Social Prescribing Unit, University of Central Lancashire

<u>Research Report:</u> *Experiences of social prescribing link workers in two locations across the North of England*

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About the Authors

The Social Prescribing Unit is a multidisciplinary research and knowledge exchange unit based at the University of Central Lancashire. The Unit was formed to draw together colleagues with an interest in social prescribing and to be a focal point for activity to be developed in partnership with external partners, including communities, around three strategic priorities: Research and evaluation, learning and teaching and recognising, harnessing and developing the important role of communities.

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This report is based on research undertaken by the study team and written up by the authors.

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Glossary

Term	Explanation
SP	Social Prescribing
SPLW	Social Prescribing Link Worker
MDT	Multi-Disciplinary Team

Executive Summary

The fieldwork was completed between September 2023 and January 2024

This report provides a summary of the findings of a small-scale research project on Social Prescribing in the North of England. The overall aims of the project were to explore social prescribing, and the context of community reach from the perspectives of social prescribing link workers.

The project involved a collaborative approach between link workers, two community organisations, and research staff from the University of Central Lancashire. A total of eight link workers were interviewed from two different locations across the North of England.

This study contributes to knowledge about the impact and effectiveness of social prescribing by reporting on the experiences of the link workers. The rich testimony revealed practice in social prescribing and identified barriers.

Key Findings:

- The value of relationships and one to one work carried out by link workers
- Rich examples of the impact and effectiveness of social prescribing were revealed
- Link workers were shown to have a comprehensive knowledge of services and supports available in their areas
- Link workers were key to providing benefits through community reach
- A lack of knowledge about social prescribing amongst professionals can be a barrier
- Working with multidisciplinary professionals can have difficulties
- In our study (In common with literature) the issue of resources, particularly in areas of deprivation where available services may be more limited emerged as a strong theme.

The report concludes by emphasising the value of social prescribing link workers and recommending improvements to the link worker role consistent with the challenges that they identified. Social prescribing is still in its infancy as a profession. More could be done to support the development of a stronger identity for link workers and the role and importance of community resources needs stronger strategic recognition and funding.

1.1 Background – Overview of Social Prescribing

Social prescribing has become increasingly utilised in recent years within health and social care settings, and it has a central place within the NHS Long Term Plan. 'Social prescribing' is based on the idea that non-clinical interventions, usually situated within the community, can help to improve an individual's health and wellbeing. Social prescribing aims to complement medical intervention, such as from a GP practice. It does this by addressing social factors that have contributed to (or result from) long-term medical problems - these factors could include social isolation, housing or financial problems.

To bridge the gap between medical and non-medical care, new link worker roles have been created to help to broker connections between, on the one hand, health care professionals, patients and service users, and on the other, a range of community providers in order to try and ensure that appropriate community services and activities can be identified and recommended. Examples of socially prescribed services might include exercise groups, cooking classes, debt and housing advice or volunteering opportunities. The aim is to bridge the gap between health services and community-based services better suited to deal with social issues outside of the remit of healthcare professionals.

1.2 Key Literature

The benefits of social prescribing are becoming acknowledged, increasingly seen as a useful addition to health and social care, with studies showing that it can have the effect of improving an individual's quality of life and a sense of belonging (Kilgarriff-Foster *et al*[1]., 2015). It has also been shown that it can lead to a reduction in unnecessary medical appointments or emergency hospital admissions (Moffatt *et al*[2]., 2017; Polley *et al*[3]., 2017). Social prescribing in action in the community has helped to strengthen communities, with greater social tolerance resulting from individuals from different backgrounds engaging in activities in the community, helping to break down barriers (NHS England, 2019[4]).

[1] Kilgarriff-Foster, A. and O'Cathain, A., 2015. Exploring the components and impact of social prescribing. *Journal of Public Mental Health*, *14*(3), pp.127-134.
[2] Moffatt, S., Steer, M., Lawson, S., Penn, L. and O'Brien, N., 2017. Link worker social prescribing to improve health and well-being for people with long-term conditions: qualitative study of service user perceptions. *BMJ open*, *7*(7), p.e015203.
[3] Polley, M.J., Fleming, J., Anfilogoff, T. and Carpenter, A., 2017. *Making sense of social prescribing*. University of Westminster.
[4] NHS England, 2019b. Social prescribing and Community-Based Support: Summary Guide: NHSE; 2019 [Available from: https://www.england.nhs.uk/publication/social-prescribing-and-community-based-support-summary-guide/

The role of social prescribing practitioners, particularly link workers is crucial, but studies show that there is a lack of awareness of the role amongst both health professionals and the general public. This can hinder getting it embedded into current services and communities (Khan, Ward, Halliday & Holt, 2022)[5]. The benefits of social prescribing improving the health and well-being of individuals could become clearer with further research on best practise in social prescribing, in making the role of link workers clearer, and emphasising the benefits of integrating social prescribing into current health and social care systems.

