Scientific Research Publishing

Open Journal of Social Sciences, 2023, 11, 63-80
https://www.scirp.org/journal/jss
ISSN Online: 2327-5960
ISSN Print: 2327-5952

Social Prescribing: Link Workers' Perspectives on Service Delivery

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How to cite this paper: Griffiths, C., Jiang, H., & Walker, K. (2023). Social Prescribing: Link Workers' Perspectives on Service Delivery. *Open Journal of Social Sciences, 11,* 63-80.
https://doi.org/10.4236/jss.2023.115006

Received: March 24, 2023
Accepted: May 13, 2023
Published: May 16, 2023

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Abstract

Purpose: In social prescribing (SP) a primary care based "link worker" assesses patient needs and goals, and makes appropriate links and referrals to community-based resources and services. This study explored SP service provision in England's NHS, investigating social prescribing link worker's (SPLW's) perspectives of service delivery, service goals, theories and approaches used, challenges, what works, and barriers to success. **Methods:** Semi-structured interviews were undertaken with eighteen SPLWs delivering SP. Data were analysed using thematic analysis. **Results:** Social prescribing mechanisms and frameworks were identified. Five organising themes describe a solution-focused, strengths-based theoretical underpinning; a patient-led process; role of SPLWs as a support person, guide, and facilitator; supporting collaborative networks; patient and wider outcomes; and threats to success of SP. A solution-focused, strengths-based approach underpins many aspects of SP. **Conclusion:** The effectiveness of SP could be improved by SPLW motivational interviewing and solution-focused training to promote patient behaviour-change, salutogenesis, and positive outcomes, enabling SPLWs to feel they have the skills required. Workload and referrals should be appropriate for the role of SPLWs. Now that there is widespread implementation of SP in the NHS, there is a need to interview patients in receipt of SP to gain their experience, views, and recommendations.

Keywords

Alpha-Stim, Cranial Electrotherapy Stimulation, Anxiety, Social Prescribing, Primary Care

1. Introduction

Evidence indicates that people's resilience, health, and wellbeing are determined by a range of social, psychological, economic, leisure, activity, and environmental

resources and factors (The King's Fund, 2018). Building on this evidence, social prescribing (SP) is a relatively recent and extensively advocated for innovation that seeks to address holistic health and wellbeing needs by assessment and referral to appropriate community based resources and services (Department of Health, 2006; NHS England, 2016). SP is: "a mechanism for linking patients with non-medical sources of support within the community" (CentreForum, 2014: p. 6). A SP link worker (most commonly referred to as a social prescribing link worker [SPLW]), seeks to take a holistic view of the lives and needs of patients referred to them by asking "what matters to you?", and linking patients with appropriate services, resources, and sources of support within the community (NHS England, 2021).

Evidence has demonstrated improved patient health, and wellbeing outcomes of SP (Bickerdike et al., 2017; Griffiths et al., 2022; Moffatt et al., 2017). Health and wellbeing improvements may also occur over a longer period of time than the data period monitored by RCTs, and it is acknowledged that behaviour change to healthier lifestyles can often occur slowly (National Academy for Social Prescribing, 2021). Qualitative evidence indicates that SP services are valued by both patients and general practitioners (GPs) (Smith & Skivington, 2016). Many groups of people are targeted by and can benefit from SP, including people with mental health problems, complex needs, multiple long-term conditions, social isolation, lack of support, and financial problems, and those who frequently attend primary or secondary health care services (Friedli et al., 2009; The King's Fund, 2018; NICE, 2022).

A number of research studies have interviewed staff working in the delivery of social prescribing services. These studies have identified various gaps in knowledge and recommended research questions to be addressed, such as the need to better describe and delineate social prescribing mechanisms (Payne et al., 2020). There was also an identified need to further understand the role of the SPLW as they are a crucial enabler to the success of SP programmes, as "there was an enormous amount of variability in understanding of the navigator role…" (Zurynski et al., 2020: p. 21). Another knowledge gap identified in previous research is the need to understand the complexity and challenges of the role of SPLWs to make recommendations in order to maximise effectiveness (Frostick & Bertotti, 2019). In addition, a need to understand training needs of SPLWs, as they "need to be professional, empathetic and motivated by their contribution to both patients and the communities they support" (Bertotti et al., 2018: p. 234). In seeking to answer these identified gaps, this current study explores the perspectives of SP staff in United Kingdom (UK) NHS social prescribing services.

2. Methods

1) Design

A qualitative approach employing semi-structured interviews with SPLWs delivering social prescribing services.

2) Setting

Social prescribing services delivered through primary care services across a county in central England.

