More than signposting: Findings from an evaluation of a social prescribing service

Abstract

This paper presents findings from an evaluation of a social prescribing service, undertaken between January 2019 – December 2020. Data was collected through interviews and focus groups with a range of groups including social prescribing managers, link workers (LWs), referrers (GPs and social work practitioners), clients, Voluntary and Community Sector (VCS) agencies and groups. Thematic analysis of data was undertaken, and findings presented in respect of clients' journeys into social prescribing; the support received from LWs; their onward journeys to VCS support. The findings highlight the challenges for individuals in contacting new agencies/groups and the importance of practitioner referral into and onwards from social prescribing, as well as buddying to support clients on initial agency visits. The depth of the LW role is highlighted, as well as the complexity of client circumstances, highlighting a need for 'more than signposting', and challenging the notion of self-referral as an indicator of motivation. Social prescribing has been positioned as among the solutions to the challenges of primary care. However, referrals from GPs were low and significantly outnumbered by those from social workers; this suggests a need to explore in greater depth the use of social prescribing by social workers, who have, to date, been absent from social prescribing research.

What is known about this topic

- Social prescribing forms a key element of current primary care policy
- It's use in other health settings has also been explored, but there has been little consideration of its use by social workers
- The evidence base for the impact and effectiveness of social prescribing is currently unclear.

What this paper adds

- Few referrals for social prescribing were made by GPs; self-referral and social worker referral predominated
- The link worker role can involve in-depth support and navigation
- Active referral into and onwards from social prescribing, and buddying, are important in enabling access to support for many clients.

Keywords

Social prescribing; Link Worker; Primary Care; Social Work; Referral; Signposting.

Introduction

Social prescribing has received considerable attention as a means of linking people to voluntary and community sector (VCS) services. Policy intentions are broad, with multiple anticipated benefits, including addressing ongoing challenges within primary care. Consequently, social prescribing has been positioned as a core element of recent English health policy (HM Government 2018; NHS England 2016, 2019), with accompanying investment. Primary care challenges include: significant GP workloads; recruitment and retention difficulties; increasing levels of patient need and complexity of conditions; short consultation times; frequent presentation of problems lacking biomedical solutions (Hobbs et al., 2016; Husk et al., 2019; NHS England 2016; Owen et al., 2019). Social prescribing also aims to address individual need in respect of psychosocial problems such as reduced wellbeing; anxiety and depression; loneliness and isolation; unemployment; debt and financial problems. VCS services provide diverse options to ameliorate such problems. However, GPs and patients often lack awareness of these services, therefore social prescribing can act as a conduit for enabling patients to access appropriate support beyond primary care, thus addressing wider determinants of health and wellbeing (Bertotti et al., 2018; Popay et al., 2007a, 2007b; Skivington et al., 2018).

Social prescribing may also be useful in other health settings such as secondary mental health care (Dayson et al., 2019; Scott et al., 2021). Moreover, the Local Government Association (2016) highlighted the role of councils in social prescribing, although its contribution to social work and social care has been little studied.

Social prescribing has been variously defined and implemented (e.g. Bickerdike et al., 2017; Carnes et al., 2017). NHS England/NHS Improvement (2020) defines it simply as enabling *all local agencies to refer people to a link worker*. This reflects the centrality of the 'link worker' (LW), a multi-faceted role that includes: providing time to focus on client concerns; developing support plans; connecting individuals to community agencies/groups; collaborating with local partners to support the development and sustainability of groups (NHS England/NHS Improvement 2020).

Despite policy optimism that social prescribing can benefit patients and address deep-seated problems in primary care, establishing an evidence base for its effectiveness is complex and challenging. There is considerable heterogeneity among programmes, in which there may be differences in the needs of those supported, service models implemented and outcomes sought (Bentotti et al., 2018; Husk et al., 2019, 2020; Pescheny et al., 2020), making comparisons difficult. While population level studies have not demonstrated benefits, qualitative studies have identified positive outcomes for individuals including improved health and wellbeing, and reduced isolation (Carnes et al., 2017; Husk et al., 2019; Pescheny et al., 2020).
A mixed methods study, jointly commissioned by a Clinical Commissioning Group (CCG) and a local authority, of one city-based social prescribing service, was undertaken from January 2019 -

December 2020. This sought to examine the effectiveness of the service from multiple perspectives. Quantitative data on clients referred and sources of referral into and onwards from the service was collected, alongside qualitative data through interviews, focus groups, and a survey. This paper reports the qualitative findings and focuses on client journeys into and through social prescribing, and the client support required.