NHS England (2019, ibid) has identified six elements that need to be in place for social prescribing to be successfully implemented:

- Collaborative commissioning and partnership working
- Easy referral from all local agencies
- Workforce development
- Common outcomes framework
- A personalised plan
- Support for community groups

This study contributes to knowledge about the impact and effectiveness of social prescribing by reporting on the experiences of eight social prescribing link workers, employed in two different locations across the North of England.

[5] . Khan K, Ward F, Halliday E, Holt V. Public perspectives of social prescribing. Journal of public health. 2022;44(2):e227-e33

2 Methods

This section provides an overview of the methods used to carry out the research, and the stages involved. The overall aims of the project were to explore social prescribing, and the context of community reach from the perspectives of link workers. The study drew on the partnership with the two community organisations undertaking SP in the NW England.

Ethical approval was obtained at the University of Central Lancashire to undertake the study, with participants being given both written and verbal information about the purpose of the study and asked to provide written consent to participate before the interviews were conducted. Data collection was undertaken by two members of staff, one based at each of the research sites. Individuals had experience of conducting research interviews. Purposeful sampling was used to recruit participants from each of the two sites. Inclusion criteria included participants employed in SP link worker roles.

The questions were devised following discussion between the researchers. In total 8 interviews were conducted, 4 in each research site. Interview questions were developed jointly by colleagues from The University of Central Lancashire and from the two community organisations. The questions were:

Q1: What do you hope to achieve for your clients and the people you work with?

Q2 : How do your hopes relate the objectives of social prescribing that you are working to?

Q3. What tools and mechanisms do you use to collect information about the outcomes of your work for your clients?

Q4 What are the challenges of working in Primary Care Networks and NHS Teams in terms of meeting the objectives of social prescribing?

Q5 What are the wider impacts of the work that you do and how it impacts on individuals, families and communities?

Q6 Are you familiar with the support and activities locally to help you achieve the outcomes for your client? What type of organisations do you refer to?

Q7 Do you think it is part of a social prescribing link workers role to develop more local activities and support and if you do this, how?

Q8 If you could change on thing about your role what would it be?

Individual interviews lasted between 20 minutes/1 hour and were recorded, transcribed, and analysed thematically using reflexive "thematic analysis" (Braun & Clarke, 2022[6]). Themes were "generated" and "reviewed" (Morris, 2024)[7]. The data analysis involved wider team data validation by two colleagues from the Social Prescribing Unit, University staff and one member from each of the community organisations involved in the study. Coded data was shared and reviewed for consistency in coding in several sessions. Additionally, the SPLWs were consulted to check the interpretation of findings.

- [6] Braun V, Clarke V. Thematic Analysis: A Practical Guide. QMiP Bulletin. 2022(33):46-5
- [7] Morriss L. Themes do not emerge. An editor's reflections on the use of Braun and Clarke's thematic analysis. Qualitative social work : QSW : research and practice. 2024;23(5):745-9.

3. Findings

The findings are presented below in relation to the themes from each question, with selected quotes included.

Q1: What do you hope to achieve for your clients and the people you work with?

Respondents were asked what they hoped to achieve for their clients and the people that they worked with. The question elicited a variety of responses which centred around a number of different themes, including a focus on improving health and wellbeing outcomes for service users, the diversity of needs that clients presented with, and the importance of a person-centred approach. Respondents talked about social prescribing as a journey, emphasising the importance of relationship building with service users and the importance of skills such as compassion, listening, empathy, empowerment and facilitation.

Four out of the eight respondents talked about social prescribing as being about a person-centred approach.:

> *Social prescribing is all about person centred care. It's all about putting the client or the patient at the centre of care.*
>
> *Social Prescribing is a very person-centred approach, a very person-centred intervention. I can't really come to it with my agenda saying 'oh you should do this, or you should do that'.*

Three respondents emphasised this point slightly differently by talking about the diversity of needs that service users might bring.

> *Because each case is different it could be a variety of different things that the person has asked for.*
>
> *Everybody's different. Everybody comes with challenges.*

Seven participants talked about having a focus on wellbeing and mental health, with six talking more widely about improving a range of health and social outcomes more generally.