3) Participants

Inclusion criteria was that participants had to work for NHS social prescribing health services and directly deliver social prescribing services to patients. Exclusion criteria was not delivering social prescribing services directly to patients.

4) Methodology

Interviews were conducted to generate rich exploratory data of SPLWs' experiences of social prescribing. Qualitative research was deemed appropriate as it aims to enhance understanding of human experiences and processes (Harper, 2012). A critical realist (data is an informing mechanism of reality) position was adopted (Willig, 2012), encapsulating a realist ontology (assumption of an external reality independent of human minds (Bhaskar & Hartwig, 2016)) and being epistemologically relativist (different methods produce diverse perspectives on reality and that reality is a finite subjective experience (Denzin & Lincoln, 2005)).

The semi-structured interview schedule was developed from a review of previous relevant research (Bertotti et al., 2018; Frostick & Bertotti, 2019; Payne et al., 2020; Zurynski et al., 2020) and with input from a clinical expert advisory panel. Interview topics covered included: 1) social prescribing mechanisms; 2) application of the social prescribing model; 3) interventions delivered; 4) understanding roles; 5) professionalisation of the role; and 6) relationships between social prescribers and resource/service providers. The participants were able to discuss topics that they felt were pertinent to their role and the delivery of SP.

5) Sampling and recruitment

All primary care providers delivering social prescribing in the county were contacted and from these contacts, 18 out of 49 SPLW's who were approached agreed to participate. Data was collected between January 2022 and March 2022. A sample size of 18 was appropriate for the aims of this study based on recommendations by Malterud et al. (2016); i.e., sample size was accessed through five dimensions of: 1) study aim, 2) sample specificity, 3) use of established theory, 4) quality of dialogue, and 5) analysis strategy. Sampling was non-probabilistic, accessible, and purposive (Lynn, 2016). A purposive sampling design was chosen to recruit SPLWs who worked for the various providers in the location, and who practised in town centre and/or rural locations.

6) Procedure

Emails were sent to SPLWs inviting them to take part. SPLWs were given study information sheets and informed consent forms before informed consent was sought. One-to-one interviews were conducted via video calls. Interview length ranged from 37 to 72 minutes ($M = 53.9$, $SD = 9.6$), they were audio recorded, transcribed verbatim, anonymised, and uploaded to NVivo (V.20).

7) Data analysis

Reflective thematic analysis (RTA) was used as a way of identifying, organis-

ing, describing, and reporting themes using a six-step process (Braun & Clarke, 2006, 2021). Networks were built from basic themes (lowest order of themes driven by the textual data), organising themes (middle order made up of the basic themes), and global themes (superordinate things that comprise the principal concept in the data as a whole) (Attride-Stirling, 2001). Coding was undertaken by two researchers. To ensure rigour of the coding and strength of the interpretation and theorising, a third researcher was involved in reviewing analysis to collectively define final results.

8) Ethics approval

Ethical approval was granted by review panel of the NHS Trust leading the study (review panel name: Ideas Forum). All participants provided informed written consent.

3. Results

3.1. Participant characteristics

All participants were SLPWs, two males and 16 females. Average age was 47 years (Range 33 - 60, *SD* = 8.4). Eight SPLWs worked in a town location only, two worked only in rural locations, and eight worked across both. The length of time worked in the role ranged from 5 to 30 months (*M* = 17.4, *SD* = 8.44). Participants had a range of qualifications, including academic healthcare degrees and qualifications in cognitive behavioural therapy (CBT), compassion-focused therapy training, mindfulness training, motivational interviewing (MI) techniques, counselling, and teaching qualifications. Participants had varied previous job roles with examples such as working: in schools, with adults with learning difficulties, in mental health services, for charities, in nursing, in occupational therapy, and in primary care services.

3.2. Themes

Mechanisms and frameworks underpinning SP were identified, represented by four organising themes. Linking into the overarching theme of "mechanisms and frameworks", two service delivery themes were identified: "outcomes achieved from social prescribing", and "threats to the success of this approach" (see **Figure 1**). For example quotes for themes see **Table 1**.

3.2.1. Theoretical Underpinning: Solution-Focused, Strengths-Based

This organising theme is made up of five sub-themes which represent elements of a solution-focused (SF), strengths-based approach.

1) Solution building, strengths, positivity and future-orientated

Examples included: identifying and building on patient's strengths and assets, defining solutions, taking a future focus, and looking for and working with the positives in a person's life.

