Working in social prescribing services: a qualitative study

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Table 1 – Kimberlee's Four Models of Social Prescribing	
SP Signposting	The client is simply pointed in the direction of potentially useful or helpful organisations.
SP Light	The client is referred to a specific intervention in order to reach or work towards a desired outcome.
SP Medium	The client is referred to a health facilitator who helps identify their needs and navigate the services available to them.
SP Holistic	Services that aim to treat the whole person in a holistic manner over a longer period of time, aided by a link worker who helps the client navigate and access suitable services.

Table 2 – The sample

Service	Gender	Part time/Full time	Role (Participant Identification Number in parentheses)	Type of organisation	Kimberlee SP Type
1	M	FT	**Social Prescriber (1a)** Working one-to-one with clients to connect them to local groups and activities.	Based within the NHS, offering SP to individuals with additional support needs. Targeted at individuals with a specific condition.	SP Medium
	F	FT	**Social Prescriber (1b)** Working one-to-one with clients to connect them to local groups and activities.		
2	F	FT	**Managerial Social Prescriber (2)** One-to-one work with clients over a set time period. Only member of full time social prescribing staff with little additional support.	Community organisation based in an area of deprivation. A discrete service offered as part of a community action group.	SP Holistic
3	F	FT	**Managerial Social Prescriber (3)** One-to-one work with clients over a set time period. Only member of full time social prescribing staff with no additional support.	Community organisation based in an area of deprivation. A discrete service offered as part of a community trust.	SP Holistic
4	M	PT	**Manager (4a)** Manages a team of social prescribers who are working in the community.	Based within a local authority, SP services are offered to isolated members of the community.	SP Medium
	F	PT	**Social Prescriber (4b)** Working one-to-one with clients in the community to		

			connect them to local groups and activities.		
5	M	PT	**Social Prescriber (5)** One-to-one work with clients over a set time period.	Based within a voluntary sector organisation, the service offers tailored support over a number of sessions to increase social connections.	SP Holistic
6	M	FT	**Senior Practitioner (6)** One-to-one work with clients over a set time period. Some managerial duties but does not have sole responsibility and there are others in the team to support.	Part of a larger, well established community charity organisation co-located in a GP surgery. Offers tailored support and advice for improving wellbeing.	SP Holistic

Introduction

Social prescribing (SP) is a public health strategy that seeks to treat individuals with chronic illnesses, mild mental health issues or psychosocial problems in a holistic way (Baddeley et al, 2016). It often involves patient referral from primary care services to a link worker or 'navigator' who helps empower them to make changes to their lives through accessing community support interventions (Dixon and Polley, 2016). It is currently of particular interest to health providers and commissioners as it appears to have the potential to treat patients whose persistent and long-term conditions are adding to an ever-increasing pressure on primary care (Bickerdike et al, 2017), and because it widens the offer of support that has been traditionally accessible through general practice (Skivington et al, 2018).

Furthermore, SP is rapidly becoming recognised at a national strategic level as a way of diverting people with non-medical needs away from primary care services. The UK Government's recent publication 'A Connected Society' refers to SP as a potential tool for combatting loneliness and social isolation, thus further validating it as an effective way of maintaining population health and wellbeing (HM Government, 2018). It is also a key part of the personalised care element of the recently published NHS Long Term Plan (2019), which clearly states that over a five-year period there will be 2.5 million more beneficiaries of SP services, and that to achieve this the NHS intends to train more 'link workers', totalling 1,000 individuals by the end of 2020/21. This new focus and increased importance within the overall healthcare agenda is

evidence that further exploration of SP services and the workforce who operate in them is increasingly pertinent to discussions regarding sustainable healthcare systems.

What is meant by the term 'social prescribing'?

In the search of a definitive answer to this question, attempts are often made to describe the broad range of interventions on offer. These tend to be vast and can include a range of life skills based initiatives (such as advice on parenting, debt and returning to employment) creative classes (such as arts therapy, music therapy or crafting) or specific interventions targeted at recovery from mental ill health (such as accessible alternatives to cognitive behavioural therapy or other medicalised interventions) (CentreForum Mental Health Commission, 2014; The Care Services Improvement Partnership North West, 2009 and The Scottish Development Centre for Mental Health, 2007, cited in Thomson et al, 2015). SP interventions can therefore take many forms, and do not always fit neatly within the existing structure of health and wellbeing services, making the search for a single definition problematic.

