to them.

"With mental health and the provision, those were personality disorders...they're not accepted by IAPT talking therapies. They're often seen as not being complex or bad

enough to qualify for PCLS and recovery team.... people waiting for autism diagnosis as well.... things like self-harm and eating disorders. They're all ones where they fall between the cracks of all...the services that are available... they come through to us." (P5, Female)

"Talking therapies won't work with people if they've got a suicide risk.... then they get sent to the mental health services.....for a one off...discharge the.... and oftentimes sign posting them back to talking therapies, which is a service that won't work with them" (P4, Female)

Another link worker had been referred a patient with severe brain damage due to abuse from childhood who consequently was unable to read or write. Despite this they did not fit the criteria for the learning disability team and thus ended up being 'held' by the link worker.

"It didn't fit criteria for and the learning disabilities team because he had no physical Disabilities...He had brain damage when he was a baby.....that meant he couldn't read and write, and he's understanding was not of his age.... I felt like he needed somebody that when he's struggling, he can ring and which it was me. But I'm not the person because.... I could listen, but I couldn't action anything..... So, learning disabilities, he wasn't eligible for, social services he didn't want to engage with them. What else is there?... I held him for quite a long time. And he found it difficult to understand that I couldn't help him anymore and that was difficult for me. Especially with no supervision initially" (P8, Female)

Some link workers saw acting as this bridge between services as a key part of their role. In contrast, others felt that support from the social prescribing service could be beneficial in future after an intervention was provided to the patient to allow them to be ready to engage with social prescribing.

"there's gaps in healthcare, social care and that is what this role is there to promote being that link" (P2, Female)

“Social prescribing has become like its filling lots and lots of gaps… there are people who could… really benefit from social prescribing in six months' time after they've had some other interventions that will help them be less anxious, for example. But…there's not necessarily those services. So, then they're referred to us” (P10, Female)

“Yeah, sometimes it is bridging that gap. How would people support in their well-being whilst they're waiting for other services or you know, just trying to reassure them that they're in the right place and they've done what they can.” (P7, Female)

The gaps in the statutory services led to social prescribing paving over the cracks and offering a holding service for patients. This use of social prescribing to bridge these gaps was further exacerbated by the lack of boundaries in the social prescribing referral criteria. This was explored in the sub theme ‘boundless boundaries. The impact of this use of social prescribing in this way is further explored throughout the themes.

4.3.2 Boundless Boundaries

This difference in approach was further evident in the way in which link workers manged their referral criteria boundaries. These boundaries and referral criteria were developed by the link workers based on their own knowledge and comfortability.

“The criteria are basically anybody over 18 who doesn't have major mental health issues that aren't dealt with. You know, if you've got bipolar or schizophrenia or I'm happy to deal with you if your issue is housing, but not if your issue is your bipolar or your schizophrenia.” (P11, Female)

In cases in which link workers had set inclusion and exclusion criteria there this was also flexible in its approach.

“We do…very much a case-by-case situation, so it could be that someone's kind of covering both the exclusion and the inclusion criteria, but it's…. judging and weighing up…does the… exclusion…. affect what I'm gonna be doing with that patient” (P1, Female)

Often the development of these referral guidelines was reactionary after link workers received a high level of unsuitable referrals as opposed to being offered to health professionals at the origin point of a social prescribing service.

"In the beginning I flagged up that we're getting all sorts of referrals, really some that were quite medical that wouldn't be me and some that were quite serious mental health that that wouldn't be me. And so, I did flag that up and I did get some support with that. So, we then put together a referral guide" (P8, Female)

This lack of defined referral criteria across the link workers meant in some areas the mental health needs of the patient left the link workers out of their professional depth.

"I was working with someone who had psychosis and dependent personality disorder. And to be fair I had no idea what was real and what was not that she was saying like absolutely" (P5, Female)

Another area in which link workers trying to provide support in areas beyond their boundaries was working with patients with housing needs. Several of the link workers raised that they were tasked with offering patients support for their social needs but the crux of the challenges the patients were facing was unsuitable housing with no support in sight to resolve this need.

"There is a housing crisis, people can't access. It's not as easy as OK, let's go to the social prescriber and there'll be a fix. We're not that that we can't do that…sometimes it is bridging that gap." (P7, Female)

"it's trying to liaise with the housing officer housing and obviously other needs that come with that like food bank and home teams needed. And obviously that's a lot of emotions, psychological stuff going on as well. So, while they're waiting for those referrals you're there as a listening ear." (P2, Female)

The impact of the mismatch in understanding of what social prescribing was there to deliver and this silver bullet approach seen by the GPs, that social prescribing could fill gaps left by other services, often meant that the referrals received by link workers were

inappropriate. As more complex issues were revealed to be hidden beneath the surface during the social prescribing appointments combined with the lack of additional support from specialist services the link workers were often unable to address the real nature of the patients' problems. In some instances, this resulted in the patients returning to their GP as the necessary kind of support was not solvable through solely offering a social prescribing referral.

"If a patient's going to a GP with anxiety.... but in actual fact the anxiety is caused by a housing problem, then they're going to keep going back to the GP with anxiety until that housing problem is sorted out" (P10, Female)

This inability to resolve the issues of the patients they were seeing effectively created a cycle of unmet needs for patients. This also had an impact on the link workers own mental health and their feelings about the job role.

In addition, if a need such as housing, addiction etc was a pressing issue the link workers recognised the difficulty of trying to offer social prescribing as a solution.

"we'll have referrals for people who are...in a substance misuse Situation. Which again.... I'm not going to say, oh, do you wanna fancy going to a lunch club when it's not really appropriate timing" (P10, Female)

The impact of referrals of these patients with such a wide range of complex needs and without a clear solution in sight had a high emotional impact on the link workers and could lead link workers to a feeling of helplessness.

"Setting goals can be really difficult, you know, and even empowering them to make.... a referral or self-referral and things like that, that that sometimes...is impossible.... I think having to just recognise that they do have different needs.... they may not get as much out of the service, perhaps.... that can be quite frustrating for us.... I can feel definitely very helpless when I can't provide you know, an option for them." (P5, Female)

"I think the housing thing makes me feel quite bleak. That's that. That's quite a an upsetting one" (P4, Female)

This challenge in managing the emotional impact of the role also highlighted the importance of maintaining professional boundaries with patients when offering support. However, as previously discussed the boundaries enforced by link workers were often self-determined which created opportunities for lines to become blurred. As the link workers had time to listen and there was little opportunity to provide concrete support it was easy for the role of the link worker to become that of a befriender which link workers tried to safeguard against.

"I think it's demoralising to a certain extent because you recognise that you…can't change anything for that person. You are trying very hard to support them and you will continue to support them, but of course you've got to be very careful that…they don't then start seeing you as the befriender and that's a bit of an issue.…it is a matter of…trying to remain one step removed.… to keep it more professional. Yes…we get to know people and…they trust us because they know us. But at the same time there has got to be that professional boundary." (P9, Female)

The pressure on link workers to accept referrals without a guided criterion and to create their own defined boundaries led to a deeper negative impact on link workers as it created feelings of guilt when they were unable to provide solutions to their patients. Link workers described having to work through the recognizing that referring a patient onto another service was not a failure of their skillset but was an important step in maintaining professional boundaries.

"I'm slowly getting my head around the idea that I can't fix everybody and that actually it isn't necessarily my fault so that they are not fixable or haven't been fixed. And sometimes it is alright to call it quits and go actually…your level of need is above what I'm capable of doing, so I'm going to refer you onto somebody else" (P11, Female)

"I would say it's definitely quite blurry, but with experience, I'm sort of getting better at distancing myself when it's not my role. So, one patient I did have quite recently, I did feel like I was doing a social workers role" (P4, Female)

The viewpoint of referrers that social prescribing could be a silver bullet to resolve all a patient's complex needs, combined with the responsibility on link workers to try and create boundaries in their referral criteria while simultaneously meeting the expectations of their employers, created an impossible situation for the link workers. The link workers had to process feelings of being demoralised while also trying to create professional boundaries to limit the responsibility they felt to help these patients. This at times also had negative impacts on the link workers mental health.

"There's definitely been instances where I've had a session with the patient, and I've ended up crying afterwards and... obviously...we've all had kind of issues in our lives and certain things can resonate with us.... in the last couple of weeks, I've had...three incidents where they've touched a bit of a nerve for me, and it's had an impact on my own mental health." (P5, Female)

As explored in theme 1 there was a mismatch in the understanding of what the link workers delivering social prescribing were facing. This discrepancy in the view of the social prescribing service led to a skewed perception that social prescribing could act as a silver bullet to overcome all a patients' problems. This view of social prescribing was explored in theme 2 which demonstrated that social prescribing was often used to fill in the gaps left by over specifically services which were oversubscribed. However, the lack of boundaries applied to social prescribing meant link workers were dealing with highly complex cases without any clear solution in sight. This led to the link workers feeling demoralised in their roles as they were working with patients with unresolvable needs.

When link workers struggled to manage the emotional impact of the role, they often did not have access to regular or any clinical supervision. Additionally, the link workers were provided no formal training of how to manage the impact of the role or how to maintain a professional distance. The discovery of the lack of structured support available to the link workers led to the discovery of the next theme in which social prescribing operates in a fashion akin to the Wild West; a lawless landscape in which no rules apply.

4.4. Theme 3 - The Wild West of the NHS

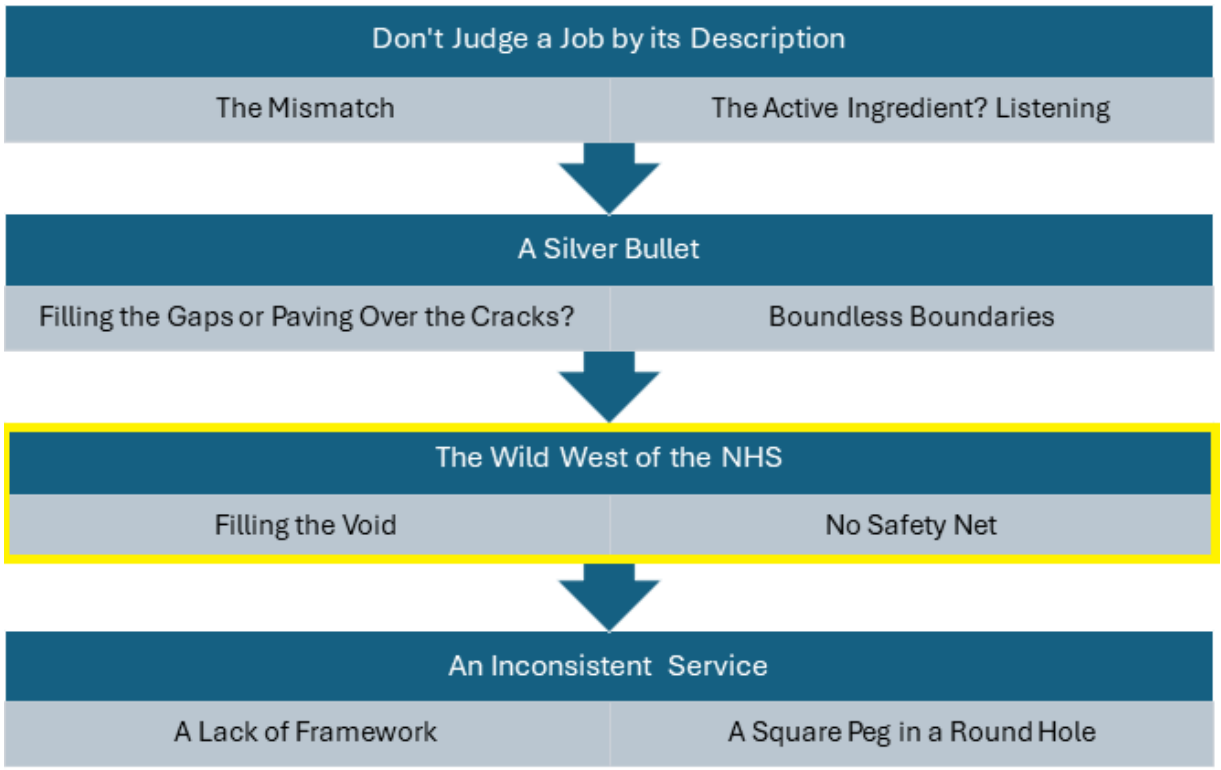

Figure 4: Theme 3 The Wild West of the NHS

The Wild West of the NHS theme speaks to the impact of much of the lack of definition evidenced in theme 1 and 2. Link workers spoke about how this reliance on their own definitions of their role was compounded by the absence of any formal training or supervision structure in the model of social prescribing within primary care.