2) Asking questions rather than telling patients what to do

The premise is asking appropriate and probing questions rather than telling the patient what they need and what they should do. SPLWs ask questions to

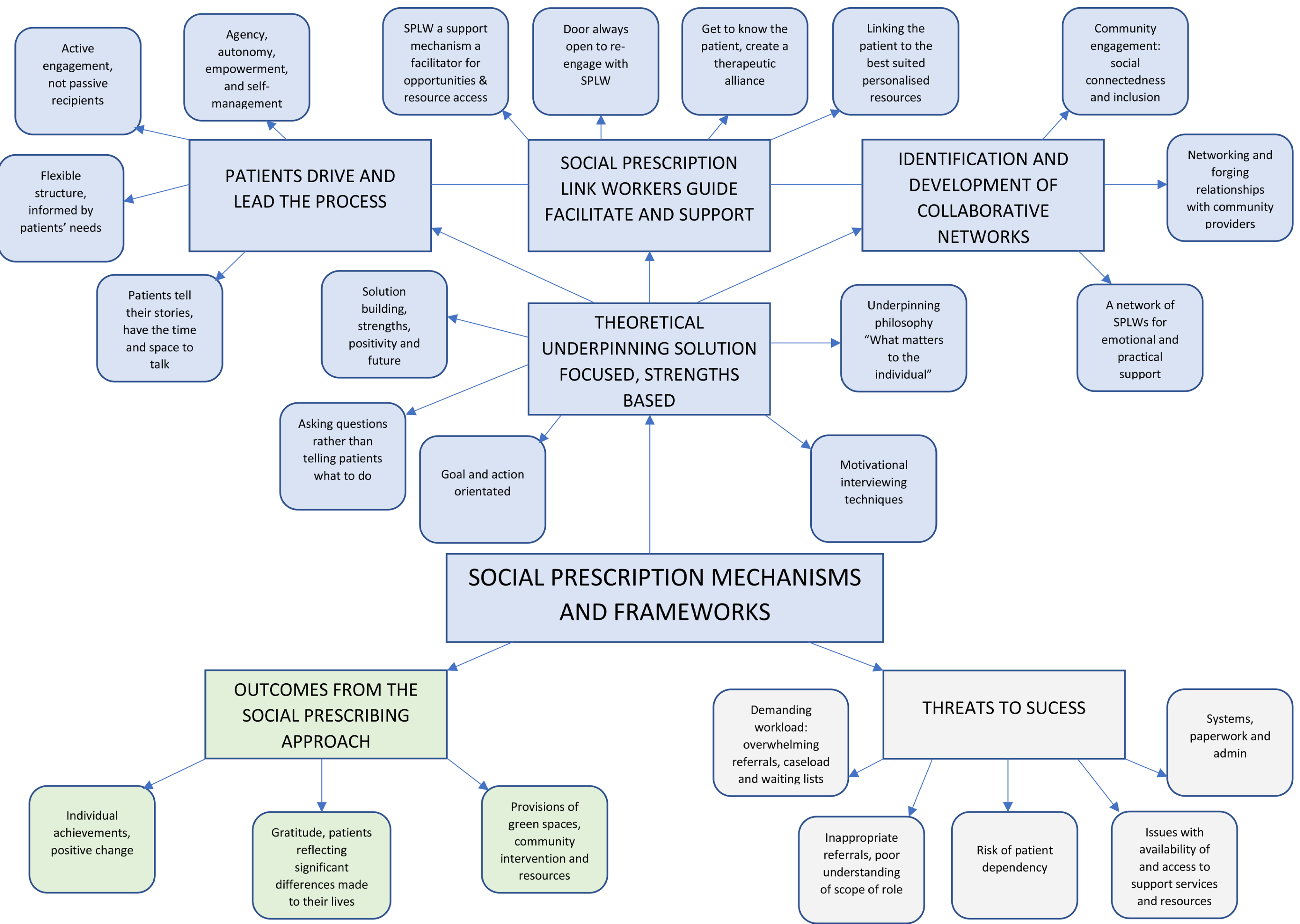

Figure 1. Concept map of themes.

Table 1. Themes with example quotes.