Acknowledging the difficulties in applying a single one-size-fits-all definition, Kimberlee attempts to make different SP offers easier to identify within the existing system by suggesting that they tend to fall into one of four distinct categories (Kimberlee, 2013; 2015 - see Table 1). These categories vary depending on the intensity of the intervention, the level of 'hand-holding' on the part of the navigator or on the service's connection to the primary care system (some sit within medical

practices for example, others in the local community). These categories are discussed in more detail in the methods section below, and services chosen for inclusion in this paper have been categorised using this model.

<TABLE ONE>

The social prescribing workforce literature

Despite a rapid increase in the availability of SP services across the UK in recent years, there has until recently been little evidence to validate the power of SP services to change outcomes for individuals (Kimberlee, 2015) or to demonstrate effectiveness (Bickerdike et al, 2017) . However, this does appear to be slowly changing and the body of evidence regarding social prescribing services is growing, with some randomised control trials (seen as the 'gold standard' in health research) starting to emerge (Grant et al 2000, Mercer et al, 2017).

Nevertheless, considering its growing importance - and within the context of this paper – there still appear to be very few studies that focus purely on working life within the sector. For example, a review by Kilgarriff-Foster and O'Cathain (2015) does not appear to contain any information specifically related to workforce attitudes or associated issues but concludes that further evidence for 'effectiveness and cost-effectiveness' is needed. A more relevant piece of work is Bickerdike et al's systematic review (2017) which provides a useful synopsis of how SP services operate, who uses them and how clients experience SP services. Some nuggets of information specifically regarding the SP workforce can be gleaned from the review, such as the fact that training and knowledge for individuals working in SP services

varies greatly between organisations (some bring years of experience to the role, whilst others are relatively unskilled in the area and are only offered basic training). In general, evaluations of specific SP projects tend to focus on the processes involved in service delivery and participant input is largely related to what constitutes an effective service (White and Salamon, 2010). Where evaluations do discuss the SP workforce it tends to be on a more macro level and is often included in addition to a wider exploration of a specific service (Skivington et al, 2018; White, Kinsella and South 2010). For example, one such study that looked specifically at staff experiences of working with stakeholders within healthcare (as well as exploring whether there is anything distinctive about SP health trainers and the way they work) was part of a wider service evaluation and not a study of the workforce per se (White et al, 2017). Other research tends to focus on the skills required to do the job successfully (Brandling and House, 2009) or the day-to-day tasks involved (Bickerdike et al, 2017), but does not tend to offer a great deal of insight into who the workforce are, their wellbeing in the workplace or any future career development.

The aims of this study

This study's primary research aim is to explore who works in SP services and how they experience the role. It draws on narrative accounts of those working in the SP services in order to further identify themes that can be applied to the social prescribing workforce more generally, in order to inform commissioners, funders and SP services when they plan future recruitment and retention of staff in the sector. Given that funding for such services is often limited, the findings may also help

commissioners prioritise areas that need additional investment in order to retain staff.

Methods

Sampling, access and recruitment

Study participants were purposefully chosen from a pool of known SP interventions within a large urban and suburban area of South West England and were asked to participate in the research via email invitation. Interview subjects represented organisations from two of the four Kimberlee categories of social prescribing noted in the introduction and shown in Table 1, namely Medium and Holistic - none were interviewed from providers of SP Signposting or SP Light services (see Kimberlee 2013; 2015). Interventions were assigned to these categories as the interviews progressed and the client group and nature of the work became clear.

Individuals had varying levels of responsibility within their organisations and all were currently undertaking client-facing work, with the exception of one who had moved into a managerial position. Semi-structured interviews were undertaken with participants, consisting of 11 questions as a topic guide.

Details of those interviewed can be seen in Table 2, with participant identification numbers in parentheses after their role description. Of the eight interviewees, four worked for social prescribing services situated within larger statutory organisations (NHS and Local Authority), whilst the remaining four were employed by community or voluntary sector organisations.