The service context

The social prescribing service was launched in 2017 in an urban area in Northern England with higher than average social deprivation indicators. It was co-delivered by two VCS organisations, and was available to those aged 16 years and over. Support was provided by Link Workers (4 or 5 variously during the evaluation) based within GP practices and other locations including community centres. Access was by referral or signposting, defined by Harris et al. (2020) respectively as 'connecting' and 'directing', and by self-referral. Referral is a formal, practitioner led process of linking individuals to services; signposting involves practitioners providing information, with the process of contacting the service (self-referral) undertaken by the individual; the latter requires less work for practitioners, but makes greater demands on individuals (Carstairs et al., 2020; Harris et al, 2020). The service aimed to work closely with GPs, but other health and social care practitioners and VCS workers could also refer/signpost. Following LW support, clients were referred or signposted on to VCS services and community groups.

Methods

Participants

The study sought the perspectives of multiple stakeholders (see Table One). Participants included: social prescribing managers; LWs; GPs, social workers and social care advisors (who could refer/signpost); clients; VCS staff (who could refer/signpost to social prescribing, and delivered community-based services). Managers and LWs were approached by the researchers, who attended team meetings. Long-term managers and LWs were invited to participate at two or more time points to facilitate exploration of how the service and their roles evolved. Social workers were contacted directly or through their managers. The researchers attended a GP forum at which they facilitated three 'mini-focus groups'; further, an in-depth interview was undertaken with one GP. VCS agencies were identified through information provided by the social prescribing service about services/groups to which clients were directed and were approached by the researchers by email or phone.

Multiple approaches to client recruitment were employed. The service contacted former clients at the beginning of the study, where permitted. They also informed clients about the research during meetings, providing an information flyer. Those interested could permit their LW to share contact details or contact the researchers directly. The researchers provided more detailed information prior to interview.

Qualitative data collection and analysis was undertaken by two independent, female researchers with backgrounds in psychology and social work, and with experience of conducting research and evaluation in adult health and social care. The research team had no prior relationship with either service providers or users.

Data collection

Participants were invited to interviews and/or focus groups. Key questions for each participant group are detailed in Table One.

Following the COVID-19 lockdown, interviews were conducted online or by phone. Interviews were audio recorded, transcribed verbatim and anonymised. An online client survey was available from July – November 2020 to facilitate socially distanced participation.

Participants were asked to provide written consent; when interviews were conducted remotely verbal consent was sought before the interview, and consent forms returned by email. The survey was completed anonymously, and completion taken to signify consent. Interviews and focus groups lasted from 0.5 – 1.5 hours.

Data were collected by the social prescribing service on numbers referred/signposted into and outwith the service, and were shared subject to a data sharing agreement with the researchers, in an anonymised format, for a three-year period (2017 – 2020).

This paper focusses on the findings from the qualitative data collected.

Data analysis

Qualitative data from all participant groups were analysed as a single data set by two researchers, using thematic analysis (Braun and Clarke, 2006). A combined inductive/deductive approach was undertaken whereby a close reading of early transcripts and social prescribing literature enabled the inductive generation of initial codes. These were used to develop thematic tables, consisting of main themes and sub-themes, into which all data was entered (deductive analysis), while an ongoing inductive approach allowed for the development of new themes/sub-themes. Themes were refined and a narrative of the data developed.

Five themes were identified and are detailed in Table Two.

In this paper we explore the first three themes, which reflect the social prescribing journey; these detail how clients gain access to social prescribing, the support provided by LWs, how they move on to access VCS support. The remaining themes outlined the reported benefits of social prescribing for clients and others, and the approaches undertaken to support the development and delivery of social prescribing.

Ethics

The study received ethical approval from the University of Hull Faculty of Health Sciences Research Ethics Committee.

Findings

Table Three shows the number of participants in each group.

Data provided by the social prescribing service indicated that 2199 people were referred between September 2017 and August 2020. Sources of referral included self-referral (28%); social workers (20%); health professionals (12.5%). Despite the emphasis on social prescribing as a resource for primary care, GPs accounted for only 4.2% of referrals (although some may have signposted individuals); a significant proportion of these (41.5%) came from two practices. Key reasons for referral were loneliness and isolation; anxiety; becoming healthy and active. Other social prescribing services also address support needs for housing, debt and welfare benefits (Bickerdike et al., 2017); here such issues were directed to a separate in-house welfare service, and, while mentioned by participants, were generally not dealt with directly by LWs, and therefore did not form part of the data analysis.

Theme 1: Accessing Link Worker support

As a relatively new form of provision, practitioners and clients alike need to understand the role and scope of social prescribing. Social prescribing was not universally well understood. This could lead to 'inappropriate referrals' and divergence between client expectations and the support offered:

A lot of people come to us but still they don't know exactly who we are and there's still a lot of misunderstanding (LW3).

Where practitioners themselves understood social prescribing, they could shape awareness and encourage engagement among potential social prescribing clients:

We explain it's about social wellbeing, being content with how you're spending your days, improving your routine, your emotional wellbeing... once we've given that whole picture of what it is, then they seem a lot more receptive (Social Worker 5).