> *For them to feel better. For them to feel that there is something else.*
>
> *We hope to move them forward, improve their physical and mental health, making them better able to cope.*
>
> *By linking them into services which can hopefully improve their mental, emotional and physical wellbeing.*

Four emphasised social prescribing as a journey that service users were on that link workers could help service users to navigate.:

> *We hope to move them forward…getting them on their journey from A to B which they wouldn't be able to do if they weren't involved with social prescribing.*
>
> *As long as I have got them so way closer to the aims that are required, then I am happy.*
>
> *It is really about helping people to navigate their own way to greater happiness, independence, sense of self-worth and well-being.*

This included by linking service users into wider networks and services that they may not have been aware of, as well as working collaboratively with GPs.

> *……linking them up with groups and activities and things like counselling.*
>
> *…….to access services that they wouldn't normally either know about or be able.*
>
> *we work in cohesion and in collaboration with say a GP practise, for example, that's at the core of what we do. Not just GPs but all health professionals across the board*

In being able to do this, respondents talked about the importance of link workers being able to take the right approach with service users. Four respondents emphasised the importance of using skills such as compassion, listening, empathy empowerment and facilitation.

> *In terms of the one-to-one relationship with the client, it's about listening, it's about showing empathy, it's about being kind, considerate*
>
> *how we can …show compassion and empathy to the people that we work with*
>
> *I hope to…empower people to make their own choices and take more control over their lives.*

Q2 : How do your hopes relate the objectives of social prescribing that you feel you are working to?

In the second question, respondents were asked how their hopes related to the objectives of social prescribing that they felt they were working to. Some similar themes emerged to the previous question about what they hoped to achieve. This suggests that there is a high degree of congruence between what it is that link workers hope to achieve and the wider objectives and strategies within which they operate. Again, respondents emphasised themes such as being person centred, focussed on the real needs of individuals, building trusting relationships, empowering people by giving them knowledge and linking people

into local services and building community connections. Again, the idea of social prescribing as being a journey emerged.

Three respondents reiterated points about social prescribing being person centred:

> *Ultimately, it's what matters to that person and what they are struggling with.*

Three respondents emphasised the importance of building good relationships with service users as being central to the success of social prescribing.

> *....using empathetic understanding...It's about listening. But it's also about being genuine*

The importance of working alongside service users to empower them was again emphasised by three respondents:

> *I suppose it's about empowering people... with the knowledge of what's available to them and supporting them to access them if they can't do that for themselves.*

Four respondents talked about the centrality of linking people to communities, community resources and building community capacity as an asset:

> *it's about improving that sense of belonging and where people can kind of get involved in community groups and have that sense of belonging to the community that they live in.*
>
> *social prescribing is about creating a network within our area to bring a community of people together who wouldn't work together*

Again, two respondents talked about social prescribing as a journey and about the important part that link workers played in helping people to navigate their way through systems:

> *when working with clients and also so in day-to-day is to really help the clients to really move forward to...erm...get to where they, you know, they're looking to be*
>
> *And if you're not familiar with NHS and how it works, it can be quite a big minefield to navigate so it's important in early doors just to get that understanding*

Only one respondent mentioned the national strategic aim of trying to reduce the impact of increased demand for care on GP services and the aim of reducing pressure on GP services, thus saving the NHS money:

> *I suppose in terms of some of the general things like lowering the numbers of people frequent attenders at GP surgeries, which is a big thing that social prescribing wanted to achieve,*

Although slightly at adjunct to the question, one respondent raised concerns about the general shift to digitalisation, raising concerns about digital exclusion for some potential beneficiaries of social prescribing.

> *I know we put stuff on social media ....and I do a lot of social media....which is unusual for someone of my age. Because I have got people who have got*

a landline telephone and five channels on their television, and that's it. And they don't know all of these things that are out there.

Q3. What tools and mechanisms do you use to collect information about the outcomes of your work for your clients?

In question three, respondents were asked about the tools and mechanisms they use to collect information about the outcomes of the work that they do with clients. While the workers in both locations had systems for collecting outcome data, the systems that they used were different in the two locations.

In one of the sites the team were using a software system called *casebook*. This allowed the team to record the reasons for the referral, with a set of custom questions about (mainly soft) outcomes. The worker in the site was required to make a judgement about the outcomes achieved with the client, adding outcomes on an ongoing basis depending on what was happening with the client over time.

In the other site, workers reported using a range of different systems, but with ONS4 being a consistent feature. ONS4 is a personal well-being score measuring well being across four domains: life satisfaction; how worthwhile people feel the things that they do in their life are; happiness; and levels of anxiety. Workers said that they would do an initial screening with ONS4 to see where people were at when they first came in to the service and that they would then repeat it at intervals, including discharge. The other systems that workers reported using included EMIS - an electronic patient record system, widely used across the NHS, including around 50% of GP practices – and a local CRM system.