The link workers all expressed that their previous experience from other job roles and prior training was key in their work as a social prescribing link worker. There was no consistency in the training received by the link workers in the social prescribing service with some link workers receiving no formal training in their roles. In cases in which link workers had accessed training, this often came from their own initiative to seek this out. This reliance on the individual to determine their training needs demonstrates the Wild West nature of social prescribing in which there are no laws to give structure and meaning to the service. Instead, link workers made it up as they went along as the link workers shaped the role as they started it.

The mismatch in the understanding of the social prescribing role found in theme 1 compounded with the gaps left in statutory services led link workers to adopt an approach of making it up as you go.

"I was the first social prescriber to start at my surgery.....I did a lot of shadowing, which was really helpful especially from.....a mental health nurse as well.....but for the most part it was having time for myself to work out what actually is the role...and feeding that back to managers....looking at....online trainings" (P7, Female)

"I completed...the 10-part module that's on the NHS personalised institute, it's the...official module.... I have been doing extra training recently to kind of cover myself" (P2, Female)

"It was nearly non-existent. I think we were sort of expected to sort of hit the ground running. I had maybe a couple, maybe one or two sort of shadowing sessions with another social prescriber who wasn't very experienced...I could then do a bit more training a year [into the role] ... to do...what I consider basic level training in terms of motivational interviewing, in terms of health coaching" (P4, Female)

"I didn't really get any training cause the service was launched three weeks before they employed anybody, and then there was nothing. We had 100 referrals and nowhere to meet people. No systems, nothing.... we really hit the ground running.... I did get some motivation interviewing training...after a couple of months and... We've had a lot more training since then, but really, we... just had the basics of.... safeguarding....it was the very early days of social prescribing. So, we were deciding what we thought it looked like and then what training we might need depending on what we would deciding we were doing." (P3, Female)

Link workers recognised the impact of the lack of a formal training structure. This was highlighted by link workers as particularly concerning given the complexity of the referrals they received.

"There's the kind of the online kind of portal social prescribing sort of training.... there should be more training and support because I think the case is that people are dealing

with a lot more complex than what the job role suggests so. I've brought my own kind of knowledge and whatever as well....and just the type of person that I am to the role as opposed to there having been lots of training." (P10, Female)

"It's a skill communication... it's not something I don't think you can just learn by attending a session. I think it is something you develop, but I think if you if you have some training...it helps...you to reflect and think about the words that you use...think about what's behind the words that the patient is using. It's a big thing" (P8, Female)

4.4.1 Filling the Void

This void created by a lack of training structure meant that link workers relied on their previous experience and job roles to guide what support and skillsets they utilised while working with their patients.

"I've had mental health first aid training, which is very basic.... and that's basically it. I have previous experience working with mental health. I'm a clinical hypnotherapist, so...I'm very interested in in kind of things like schizophrenia and psychosis.... So, I have...some understanding of it, but... I've got no training in how to actually work with people in in a way that helps them but also safeguards me as well" (P5, Female)

"One of my backgrounds...is as a counsellor so sometimes I do find myself heading down that route a little bit because I think this is... what they need at the moment. (P3, Female)

This utilisation of the link workers' previous experience and clinical skills was again used to fill in the gaps left by the lack of structure in social prescribing. This was again reflective of themes 1 & 2 in which gaps in the model led to link workers creating their own structures of the service. One link worker recognised the impact this would have on social prescribing by creating an inconsistent service model.

"The social prescribers that I work with we're all very different. We've all got different backgrounds...I like to focus a lot on self-help processes...but my colleague is a background is counselling.... Another person who's got background in housing...so we all have...different backgrounds and I feel like we've brought that to the service, which

again is not necessarily a bad thing, but I just think the continuity and quality assurance maybe, and expectations for patients, …. I feel a bit uneasy about that sometimes." (P5, Female)

The lack of a formal training structure also meant that link workers without any previous experience were entering the role with even less safeguards in place of how to manage professional boundaries and support patients with complex needs. This risk of working without any clear guidelines was further exacerbated in instances in which link workers were asked to provide complex advice that was liable. For instance, in scenarios in which link workers were asked to provide financial advice and benefit guidance to patients without any formal training. The full extent of the risk of working in this way was also not always well understood by the link workers until it was raised with them.

"They were talking about benefits and financial advice and support which is something that as a social prescriber you cover…it was very much saying that if you give the wrong advice or if you tell them to go and get something and they don't get it, they can come back and sue you….that is well within their right it…is a legal thing….and …you sit and you think God actually what am I saying? What am I doing? How can I keep myself safe? How can I keep my surgery safe? How can I keep the patient safe" (P1, Female)

Even when link workers had a full understanding of the risks of working without any professional structure or guidelines, they often had nowhere to raise these concerns or access support. This led to the next subtheme which highlighted the link workers lack of safety net.

4.4.2 No Safety Net

In addition to receiving to receiving no formal training link workers often did not have access to any clinical supervision to help provide a safety net.

The reality of the working environment of the link workers interviewed in this study was that supervision was often inconsistent or does not exist at all.

"I currently don't have supervision and I'm trying to persuade my current management that actually giving me a clinical supervisor of somebody who is not qualified in clinical

supervision is not where it's at and also that that person cannot know anybody within the PCN either" (P11, Female)

"We started having supervision with the, with the mental health nurse, and that can be helpful. But... it's quite difficult... to access and has taken a long time... to kind of get that support in place" (P7, Female)

"I think in terms of formal timetabling we have maybe a one-, one- and 1/2-hour peer support session one hour a month divided between six people. So, you might get some 10 minutes of reflective practice per.... month and in my mind 10 minutes isn't enough time to do reflective practice" (P4, Female)

These gaps in the support offered to the link workers was again reflective of the themes 1 & 2. The link workers themselves recognised the importance of supervision support and in areas in which a formal structure of support was not available, they reported again filling the gap with peer support from other social prescribing link workers to help them manage the impact of the role.

"I don't think the clinical support; the clinical supervision is working very well...we get peer support and I'm lucky that we're... an experienced team...." (P4, Female)

"We do have a very supportive team and .... that to me makes this job possible because it's a very stressful job. And carrying the weight of... loads of patients with severe mental health problems and highly suicidal...and incredibly stuck, and particularly post pandemic" (P3, Female)

As noted in themes 1 & 3 the lack of clear understanding of the social prescribing role led to a view that social prescribing could be stretched to accommodate any type of patient cases or needs. The link workers were also acting as a net to catch patients who fell through the cracks in statutory services. Simultaneously the link workers were trying to fill the gaps in their own role's definition, training, and supervision. They used their own previous experience to fill these gaps in their role. However, this ultimately left them vulnerable as they were operating a service of support with patients with complex needs without any clear framework to keep themselves safe. The link workers sought out peer

support to help manage the impact of working with complex patient needs. However, the consequence of informal support through peers is that the variability in how link workers were doing the job emphasised the 'making it up as you go along' approach vs offering reassurance. The group discussion with other link workers highlighted the variety of approaches link workers were taking across the social prescribing role. This was explored in the theme 4 'An Inconsistent Service'.

4.5 Theme 4 – An Inconsistent Service

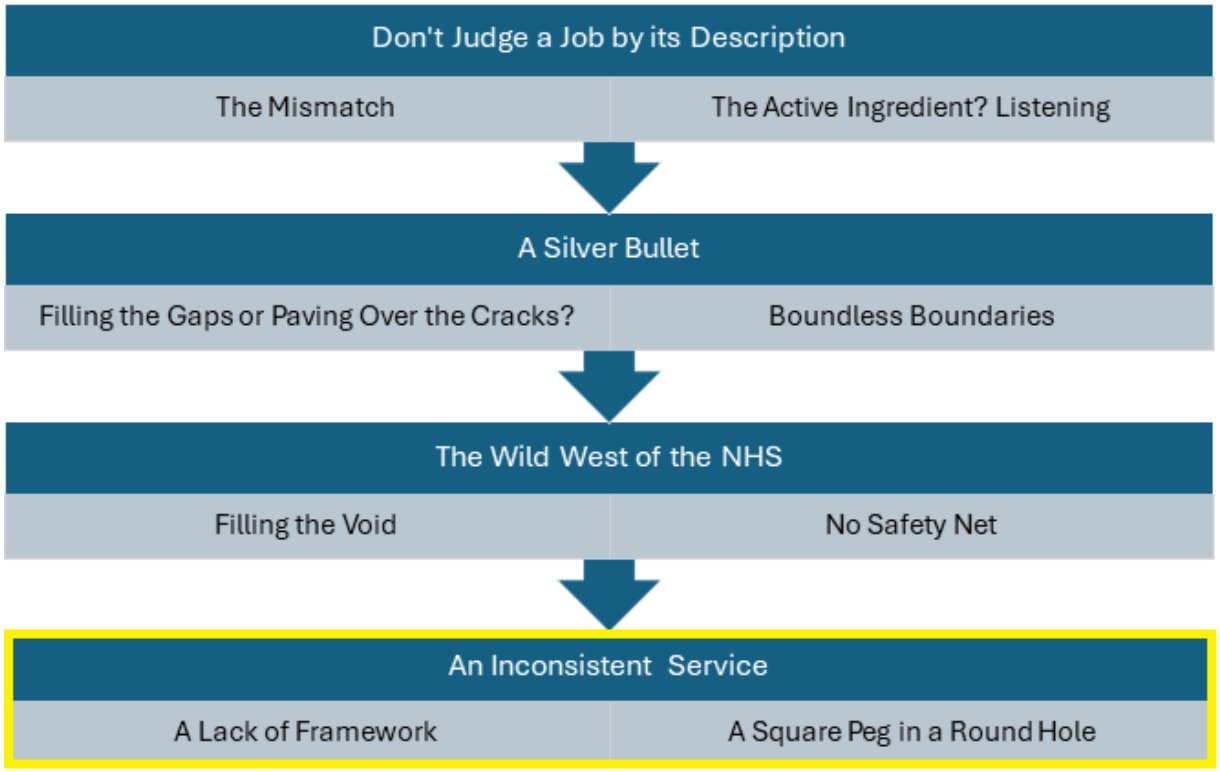

Figure 5: Theme 4 An Inconsistent Service

As link workers engaged with their peers across different regions and in other services it became apparent that link workers enacted the role in different formats leading to an inconsistency in how social prescribing is delivered.

"But the only thing with…peer support is everybody does different things for the PCN that they work for, there's no. You know right across all the services. There's no consistency. People are doing different things as a social prescriber." (P7, Female)

"The social prescribers that I work with we're all very different. We've all got different backgrounds…I like to focus a lot on self-help processes…but my colleague is a background is counselling…. Another person who's got background in housing…so we all have…different backgrounds and I feel like we've brought that to the service, which again is not necessarily a bad thing, but I just think the continuity and quality assurance maybe, and expectations for patients, …. I feel a bit uneasy about that sometimes." (P5, Female)

"It's so varied that actually if you come and see a social prescriber, you are not going to get the same service. If you go and see a social prescriber here or a social prescribing somewhere else, it is going to be very different" (P11, Female)

This inconsistency in how the role was operationalised was evident in the accounts of the link workers across the UK interviewed for this study. In some areas link workers offered home visiting services and would attend community groups with patients. In other areas link workers offered primary telephone support and reported not having the capacity to offer many in-person appointments and no community visits due to capacity.