Barriers to referral/signposting were identified, highlighting the need for ongoing awareness raising. GPs reported that, as generalists, they direct patients to diverse services (within and outside of the NHS). In this context, remembering the range of options was challenging, and they identified a need for frequent reminders and prompts; in contrast there was a box on social work assessment forms asking whether social prescribing had been considered. A lack of feedback was reported, without which the benefits of social prescribing were not reinforced. Where LWs had been moved from surgeries, GPs identified that it was harder to remember to use social prescribing, indicating that co-location may be beneficial. GP perceptions of the value of social prescribing also appear significant; while some appeared to have positive perceptions, others were sceptical:

I've managed up until now and I still am, simple as that (GP Focus Group)

That's just one more….do-gooding kind of thing…coming [patients'] way (GP Focus Group).

The predominance of the medical model also appeared a factor for patients and GPs:

It's easier to give prescriptions and say off you go…..rather than taking some time and say look, I don't think there's anything medically we could do for you, these are the things that we can do that might take a bit more time and effort as well ... it's not always possible in GP surgeries sometimes, they just want to move on (GP Focus Group).

In contrast, other practitioners valued being able to refer/signpost clients to social prescribing when they did not meet the threshold for support from their service; when they did not know what resources were available; where they had limited time or the support they could offer was time-limited.

<u>Use of referral or signposting</u>

For many practitioners, deciding whether to refer or signpost appeared to be based on their awareness of individuals' needs and circumstances, and whether they believed that, if signposted, they would initiate contact with the service:

If I'd have said to him 'oh you can call these, they'll be able to help you' he would never have done that (Social Worker 2).

Signposting appeared valuable when individuals' circumstances meant that an immediate referral was not appropriate (for example, during acute illness, hospitalisation or crisis), and allowed for flexibility and optimal timing:

It's not always a case of this is what you need and we have to refer you right now they can sort of say oh well I'll do it in a couple of months when my mum's settled or my dad's settled….and they'll pick it back up themselves later (Social Worker 4).

Some practitioners appeared to equate self-referral with empowerment and autonomy, perceiving that practitioner-led referral risked cultivating dependency, apparently believing that clients would be unlikely to engage with services unless they referred themselves, as well as creating practitioner work:

If they don't want to take that step to contact the service it's unlikely they're gonna get much from it, they don't really have the motivation (GP1).

I do both... depending... sometimes you just need to say… well, I'll make a referral for you…with other people... .I'm more for encouraging people to maintain their own independence rather than be the person that is doing all the work for them... You give them advice on how to do things but you keep it in their court....you don't want to make them too dependent (Social Care Advisor 1).

In contrast, this VCS worker came to recognise the value of referral:

When I first started it was a lot of signposting and trying to empower them….... but then… you see them again – did you refer yourself? And it's like oh no, it slipped my mind. So I've learnt to do the referrals for them (VCS Practitioner 4).

Client interviews underscored the importance of practitioner referral, with emotional difficulties, social anxiety and problems using the phone/internet cited as barriers to self-referral. Despite managing to self-refer, this client reported a preference for GP referral rather than contacting a new service while experiencing personal problems and distress:

I weren't feeling very well within myself to be honest to make contact with people (Client 3).

Others had felt unable to initiate contact:

I find phone conversations hard, so my partner contacted them on my behalf (Client 5).

Overall, this theme highlights the importance of awareness and understanding of social prescribing among practitioners and clients. Further, it outlines diverse ways of accessing social prescribing. Some practitioners used professional judgements to decide whether referral or signposting was most appropriate. Others appeared to judge that self-referral was an important element of empowering clients towards autonomous help-seeking and demonstrating motivation. This contrasted with client views about the difficulties in taking the first step, due to low self-confidence, and the need for support to facilitate this.

Theme Two - How Link Workers support clients

Important elements of the LW role were described including: exploration of client problems; developing effective relationships; providing information.

While some clients could articulate their needs clearly, others reportedly struggled to do so. Many were reported to have 'complex needs', in which they experienced additional or multiple issues, beyond those given on referral. Therefore, LWs often worked intensively with clients to identify their full range of needs, and potential sources of support:

Even if they're presenting perhaps with a physical health issue there's often underlying anxiety and depression that have come alongside it….they might have a different reason down on their referral but when we sit down and have a chat there's….breakdown of relationship, bereavement, etcetera, etcetera….the wider picture is my mental health has changed……and I need some other things to do to improve it (LW2).

This necessitated skilful questioning and listening from the LWs, who reported working to 'dig deep' or 'unpick' clients' problems:

Sometimes they just don't know what they need and they need to talk, so it's important to just listen….the questions that you ask them are important for getting out information (LW1).