Organising Theme	Theme	Example quote
Theoretical underpinning: solution focused, strengths-based	1. Solution building, strengths, positivity and future-orientated	P3: *We use an assets and strength based approach. And when you support them to recognise their strengths and their assets, that can be really empowering for them* P3: *We ask them about their, their sense of positivity, their sense of hope for the future, where they feel at moment there*
	2. Asking questions rather than telling patients what to do	P6: *So, it's not, it's not telling people it's questioning them. So, they can give their own answers, I would never tell them to, you know, attend this group, it will be great for you. Because it might not be*
	3. Goal and action orientated	P9: *So, we do a lot of reflection back, summarising what they've said, clarifying what they've said, helping them to set some goals that are realistic. Often people have got high expectations of themselves. So, the goal setting, SMART Goal Setting element of it*
	4. Motivational interviewing techniques	P7: *I think I do use them* [*MI techniques*]*, but without actually knowing, or didn't know what they, that I was actually doing it. Just person-led and, you know, showing empathy to, to the person and listening and taking the time*
	5. Underpinning philosophy 'What matters to the individual'	P1: *It feels like it's quite a profound thing about talking to someone, hearing their story, hear what matters to them, the meaning that they give to their lives, and what they would like to be different*
Patients drive and lead the process	1. Agency, autonomy, empowerment, and self-management	P12: *It's about personal empowerment, people taking their health and really self-care, self-care tips, you know, do something for yourself, taking the agency for yourself, go for a walk, there's a lot of people that are relying on everybody else to sort things for them. But really, we're accountable for ourselves, we're responsible for ourselves*
	2. Active engagement, not passive recipients	P7: *They have to be motivated to make change… otherwise, it's never it's never going to happen. I think they need to be prepared to try new things that might take them out of their comfort zone. And I think they have to put in some time and effort*
	3. Flexible structure informed by patients' needs	P17: *So, most of the time everything is over the phone, although I did have patients who felt a face to face is more appropriate for them because of anxiety, you know, whatever reasons. So, I do see them. If they're scared coming out their homes, we'll go to their homes.*
	4. Patients tell their stories, have the time and space to talk	P3: *Listening, giving someone time to talk, and tell their story* P16: *I think it's listening. It's listening to their story. That makes a massive difference to be able to hear their story, but also hear it well enough that they know that you're properly listening*
Social prescription link workers guide, facilitate and support	1. SPLW a support mechanism, for opportunity and resource access	P7: *It's making people aware of activities and opportunities that are available in the community that they might not have been aware of and walking alongside those people to introduce them and help them to access those*
	2. Door is always open to re-engage with SPLW	P4: *So, there is kind of the doors are always open, kind of feel. They are always welcomed back in* P12: *And I'm trying to discharge people, but always say you're very welcome to really re-refer in the future if you need us*

Continued

	3. Get to know the patient, create a therapeutic alliance	P7: *So, just have an open conversation. And because you've invested the time, building that rapport and that confidence with that person, then it does mean that you can have more real-world conversations with them. You don't have to tread on eggshells, you can be quite direct about certain things, because you have got that bond. And they do trust you*
	4. Linking the person to the best suited personalised resources	P4: *The role in itself is linking patients or people into support that can offer either for emotional or practical support, so that, that would mean identifying needs and where that support may come from*
Identification and development of collaborative networks	1. Community engagement: social connectedness and inclusion	P10: *Being stronger and more confident, more resilient. Embracing more social opportunities in their community, hopefully taking part in different activities, different exercise opportunities in their local community, and building links in friendships*
	2. Networking and forging relationships with community providers	P5: *A really big part of my role has been sort of building those relationships with community groups and things that we can, sort of the people might access. I'd say quite a lot of my work is around that relationship building, building those relationships for referrals*
	3. A network of SPLWs for emotional and practical support	P2: *We're a very big county, we have four or five different providers. There are opportunities to get together. So, we've got what we call communities of practice, that we meet once a month, we also have county wide groups that meet*
Outcomes from the social prescribing approach	1. Individual achievements, positive change	P1: *They're in better social networks they don't feel so isolated, but also physical health benefits as well that come from that feeling of well-being*
	2. Gratitude, patients reflecting significant differences made to their lives	P18: *Somebody said how much difference the work that has been done around social prescribing with them. Yeah, that just made a huge amount of difference to their lives. And somebody once told me that it saved their life*
	3. Provision of green spaces, community interventions and resources	P12: *We've got these workshops that are more targeted, health and wellbeing the next one is a series of bereavement, and then I think we've got anxiety and mindfulness. I think things will grow organically*
Threats to success	1. Demanding workload: overwhelming referrals, caseload and waiting lists	P7: *I think on our current project, the expectation is that would work with* 60 *people. I've got over* 30 *at the moment, and I'm kind of maxed out on, on that. But that's a constant sort of pressure that's in the back of your mind*
	2. Inappropriate referrals, poor understanding of scope of role	P2: *I think just, overwhelming number of referrals. Just too many, and a misunderstanding of what social prescribing is. So, we get, get too many referrals because of the misunderstanding of what it is*
	3. Risk of patient dependency	P14: *Some Social Prescribers are offering that some people ring every week, which is not, they become reliant on you. but we try not do it weekly, because first of all, they just, they become very reliant on you*
	4. Issues with availability of and access to support services and resources	P15: *I think for some people, the one thing that does seem to be quite lacking, when people do have particular mental health issues. I dealt with one issue that was far and above my, remit*
	5. Systems, paperwork and admin	P10: *Admin. In fact, I had my annual review, two or three weeks ago now and speaking to my manager about this, and there are days when I'm spending more time doing admin than I am seeing patients, to me that priority, that priority is wrong*

explore patients' current situation, needs, what they do that is beneficial and not beneficial, and what needs changing, and preferred and hoped for futures.