For the purposes of preserving anonymity in what is a relatively small geographical area offering some unique, targeted services, roles have been summarised into the following four distinct categories and interviewee responses attributed solely to their role, service and type of SP on offer within that service:

- Social prescriber –a worker who mostly undertakes client-facing work with little or no responsibility for supervisory or managerial duties
- Senior practitioner –a worker who mostly undertakes client-facing work with some supervisory/managerial responsibility
- Managerial Social Prescriber – an individual who works closely with clients but also takes on the majority, if not all of the managerial responsibility within the organisation
- Manager– an individual who does not participate in client-facing work and only has supervisory or managerial duties within an SP service

<TABLE 2>

Data collection and analysis

Eight semi-structured interviews were conducted over a 3-week period . Interviews lasted between 21 and 37 minutes with a mean length of 29 minutes, and were transcribed verbatim. Hypotheses were developed inductively as the interviews progressed and were honed further as patterns in the transcripts started to emerge (Bernard, 2011). These patterns were identified using thematic analysis, which

allows meaning to be derived from the data by organising the transcribed text into codes and themes (Braun and Clake, 2006).

Broad categories were developed during the analysis and four key themes identified: 1) The social prescriber's experience 2) working with clients 3) working in services and 4) wider issues in SP practice. Within each of these larger themes, a number of sub-headings were introduced to further organise the data. The first broad three categories are addressed in the results section, but the fourth was a theme that ran throughout the dataset and many of the comments made under the other theme headings have implications for social prescribing in general and are therefore included more generally in the discussion section.

Results

The findings of this study raise some interesting points of reflection about the experiences of the SP workforce, as well as highlighting some valid concerns and issues that the sector may wish to take into consideration when developing future SP services and recruiting staff. These findings have been grouped into key subheadings and are presented here.

1) The SP's experience

Professional background

There appeared to be no clear pathway into SP and participants came from a range of professional backgrounds. Interviewees reported having previously worked in a range of professions that included social work, teaching and alternative therapy.

Typically, these were professions in which a holistic, whole-person approach was required, or where the focus was on improving health or wellbeing. Of all respondents, only one reported having always been a social prescriber (although that was not the original job title). For some interviewees ending up in social prescribing was a progression from other caring, charitable or supportive professions. However, this was often not a linear series of events, and many went through a number of other jobs before they entered the profession. For example, one respondent had started their working life as a teacher, but economic circumstances in his home country had led him to seek work in a completely different geographical area. Here he found that he wanted to do something at least slightly related to his earlier career, and through a series of similarly supportive and nurturing type roles he found himself working in SP.

However, not everyone had come from a relevant professional background with such obvious transferable skills. One respondent - unlike all the others – had had a complete change of career, moving to SP from a high-powered job in the private sector:

"My professional background is international sales management […]. To put that in context I was managing companies across Europe, earning over £100,000 a year […] then I went travelling around the world […] came back […] got involved in volunteering […] and a job came up and they said 'you want to go for this?' And it

was small hours, and I was only slightly better off after taking it than I was when I was signing on, but that was fine because I absolutely loved it."

(Manager, Statutory Service, SP Medium – 4a)

Reasons for working in social prescribing

The idea that people don't become social prescribers for monetary gain was important for more than one participant, with two expressly stating that they had either taken a large pay cut to work in the field, or that they were not 'doing it for the money'. Yet, despite the potentially negative impact of a lower salary, overall job satisfaction appeared to be very high:

"I just love working with people. It's quite a privilege to be part of someone's journey, even if it's very subtle - and sometimes social prescribing is very subtle. It's just about helping someone build confidence and having faith, and giving some hope to someone, and saying this is possible."

(Social Prescriber, Community-based Service, SP Holistic - 2)

'We haven't got a magic wand, but you soon see when their confidence builds up – you see the difference it makes. That is the best thing.'