"I attend with people…. like someone's first Group session at mind…. local groups… Sadly we can only go once or twice" (P2, Female)

"there's no funding for that in our PCN. So, there's the, there's a me across some you know 30,000 patients, right. So, there's…no way I can be going to events and people." (P4, Female)

In some cases, this adjustment to the service was a result of covid.

"I think it's a post COVID… we do home visits umm and we can book in at the GPs for face to face…. a lot of its telephone…. I'd say so maybe a third or a 1/4 of our workload is home visiting." (P2, Female)

As explored in themes 1, 2 and 3 this inconsistency in how social prescribing was delivered was due to several factors: the lack of definition in the role, the making it up as you along approach adopted by link workers and the influence of their individual backgrounds. The impact of this difference in how social prescribing was operationalised adds to the challenge of evaluating the service. Another factor which

contributed to this lack of standardization in the role was the lack of framework for social prescribing.

4.5.1 A Lack of Framework

Unlike their other health professional counter parts such as GPs, Nurses, Physiotherapists etc. the link workers did not have a structured framework from which they could draw from to help manage their roles. This lack of structured guidance was also recognised by the link workers as a key difference in the service they were delivering versus their medical professional counterparts.

"GP's have.... the NICE guidelines. It's strictly laid out, they've got their...book of medicines that they prescribed for XY and Z and.... they've got very systematic route that they take. And whilst they all have slightly different...preferences on what route they might go down.... ultimately the service is...the same.... we don't have that flow chart; we don't have that like if X do Y. It's it. It's a little bit more fluid" (P5, Female)

"it's not set role. It's not like a physiotherapist where.... I'm going to give you some exercises and help you to strengthen your knee" (P3, Female)

The inconsistency in the way the role was delivered made it challenging for managers to have an oversight of the link worker role and give feedback or appraise the role. As there was no guidance on how the role should be delivered it was challenging for managers to assess the work being conducted by the link workers or to provide feedback.

"I've never had any feedback" (P4, Female)

"Managers to get their head around what social prescribing is....is quite difficult.....when you're not used to working in in the way that social prescribers....do" (P7, Female)

The lack of consistency in the operationalisation of social prescribing was found in all the link workers accounts of their experiences. This difference in approaches to the role was also found in services in which link workers worked in the same geographical area. This highlighted the individualistic approach of social prescribing from which the lack of

framework, definition and training program has led to link workers using their own experiences to shape the link worker role.

The lack of framework in social prescribing was also very different than would be typical in a health professional role. The medical model of healthcare role provides a clear structured framework of how professionals should deliver a role and allows them to follow a systematic approach in their delivery of health care which is standardised. In contrast social prescribing has no such structure or standardisation. For link workers delivering social prescribing in a medical setting often felt as though they were a square peg in a round hole.

4.5.2 Square Peg in a Round Hole

Link workers sometimes felt that working in a medical model was challenging as they did not follow the same structure of working as other professionals. This led to a feeling of not fitting into the medical model which link workers were operating in.

"we're a square, a square peg in a round hole." (P8, Female)

This feeling of being other was further exacerbated by the mismatch in understanding of the social prescribing role explored in theme 1. This misunderstanding of the link worker role left link workers feeling, in some cases as though there was a lack of connection between the staff in the primary care setting and themselves.

"There's a disconnect between us and the GP practice and their staff" (P6, Female)

"We're completely surgery based now and so that really changes the dynamic of the job because although we're support each other as a team…because we have a social prescribing team…it doesn't feel like a team. A lot of the time because you're not physically with them. So, it's… a more alone working role……although you're sitting in the surgery. They're not your colleagues in the same way as other social prescribers are because they don't get what you do." (P3, Female)

This mismatch of the social prescribing role not fitting into a medical model also added to the lack of safety net provided to link workers discussed in theme 3. As social

prescribing did not fit into the medical model there was a lack of recognition that these link workers would require support.

"It has been difficult because really, everybody else is from a medical background and...when you're looking at things like...support and supervision There's nobody to go to that is from that background. It's very much again the medical stuff." (P8, Female)

This lack of understanding of the SP role also at times affected the link workers ability to access to escalate a referral for a patient.

"We sit in a really funny position where ...I am imbedded in surgeries. I have access to all the clinical systems within surgeries.... technically I could do almost any referral within the medical based system but there are limitations on what referrals are acceptable from people in clinical roles.... if I'm wanting to get someone picked up by the... mental health triage system for what I consider to be an urgent case, you know, I have all the technical means of doing that, but... sometimes I don't think it's taken with as much weight as if it's come from a GP" (P4, Female)

This experience of link workers feeling other in a medical model was also reflected in the challenges they experienced of cataloguing their work through typical medical appointment systems. Link workers felt in some instances that the work they did was not understood by management and that a lot of the pressures they were under were being conducted behind the scenes and not always evident to management.

Link workers described how an encounter with a patient often then triggered a whole series of tasks that needed to be actioned on behalf of the patient that was challenging to represent in a typical appointment structure to catalogue their work. One link worker explained the challenges of trying to catalogue the work they were conducting in an appointment stream used by GPs.

"They just introduced this thing where we've to put appointments on the system...There's lots of gaps, but again, it's not medical model, so a medical model might be seeing patients all day, one after the other, with us you come off the phone and you thinking right. I need to refer that Lady to so and so. I need to find out if there's I've got this. They

got an entitlement to this, and I can refer to that. I need to ring the probation officer and liaise with them got consent. You know, so… it isn't just about that conversation. It's everything I need to do a letter on behalf of. I need to task the GP and ask if they'll do a letter, I need to…. it's all different things that that follows on from that one hour, 1/2 and hour conversation with the patient that I don't think is understood because in a medical model. You might do a quick referral to somebody, but… that involvement…. I don't think it's understood." (P4, Female)

This again highlighted a mismatch in social prescribing of the systems used in primary care and the social prescribing role.

"I did get the impression that there wasn't that understanding that a lot of the work is done behind the scenes" (P6, Female)

This misunderstanding of the work behind the scenes being conducted by the link workers further highlighted the challenges of measuring the social prescribing effectiveness and defining of the role.

Another aspect of the social prescribing link worker role that often occurred behind the scenes was the responsibility for link workers to be an expert on community resources. Link workers were expected to keep up to date with these everchanging community resources available to support patients. These organisations were often funded through charity schemes or funding pots which were time limited. The link workers were responsible for keeping databases or catalogues of these resources and had to manage their time to find out about these community groups while managing their caseload demands. Providing patients opportunities to connect with their community was in line with the official concept of social prescribing however it presented a challenge for link workers to keep this information up to date.

"One of the trickiest parts of our role…. we're constantly sharing updates about resources because you know the…way that you find out about things is usually I'm researching it on behalf of a patient, right, or getting feedback from a patient…. there's no sort of updated database you in BANES. So, I think this sort of fledgling attempts to

kind of do that kind of catalog. It just doesn't have the kind of funding that would be needed…to keep it…. updated" (P4, Female)

"Things stop running like or like funding stops and then they're not doing it anymore or they're full or there, you know, those… kind of things obviously happen all the time. So, it's yeah, it's quite it can be a bit of a challenge to keep on top of all of that." (P11, Female)

"there's a lot of research that's needed, a lot of like looking up stuff, trying to find out, you know, is this still available…. There's an ADHD support group here. Oh, it doesn't run anymore. OK. So, like I think you know we don't get notified when things close…. it's a little bit tricky sometimes." (P5, Female)

Theme 4 'An Inconsistent Service' highlighted the challenges in social prescribing that were not always obvious. As explored in theme 4 the link workers filled in the lack of structure of social prescribing with their own previous experience and knowledge. This led to social prescribing being very inconsistent in its delivery as link workers were applying an individualistic approach to the services based on their own backgrounds and interests. This individualistic approach was further exacerbated by the lack of framework applied to social prescribing. This lack of framework of social prescribing highlighted the differences of the social prescribing model and the medical model of primary care in which most link workers were working within. This led to a feeling of being a square peg in a round hole and caused some link workers to feel they did not have a team to support them in their job. This lack of team environment was a challenge for link workers as they did not receive formal clinical supervision and relied heavily on peer support as examined in theme 3. Link workers also did not feel management always understood the full scope and responsibilities of their role.

Chapter 5: Discussion

5.1 Overview of discussion points

This study interviewed 12 social prescribing link workers in the aim to understand the model of social prescribing from the perspective of those who are enacting the role in the absence of policy or organisation models, models that would permit effective standardisation and evaluation. The analysis of the link workers experiences further demonstrated the lack of agreed definition of the social prescribing role. This ambiguity of the purpose or structure of social prescribing in combination with the current climate of increasing social needs of patients and limited resources available, has led to social prescribing becoming the sticking plaster to mend the gaps in services available. This study explores how this phenomenon has occurred and the ways in which the absence of clear guidelines in social prescribing has contributed to its misuse. Through the analysis of areas of concern in social prescribing the researcher will also present areas of the model which should be nurtured and further explored as potential positive aspects of social prescribing. Finally, the study will suggest implications for policy makers and stakeholders of social prescribing to explore how the model can be delivered from a safe and beneficial practice.

5.2 Pressures on Primary care

A 2016 evaluation of primary care noted that it was in crisis. Since this report was published the pressures in primary care have continued to build while the workforce population of GPs has declined and the health co-morbidities in the aging population have increased (Baird et al., 2018; Loke & Lee, 2024). This increase in patients with multiple long-term conditions is showing no signs of slowing down with a substantial increase in the number of people living with a long-term illness predicted in the next 30 years and the rise of health inequalities continuing the need for intervention is crucial (Head et al., 2024). This current pressurized climate of primary care service has led to increasing challenges in clinicians' ability to develop a therapeutic relationship with patients (Goroll, 2015). Although continuity of care in a GP setting is best practice,

consultation with a consistent doctor has become increasingly difficult (Kajaria-Montag et al., 20203). Continuity of care has been shown to help reduce mortality rates and improve patient outcomes (Baker et al., 2020). As such it is necessary for policy makers to consider how services can be supported to provide consistent care to patients with the current working conditions (Maarsingh et al., 2016). Appointments have now been reduced to an average of 10 minutes, the shortest provision of GP appointment time across Europe reducing the likelihood of addressing all a patient's issues in one appointment (Bradley et al., 2024; Fox et al., 2024; Schattner, 2022).

5.3 The pressures on mental health services

In addition to the increasing demands on primary care the pressures mental health support services have reached unprecedented levels with an estimated 1.2 million people of all ages waiting to access mental health support (Clark et al., 2024). These pressures show no signs of abating with around 1 in 6 adults in England having a diagnosable mental health disorder the prevalence and severity of mental health needs has reached a new level of need (Porter et al., 2024). In an aim to meet the needs of this population the NHS invested £14.3 billion into mental health services between 2020-2021 (Lorimer et al., 2024). Despite this investment barriers to patients accessing support still exist due to a lack of trained professionals to fill the required roles, leading to increased waiting times to access support and consequently exacerbated need (Lorimer et al., 2024).

5.4 The emergence of social prescribing

As pressures continue to mount in physical and mental health support services and the recognition of the influence of social determinants of health has increased social prescribing has emerged as an increasingly popular resource (Aughterson et al., 2020; Dayson et al., 2020; Maughan et al., 2016; Nowak & Mulligan, 2021). The necessity of addressing the social determinants of health is recognised to be a critical factor in the treatment of health as is the recognition that support for social determinants of health needs to be provided outside of the clinical setting in which other health needs are addressed (Marmont & Wilkinson, 2005). It is understood that for health to be

maintained it is necessary to address the environment which has contributed to the development of ill health in its origin (Marmont & Wilkinson, 2005). There has been an equal increase in the recognition of the impact of social relationships and connection on physical and mental health and wellbeing this phenomenon has been entitled the 'Social Cure' (Jetten et al., 2012).