The fact that the workers in the two sites use different systems is interesting as it clearly places limitations on the extent to which comparison about outcomes can be made between them.

Workers in both sites emphasised the limits of the tools that they used spoke about the skills that were necessary in order to us the tools to best effect. For example, one respondent pointed out that service users with a mental health problem or a learning disability might struggle to understand some of the questions, or that the answers for someone who was homeless might be influenced by what had happened in the immediate past rather than being able to contextualise an answer over a longer period. Another suggested that the best tools for gathering information about outcomes were not tool driven, but were relationship driven.

The best tool I think anyone has got is this one (points to mouth). It's speaking to people. And asking them how they're feeling and listening to how they react to you.

Others talked about the importance of anecdotal feedback from other agencies or from clients themselves.

We also get feedback from other agencies and professionals about outcomes they've seen in the clients that they referred into us. So we try to capture all that to put in our monthly updates.

Two of the workers said that they kept their own independent sets of notes to monitor outcomes.

We also just keep our own personal log of the clients that we have personally.

Q4 What are the challenges of working in Primary Care Networks and NHS Teams in terms of meeting the objectives of social prescribing?

In question four, respondents were asked what they saw of the challenges of working in Primary Care Networks and NHS Teams in terms of meeting the objectives of social prescribing.

Seven of the respondents talked about the problems of inappropriate referrals and being used as a dumping ground for patients who others didn't know what to do with. Often this was seen as consequence of services being overwhelmed.

So we find that sometimes GP and other health staff are not fully understanding the role of the social prescriber and are sending through inappropriate referrals.

I think we're just seen as the dustbin. Don't know what to do with this, I'll fire it to them. They can sort it out

Mental health services are completely overwhelmed. NHS practitioners need to be seen to offering support to people and when all of the other places are operating with such huge waiting lists then they send a lot of people to us.

Sometimes however it was seen as more of a consequence of referrers (often GP's) not listening to patients sufficiently and not having a grasp of their needs.

Another challenge is the GP or whoever refers not really taking the time to find out what the client wants and just ticking the boxes that they think and not putting any accompanying information.

Sometimes doctors don't actually listen, or referrers don't actually listen to the patient and they put down what they think the problem is, and when you talk to the client, that is the least of their worries.

Six of the respondents thought that part of the problem was that GP's did not really understand what social prescribing was, what it had to offer and what the role of a link worker was.

It's about recognition so I've almost been three years in this roll now and I still get asked what you do, believe it or not. You know from some of the GP practises so you've got to have a thick skin. It can be quite frustrating at times.

Several link workers talked about the challenges that they had had in trying to educate GP's and other primary care staff about what social prescribing was about.

When I when I reject a referral, I don't just reject it. I'll attach the referral form that is required for the service that they should have sent it to and say, you know, we've discussed it in our allocation. Many thanks for the referral, but it isn't suitable for SPLW. This is where it needs to go and I have attached to referral form for you. You know, look forward to receiving referrals in the future, kind regards blah blah blah and ping it back. And it's just about education I think.

You have to do mandatory training right? Why not incorporate a module within that training where it talks about health development...And then mention, you know, in the subsections about social describing, the teams that we have, why it's important.

I think it was a lot it with the re-education... I think a lot of it is unfortunately, obviously, with GPs, that they are really busy. There is a turnover in a lot of GPS in terms of locums and also, because of what GPs deal with day-to-day...

We even held an integration event not so long ago and invited staff from all the GP surgeries that we work with...all the five surgeries...and there was a not very good turnout from the surgery staff. None of the GPs came...and I know they're so busy... but...you know

One respondent described their experience with GP's a being patchy:

With our PCM covering 7 surgeries, some surgeries send through a lot more referrals than others. I think the level of appreciation for social prescribing varies as well.

The lack of understanding and recognition could sometimes cause problems with getting things done efficiently. One link worker complained about being asked to pay for a letter for medical evidence for a housing provider. Another complained that a GP had simply not prioritised what was seen as an essential letter to allow a client to access benefit support.

Surgeries wanting to charge us anything between £15 and £45 for doctors letters, you know, for medical evidence towards things like housing.

One GP has got a health questionnaire sitting in his tray that requires filling in to support a client with a Universal Credit claim. I've liaised with the Job Centre. It's imperative we get that back. The 6th of September that that questionnaire went into that health tray. Four urgent messages have been sent by myself and by reception staff at the surgery to say this really needs dealing with. It's still there now. In January has not been completed.

Four respondents complained that they sometimes received referrals from patients who were too poorly to benefit from social prescribing. Often these were patients with severe mental health problems.