(Senior Practitioner, Community-based Service, SP Holistic - 6)

For one respondent with managerial responsibilities the ability to shape and mould a service from scratch was also a major benefit. She had been given a large amount of autonomy in her role from the start and enjoyed the process of building an

organisation specifically in response to local need. Here she describes the benefits and freedom that this has given her:

"I love the variety of it, the fact that when I started I was just given a blank piece of paper. It was very much design, implement, manage a social prescribing service, and from that through writing funding bids, winning funding bids, I've managed to completely expand it…"

(Managerial Social Prescriber, Community-based Service, SP Holistic - 3)

However, flexibility wasn't just something enjoyed by managerial social prescribers, with many participants reporting that the ability to shape their own working day and get out of the office with clients was one of the things they enjoyed most.

2) Working with clients

Caseloads

Generally speaking caseloads appeared manageable, although there was some anxiety around whether individuals could take on many more clients if referrals increased. The lowest number of active cases reported was approximately 15 people, whilst one respondent had an active caseload of nearer 30. Although all interviewees considered these numbers to be manageable, there was an awareness that some may be working at or near full capacity. Furthermore, waiting lists in services weren't uncommon.

Two interviewees who worked for the same organisation both described how clients were shared across the team depending on individual workload, with one of the two describing the benefits of working in a team:

"They are very supportive. So, it's like, 'are you ok with this? Do you need extra help? Do you have capacity to take someone else?" ***(Social Prescriber, Statutory Service, SP Medium – 1b)***

However, for this person's colleague the lack of a formal structure in managing caseloads was something that she thought might be an issue in the future, as she explains here:

"I feel like... sometimes it's easier to take stuff, but actually because we haven't got a real formal process I think that's something we should work on, because at the moment we are just kind of taking things, but you don't want to get to the point where you're just taking too much and you just can't be proactive with people. At the minute I feel a little bit on the edge of falling behind a bit." ***(Social Prescriber, Statutory Service, SP Medium – 1a)***

Where waiting lists were in operation, only one respondent reported a long wait to access their service of approximately four months. Others described it more as a delay in accessing the service, and one respondent noted that in times of high demand he would just delay the first appointment to a time when he knew he would have capacity (often no more than one or two weeks).

Both Managerial Social Prescribers working in community-based services reported that when other providers were over capacity (such as agencies dealing with mental health issues) they would often attempt to refer clients into social prescribing services. This was not only viewed as inappropriate, but also as a way of skewing the figures so that other services appeared to have smaller waiting lists. One of these participants was particularly vocal about this practice, as they felt that those commissioning services should see the degree to which they were over capacity:

"[Mental health services] have no capacity and they are always trying to get rid of their clients, so I have to say no – you're not referring to us because we are not using our service to boost up a crippled mental health service – you need to get the funding from the Clinical Commissioning Group." ***(Managerial Social Prescriber, Community-based Service, SP Holistic - 3)***

3) Working in services

Staffing, support and training

In larger projects with more members of staff there was a strong appreciation of the support offered by the wider team, whilst others praised the efforts of supervisors in making them feel able to perform their role effectively. However, staff with more senior responsibilities - particularly those working in community-based organisations - felt less supported to carry out their role. For example, one respondent reported that as the service had expanded she increasingly found herself supervising staff

and working with stakeholders, as well as continuing some one-to-one work with clients. Whilst this was good for her career development, she had been offered no training to support her newfound levels of responsibility:

"Managing staff can be a nightmare sometimes. Things like staff dismissal, having to go through all of that is a new kettle of fish. […]

Interviewer: and have you had any training in leadership or management to support you in that?

No – there's no money for that stuff, so it's all learning on the job. And I have nice bed time books!" ***(Managerial Social Prescriber, Community-based Service, SP Holistic - 3)***

Again, staff who were aligned to larger organisations or statutory services were much more positive about training opportunities available to them, with one individual reporting that they had signed up to numerous courses since starting in their current role. Furthermore, if a training need was identified then there was often money or the resources available to meet that need.