As a result of this increased understanding of the necessity of addressing social determinants of health and the importance of social connection social prescribing has emerged as a potential solution. Social prescribing has been suggested as offering support to patients to improve their positive mental health, enhance quality of life and to allow patients to grow their emotional, psychological, and social wellbeing (Dayson et al., 2020). Although evaluations of the effectiveness of social prescribing services in mental health improvement have called for the need for further evaluations (Cooper et al., 2022)

This support is advertised as being offered through social prescribing by bridging the gap between health care and community support by offering a service that provides support to individuals to improve wellbeing through offering help with non-clinical needs by targeting social needs (Morse et al.,2022). This support is defined as being offered through providing connection to community connections (Muhl et al., 2023). Despite this advertisement of social prescribing to offer support through providing community connections the reality of the role being conducted by link workers was much more complex.

This was evident in this study as participating link workers described the discrepancy between the advertisement of the job role and reality of work, they were tasked with delivering. Previous studies investigating the experiences have noted the same experience of this discrepancy between the advertisement of the role and the reality (Rhodes & Bell, 2021). This discrepancy between the idea of the social prescribing role and the reality of the work being done has stemmed from the lack of agreed definition of what or how social prescribing should be utilised (Bickerdike et al., 2017; Oster et al., 2023; Cooper et al., 2022).

This mismatch in the description and reality led link workers to feel their jobs were not understood by their employers and referring health professionals. In practice this mismatch between the advertisement of the social prescribing role and the reality of the job has led to challenges in the implementation of social prescribing services with referring professionals having a mismatch in the perceptions of the type of support that could be provided by link workers. Previous studies have noted that the mismatch in the understanding of the social prescribing role can lead to a poor uptake of health professionals referring into the service (Moore et al., 2022). Similarly, studies have noted the influence of how the social prescribing referral is introduced to patients can impact their willingness to engage with the referral (Husk et al., 2020).

Furthermore, this lack of understanding of the social prescribing role was noted as a roadblock in the implementation of social prescribing services as it created mistrust between professionals, led to unrealistic expectations for patients and increased the number of inappropriate referrals to social prescribing services (Peschney et al., 2018; Turk et al., 2024). The effect of increased inappropriate referrals was noted in this study as link workers described having to repeatedly remind referring professionals of the type of support they could provide and advise of why referrals were not appropriate for the social prescribing service.

5.5 An undefined role

Throughout investigations into social prescribing and descriptions of its model there is a constant changeableness in several aspects of social prescribing. This ranges from the title of what link workers are titled from social prescribers to community navigators, to the settings appointments are offered in, to the length of support offered to patients, the structure of employment and the referral criteria or the lack thereof in accepting what patient groups should be supported (Ayorinde et al., 2024; Carnes et al., 2017; Fixsen et al., 2021; Moffat et al., 2017; Skivington et al., 2018; Rhodes & Bell, 2021; Wildman et al., 2019, Frostick & Bertotti, 2021; Vidovic et al., 2021). This continued difference in all aspects of the social prescribing model has become a key criticism in attempts to evaluate the service as no one model of social prescribing is delivered in the same way.

5.6 No road map

The inconsistency across the social prescribing model was due to the lack of road map for link workers or stakeholders to guide how social prescribing should be delivered or what the role should entail. This led to link workers adopting a 'making it up as you go' approach to delivering social prescribing services. The necessity of carving out their own models of social prescribing was also due to link workers often being the first in the role thus having no existing template to follow. Several of the link workers interviewed in this study were the founding members of a social prescribing service which was often not understood by managers or funders. As such link workers were relied on to shape the social prescribing service based on their understanding of what the role should be. This reliance on the link workers to shape and define their own roles led to an increased reliance on their previous work experience and interpersonal skills. For instance, some link workers described offering a form of counselling support in their initial sessions with patients. This experience of the role being shaped by the individual was also demonstrated in previous evaluations of social prescribing services (Frostick & Bertotti, 2019; Hazeldine et al., 2021; Moore et al., 2023; Rhodes & Bell, 2020; Sharman et al., 2022; Wildman et al., 2019).

This reliance on previous experience and interpersonal skills was further fuelled by the lack of training and structured support offered to the link workers. This led to them 'Filling the Void' with their own skillsets and knowledge basis. For some link workers the lack of training offered in the social prescribing role was concerning and led to further challenges in maintaining boundaries with patients making the emotional impact of the role more challenging (Frostick & Bertotti, 2019; Sharman et al., 2022; Wildman et al., 2019). In instances in which link workers had received more in depth or focused training this was often borne out of their own initiative to seek out training opportunities and further develop their skill sets (Makanjuola et al., 2023). This lack of formal training structure led to an increasing variability among the link workers delivery of social prescribing. This high variability in the service created an environment for social prescribing to thus be used to fulfil another purpose.

5.7 A sticking plaster

The increasing pressures on health care and meant health support services combined with the lack of formal definition of social prescribing has led to a referral to a social prescribing link worker to act as a solution for all issues that cannot be solved in primary care. This was reflected in link workers experience of the role they viewed that health professionals often referred patients to social prescribing that they had run out of other support ideas (Rhodes & Bell, 2021; Turk et al., 2024).

The use of social prescribing as a sticking plaster has been further inflamed by the lack of defined criterion for what is or is not an appropriate referral for social prescribing. Throughout this study it was noted that there were no boundaries in social prescribing referrals and no clarity in the provisions of support that could be offered by link workers. This lack of criteria led to health professionals developing a view that link workers be able to provide a 'silver bullet' service which would help alleviate all a patient's complex needs. Link workers described feeling as though health professionals often referred patients to social prescribing that they had run out of other support ideas for viewing social prescribing as at least some form of intervention provided (Rhodes & Bell, 2021; Turk et al., 2024). This was further compounded by the oversubscribed nature of other statutory services such as mental health and social care as professionals could not rely on these services to support these patients making social prescribing an attractive alternative (Rhodes & Bell, 2021; Turk et al., 2024; Westlake et al., 2024).

This perception of social prescribing as a hyper solution is reflected in the wider discussions around social prescribing as an intervention (Calderón-Larrañaga e al., 2022). Advertisements of the social prescribing model describe it being able to offer support in addressing the social determinants of health, reducing pressure on health professionals, contribute to society by offering opportunities for social development and bridge the gap between community and general practice (Chatterjee et al., 2018; Pot, 2024; South et al., 2008). This promotion of social prescribing as a cure all to the wider social determinants of health fails to recognise the complexity of these social needs and

has led to an oversimplification of the view of how these issues can be resolved (Calderón-Larrañaga et al., 2022).

5.8 A resource to reduce uncertainty.

Evaluations of primary care services have noted expectations for health professionals to have a knowledge base of community resources and social support services is unrealistic due to the increasing pressures on primary care to meet the demands of an ageing population (Baird et al., 2016; Stott et al., 2024; Valabhji et al., 2024). As such the uptake of social prescribing has offered a solution in primary care settings by offering health professionals a new referral pathway to refer their patients presenting with non-medical needs. This desire of health professionals to make an onward referral to some form of support may be related to the challenges of managing uncertainty in clinical practice. Uncertainty is recognised as a core feature of clinical practice and is a phenomenon all health professionals will encounter in their career (Moulder et al., 2023). Despite this recognition of the inevitability of facing uncertainty the experience of this feeling can impact psychological wellbeing of health professionals (Gardener et al., 2024; Lee et al., 2023).

As such the offer of link workers to refer these patients with complex needs may help reduce the pressures of dealing with uncertainty for health professionals who feel they have no other options to support these patients. This may be viewed as a positive aspect of social prescribing for social prescribing. A further study evaluating GPs perceptions of social prescribing noted the necessity for psychosocial problems to be de-medicalised in the patient population with social prescribing being cited as a solution to allow for this shift in perspective to occur (Aughterson et al., 2020). The placement of social prescribing in a biomedical setting however is counterintuitive to reaching this goal of de-medicalising social needs.

5.9 The need for partnership working.

Another advertised benefit of social prescribing has been the promotion that the service can be used to reduce the pressures on GP workload by offering a resource to divert

psychosocial needs (Boardmore, 2020). Studies which have measured this impact have noted that this proposed reduction in contacts with GPs and other health professionals has not occurred (Loftus et al., 2017). GPs who found social prescribing an effective resource described a key aspect of when social prescribing worked well for them occurred when the GPs had little involvement with the referral and simply passed on the referral to the link worker (Ajibade et al., 2024). However, this perception that link workers should handle the referrals without any further intervention from other health professionals' conflicts with the complex needs displayed by the patients (Wildman et al., 2019). For social prescribing to offer a safe and sufficient support to patients to meet their needs it is necessary for the engagement with other health professionals to continue to meet their physical health needs working in partnership with link workers offering psychosocial support.

5.10 A medicalised model for a social solution

The model of social prescribing in the NHS requires patients to access the service following a presentation to a health professional with a social determinant of health (Moore et al., 2022). This integration of social prescribing in a health care setting creates a shift in the model of health care by suggesting social solutions are health care interventions and thus healthcare should now be considered a social intervention (Pot, 2024). Similarly, the use of ‘prescribing’ and ‘prescription’ further add to this medicalised approach to social prescribing and the language denotes a further expectation that the resources offered by the link worker are only accessible through a guided referral route in which a link worker will offer a ‘prescribed’ form of support to meet the patient’s needs (Bradley & Scott, 2022; Phizackerley, 2019).

This creates a view that patients cannot access these community resources without the guidance of a link worker which promotes a culture of reliance on a professional to access support as opposed to encouraging a level of self-seeking to find and tap into resources in patients own communities (Bradley & Scott, 2023). As a result, patients locus of control is reduced and the ability to improve your physical and mental health is now viewed as something a health professional needs to fix for you as opposed to

patients being encouraged to take ownership of their health. This thus creates a dependency between a health professional and a patient on how to not only access their community resources, but also on how to make positive changes to their lifestyle to improve their overall health and wellbeing (Kesavayuth et al., 2020).

5.11 The challenges of supporting patients with ill health.

The consequence of referrals being accessed in a health care setting has also led to patients having continued complex physical and mental health needs that need to be treated in conjunction with their social needs, as most patients who present in a healthcare setting do so due to ill health (Sweeney et al., 2024; Wiedemann et al., 2024). This effect of complex physical and mental health of patients referred to social prescribing was reflected in this study with link workers describing supporting patients with issues ranging from homelessness, complex mental health, learning disabilities, childhood trauma, safeguarding issues, and substance misuse. Due to the complexity of the needs of patients referred to social prescribing services offering a light touch support and signposting to community resources was not appropriate for most of the patients link workers worked with (Brunton et al., 2022; Hazeldine et al., 2020; Holding et al., 2020; Rhodes & Bell, 2021; Skivington et al., 2018; Wildman et al., 2019; Frostick & Bertotti, 2021; White et al., 2022).

Patients also presented with complex physical needs such as long-term neurological conditions which had both physiological and psychological consequences to accessing social prescribing support such as a lack of accessibility of groups and anxiety (Simpson et al., 2021). This level of patient need referred to link workers was consistent across previous studies examining the social prescribing service with link workers regularly receiving referrals for patients with complex social needs and challenging physical and mental health (Brunton et al., 2022; Hazeldine et al., 2020; Holding et al., 2020; Rhodes & Bell, 2021; Skivington et al., 2018; Wildman et al., 2019).