> *There maybe high levels of mental health issues going on that wouldn't be suitable for an SPLW.*

Covid was seen as a contributory factor to poor mental health for some patients, which had led to increased social anxiety.

> *They are scared to go out, and we are trying get them socially prescribed and to get them to go out in to the community to do things and get them involved in different groups etc. and if that individual is not coming out of their bedroom for love nor money, then that is something that is such a struggle*

Link workers talked about how their role had changed during the pandemic.

> *We were employed in in 2020 and then the pandemic commenced. We were a rapid emergency force, you know to help with people who needed help, you know delivering meds, you know, sorting out food parcels and so on and so forth.*

Being based within a PCN as part of a multi-disciplinary team was seen something that presented real opportunities for improved and joined up services, but unfortunately the opportunities were not always seized.

> *We cover a locality that has very high levels of deprivation and also high levels of older generation or people that would have quite a lot of comorbidities and we have to work very closely with the medical teams as well, which is why it's great that we're in that kind of MDT arena. And we have regular conversations when it comes to individuals that do have the complex needs. We will pull a professional meeting just about that individual, and so it allows, kind of, you know, support for us as individuals to know that we are supporting this person correctly.*
>
> *Integrating ourselves into their teams has sometimes been a challenge. We have done it better in some areas than in others.*

For link workers, sometimes this could come down to feeling like they were working to two different masters with two different sets of objectives. Some link workers reported tensions in priorities or duplications in work.

> *Communication between the two organisations can sometimes create difficulties…*
>
> *There can be different expectations from the NHS and say for example, from the CVS. Things like reporting mechanisms…supervisions….You know we have two sets of supervisions. Now it's called clinical supervision. But before it was one supervision with CVS and one with NHS. Great, but you know it's duplication at times.*

We've been asked not to do home visits. If we have to do a home visit, we've got to ask permission. PCN didn't know anything about that, so you know, it's that lack of communication between the two. You know, for me, I'd rather just be employed by and just have one employer. And that's where you go when you've got these two conflicting, you know it's very, very difficult.

And so also we found that the primary care network is now kind of putting more workload on form filling and kind of wanting more data from us on a monthly basis

Workers in one of the sites liked being co-located with PCN staff as it facilitated good communication. It did present problems with office space however.

We're working as part of a multidisciplinary team, which is absolutely in my opinion, the best way to work.. but unfortunately we're all together in a very small space so, you know, if we need to go make a call to a client, finding that space that quiet space where you can have a confidential conversation...You know, we're all kind of crammed. Desktop space storage space for files and so on... and where I sit I've...it depends on what day it is because different people are coming in on different days.

Q 5. What are the wider impacts of the work that you do and how it impacts on individuals, families and communities?

In question five respondents were asked about the wider impacts of the work that they did and how they thought that it impacted on individuals, families and communities. All of the respondents pointed to a wide range of impacts across a number of different domains with both individuals and families. The most commonly reported impacts related to improvements in mental health and relationships. Five pointed to examples of individuals that they had worked with where mental health was the main issue.

I think there is a huge impact, especially where there are mental health and emotional issues. For example I can think where we worked with a woman and sorted her issues out. The family have become closer and more bonded and they are able to communicate and she has now got a relationship with her sister, so I think it can restore some family harmony.

If someone has been carrying something like sexual abuse around with them for a very long time and that's been impacting all of their relationships, their ability to work, their ability to parent their own children, their ability to know when too many drugs or alcohol is too much...you're putting them in a place where they can start to address those things and thread their life back together.

Other outcomes achieved included in relation to addiction, parenting, finance, utilities, foodbanks, stress, physical health, housing, confidence, self-esteem, safeguarding, domestic violence, gaining employment, volunteering and accessing education.

All of the respondents could cite examples of where they had impacted not just on the individual that they were working with, but also with wider family members.

> *We have worked with someone to get the electricity and the gas on. The family is going to be warmer, the family is going to be healthier.*
>
> *If one person is angry or upset or sad, that generally creates a negative feeling in the person, that is, you know... you feel empathy or you feel sad too or ...you know.... by improving one person's wellbeing that should have a positive outcome with the rest of the family.*
>
> *I've seen a positive impact on family members through working for a client. Especially the family who are in a caring role or having to support a family member. It can reduce the pressure and the stress from them because they might feel a responsibility to that person.*

Respondents also perceived wider benefits to community. These benefits could be split in to benefits accrued through savings to the health economy or in crime reduction on the one hand and benefits through strengthening community and social capital on the other.