Many interviewees reported that they did not have enough administrative support or that they did not enjoy the administrative part of their role. Whilst it was accepted to be a necessary part of the job, most disliked performing such tasks themselves as they felt it meant less time working face to face with clients:

"Having a PA and administrator [would really help], because the phone is going constantly, but you're in one-to-one sessions all the time. Especially at the moment because I'm the main referral route, and you're not at your desk so then you've got a pole of messages and stuff to catch up on." ***(Senior Practitioner, Community-based Service, SP Holistic - 6).***

Managing stress and workload

Social prescribers without managerial or supervisory responsibilities seemed reasonably protected from the stresses of work spilling over into their personal lives. Some did feel the impact however, with one social prescriber in a statutory organisation reporting that sometimes he would worry about clients outside of work time, particularly if they had expressed suicidal thoughts. Nevertheless, issues were often discussed with colleagues or in supervision, and this seemed to be enough of an outlet in most cases. Again, it appeared to be the managerial, community-based social prescribers who shouldered most of the emotional burden here, particularly where there was a lack of peer support within an organisation. Here another respondent recounts a time when she struggled to deal with information a client had given her:

"I can hear a lot of things that don't really faze me, and then there are some things that I would never expect that do really faze me. So you never know what's going to get in. So in terms of the impact, you know, I did have thoughts coming up over the

weekend about stuff which I found quite difficult because of something that had happened."

(Managerial Social Prescriber, Community-based Service, SP Holistic - 2)

Where staff were working more in isolation to others or where they were operating at a more senior level, the lack of a team on which to offload or discuss cases was a problem. The same respondent - a managerial social prescriber who offers some psychological support to clients in addition to helping them with their social needs - spoke of another recent incident that had affected her more deeply than she had anticipated:

"Interviewer: So you've got nowhere to particularly go with that [the incident]?

I have, I've got supervision, but that's not daily, it's monthly.

Interviewer: Yeah, a month is a long time to wait.

Yeah. So it's about if I had someone working with me we could debrief each other, whereas I don't have anybody really in the office - everybody's doing very different things. […] And it wouldn't be appropriate for me to offload in the office, that's the other thing." ***(Managerial Social Prescriber, Community-based Service, SP Holistic - 2)***

For another individual the more important issue was that there was no one who could deputise for her if she wanted to take time off:

"So with the staff I recruit now, I try and recruit people that I think would be able to take on stuff so that I can have a week's holiday, and I can gradually get them skilled up.

Interviewer: So what do you do now if you need a holiday?

I don't really have holidays."

(Managerial Social Prescriber, Community-based Service, SP Holistic - 3)

In addition to the increasing demands on the participant's time, dealing with stakeholders was also a challenge reported by managerial social prescribers in community-based services, with one respondent citing challenges around maintaining good relationships with partnership organisations. Again, this individual highlighted the fact that she had had no training in this area and was having to acquire these skills by 'learning on the job'.

However, not everyone had got used to working in a silo, and staff working in larger organisations with a clearer hierarchical structure expressed a strong appreciation for the support of the wider team. As mentioned previously, this included sharing caseloads but other respondents praised the efforts of supervisors in making them feel able to perform their role effectively:

"It's good to be part of a team, and I'm part of a really good team […]. [My supervisor] is a really good team leader, he's very enthusiastic and although the job

itself has pressures, he's careful not to increase that pressure" ***(Social Prescriber, Statutory Service, SP Medium – 4b).***

Future career progression

There was some recognition from staff that opportunities for career progression were limited within SP, and one respondent in particular expressed concern about career prospects within her current organisation:

"I had an appraisal in April and I'm very much at the peak of what I can do in this organisation at the moment. If I wanted to go further then I'd have to leave."

(Managerial Social Prescriber, Community-based Service, SP Holistic - 2)

In community-based services like this much of the knowledge appears to be held by one person, which could potentially put the future of some projects at risk of closure if certain members of staff moved on, or at the very least effect continuity of service for clients. This was a particular concern for another interviewee, probably because she had set up and grown her organisation almost single-handedly:

"For me the challenge is that I need to get more people. We need to get some more funding so that I have someone else working, because at the moment if I go the project will go."

(Managerial Social Prescriber, Community-based Service, SP Holistic - 2).

However, some non-managerial staff didn't feel quite so irreplaceable:

"Knowledge can be written down. It can be passed on, it can be handed over. There is an element of advantage of being somewhere for a while, but that's the nature of the game."