3) Goal and action orientated

SPLWs facilitate patients' identification of and setting their own goals, and enabling them to put actions in place to move forward and to achieve goals. There is a focus on clear, concrete, achievable, specific, and measurable goals, as this enabled clarity around what is required to achieve goals, progression, and positive outcomes.

4) Motivational interviewing techniques

The use of motivational interviewing (MI) techniques was seen as important by the majority of the SPLWs. MI techniques were used by the SLPWs to engage clients, identify, and clarify their strengths, and to promote autonomy. Some SPLWs had training on MI and valued this and the application of MI techniques; others stated they would like MI training. Specific MI techniques were found to be used by the SPLWs, including: open questioning, affirmation, reflective active listening, and expressing empathy through careful listening, non-judgmental curiosity about problems and issues, and questions to identify where behaviour does and does not align with goals.

5) Underpinning philosophy: "what matters to the individual"

A foundation for SP was identifying and establishing "*What matters to the patient*": what is important, what they value, their priorities, what they want, and what is their preferred future.

3.2.2. Patients Drive and Lead the Process

Patients are empowered to drive and lead the process; the process is patient-centred and led. This comprises four sub-themes:

1) Agency, autonomy, empowerment, and self-management

One of the mechanisms underpinning SP is enabling the patient to change and not trying to enforce change on the person. The process is based on promoting autonomy and agency, and empowering patients to make decisions for change: deciding what they require, implementing change, and being self-accountable and less reliant on and accountable to others. Patients are empowered to make their own choices and self-manage; the mindset is that they can take actions and engage in behaviours to help themselves, it is about the patients taking control. SPLWs supporting identification of what patients need based on concept of patients being the expert on themselves; the SPLW initiates the conversation of change and facilitates the process, not dictating it.

2) Active engagement, not passive recipients

Patients are encouraged to actively engage with the SPLWs and their "social prescriptions", and not simply be passive recipients. Patients need to have, or develop, readiness and motivation to engage, change and try new things that can then make a positive difference, and to put in the required time and effort. The patients need to be proactive otherwise positive change is unlikely to occur.

3) Flexible structure informed by patients' needs

A mechanism of SP was having a flexible structure around time, frequency, intensity, and mode of delivery; there is not a one size fits all structure as this does not take into account individuals' preferences, needs, and complexities. The delivery structure is dictated mostly by the patients: their preferences, what worked best for them, what they feel would be helpful, and what they could commit to; this facilitates better engagement and outcomes.

4) Patients tell their stories, have the time and space to talk

SPLWs have an in-depth exploration discussion with patients: giving the patients time to speak, hearing their personal narratives, and seeking to understand personal circumstances, what is important and relevant to them. This enables patients to share the meaning they attach to aspects of their lives and what they want to change and achieve.

3.2.3. Social Prescribing Link Workers Guide, Facilitate and Support

SPLWs are facilitators, and their role is to guide and support, not to tell and dictate. The SPLWs work to implement the SP based on patients' needs and choices. This organising theme is made up of four sub-themes:

1) SPLW a support mechanism, for opportunity and resource access

SPLWs do not tell patients what to do, they act as a facilitator, a guide and provider of information, options, opportunities, and resources for patients to consider and chose, and linking them to the relevant or appropriate resources. In some cases, there may be the possibility of going with the patient to their chosen community asset in the first instance if the patient wants this.

2) Door is always open to re-engage with SPLW

One mechanism of SP is having an open-door policy for patients to re-engage and access back into the service if they leave. Some individuals decide that the time is not right for them to work with the SPLW; SPLWs explain to patients that they can re-refer themselves when they feel it would be right for them.

3) Get to know the patient, create a therapeutic alliance

An important factor for successful SP is the development of a trusting relationship which can act as a platform for a strong working relationship. SPLWs get to know and understand each patient and build rapport, enabling them to engage in an open and honest relationship which is then more likely to allow for appropriate conversations to take place that will be beneficial to the patient. SPLWs seek to establish a therapeutic alliance.

4) Linking the person to the best suited personalised resources

A key element is linking patients to resources: the SPLWs introduce or signpost the patients and facilitate access. The SPLWs seek to match the appropriate resource to each individual based on their needs, goals, and desires, and what they feel would be the best fit. A role of the SPLWs is to share opportunities and locate the appropriate resources through existing services or identifying new ones.