5.12 Resolving the unresolvable

The challenge of supporting patients with ill health was further compounded by the impact of austerity and increasing deprivation of the population. The continued lack of investment in communities and social resources has added increasing pressures to link workers to offer some form of solution in often unsolvable situation. For instance, link workers were attempting to support patients with housing needs while managing the pressures of the current housing crisis (Chng et al., 2024). Link workers recognised the loop patients were often stuck in because of these unsolvable needs for instance if a patient presented to the GP due to their anxiety over their housing link workers recognised that this would not be resolved until their housing needs were met. Despite this recognition link workers did not have the access to resources or expertise to make significant change for these patients and had to rely on other services engagement to help the patient access the appropriate support. This was similarly demonstrated in link workers experience of working with patients with severely complex mental health conditions and needs. Link workers described in some cases feeling out of their professional depth with the level of need patients presented with (Rhodes & Bell, 2021). Nevertheless, link workers did not always have access to other professional services to refer these patients onto and thus a level of holding patients further ensued (Westlake et al., 2024; Wildman et al., 2018).

5.13 A holding service.

While social prescribing is being utilised as a sticking plaster it is important to recognise the support accessed by patients by this service does not act as a substitute for the specialist support required. Instead, social prescribing has been described as offering a form of a ‘holding service’ while patients await the specialist services (Westlake et al., 2024). The provision of link workers to act as a holding service was noted as being a positive use of social prescribing as it reduced the emotional burden on primary health care professionals, allowed patients to have their emotional distress witnessed and supported patients to be ready for change when specialist support became available (Westlake et al., 2024). Despite this positive perception of the ability for social

prescribing to offer a ‘holding’ service to patients’ other evaluations have noted the negative impact on link workers assuming an ownership of these complex cases.

5.14 A sense of responsibility

While other care provider’s enforced strict professional boundaries and refusal to accept inappropriate referrals link workers did not exhibit such boundaries and instead accepted referrals despite the complexity of the case. Link workers described feeling a sense of responsibility in their need to support these patients which often stemmed from the lack of clarity of the professional identity of their role (Turk et al., 2024). As link workers were unable to refer to any professional body or official guidance on how they should be supporting patients this created a vacuum which was then filled by the individual link workers perspective of what the boundaries of their role should be. This lack of definition bred a culture of unrealistic expectations in both professionals who referred into the social prescribing service and the link workers themselves. While some link workers recognised, they were not able to act as a substitute for other support services that patients required, the recognition that they were not responsible for solving a patients’ problems was not always easily accepted. Similarly, referring professionals often had unrealistic expectations of what was achievable by link workers given the complexity of the patients’ needs (Rhodes & Bell, 2021).

5.15 A square peg

The differences between other health professionals' way of working and link workers holistic approach to care led to some feelings of being a ‘square peg in a round hole’ in a medical setting. This feeling of otherness was exacerbated by the mismatch and lack of understanding of the job role from staff the link workers engaged with. Link workers who were based in primary care settings described the isolation of not working with other link workers who understood their role. While in some settings other colleagues were supportive and inclusive of the link workers a team support environment was still lacking. This was particularly important for link workers due to the reliance on peer support in the absence of formal clinical supervision. These feelings of isolation in the role have been reflected in accounts from other link workers in previous studies (Fixsen

et al., 2021; Sharman et al., 2022). The prevalence of link workers lone working has also been increased due to the Covid-19 pandemic (Brunton et al., 2022; Fixsen et al., 2021). Future studies should explore the impact of working in isolation on link workers emotional wellbeing.

5.16 The absence of supervision

Despite this complexity of need of patients there was often little to no formal clinical supervision in place for link workers to access (Frostick & Bertotti, 2019). In the absence of a formal clinical supervision structure link workers heavily relied on peer support to help manage the demands of the job and seek reassurance in their practice. However, this at times was also flawed due to the high variability that existed in link workers practice of social prescribing. This caused some link workers to feel more isolated as they recognised the difference in their operationalisation of the role made it difficult to access this much needed reassurance. The reliance on peer support to meet the needs of link workers was also challenged in areas in which link workers operated in isolation. In some areas link workers were the only social prescribing support and they did not have access readily to other link workers to offer peer supervision. The lack of understanding about their role from other health professionals furthered this isolation as link workers expressed feeling as though other clinical professionals did not understand the role and as a result were not a useful resource of support. Given the importance placed on peer support by the link workers in this study and previous literature efforts should be made to provide link workers with opportunities to connect with others in their role.

The necessity of clinical supervision for link workers has been well understood and highlighted as a key component to safe practice and successful delivery of a social prescribing service (Calderón-Larrañaga et al., 2021; Tierney et al., 2020). The importance of clinical supervision is also widely accepted in other health professional roles as a key component of delivery of practice and vital to staff wellbeing (Rothwell et al., Snowdon et al., 2020). The use of peer support to provide supervision can also be a useful practice and has been noted as a positive resource when typical supervision

structures are unavailable due to limited resource availability (Pallikkuth et al., 2024). However, this analysis has been considered when peer support is led by trained professionals who receive guidance on supervisory practices before acting as peer supervisors. As noted previously however it is important that future models of social prescribing consider the prominent level of complex needs patients are presenting with to social prescribing services. Additionally, in the case of social prescribing the combination of lack of formalised training, high variability in practice and experience highlights the need for formal clinical supervision support. For this to be successful it is also necessary for those providing the clinical supervision to understand the role of the link worker and the challenges that are experienced in the role delivery.

5.17 Link workers demoralised.

This feeling of responsibility of patient's wellbeing and lack of provisions of support to refer them onto often led to link workers to feel demoralised by the role at times. The inability for link workers to make changes for the patients they were supporting created an emotional burden of the social prescribing role as link workers. The characteristics of link workers as helpful, engaging, caring, and listening individuals has been highlighted as a key to the positives that social prescribing can provide (Beardmoore, 2020; Frerichs et al., 2020; Moffat et al., 2017; Wildman et al., 2019). The contrast to the positivity of these characteristics was the link workers having to recognise and overcome that it was not their responsibility to 'fix' their patients' problems and to learn to not carry the emotional burden of their patients' needs with them (Calderón-Larrañaga et al., 2024; Wildman et al., 2019). This challenge in maintaining professional distance between patients and separating responsibility from the link worker and the patient was found in this study. Link workers were also often supporting patients who were highly vulnerable and who presented with complex emotional impact. Previous studies have also noted the experience of link workers working with patients expressing suicidal intent, emotionally distressing past events, and disclosing traumatic experiences to link workers (Frostick & Berrotti, 2019; Hazeldine et al., 2021; Wildman et al., 2019).

Link workers further described the challenge in maintaining professional boundaries with patients as they straddled the boundary of health professional but offered holistic support that could be interpreted by some patients as the role of a befriender. The lack of clarity in professional identity and purpose of the social prescribing role needs to be further reviewed to understand the implications of working in this grey area role. If the future of social prescribing is to become an evidence-based model which adopts a structured model of delivery and morphs into a formal health professional role the impact on populations who struggle to access help from health care services needs to be considered. Equally, if the model of social prescribing is to offer a community strength-based approach which reduces barriers to accessibility impact of the lack of supported structure and complex nature of patient needs should be explored.

5.18 Link worker retention

The lack of support offered to link workers in the social prescribing role has also had a practical impact on the job retention rates of link workers. A report from the National Association of Link Workers (NALW) reported a third of the workforce were considering resigning due to a lack of clinical supervision or support (NALW, 2019). The impact of a link worker leaving a job role has been discussed as having several implications on both service delivery and on the patient's experience. The link workers depth of knowledge of services available is often deep and the link workers connection to the community groups is something that is difficult to replicate easily. Studies examining services in which link workers have departed the role have also noted the negative impact on patient's engagement with the support they were signposted to as well as implications to the patient's wellbeing through the loss of an important connection with a link worker (Beardmore et al., 2020; White et al., 2022).

Another challenge in the social prescribing model in retaining staff is the current absence of career progression opportunities for link workers. As previously explored link workers job descriptions did not often encapsulate the reality of the job role they were delivering for services. In addition to creating opportunities for inappropriate uses of the link worker role this mismatch in understanding also caused some link workers to feel

they were not appropriately compensated for the level of work they were delivering (Beardmoore et al., 2020; Moore et al., 2023; Rafiei et al., 2024). This was coupled with a lack of future development opportunities for link workers to progress into and as a result created a difficulty in the opportunity for social prescribing to be a long-term career option (Beardmoore et al., 2020). This lack of future development opportunities may create more discourse among link workers and lead to higher rates of staff turnover in future. Policy makers should consider the potential for career progression opportunities as well as ensuring the job description and salary are representative of the work required in the job role.

5.19 Behind the Curtain

Link workers faced additional challenges in working in a health care setting and trying to capture the full scope of the work their job required. Working in a medical setting in which treatment options often followed a set guidance based on presenting symptoms was challenging for link workers when offering tailored approaches to patients' needs. Link workers described pressures to provide data on their workload to managers but struggled to quantify the support they offered compared to their physiotherapist colleagues who could document each number of physical ailments treated. Link workers felt managers often had little to no understanding of the leg work conducted behind the scenes that occurred to support a patient. This was felt to be an added pressure due to newness of the role and the desire for managers and funders to receive evidence of the impact of the role on the patient population. This lack of understanding of the work being conducted by link workers further highlighted the mismatch between the view of the job role and the reality. For social prescribing to be evaluated and understood this description and understanding of the role needs to match the reality of the experience of link workers who are operationalising the service.

5.20 An unmeasurable service

The current model of social prescribing with its lack of agreed definition, failure to provide guidance on how the service should be delivered, reliance on the individual strengths of link workers, and sticking plaster nature has resulted in social prescribing

being an unmeasurable service. Previous attempts to evaluate social prescribing services have consistently highlighted the variability in the delivery of the model and have called for more robust evaluations and evidence (Calderón-Larrañaga et al., 2024; Dubbeldeman et al., 2023; Dubbeldeman et al., 2024; Moore et al., 2022; Oster et al., 2023). While social prescribing continues to operate without any professional body oversight or agreed approach the high variability of the social prescribing service will continue to prevent robust evaluations of the service from occurring.

5.21 The risks to practice

As previously discussed, social prescribing link workers are supporting patients with increasing levels of vulnerability, complex needs and across populations of health inequalities. Despite this provision of support for such elevated levels of need there is currently no professional standard that link workers are required to follow in practice nor is there any official governing professional body which regulates the standards of practice of social prescribing. This coupled with the inappropriate referrals received by link workers and the lack of understanding of the role by stakeholders has a substantial risk of vulnerability for both link workers and the patients they are supporting. The link workers account in this study and previous explorations of social prescribing have noted the challenges link workers experience in maintaining professional boundaries with patients with such high need and few options for onward referrals. This alone demonstrates the necessity for safeguards to be put in place to protect patients and link workers to ensure safe practice is being delivered (Tierney et al., 2024).

5.22 The importance of a framework

This current challenge of operating without such a framework was highlighted by link workers in this study as a key discrepancy between them and their other clinical health professional counter parts. Link workers expressed recognition of the value of the National Institute for Health and Clinical excellence (NICE) guidelines clinical professionals were able to follow to provide some structure and evidence-based practice to the work they delivered. The development of the NICE guidelines allows clinical staff to work from a guided model of support. This was recognised by link

workers as offering a standard of practice that was lacking in social prescribing. The link workers discussed the implications of the inconsistency in the service delivery of social prescribing impacting the quality and continuity of care offered to patients. Link workers further highlighted concerns that the level of support received by a patient may even vary too greatly between link workers operating in the same service.

The establishment of NICE in 1999 was driven by a desire to promote clinical excellence and effective practice within the NHS ensuring care is provided based on the foremost evidence available (Chidgey et al., 2007). The creation of the NICE guidance also ensures clinicians are meeting the standards set out by the regulatory bodies that oversee health professionals (Chidgey et al., 2007). Similarly, psychologists are governed by both the British Psychological Society (BPS) and the Health and Care Professions Council (HCPC) standards of ethics and conduct. The creation of professional bodies and ethical standards of practice has historically been borne out of disputes in care delivery and investigations into poor practice (Berdondini et al., 2020). Before the inception of professional bodies and ethical standards operating an ethical practice was based on an individual's own code of honour. This came under dispute during an epidemic in 1792 during which two surgeons disagreed how to care for people and led to the closure of the Manchester Infirmary leaving vulnerable patients without access to care (Tribe, 2005). The provisions of ethical principles in health care have been a vital tool in ensuring the wellbeing of patients is prioritised and that provisions of care are offered equitably (Ahmed et al., 2020).