(Social Prescriber, Community-based Service, SP Holistic - 5).

Discussion

The findings of this study highlight some interesting details about working life in the SP sector and about who chooses to work in SP services. It is clear that those working in SP are more likely to come from caring or holistic professions that involve working closely with patients, students or vulnerable members of the public. Job satisfaction overall was reported to be high amongst social prescribers, a fact which is perhaps best illustrated by the fact that two respondents reported taking significant pay cuts in order to join the sector.

However, in addition to the positive responses there were some obvious areas for development, particularly with regard to three major support needs:

1) Better emotional support for staff dealing with complex and challenging situations

Support for staff was good in the services that were part of larger organisations and therefore benefited from more hierarchical structures and official procedures. The extent to which individuals felt supported in smaller, community-based organisations was less positive, and those with coexisting client-facing and managerial responsibilities felt more isolated than others. There was also some disparity

between how more senior staff experienced working for a social prescribing service compared to their junior counterparts, with the latter apparently benefitting from some protection against associated stress (although again, senior staff in statutory organisations appeared to be less vulnerable to this than those in community run initiatives).

2) Additional staff to take on some of the caseload, perform admin duties or to deputise for others

Many participants voiced a need for additional funding to employ either more social prescribing staff or administrative assistance. This call for additional capacity is supported by others who have warned that the quality of service provision could suffer if social prescribing services are not sufficiently funded to meet with demand, particularly in community organisations (Skivington et al, 2018). Whilst there does not appear to be any guidance on what constitutes a maximum caseload within SP (to some extent this will depend on the intensity of the work, regularity of client meetings, the complexity of the client's issues and so on), clearly it would be beneficial for employers to produce their own guidelines within organisations. Managers should also be mindful of what individual workers have personal capacity for within those guidelines in order to avoid unnecessary stress. It was beyond the aims of this study to explore funding for extra capacity in SP services, but this should clearly be a consideration in the planning of services in the future.

A further point can also be made here about the significance of working within a team, particularly where the SP service is closely connected to or co-located within a

primary care service. Previous studies have highlighted the importance of team working within primary care, and the many benefits of doing so. These include (but are not limited to) effective communication and the development of creative working methods (Molyneux, 2001) as well as understanding and respect for each other's roles, understanding the mechanisms of primary care and sharing practical 'know-how' (Sargeant, Loney and Murphy, 2008).

Finally, one participant suggested that mental health services appeared to be referring some of their caseload into SP providers, and the critical view of this practice might be that social prescribing offers a cheap alternative that can prop up a failing mental health service. However, this appears to be largely disputed by advocates of SP who argue that it is a cost-effective way of taking some of the pressure off an overburdened mental health system by assisting patients with lower level conditions outside of the National Health Service (South, Higgins, Woodall and White, 2008).

3) Support and/or training in managing staff and dealing with stakeholders.

In addition to support for individual workers to ensure their health and wellbeing in the workplace, there were also clear staff development and training needs. One particular gap that was identified by respondents was a lack of training around dealing and collaborating with stakeholders (this finding is also noted in a similar study which observed that building relationships with stakeholders was left almost entirely to individual SP workers (White, Kinsella and South, 2010), and is further supported by Skivington et al (2018) who notes the importance of collaborative

working in the sector). The importance of collaboration in primary care has also been noted by Supper et al (2015), and the benefits of working closely with partners at this level include maximising professional competencies and using resources in the best possible way to increase efficiency (Samuelson et al, 2012). Given the tight budgets and limited funding currently available within an already stretched primary care system, it seems imperative that training in best practice for collaboration and partnership working is factored in to SP services to increase sustainability and avoid inefficiencies further down the line.

Social Prescribing as a career

Some SP staff with managerial duties felt that there was limited career progression within their current organisations. A few services in the sample also appeared to be increasingly reliant on a reservoir of goodwill on the part of their staff, some of whom were performing tasks beyond their contractual remit. Once again, this was of particular concern in community-based organisations where staff appeared to have amassed large quantities of knowledge that might not easily be passed on to someone else. In some cases there was major concern that if an individual left then the organisation itself would in turn cease to exist, posing questions around consistency of service provision for clients if staff were to become overwhelmed by caseloads (Skivington et al, 2018).