3.2.4. Identification and Development of Collaborative Networks

This organising theme has three sub-themes which represent networks that need

to be in place as part of SP. This includes the connections and networks made with other SPLWs and services, assets, resources, green spaces, and other community-based provisions.

1) Community engagement: social connectedness and inclusion

For SP to be effective, it is reliant on patients having a sense of inclusion and being connected to the community. The community is viewed as a social setting which can act as a support system for patients, that they choose to engage with, and can continue to access over time. SPLWs discussed how many patients can feel isolated; through connecting and engaging with the community they can develop a feeling of inclusiveness, which can result in positive outcomes. Through SP referral, the local community provides activities and resources, and the opportunity to develop friendships and social capital, which can have a positive effect on physical and mental health, and wellbeing.

2) Networking and forging relationships with community providers

SPLWs discussed the importance of the creation and building of relationships with the community providers. This is an active process, meeting and getting to know the community-based resources and providers. SPLWs assess what they offer and its suitability as a resource, ensuring it is appropriate for the patients: developing a working relationship with the providers. SPLWs establish the best way to refer patients and make the services available to them. Organisations delivering services and resources provide updates and proactively make SPLWs aware of what is available.

3) A network of SPLWs for emotional and practical support

A collaborative network between SPLWs is an important mechanism for successful SP. This creates an environment that can provide emotional support and reduces potential isolation in the job. SPLWs tend to work autonomously, so having effective links with colleagues is very important. There is unstructured and informal support such as check-ins with their teams, as well as structured input which includes organised team meetings. Formal clinical supervision with a senior team member is also a valuable support mechanism for SPLWs.

Support and networking with other SPLWs was found within their immediate team, where close bonds and friendship were made. Peer supervision opportunities provided a "sounding board" for the SPLWs. The network of support also extended beyond individuals' immediate team, to other practices and teams, county wide. SPLWs have established communities of good practice where they can draw on the experiences of others and exchange knowledge and good practice.

3.2.5. Outcomes from the Social Prescribing Approach

This organising theme focuses on the outcomes and impact of the service, and what success looks like. This is made up of three sub-themes which relate to different positive aspects and impacts for the patients and the wider community.

1) Individual achievements, positive change

SPLWs discussed the changes made by the patients and positive outcomes observed. Examples were described in terms of improvements in physical health,

mental health, wellbeing, independence, resilience, sense of control, coping mechanisms, social networks, and social capital. Some patients adopted new activities such as volunteering and physical exercising/sport. Some became less reliant on their GPs: as previous frequent attendees some were now not using this resource as much. Most patients were reported to be able to successfully move on beyond the support of the SPLW.

2) Gratitude, patients reflecting significant differences made to their lives

Patients were grateful for the input from the SPLWs, which they felt made a significant positive difference. SPLWs explained that patients described how the service provided a "lifeline" and resulted in positive outcomes in the present and for their future.

3) Provision of green spaces, community interventions and resources

Positive outcomes were linked to the provision of green spaces and community resources and the implementation of a community-based social response for supporting physical and mental health and wellbeing. A focus not on medication and medical intervention but on SP interventions. The outcome of the provision of SP services are that there are more and more accessible social spaces, green spaces, groups, activities for the patients to access and use as part of their recovery, improving their health and wellbeing. Groups become embedded in the community; for example: groups for menopause, diabetes, and long-term conditions; groups providing workshops targeting health and wellbeing, fitness class groups, and walking/rambling activity groups.

3.2.6. Threats to Success

This organising theme comprises five sub-themes which represent factors that SPLWs identified could threaten the success of SP.

1) Demanding workload: overwhelming referrals, caseload and waiting lists

The majority of the SPLWs commented on their workload as unsustainable and could be negatively impacting on their work. There was great demand on the SPLWs in terms of number of referrals, caseload, and long waiting lists, which was compounded by staff shortages (not having the full numbers of staff, have high staff turnover, staff burnout, and staff sickness). A key issue with the high workload is balancing quality and quantity. To provide a high-quality service, the SPLWs need to have sufficient time with their patients. If this is not possible because of excessively high workloads, the ability to achieve positive outcomes is threatened.

2) Inappropriate referrals, poor understanding of scope of role

A challenge that SPLWs experience is that they do not always get appropriate referrals. There can be a misunderstanding of the role of SPLWs: they are sometimes wrongly perceived to be able to deal with patients in crisis or that SPLWs are qualified counsellors or medically trained to prescribe medication and deal directly with medical issues.