While the introduction of a structured framework to ensure patient safety and some form of standardisation would be beneficial for social prescribing arguments have also been made that the flexibility in social prescribing allows for a personalised care approach when working with patients (Berotti et al., 2022; Tierney et al., 2024; Wood et al., 2021). Personalised care has become a focus of NHS services for the last 20 years (Ahemed et al., 2021; de longh et al., 2019; Tsiga et al., 2013). The ability to offer patients a tailored approach to support both in the length of time support is offered and the interventions suggested is prominent feature in social prescribing. As such any

development of a framework for social prescribing should consider the benefits of allowing for some flexibility in practice. For a framework for social prescribing to be developed it is also important to consider the positive aspects social prescribing offers to patients.

5.23 Link worker characteristics

One area which could be considered in the development of professional standardisation is the importance of link worker characteristics. Despite the promotion of taking a personalised approach to care the structure of health care services under pressure and budget cuts have often led to qualities such as being empathetic, providing active listening and creating a supportive environment being jeopardized with time offered to patients at an all-time low (Bola et al., 2014; Cole et al., 2022; Morgantini et al.,2020). Conversely social prescribing link workers offer of these characteristics is hailed as a key feature of the service (Berotti et al., 2022). Given the importance of personal characteristics on the success of social prescribing support it is important to consider if the professionalisation of social prescribing requires a structured education qualification structure; or if training should be adapted to meet the gaps in link workers knowledge and to provide the necessary training to the personal skills and previous experiential learning possessed by link workers (Oster et al., 2023; Tierney et al., 2024).

5.24 The resource of time

The provision of the social prescribing service is providing patients with a resource to access time from a professional in a health setting and build a therapeutic relationship. The relationship built between link workers and patients was seen as a crucial aspect of the social prescribing service which impacted the success of the support offered (Foster et al., 2020;Fixsen et al., 2020; Freichs et al., 2020; Frostick & Bertotti, 2021; Hanlon et al., 2019; Hazeldine et al., 2020; Holding et al., 2020, Moffat et al., 2017, Pescheney et al., 2018; Pollard et al., 2023; South et al., 2008; Woodall et al., 2018; Wildman et al., 2019; Wildman et al., 2019).

Link workers offered this form of support to patients as they were given longer appointments, letting them engage with patients for 45 minutes to an hour for their sessions for an average of 6 to 8 sessions. This resource of time to offer patients was seen as rarity in the health care service in which time was viewed as a limited resource. The length of time offered to patients across social prescribing services did not follow a consistent structure. Applying a consistent approach across the number of sessions offered to patients should be considered in the development of a standardised approach to social prescribing support.

Although this time provided to patients was seen as beneficial research has demonstrated that the time spent with a patient is secondary to how the patient experiences feeling heard in the time they have with a professional (Kishton et al., 2023). As such the importance of listening patients cannot be understated.

5.25 The importance of listening

The importance of listening in health care has been noted as a fundamental component in delivering safe and quality healthcare provision which patients highly value (McKenna et al., 2020). Listening has also been hailed as being able to create healing through the building of a therapeutic relationship and is understood as a principal factor in a patients view of their experience of an interaction (Harris, 2020; Jagosh et al., 2011; Katzif, 2023). Despite this recognition of the importance of listening most health care settings are designed to promote methodical interactions from patients to find the cause of the problem as opposed to creating an environment which allows for deeply listening to a patient's concerns and life experiences (Browning & Waite, 2010).

The benefits of accessing listening services through social prescribing have also become increasingly important due to increasing pressures on other services that have resulted in this provision of being listened to becoming reduced. As previously discussed, time limitations in primary care have led to shorter and shorter appointments offered by GPs reducing patients experience of being listened to in health care settings (Bradley et al., 2024; Fox et al., 2024). The most common complaint of those in health care settings is

not feeling listened to by a health professional (King, 2022). The experience of being listened to and heard is an experience highly valued by patients (Epstein & Beach, 2023).

The importance of offering this opportunity for patients to experience being listened to and feeling heard was recognised by link workers as a key component of the support they offered to patients in this study. This study's findings support previous studies (Carnes et al., 2017; Skivington et al., 2018; White et al., 2022; Wildman et al., 2019) which demonstrated the depth of the link worker role which using time allowed patients to access a deeper understanding of their needs, motivations, and priorities by building a therapeutic relationship. While social prescribing can be utilised to offer more opportunities for patients to access listening support it should not be used to negate other health professionals listening activity. As such, policy makers must consider the design of health care services to allow for productive consultations between patients and health care professionals.

5.26 Offering a personalised approach.

The provision of offering listening support to patients is also evident in the promotion of the personalised care planning in the NHS long term plan (de longh et al., 2019). The personalised care approach is designed to improve patients' confidence in their ability to self-mange conditions (Stellman et al., 2022). Social prescribing has been highlighted as a key feature of personalised care planning in its ability to provide this opportunity for patients to discuss what matters to them, to develop skills and to learn of resources to help them manage their health conditions (Mann et al., 2021). This model of personalised care in social prescribing promotes link workers to adopt a strengths-based approach in their discussions with patients (Griffiths et al., 2024; Howarth et al., 2021). Link workers in this study recognised a key aspect of their role was offering strength-based conversations to patients.

5.27 Motivational support

As link workers described offering a strength-based conversations to patients it may be beneficial for structured training to be provided to build upon this foundation. For

instance, formal training in motivational interviewing could be provided. Through link workers provision of listening support patients had the opportunity to explore their own motivations for making behavioural changes to help manage the problems they were facing. This use of conversation and listening to help patients discover motivations showed similarities with motivational interviewing techniques. This ability to offer a motivational interviewing and a strength-based approach to patients was also noted in previous studies as a key intervention provided by link workers (Fixsen & Polley, 2020; Frostick & Berrotti, 2021; Griffiths et al., 2023; Linceviciute et al., 2023; Tierney et al., 2020; Walker et al., 2023). Motivational interviewing is described as a style of counselling during which a counsellor utilises empathetic listening techniques to build a collaborative conversation in which the counsellor helps to elicit motivations from the patient for behaviour change (Rollnick, 1995). Since its development motivational interviewing has been employed for several health conditions and psychological treatments (Miller & Rollnick, 2009).

The deployment of motivational interviewing across a range of therapies has led to an occasional simplification of the complexity and skill required to effectively deliver a true motivational interviewing-based intervention (Miller & Rollnick, 2009). The use of motivational interviewing strategies in social prescribing demonstrated characteristics of ways in which the model has been simplified and not fully understood. Link workers described using motivational interviewing styles of conversation but had not had any in-depth training or development of this skillset in their social prescribing role. Some link workers described having received some training in this form of counselling style while others had received none. For motivational interviewing to be conducted effectively and consistently training is an important aspect (Madson et al., 2009). As such if link workers are going to utilise motivational interviewing training should be incorporated into the induction provision of the social prescribing role.

The adoption of motivational interviewing training officially into social prescribing would be further beneficial in providing an evidence-based structure to social prescribing. Unlike social prescribing which lacks an evidence-base and has yet to be effectively

evaluated motivational interviewing has a depth of evidence of its effectiveness and clear model of delivery (Bischof et al., 2021; Frey et al., 2020; Hohman et al., 2015; Levensky et al., 2007). The use of motivational interviewing techniques in a primary care setting has also been tried and tested proving it to be an effective tool to support individuals with long-term health conditions (Anstiss, 2009; Rollnick et al., 2010). As such the use of an established intervention in social prescribing would aid the development in future evaluations of social prescribing allowing it to be effectively measured as it adopts a consistent approach.

5.28 The application of Health Psychology Theory

As detailed previously social prescribing is currently operating in a vacuum without any framework or theory underpinning the model to support it. Despite this there is the opportunity for social prescribing to benefit from the adoption of theory from health psychology to offer insight into patient's behaviour and to provide guidance on how support may be delivered to patients to meet their needs. One such example of this is the potential use of the Health Locus of Control theory. The utilisation of the Health Locus of Control could be employed by link workers during initial consultations with patients to gauge their understanding and view of their perception of their own responsibility and ownership of their health (Cheng et al., 2016; Wallston & Wallston, 1981). The use of the Health Locus of Control scale may also be beneficial in gaining a deeper understanding of patients' health behaviours across different areas of socioeconomic status to understand the cultural impact of the environment in which beliefs have been developed (Poortinga et al., 2008).

Further exploration of the impact of a patient's health beliefs on their behaviour may be explored by the adoption of the Health Belief Model into social prescribing. If link workers were provided training on the Health Belief Model, they would be able to gain an insight into the behaviour's patient exhibit around their health enabling them to explain health behaviours, why these behaviours are maintained by patients as well as gaining understanding of how patients may be supported to make changes to their behaviours to ultimately improve their health and wellbeing (Champion & Skinner, 2008). The use of

the Health Belief Model in social prescribing would also allow link workers to support patients to develop self-efficacy, reduce risk behaviours and gain a deeper understanding of health challenges while also considering the wider social influences and context in which these health beliefs have developed (Green et al., 2020). By helping patients to identify their health beliefs and exploring the impact of the social context link workers could support patients to make lasting behaviour change and develop health beliefs to support behaviour change.

Similarly, the introduction of the Theory of Planned Behaviour model would also allow link workers to help identify how patients attitude towards behaviours, their perceived control of that behaviour, the subjective norms related to that behaviour and the patient's intention to make changes to their behaviour influence their actual ability and prediction of success in making change to health behaviours (Ajzen, 1991). If link workers were able to gain an insight into the likelihood of patients making behaviour changes by understanding their level of intention, they would be able to adapt the support provided to patients to support behaviour change based on this need. They could also use the insight into a patient's intentions to predict the likelihood of behaviour change occurring (Ryan & Worthington, 2021). The use of this model could also be employed as an assessment tool at the beginning of working with a patient and allow link workers to help patients create specific and measurable goals in what they want to achieve in working with a social prescribing link worker.

5.29 The benefits of active signposting

As previously discussed, the placement of social prescribing in a health care setting has the potential to create dependency on health professionals to offer access to community resource and prevent patients from seeking social support through their own initiative. This dependency on a link worker to offer guidance to access these community resources was evident in studies which examined the impact of a link worker leaving a role or having an unsuccessful therapeutic relationship with a patient as in these cases, the patients disengaged with the resources they were linked to (Beardmore et al., 2020;

White et al., 2022). Thus, suggesting that the link worker connection to referring to community support was a key aspect of the intervention (Wildman et al., 2019).

While this creation of dependency is concerning evidence has conversely demonstrated that if the link worker role is removed from the equation the uptake of signposting to community resources alone does not result in uptake of these suggested resources (Gildlow et al 2005; Williams et al 2007). As such there is a need for a supported connection between community resources to promote engagement among patients. This demonstrates there is a role for social prescribing link workers to promote uptake of alternative remedies for health and wellbeing. However, social prescribing link workers should not be treated as the gate keeper of resources but instead act as a supportive guide to help patients access the resources available in their communities and to help patients develop skills to self-manage their needs in future.

5.30 The use of social prescribing as a support for loneliness

The promotion of social prescribing as a resource to treat loneliness has been well documented with numerous papers highlighting social prescribing's advertisement as a solution to reduce loneliness (Haslam et al., 2024; Kellezi et al., 2019; Reinhardt et al., 2021; Wakefield et al. 2022). Despite this advertisement the complexity of loneliness is often overlooked when considering the ability for social prescribing to act as a solution. Loneliness can exist on acute basis or become a more enduring state of disconnection (Motta 2021). The prevalence of loneliness and social isolation is a rising concern especially in older adults with a predicted 50% of individuals over 60 predicted to be at risk of social isolation (Fakoya et al., 2020). The pandemic and subsequent lock down measures resulted in a further increase in the population who experienced loneliness and social isolation with the younger population experiencing a greater negative impact and increase in loneliness during these periods of forced isolation (Bu et al., 2020; Kasar & Karaman, 2021).