Cost savings were seen to accrue through impacts such as lower attendances at GP surgeries or A&E

> *They are not going to be going to the doctor as much.*
>
> *If people are going off to the hospital or they're going to the surgery or they're going to school or college or what have you and that improves what's going on there as well. And yeah, I think it kind of reaches quite far.*
>
> *If you can get someone to address their addiction you might be contributing to lower crime stats in the local area if they are not having to fund their habit through petty theft and stuff like that.*

Community capital was seen be built through people volunteering or new groups being set up.

> *People that have gone through a mess tend to really come out of it with a desire, you know, to help others or, you know, come out so passionate about wanting to see change...and actually give back.*
>
> *I helped to re-establish a bingo group that she used to run in at Church Hall that...which used to connect all the neighbours together, which was a lifeline for...because they were mostly elderly, very vulnerable, disabled people who then had lost all contact and all connexion with their neighbours and the people in their local community.*

One link worker saw social prescribing as sometimes fulfilling a holding role or interim service need while someone was on a waiting list.

> *So a person might have to wait, say, up to five months to be seen by a service, for example counselling…so in the interim, you know, a community service will meet that person. Obviously, it's about matching what that person wants. So a person might have say mental health needs, needs counselling, but they have interested in, say arts and crafts, so we'll pair them up with a community service* which has arts and crafts as an activity.

Q6 Are you familiar with the support and activities locally to help you achieve the outcomes for your client? What type of organisations do you refer to?

In question six, respondents were asked about the types of organisations that they referred to and whether they were familiar with the support and activities that were available locally to help them achieve the outcomes for their clients. All respondents reported referring to a wide range of organisations, both locally and nationally. These included organisations from across the statutory, voluntary, community and faith sectors.

> *Such a wide range….all sorts, honestly. I could give you lists. And there's just endless lists with everything on there.*

All of the link workers named a vast array of organisations, dealing with a wide range of topics including drug and alcohol misuse, mental health, specific diseases or conditions (such as lupus, dementia and brain injury), social groups, knit and natter groups, hobby groups, sport and physical activity groups, Christmas groups, benefit advice services, LGBTQ+ groups, housing advice services and housing providers, carers groups, gender specific groups, employment support, colleges, animal charities, and environmental groups. They were keen to emphasise that they were able to take a holistic and tailored approach, depending on the needs, interests and strengths of the individuals that they were working with.

Respondents emphasised the importance of their link worker roles in networking across and between services, linking people and organisations together and sharing information.

> *We attend meetings…we attend groups…we facilitate meetings…we go out there and we talk knowledge of what community groups are out there in our locality.*
>
> *If there's any information that we need, we can put a request out, you know, send an e-mail out and you know, literally, within seconds, ping, ping, ping… everybody starts emailing back with… you know…. information that they have.*

Some link workers had a depth of knowledge about the organisations that they could refer to and were able to make qualitative judgements about how helpful they were likely to be in practice.

I think I've got a good handle on what's available locally and who are the supportive organisations that actually want to engage with our clients.

I tend to kind of like regularly check to see what they're waiting times are so that I can refer them in or sign posts them to the one that's gonna get to them the quickest

One talked about having a role in volunteer recruitment and development.

A secondary part of that for the social prescribers is to get volunteers....train them up and then they can actually assist us in our work...and that's actually recognised in the sense of it's a qualification for them as well

Two respondents discussed the challenge of staying up to date, acknowledging an ever-changing landscape of organisations and services.

Networking is a really important part of the role...keeping up to date with smaller groups and activities available locally because they're constantly changing due to funding... people leaving ...new groups starting up ...and there's numerous small groups activities ...and as a team we've been going out to visit them, introduce ourselves, tell them what we do and find out how we refer.

They are ever changing, you know, due to funding for a lot of them. But one of the things for social prescribing we have to do is work together to find out new services, keep each other informed of new services or new resources that come up.

Link workers would use a range of skills and resources in order to try to stay up to date, including use of the internet, attending meetings, visiting services, subscribing to newsletters, utilising contacts, and maintaining and using networks.

Two respondents talked about their role as having a community development role.

A large proportion of our work is to work in community development. So although we have a health remit and a health hat it's almost... it's almost one hat which at the front says health provision and at the side of the hat it says community development....and what's out there...developing or establishing links with community groups

Where there's gaps that need to be met, again, it's sometimes just looking at organisations that might be elsewhere, but saying, you know, what about offering it here.

Two talked about the challenges of funding for community groups.

In terms of provision and funding, yes, there is a distinct lack of that and so it's essential and vital that community groups get support, get funding and continue, you know, to do valuable work, particularly in light of... after covid... you know covid kind of put a stop to lots of community work, and I think we still recovering from that.