3) Risk of patient dependency

A threat to the success of SP is when patients become dependent on the

SPLWs; some patients get used to regular contact and become reliant on it. They use this contact as a form of therapy/social input as opposed to the link for finding and accessing it in the community. Patients can potentially develop a sense of dependency if they feel that the SPLWs have become a big part of their lives and like a "personal friend" to them. The nature of SP is that it is flexible as to how long SPLWs work with a patient; risk of dependency was observed in some cases where continued support was being given by SPLWs for a prolonged period of time.

4) Issues with availability of and access to support services and resources

Specific services are not available or accessible in some areas, meaning that there is a gap in provision to address certain patient needs. Services identified as lacking included: pain management; services to address hoarding; menopause support, and counselling. The most noted gap in service provision was mental health resources; services were unable to take referrals, leaving the SPLWs to try and deal with aspects related this, even though it was out of their remit and expertise. The SPLWs discussed how they felt like "holding pens" for people waiting to access mental health services.

One factor discussed by SPLWs was that several patients potentially couldn't access resources because of transport issues. This was a more prominent issue in rural locations. The SPLWs identified that poor physical mobility, the cost of transport, and lack of public transport all restricted patients' ability to be able to get to the SP services and resources they required.

5) Systems, paperwork, and admin

Systems, paperwork, and administrative elements can be too onerous. The SPLWs discussed how administrative tasks became a barrier for them, taking up too much of their time, and taking them away from their priority of time with the patients. SPLWs felt IT systems such as SystmOne were not user-friendly for their role, and that they don't always have certain facilities that are required for them to do their jobs, such as tasks prioritising. In addition, some SPLWs did not have access to certain IT systems, and as they work across different GP surgeries and heath-service providers, the systems can differ and might not be accessible or compatible, making communication and patient record access a problem.

4. Discussion

In-depth interviews were conducted to investigate SPLWs' perspectives on the SP services they deliver. This study provides a detailed "real-world" insight into roles, delivery, mechanisms, goals, challenges, what works, and barriers to success. This study addressed the gaps in knowledge to describe and delineate social prescribing mechanisms and understand the challenges of the role SPLWs (Frostick & Bertotti, 2019; Payne et al., 2020). Clarity has been generated regarding the variability in understanding of SPLW's roles (Zurynski et al., 2020).

It is clear from our study and others that there is general agreement about the

importance of the person-centred approach of SP, listening empathically and being non-judgemental to build trust, the value of getting to know service users and their needs, not dictating but empowering patients to make their own choices; and dealing with social, health and wellbeing issues over an extended period of time (Fixsen et al., 2021; Foster et al., 2021; Frostick & Bertotti, 2019; Wood et al., 2021; Wildman et al., 2019). Taking this into account, although "social prescribing" is the accepted and widely used term, the definition of "prescribing" (to order treatment for someone, or to say what someone should do or use to treat an illness) is at odds with a patient-led process identifying needs, issues, goals, and community-based solutions. Perhaps a better label is a "community connection" rather than a "social prescribing" service.

SPLWs discussed the behaviour changes made by the patients, new activities adopted, positive outcomes observed, and the appreciation shown by patients for the positive impact on their lives. This adds to evidence that SP is valued by patients and can improve patients' health, wellbeing, resilience, social networks, and social capital (Wilson & Booth, 2015; The King's Fund, 2018; Pretty & Barton, 2020; Bickerdike et al., 2017; Griffiths et al., 2022; Moffatt et al., 2017; Smith & Skivington, 2016). Another positive outcome was that the work of SP services resulted in more and more accessible social spaces, green spaces, and activities for the patients to access; for example, more health and wellbeing associated groups have become embedded in the community.

SPLWs reported that their workload was unsustainable and could negatively impact on their work, SPLWs need to have sufficient time with their patients and high workloads threatens the ability to achieve positive outcomes. SPLWs need a realistic workload to take account the complexity of cases (Wildman et al., 2019). As others have found, incorrect referrals undermine the ability of SPLWs to work effectively with patients (Frostick & Bertotti, 2019; Wildman et al., 2019). Services need to recognise that SPLW burden will be exacerbated by more complex caseloads (Fixsen et al., 2021). Steps to improve understanding of SPLWs' roles and referrals are needed (Rhodes & Bell, 2021; Hazeldine et al., 2021).

A key goal of SP is to enable patients to have readiness and motivation to engage, change and try new things. This study and others found that some SPLWs had MI training and employed this, and others stated a need for MI training (Frostick & Bertotti, 2019; Wildman et al., 2019). SPLWs need appropriate training (Tierney et al., 2020), designing MI training specific to the SPLW role and providing this training universally to all SPLWs could improve the effectiveness of SPLWs and address professional needs and skills identified by this study and Bertotti et al. (2018).