The impact of loneliness on health has been well documented with those who experience loneliness having a higher risk of poor health outcomes such as an increased risk in cardiovascular illness, mental health disorders, poor cognition, reduced sleep,

and higher rates of mortality (Lapane et al., 2022). As is often the case with poorer health outcomes researchers have also noted that those in poorer socioeconomic groups are disproportionately affected by loneliness experiencing a higher rate of loneliness than those in other socio-economic backgrounds (Macdonald et al., 2018).

Studies exploring the impact of loneliness have also recognised the importance of the distinction between loneliness and social isolation. Loneliness is understood as a feeling which can be experienced by a person when they are on their own or while surrounded by people (Lapane et al., 2022; Park et al., 2020). In contrast social isolation is defined as an objective measure of an individual's connection to society and social connectedness (Park et al., 2020). These distinctions in the definitions of loneliness versus social isolation demonstrates the complexity in offering support to individuals experiencing loneliness. As an individual may have a depth of social connectedness but may still be experiencing feelings of loneliness and isolation. Given the health implications of being socially isolated and lonely the benefits of having access to a social group and feeling connected cannot be overlooked (Singer, 2018). Humans are social beings and the benefits of existing in a socially connected group allow us to reduce stress, experience improved health outcomes and increased levels of wellbeing (Holt-Lunstad, 2024).

The presentation of literature on the impact of loneliness on health has coincided with the promotion of loneliness as a public health issue thus creating the need for a solution to be bases in a biomedical and psychological paradigm (Jentoft et al., 2024). This problematization of loneliness has further led to a shift in view of the responsibility to reduce loneliness shifting from the individual’s responsibility to become an issue which requires a public policy and intervention (Jentoft et al. 2024). As a result, social prescribing has become the most advertised intervention which can be utilised to reduce loneliness and social isolation in at risk populations (Reinhardt et al., 2021; Foster et al., 2021; Haslam et al., 2024).

While evaluations of social prescribing as a resource to treat loneliness and social isolation have noted it’s potential to improve both of these phenomenon’s, there has

been a consistent call for more robust evaluations and studies to capture social prescribing's true impact (Haslam et al., 2024; Liebmann et al., 2022; Thompson et al., 2023; Sachs et al., 2024; Yanguas et al., 2018). Studies examining the social prescribing interventions have also cited challenges in dependency developing between social prescribing link workers and the clients they were supporting as in some instances link workers became a befriender role to patients which initially helped reduce feelings of loneliness and isolation (White et al., 2024). However, this development of a befriending relationship was not sustainable long term and there were potential risks to the impact of this relationship ending (Wildman et al., 2019).

Other studies investigating the use of social prescribing to support the reduction of loneliness noted the reliance on the community groups available for the link workers to refer patients onto. If there were limited social groups for link workers to make referrals this was an added challenge for the link workers to improve social connectedness. In contrast, psychological interventions and emotional and social skills training have been cited as an effective treatment in reducing loneliness (Hickin et al., 2021). Professionals who deliver psychological interventions are trained in how to manage dependency risk in patients and help balance offering the benefit of building a relationship while maintaining professional distance (Thompson et al., 2016). Such training is not currently standard for link workers.

For social prescribing to be continued to be used as an intervention for loneliness it is important to develop a clear model of what aspects of social prescribing are going to be used for this purpose. If the development of a befriending relationship is going to be utilised as the form of support offered by link workers there is a need for clearer understanding of the long-term impact of this support on a patient's wellbeing (Liebmann et al., 2022). Similarly, if social prescribing is going to reduce loneliness through improving social connectedness by linking patients with social groups, then it needs to be recognised that increasing social connectedness may not directly reduce loneliness if quality connections are not made (Staras et al., 2024). It is also necessary to consider the correlation between the availability of social groups on the success of

social prescribing as an intervention as if there are limited resources for social prescribing link workers to refer into this will have an impact on the ability for link workers to effect social connectedness of the patient they are supporting (Holding et al., 2020).

5.31 Summary of Findings

The aim of this thesis was to explore the model social prescribing through the perspective of the link workers who are tasked with delivering the service. This study aimed to examine how these experiences would differ across link workers operating in rural areas vs cities and areas of high socio-economic status vs. those in poor economic populations. Instead of finding differences in the experiences of link workers operating in these different environments the researcher found the challenges of delivering social prescribing was universal. These included a mismatch between stakeholders' perception of the role and reality of the work being done, barriers to engagement for patients due to limited community resources, cost of living impact and challenges in overcoming physical and mental health. Link workers across the study expressed an ultimate desire to help people but were not provided with appropriate training or support to ensure professional boundaries were established and the emotional impact of the role could be overwhelming. Social prescribing across the link workers experience was viewed as a fix all solution for patients with complex needs without recognition of the challenges that link workers would face in offering solutions to patients with such intricate needs. These findings were summarised into 10 key findings:

1. There is a current incongruence between the national perspective of social prescribing as a light touch signposting support and the reality of needs of patients referred to the service.
2. Link workers are providing a time to be heard to patients in a health care service in which time is a limited resource.
3. Social prescribing requires partnership working between health professionals, statutory services, social care and housing providers to enable link workers to provide the holistic support needed by patients.

4. The complexity of patients' needs presenting to social prescribing is not being equally matched by the support offered to link workers.
5. The placement of social prescribing in a health care setting may increase the health inequities of marginalised communities and will not reduce health inequality.
6. There is consistent inconsistency across the delivery of social prescribing which will continue to inhibit the ability to conduct effective evaluations of the service.
7. There is a need for social prescribing to become professionalised with the creation of ethical guidelines and professional competencies to support safe practice for link workers and to ensure patient safety.
8. For social prescribing to be a successful intervention the communities in which it is delivered in need to be equally supported and invested in to allow for resources to exist for link workers to link into.
9. Social prescribing is currently being used to mask the cracks in other services. Social prescribing is not a suitable intervention to support an underfunded and oversubscribed health and social care system in the long-term.
10. The purpose of social prescribing needs to be established and agreed to allow the model to be purpose built.

5.32 Implications

5.32.1 For Policy Makers

Policy makers focusing on social prescribing need to capture the level of entanglement of needs patients are presenting with from their physical, mental health to the socioeconomic factors and resources available in communities. There needs to be a recognition of the importance of equal investment into community resources as well as social prescribing services. Without the development of community-based support social prescribing will have limited resources to refer patients into which acts as a barrier to providing successful support and intervention.

Equally the use of social prescribing to act as a catch all for patients who slip through the net of other statutory services is not a sustainable use of resources. Without the

investment into statutory services patients will continue to have unresolvable needs that cannot be supported by link workers alone. Continued referrals to link workers of this nature will result in increased risks to patient safety as link workers strive to provide support that is beyond their professional scope with no oversight or safety net to catch them when this fails. As such more resource needs to be injected into services to ensure there is sufficient resources for link workers to refer onto for more specialist support.

5.32.2 For Referrers

This study highlighted the current mismatch between referrers perspectives of social prescribing and the level of need patients are presenting with. Referrers should strive to better recognise the complexity of the needs of the patients they are referring into social prescribing services and adjust expectations of what outcomes are achievable in link workers supporting or solving these issues for patients. Referrers should also strive to communicate with patients what the link worker will offer at the time of the referral to help promote engagement from patients when engaging with social prescribing support.

5.33 Recommendations

5.33.1 Standardisation

While the benefits of offering patients time through the opportunity to access an average of 6 to 8 sessions was useful this did not remain consistent across all services. To allow for clarity for patients and referrers a set number of sessions should be established to allow for a clear understanding of the terms of engagement with social prescribing support. Once guidance is produced for a recommended length of support further guidance can be implemented to allow for a review of needs. Thus, if the maximum amount of support available is not suitable to meet the demands of the patient's need link workers should be able to discuss this with a manager to discuss the necessity of further ongoing support or a referral to onward interventions.

Similarly, guidance should be created to advise the types of referrals that can be accepted by link workers and a policy should be created to advise of steps if the referral received is inappropriate for link worker support. A screening template should be

developed to allow for an assessment of patient needs to be conducted to assess the appropriateness of the referral of the service.

5.33.2 Formal training

Training in motivational interviewing should be standard practice for link workers to allow for an evidence-based approach to be utilised in social prescribing support sessions. The utilisation of motivational interviewing training will allow for a consistent approach to be adopted by link workers and to build upon the foundational work already being undertaken to conduct strengths-based conversations with patients. Where appropriate the use of motivational interviewing will also provide a supportive structure for active signposting opportunities in social prescribing support.

Where patients need exceed signposting the use of motivational interviewing will allow for link workers to have productive conversations with patients without entering unauthorised counselling support. The use of motivational interview techniques will also help link workers recognise the limits of their responsibility to solve a patient's problem and instead allow patients to develop self-sufficiency in finding solutions and motivations to make behaviour changes. This will help to alleviate some of existing pressures on link workers feeling of responsibility and challenges of creating dependency in patients.

5.33.3 Formal clinical supervision

To reduce the risks to link workers and ensure that patients are also receiving appropriate support the introduction of formal clinical supervision is vital in social prescribing. The implementation of clinical supervision will allow link workers to access the necessary support to help manage the emotional burden of supporting patients with increasingly complex needs. Having oversight from a trained professional will also ensure link workers receiving support in managing boundaries with patients and patient safety is considered.

5.34 Limitations & Strengths of this study

The study captured perspectives from a wide geographic scope and from link workers operating in varying locations across England. The study also used a semi-structured interview approach based on previous research into social prescribing to guide the focus of the interviews and to capture and in-depth understanding of the experiences of link workers understanding of social prescribing.

However, the study had a small sample size of participants and as such the findings cannot be used to offer a transferable perspective of all link workers experiences of the role. The sample was also homogenous in that all participants interviewed in the study were white females. Future research should aim to capture a more diverse sample of link worker professionals to further explore the cultural differences on the perception of social prescribing.

This study only focused on the experience of link workers who were conducting the role. Future studies should examine the perspective of other stakeholders and patients who interact with social prescribing services to gather different perspectives on social prescribing.

5.35 Conclusions

The increasing pressures on primary care to meet the increasing needs of a complex health and growing population has led to this ‘one problem one appointment’ approach which often leaves patients feeling unsatisfied and unheard. Additionally, the recognition of the benefits of offering a non-medial solution has led to the development of social prescribing. However, due to the current financial strain on resources and the oversubscribed nature of support services social prescribing has become a service which fills the cracks left by unfunded and oversubscribed statutory services which aim to support our most vulnerable population (Rhodes & Bell, 2021; Turk et al., 2024; Westlake et al., 2024). If these services continue to operate without the appropriate resources to meet the demands of the communities, they aim to help this will only continue to add pressure to link workers who are delivering the social prescribing role.

The model of social prescribing needs to be readdressed to capture the true nature of the role and safeguards need to be put in place to ensure the safety of the link workers delivering the service and the patients who are accessing the support. This use of the social prescribing without any formal oversight or support for link workers who are delivering this support service is at a high risk of potential harm to the link workers involved and/or the patients who access support from this role. Despite this current misuse of the resource of social prescribing there is evidence that the social prescribing link worker role can offer real benefit to patients. The ability to offer longer appointments allowing patients to feel heard by their practitioners has been noted as a key benefit of social prescribing. This is particularly salient in a medical system in which being offered time is a rarity.

While social prescribing allows patients the opportunity to tell their full story and to be guided to support services tailored to their personal needs there is a substantial need for this support to be supervised and better understood. For social prescribing to continue to operate as a service a level of standardisation needs to be implemented to allow for safe practice and a consistency of what social prescribing support is to be recognised. This standardisation can maintain a personalised approach while also offering a service that has the potential to be evaluated and for an evidence-based approach to be adopted. In its current form any attempts at an evaluation or deriving an evidence-based approach from the social prescribing model is not possible due to the sheer variability in the delivery of the service.