One link worker thought that this has been exacerbate by the cost of living crisis and the rise in fuel prices.

With all the fuel price increases and the cost of living and everything, it's just added so much pressure on people that serves are feeling overwhelmed

Q7 Do thinks it is part of a social prescribing link workers role to develop more local activities and support and if you do this, how?

As noted above, in answering question six, two respondents talked about their role as having a community development role. In question seven all respondents were asked more explicitly about this when they were asked whether they thought that it is part of a social prescribing link workers role to develop more local activities and support, whether they already did this and, if so, how?

Six of the respondents thought that is was part of a link workers role to do this, but two did not. Three of them were already in the process of doing this, or had done so in the past.

> *I have applied, and I am in the middle of the longest application form ever (laughs),*

The kinds of activities that link workers had sort to develop included for a fellowship group at a local church, an extension of recovery services for people with substance misuse related problems, a walking photography group, an LGBTQ+ support group, and a support group for people caring for someone with a learning disability.

Those who thought that it a part of a link workers role cited a number of reasons, mainly centring around either there unique perspective in being to identify gaps or the practical imperative of not being about to do their job properly if resources did not exist.

> *It's definitely part of our role because we're in a really good position to be able to identify gaps in provision of services and to develop initiatives to meet those needs.*
>
> *We can't do our job without other people and without other agencies, but also we can't do our job fully if we're seeing a hole.*
>
> *I think social prescribing link workers are able to identify the gaps in the service because you're the one that's the link... you're trying to connect people to a service. And if you obviously can't find that service or you're struggling to kind of sign posts somewhere, then you know, we are the people on the ground, that can kind of identify the need.*

They also saw the importance of doing this in partnership.

> *I think it is a part of our role. Are we the only people who do it? No. I think we work in collaboration. That's very, very important. We can't move a mountain by ourselves.*

Those who did not see it as part of their role tended to cite reasons such as a lack of time, a concern about competence in doing so or a concern about longer term sustainability.

Agencies can come and go. So for me it is just trying to keep abreast of everything which is forever changing.

There is a whole issue about me having to be there, me having to get insurance, and so on. We can help in talking to people about setting up new groups, but it shouldn't be up to us to set up and run new groups.

Because we're so busy anyway.... the time that is required to setting up that group is proving quite difficult. Then you get all the red tape of everything... and the insurance, and... you know... public liability insurance.... and all the health and safety stuff.... and it all goes right over my head....

That goes way above me above and I've never done it. Of course, if we were trained enough to do it and that it would be different. And obviously there are people within our organisation that do it.

Those who did think it was part of their role acknowledged these problems, but seemed willing to try and work around them.

It's difficult time wise...because you know... myself and colleagues are going to have to run the group to begin with to get it up and going. We haven't got that volunteer base yet to be able to say off you go on your own...

I do believe that it is part of our role, but it does become quite time consuming to kind of get it off the ground.

A respondent in one of the organisations reported that the employer was in the process of recruiting a community development worker and so thought that at a strategic level the issue was recognised as being an important one.

I know that we are currently recruiting a community development worker...Is that what they're going to be called? Something like that... which I'm led to believe, will help small groups to set up, so that will be a Godsend for social prescribers

Another said that while they were not discouraged from setting up new groups and undertaking community development type work, in reality they were not given time to do it.

If I'm being honest, it's not resistance in the sense of you can or you cannot do that. It's more about manpower. It's more about time. It's more about us. How much time can we give to that agenda? How much time do we have?

Q8 If you could change on thing about your role what would it be?

In the last question, respondents were asked to discuss the one thing that they would change about their role. Six talked about resources, saying that they wanted more time, more staff, more office space or more volunteers.

I'd have a few more hours in the day please.

An endless pot of money….more staff, more money.

In articulating this, one link worker talked about the high level of complex needs that they had to deal with, saying that this was never likely to go away.

One talked about the value of volunteers on the one hand, but also the demand that this placed upon the service in order to ensure that they were properly trained and supported.

So we've got a few volunteers who can do, like, a bit of hand holding and going with people to groups…but we have to support them as well.

Three link workers said they would like to see more awareness and buy in from GP's and primary care staff about the value and role of social prescribing and suggested that education for GP's may be a way of addressing this.

I'd like to educate GPs more…but not all of them, cos some of them are really good.

As well as increasing the number of referrals and promoting effective inter-agency working this could also ensure that patients/service users knew what they were being referred to, supporting better engagement.

Clients who are difficult to reach could have something explained to them at source.

One link worker said that they would like more flexibility of how and where they could see clients as this would support client choice and better meet the needs of those who struggled to engage. This might include being more flexible over home visits or the number of sessions that clients were allowed to have.