The participants in the study came from a variety of different professional backgrounds. Overall, job satisfaction was high, and all found empowering clients extremely rewarding. Respondents showed high levels of empathy and clearly

enjoyed working with people. These findings appear to support research by others that suggests excellent communication skills and the ability to listen effectively are two key attributes of successful social prescribers (White, Kinsella and South, 2010).

Community-based SP services

Smaller community projects in the study were often situated in deprived areas, and it is known that these tend to be places with the greatest unmet social needs (Robinson and Roter, 1999; Hopton and Dlugolecka, 1995; Verhaak, 1986; Boerma and Verhaak, 1999). Interviewees frequently noted the importance of understanding the local area and the people who live there, and other studies have observed that SP services often develop in response to local need (NHS Health Education England, 2016). Although not discussed in the findings, it was observed during data collection that the organisations in more deprived areas appeared to have better connections with local GP surgeries and actively talked about referrals coming from primary care (one service was even co-located in a surgery). It is known that areas of deprivation tend to suffer more from the problem of frequent attenders in surgeries (Carlisle et al, 2002; Worrall et al, 1997), so this may explain GP's enthusiasm to engage with services in these areas. Whilst it is commendable that these GPs acknowledge the role of SP services, this too may have implications for caseloads and therefore system capacity.

Conclusion

This study suggests that there is no obvious route into social prescribing, and that the workforce can potentially be recruited from a range of professional backgrounds. Job satisfaction is high amongst the client-facing SP workforce and many people accept this in lieu of higher salaries that may be on offer elsewhere. However, some participants in this study felt they had reached the zenith of what they could do within their organisations, and if services want to retain ambitious staff then possibilities for career progression within the sector need to be addressed. This may be particularly challenging in smaller services that have a very small number of staff and no hierarchy, although could be mitigated to some extent through offering additional training opportunities or other skill-based incentives.

One of the main findings of this study is the obvious disparity between how those working for smaller community based providers experience the role in comparison to their colleagues in larger or statutory services, particularly for individuals with more managerial responsibilities. The study revealed a number of important points related to this: firstly, it is clear that a single individual often holds much of the knowledge, particularly in those smaller services, and contingencies therefore need to be considered in case those people decide to move on. Secondly, more could be done to support the emotional wellbeing of these staff, as some had limited outlets through which to debrief after difficult experiences in the workplace, or little time for reflective practice. Thirdly, there was little in the way of cover for at least two participants, so better policies for staff absences need to be developed in some organisations.

The findings of this study have clear implications for the future recruitment and retention of staff in SP services, and if the sector is to see the expansion that it is increasingly being promised, then those in charge of recruitment may need to make careful plans for supporting staff and enabling them to perform their role to the best of their abilities. Given the increasing interest in SP provision in the UK, funding and investment in the sector will need to meet the demands of staff who are working in a clearly rewarding yet challenging sector.

Limitations of this study

Organisations in this study provide a range of levels of intervention, making them difficult to compare. Furthermore, some benefit from much better defined working policies and hierarchical structures, whilst others are small community-based projects that have been built up by only one or two individuals. These substantial variations in the SP offer have previously also been noted by both Hutt (2017) and Kimberlee (2015) as potential limitations to the study of SP services in general.

Future research

Participants in the study were not asked specifically about funding, although this is clearly a major issue for the workforce and the future capacity of SP services. This merits further exploration, particularly in light of the recent release of the UK government's loneliness strategy which allocates £1.8 million for the development of SP services (HM Government, 2018) and the promise that 900,000 individuals will aim to be referred to SP schemes by 2023/24 (NHS Long Term Plan, 2019).

Those wishing to study the SP workforce in future would benefit from doing so across contrasting geographical areas and comparing a wider range of providers from Kimberlee's different SP types outlined in Table 1. Furthermore, studies that take a more in-depth look at the differences between statutory and community-based SP organisations and the experiences of more senior staff would be particularly relevant, as there are clear differences between organisations that have the infrastructure to take on some of the additional burdens, as opposed to those smaller community organisations that do not have the same support available to them.

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