At the core of social prescribing are the link workers who are tasked with delivering support to a population of people often with complex medical needs, social and environmental challenges and subjective experiences of loneliness. These link workers often share one common theme in their desire to deliver social prescribing – to offer help and support to those that are referred to them. It is important that commissioners of the social prescribing service recognise the challenges of this role and create a safe working environment for the link workers tasked with delivering it.

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Appendices

Appendix A: Participation Information Sheet

1. **Research Title:**

Understanding the model of Social Prescribing through interviews and focus groups with Link Workers in the role.

2. Invitation to Participate

You are being invited to take part in a research project. Before you decide, it is important that you have a clear understanding of why the research is being conducted and what participation will involve. Please take some time to read the following information. If there is anything that is unclear, or you have any questions you would like to ask please speak to the researcher Caitlin Hayton. Please take your time in deciding whether you would like to participate. Thank you for reading this document.

3. The Project's Purpose

The purpose of this project is to gain a deeper understanding of Social Prescribing through interviewing link workers and conducting focus groups with professionals involved in the delivery and referral process of social prescribing. The aim of gaining this understanding is to examine if/what theoretical model can be applied to social prescribing to allow for a more structured delivery of social prescribing services across the UK (United Kingdom).

The project will be conducted over a series of months and will involve one to one interview with Social Prescribing Link workers across three geographic locations: Wiltshire, Bath, and Hull. The aim of these varied locations is to try and capture a variety of socioeconomic populations. The project will also involve focus groups with professionals who can refer into the Social Prescribing service. The goal of these focus groups is to gain an understanding what clinical professional who make these referrals to social prescribing think the service should be.

4. Why have I been chosen?

You have been chosen to take part in this research as you are either a Social Prescribing Link Worker or you work in a role that allows you to refer into the Social Prescribing service.

If you have been selected to participate in the focus groups, you may or may not currently actively refer to your social prescribing service. The aim of the focus groups is to include staff who are both active referrers to the social prescribing service as well as those who do not currently actively refer. This mix of participants is to help the researcher gain an understanding of what the perceived barriers to referring to Social Prescription as well as the perceived benefits.

5. Do I have to take part?

Taking part in this research project is completely voluntary. If you decide you are willing to participate in this research project, you will be provided with this information sheet alongside a consent form. At any time, you can withdraw from the project and there will be no consequences to withdrawing and you do not need to provide a reason for wishing to withdraw.

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

If you decide to take part in the research project, you will be asked to sit for either a one-to-one interview or participate in a focus group. The interviews will be semi structured and will be recorded by the researcher using Microsoft Teams. The interview will last approximately 45 minutes to an hour.

The focus group sessions will also be around 45 minutes in length. The focus group sessions will also be recorded via Microsoft teams. The focus group sessions will also be video recorded using the team's platform to allow for the researcher to distinguish between who is speaking.

Once the interviews and focus groups are completed it will be transcribed by the researcher. The interviews and focus group sessions recording will be stored on a secured drive and will only be listened to by the researcher. Quotations from the

interviews may be used in the write up of the research. If quotes are used, they will be anonymised, and the participants will not be identifiable. The researcher will ask for your consent before using quotes and will ask you to sign a consent form approving the use of quotes in the text.

6.1 Your Personal Data

Your personal data such as your name and contact details will be collected by the researcher. This data will be kept on a secure one drive with two authentication protection. Your personal data will not be shared with anyone else outside of the researcher and supervisor. Once the research project write up has been completed and the project has ended your personal data will be destroyed.

7. What do I have to do?

For the research project you will be asked to participate in a one-to-one interview with the researcher or a focus group led by the researcher. The interviews and the focus groups will feature questions about Social Prescribing.

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

There are no anticipated risks or disadvantages of taking part in this research. The potential physical and/or psychological harm or distress will be the same level as everyday life. If you find discussing any topics during the interviews or focus groups distressing, you will also be provided with details of support services to access help.

9. What are the benefits of taking part in this research?

Whilst there are no standout benefits to taking part in this research, it is hoped that the project will have a positive impact on how Social Prescribing is delivered. Results from the study will be available to the professionals who participated if they wish.

10. What if something goes wrong?

If you have any complaints about how the research project is conducted, you can first contact the researcher to raise any issues. If you wish to take your complaint further, you can contact X.

11. Will my taking part in this project remain confidential?

All the information collected during the research project will be kept strictly confidential. You will be in no way identifiable in any reports or publications. Your workplace will not be identified or identifiable in the report or publication of this project.

The recordings of the interviews and focus groups will be stored on a secured protected drive. The interviews will only be listened to by the research team.

12. Will I be recorded?

As previously stated, the one-to-one interviews will be audio recorded. The focus groups will be both video and audio recorded. These recordings will not be shared with anyone outside of the research team.

13. What information will be sought from me and why is the collection of this information relevant to achieving the research project objectives?

The interviews and focus groups will feature questions asking about your experience of social prescribing such as what makes a successful social prescriber, what attributes are important in a social prescribing service, what is the expected outcome of social prescribing referrals and what are your thoughts on what should be referred to social prescribing. Your views and experiences of Social Prescribing is exactly what this project is focused on.

14. What will happen to the results of the research project?

The results of the project will be written up as part of the researcher's doctoral thesis. A more succinct version of the project's findings may also be later written up and published in a peer reviewed journal. Your workplace will not be identifiable in any report or publication. If you would like a copy of any reports following the research, please ask the researcher and you will be added to the circulation list.

15. Who has ethically reviewed the project?

This project has received ethically approval from the University of West England Ethics Board.

16. Contact details for further information

Redacted for publishing purposes.

17. Supporting Information for Staff

If you require support following the interviews, please be aware the following services are available to you.

For NHS (National Health Service) Staff:

If you need someone to talk to, we have introduced a confidential text support service, you can access support by texting FRONTLINE to 85258 for support 24/7. This service is available to all our NHS colleagues who have had a tough day, who are feeling worried or overwhelmed, or who have a lot on their mind and need to talk it through.

NHS staff have been given free access to a number of wellbeing apps to support with their mental health and wellbeing. Click each link below for more information, including how to access support and when this free offer expires.

#StayAlive

The Stay Alive app is a suicide prevention resource for the UK, packed full of useful information and tools to help you stay safe in crisis.

Bright Sky

Bright Sky is a free to download, confidential mobile app providing support and information for anyone who may be in an abusive relationship or those concerned about someone they know.

WorkLife Central

The WorkLife Central programme consists of a curated collection of expertise, information and inspiration available through video, live event and written format, covering five principal topic areas – Careers, Families, Inclusion, Wellbeing and Workplace.

Headspace

Headspace is a science-backed app in mindfulness and meditation, providing unique tools and resources to help reduce stress, build resilience, and aid better sleep.

Unmind

Unmind is a mental health platform that empowers staff to proactively improve their mental wellbeing.

Zero Suicide Alliance

Zero Suicide Alliance provides you with a range of free online learning sessions that provide you with a better understanding of the signs to look out for and the skills required to approach someone who is struggling, whether that be through social isolation or suicidal thoughts.

For Non-NHS Staff:

Shout 85258 is a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope.

To access support: TEXT SHOUT' TO85258

#StayAlive

The Stay Alive app is a suicide prevention resource for the UK, packed full of useful information and tools to help you stay safe in crisis.

Papyrus

Suicide Prevention for under 35s.

SUPPORT: We provide confidential support and advice to young people struggling with thoughts of suicide, and anyone worried about a young person through our helpline, HOPELINEUK.

EQUIP: We engage communities and volunteers in suicide prevention projects and deliver training programmes to individuals and groups. This includes equipping local councils, healthcare professionals and school staff with suicide prevention skills.

No Panic

Helpline, guided breathing, online support, online forums and articles for panic attacks and anxiety support.

Anxiety UK

Online support, advice, and information. Also offers web groups and peer support online for support with anxiety.

Find your local available Talking Therapies Support

Thank you for your participation in this research.

Appendix B: Consent Form

Participant ID Number:

1. **Research Title:**

Understanding the model of Social Prescribing through interviews and focus groups with Link Workers in the role and Stakeholders.

Name of Researcher:

If you agree, please initial box.

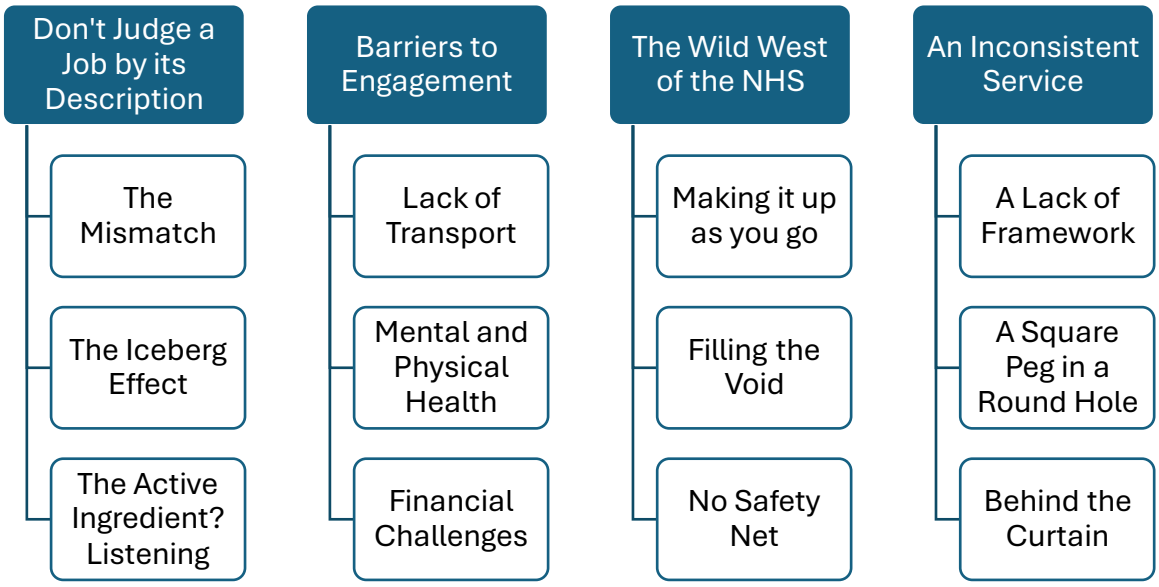
1. I confirm that I have read the information sheet dated..... for this study. I have had the opportunity to consider the information presented and ask questions. Any questions I have asked to have been answered sufficiently.	
2. I understand that my participation in this study is voluntary and that I can withdraw at any time without having to provide a reason for my withdrawal. I understand that there will no negative consequences if I withdraw.	
3. (If appropriate) I agree to participate in a one-to-one interview with the researcher. I consent to this interview being recorded and transcribed.	

I understand that this recording will be stored securely, and that any data used from the transcript will be anonymised.	
4. (If appropriate) I agree to participate in a focus group session with the researcher and other professionals. I consent to this focus group being audio and video recorded and later transcribed. I understand that this recording will be stored securely, and that any data used from the transcript will be anonymised.	
5. I agree to take part in this study.	

Name of Participant Date Signature

Name of Person taking consent Date Signature

Appendix C: Original Themes Map



Appendix D: List of Figures

Appendix E – Participant Matrix

Participant Number	Age range (years)	Length of service (range in years)	Location Type
1	21-30	1-2	Wiltshire & Surrounding County
2	31-40	0-1	Hull
3	41-50	4-6	Bath
4	41-50	4-6	Bath
5	31-40	1-2	Bath
6	41-50	1-2	Hull
7	21-30	1-2	Wiltshire

8	51-60	0-1	Hull
9	61-65	3-4	Wiltshire
10	31-40	0-1	Bristol
11	41-50	1-2	Wiltshire
12	61-65	1-2	Wiltshire & Surrounding County