As others have identified, this study found that a key aspect of effectiveness of SP was offering patients a choice and flexibility around time, frequency, intensity, and mode of delivery, and for patients to be able to access back into the service if they leave (Woodall et al., 2018). However, patients can become dependent on the SPLWs: they rely on regular contact, using this contact as a form

of therapy/social input opposed to finding and accessing it in the community (Tierney et al., 2020; Wildman et al., 2019). Clear boundaries and time limits are required.

As reported elsewhere (e.g., Frostick & Bertotti, 2019; Holding et al., 2020; Fixsen et al., 2021), findings identified the importance of skills and tools in identifying local resources, building relationships with community providers, developing referral routes, connecting patients based on their needs and preferences, and staying up-to-date with community-based opportunities. However, gaps in resources were identified, and, as others have identified, without appropriate resources SP may not be able to address the needs of patients and SPLWs may feel they are not able to effectively undertake their role (Woodall et al., 2018). Another barrier identified here and elsewhere is accessing SP opportunities due to mobility issues, the cost of transport, and limited public transport (Foster et al., 2021).

SPLWs work with complex patients and often independently, which can be very demanding (Fixsen et al., 2021) and so need (and our study found had) access to supportive systems and networks both within and outside of their team. Our findings align with Chng et al. (2021) in that successful SP implementation is associated good team dynamics and link worker support. Clinical supervision and support are essential to conduct the work safely (Frostick & Bertotti, 2019).

Working as an SPLW is a complex role, they need a theoretical underpinning to account for who they work with, how they work, how patient change is achieved, and how positive patient outcomes are generated. Frostick & Bertotti (2019) stated that there is no ascribed theoretical model of the social prescribing pathway. Tierney et al. (2020) drew upon two existing theories to explain mechanisms underpinning SP: social capital (resources that can be accessed through social connections) and patient activation (enactment of people's confidence, motivation, and ability [skills/knowledge] to manage their health and wellbeing). Wood et al. (2021) stated that SP shares many features of the asset-based theory of salutogenesis (health promoting through building resilience resources). According to Antonovsky's theory, salutogenesis has three components: comprehensibility (making sense of one's own context, life story and current circumstances), manageability, and meaningfulness (Antonovsky, 1979).

A solution-focused approach is a strengths-based model that is client-led, future-orientated, and goal-directed process to health and wellbeing (Franklin et al., 2017). Theoretical mechanisms and framework that emerged in this study linked to a solution-focused strengths-based approach, which can incorporate salutogenesis, social capital and patient activation theories. The emphasis is placed on asking patients about personal strengths, social resources, and previous successes (O'Connell et al., 2012). There is a growing body of evidence suggesting that solution-focused approaches can be effective for patients experiencing various issues (Franklin et al., 2017), including depression (Ramezani et al., 2017), anxiety (Stallard, 2017), stress (Grant, 2017), and bereavement (Gray et al., 2000); issues which are experienced by some SP patients.

There are key principles that underpin the solution-focused approach, including: a focus on solutions; an assumption that positive change will happen; the use of a collaborative working alliance; being pragmatic and flexible; knowing that the future is negotiated and created; and asking questions rather than telling clients what to do (Grant & Cavanagh, 2018). The SPLWs in this study, many of whom had no formal training in the SF approach, followed these principles in their work, and in doing so enabled patients to engage with social resources (developing social capital) and change their behaviours (behaviour activation) to achieve successful outcomes which may be linked to health generation (salutogenesis).

Due to its focus on social prescribing in NHS primary care settings in a single county in the UK, generalisability to other settings is reduced; however, the sample was drawn from both rural and urban areas. Participants self-selected, which can introduce bias, as their experiences and perceptions may differ from those who did not wish to or felt unable to participate. There was a relatively small sample size limiting generalisability; however, the sample size was deemed appropriate for an in-depth interview study, as saturation often occurs at around 12 - 15 participants in relatively homogeneous groups (Guest et al., 2006). A larger proportion of the participants were female, which reflects the larger percentage of female SP staff.

5. Conclusion

It is recommended that: 1) SPLWs are offered SF and MI training to enable patient behaviour change, salutogenesis, and positive patient outcomes, and so that SPLWs feel they have the skills they require; 2) workload should be effectively managed; 3) processes are in place to ensure appropriate referrals; and 4) clearly define and make visible the theoretical underpinning of SP so that SPLWs and referrers have a clear understanding of the process to achieve positive patient outcomes. In terms of future research, now that there is widespread implementation of SP in the NHS, there is a need to interview patients in receipt of SP to gain their experience, views, and recommendations.

Acknowledgements

The authors acknowledge the support and time of the SP service and SPLWs.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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