The flexibility to be able to see a client however they want me to see them. Give that client the option about where they would feel most comfortable having that initial assessment.

5 Discussion

The study sheds light on the clear shared values and goals from link worker perspectives. Examples include, being person-centred, using relationship building, empowering individuals, taking people on a journey. These appear to underpin the work of the link workers across the two sites, additionally, there are examples of good work that may be more prominent in one site, or even in the work of one worker within one site. By highlighting some of the work it is hoped that some of this practice may be shared so that consideration might be given to whether such ideas and approaches might be more embedded in the role. For example, some link workers tried to mobilise community resources by recruiting and training volunteers or by encouraging and supporting the establishment of new services or groups.. Given the importance of support for community groups being identified as one of the six elements necessary for social prescribing to be successful (NHS England 2019b), raising the profile of this strand of activity may be of value. One of the barriers raised by the agencies on the ability to establish quality networks and therefore enhance the practice of the link worker was agency funding. The short-term nature of this often leads to a lack of security for the link workers and also inhibits continuity of delivery as agencies are constantly looking for the next pot of funding and having to divert resources to this rather than frontline provision. The root cause of these issue appears to be lack of funding, and a lack of investment in social prescribing and link workers.

There were other differences in practice too. For example, some link workers visited people at home and undertook home visits, others did not. While the two sites each reported systems for capturing data and measuring outcomes, the systems used in each of the two sites differed. Given the clamour for evidence about the efficacy of social prescribing, consideration might be given as to whether a more universal system measuring outcomes could be beneficial. One of the strengths of social prescribing is its localisation of service delivery utilising often third sector providers to use their links with community organisations to establish a network of services, with the link workers providing a gateway to services that both professionals and the public might be unaware of. However, this strength can also lead to a wide variation in practices across different agencies providing social prescribing and an element of patchiness in the accessibility of social prescribing for potential beneficiaries that is dependent on the extent to which Primary Care Services are aware of and buy in to it. This leads to the quality of the provision being highly dependent upon the link workers ability to establish good relationships with primary care providers and the importance of these relationships in informing the primary care of the services available through social prescribing.

Therefore, Link workers thought that there was scope for more integrated and consistent working practices, both within teams but also and especially across primary care. The study highlighted the need for the concept of social prescribing to be made clearer to healthcare professionals and the potential users of the services. This clarity would allow for a more efficient use of the link workers time and also make the referral process more efficient and potentially cost effective:

And I would have the whole of (names the area) under us, and this is really important, because then there is uniformity across (names area).

Having better cohesion in terms of how we work, you know, working together.

This lack of clarity and integration with services often left the link workers experiencing themselves as operating outside of the primary care system rather than an integral part of it. However getting the message across to busy health professionals especially in area of high deprivation where these link workers operated is a challenge, that in itself would require some resource input.

Strengths and limitations

A major strength of this study was in its design and delivery being co-designed and co-produced by both the university and the two third sector organisations. This co- production is both a strength and limitation of the study. On the one hand, co-design and co-production has ensured that the questions asked are ones that make sense in the real world and are seen to be both relevant and pertinent. It has ensured that participants (link workers) could be recruited quickly and efficiently. However, this also slowed down the research process as agreement had to be reached by all throughout the process of design and delivery.

Having four people (two from the university and one from each of the third sector organisations) undertake the thematic analysis helped to ensure a balanced analysis of key themes and meaning will have helped to mitigate against individual bias.

On the other hand, participants may have felt some pressure to answer questions in particular ways and to avoid being overly critical of their employer. The questions themselves may have been designed to reflect the concerns of the third sector organisations, rather than of the wider sector.

Although the semi-structured nature of the interviews did allow respondents to answer questions how they wished, it may also have meant that some important aspects of a potential answer may have been 'skipped over', as respondents may have failed to recall or mention something important in the moment. This may have exacerbated by the fact that slightly different approaches were taken towards how the interviews were conducted in the two sites, with one interviewer being more discursive and offering more prompts than the other, possibly resulting in more full and longer answers.

Conclusion

This study contributes to knowledge about the impact and effectiveness of social prescribing by reporting on the experiences of eight social prescribing link workers, employed in two different locations across the North of England. The suggestions that respondents made for improving their role were consistent with the challenges that they identified. There is good work going on, but more needs to be done to ensure that Primary Care staff (including GP's) understand the role and significance of social prescribing as a practice.

Social prescribing is still in its infancy as a profession. More could be done to support the development of a stronger identity for link workers. The role and importance of community resources needs stronger strategic recognition, including funding and development.