To undertake this in-depth work, LWs were required to build effective working relationships with clients, ensuring they felt understood and supported. This client gave an example of such support:

I've been fighting for many, many years for someone to turn around and say 'I can see you're struggling but what I can see you struggling with is your people skills' and no-one's ever said that [before] .... they've never got to the root (Client 5).

In contrast, some clients had not experienced a positive working relationship; this was attributed to factors such as being given insufficient time; not feeling encouraged to discuss problems; not perceiving that the LW was interested in or understood their situation:

I was hoping that I could go and talk to [LW] about my problems and how I was feeling….and I was a bit disappointed when [they] didn't ask enough questions, so I wouldn't necessarily bring them up (Client 3).

The provision of information to facilitate the next stages of clients' social prescribing journeys was a key aspect of the LW role, requiring them to be knowledgeable about sources of support:

She just knew stuff, she was really knowledgeable, she was just plucking things out of her mind really and saying 'well we could try this' or 'did you know about this'? (Social Worker 2).

Just showed me what's actually about because I didn't know any of it existed and I've been through the system many times (Client 5).

Developing meaningful relationships, 'digging deep' and supporting clients to articulate the depth and breadth of issues all require time. Whilst LWs and managers described their service as offering short-term support, there was also recognition of the need for flexibility to tailor the duration of support to meet individual needs:

Our service is a very short intervention service, ideally we have an initial appointment, I address the issues, signpost and refer them where they want to be and after that we have a follow-up call and we close the case. That's an ideal case scenario and that happens a lot…many other times that's not the reality, people *have complex multiple issues, so we may see people more than once face-to-face and we may have contact with them multiple times (LW2).*

In summary, social prescribing was sometimes simply a matter of directing clients onwards. Other times it involved LWs building rapport, finding out more about the client's complex problems, then working with them in individually tailored ways to ensure that they accessed appropriate services.

Theme Three - Getting on: accessing support in the community

Important elements of LW support at this stage entailed facilitating client contact and engagement with VCS agencies and groups.

Agencies and groups differed in their requirements regarding initial contact. Some required referral prior to attendance; however, while willing to accept LW referrals, some preferred self-referral, citing a need for clients to demonstrate a level of autonomy and motivation:

Because… it's their commitment to do that then…..we reduce our DNA [Did Not Attend] rate because somebody's actually had the guts and actually the wherewithal to give us a ring (VCS Practitioner 2).

LWs recognised that some clients might lack confidence to initiate contact with agencies/groups; they preferred in such instances to make the first contact. The importance of this was also reinforced by clients and their supporters:

[LW] understood that he wouldn't do that [contact an agency] She said 'do you want to go?', 'Yes I do'. 'Leave it with me, I'll sort it, I'll give you a call tomorrow'. And she did. He had an appointment and he's been, so he's actually been to his appointment (Social Worker 2).

A client who struggled to use the phone and internet stated their preference for the LW to initiate contact; however, as this did not occur they had not themselves contacted or attended recommended groups.

There was an increased offer and use of 'buddying' over time, in which LWs attended the first session alongside clients. This was welcomed by clients and other practitioners:

Taking that first step, it's a little bit daunting (Client 1).

I needed someone there beside me just to make that initial step over the threshold, familiarise me (Client 5).

While the value of buddying was evident, it was not a guarantee of long-term engagement. Buddying support was usually offered once; however, this was not sufficient to enable ongoing attendance for some:

I think where we lose people sometimes....I've buddied people and they went for one session and they didn't go again (LW2).

Hoped somebody would go and take him [after the initial buddying visit]. Just sit with him, have a cup of tea. If he got to know people…. felt a bit more comfortable in that environment, I really feel like he would have begun to…access it in his own right (Social Worker 2).

This suggests a need for longer-term support for some clients, with attendance gradually tapering off as they gain confidence and become more settled, or for another agency to provide such support. However, concerns about client dependency were also reported:

What we don't want to do is swap a dependency from one service to another because there are people that do struggle, and all of a sudden they're latching onto the LW and ….boundaries get blurred (Social Prescribing Manager).

Difficulties in moving on were exacerbated by challenges in accessing suitable support for people with mental health needs, who appeared at risk of falling 'through the gaps' (Hazeldine et al, 2021); they could be ineligible for NHS/clinical support, while needing more support than was readily available within the VCS, including the need for long term intensive and/or specialist support.

In summary, there were tensions between the amount of support that LWs could and should provide and promoting personal independence. Without more extensive support, it was felt that some clients would not attend new services, but this had potentially significant resource implications, and personal independence was felt by some to be an inherent good.

Discussion

UK policy places high expectations on social prescribing to effect changes for individuals and for primary care. If these potential benefits are to be realised, it is essential that individuals gain access both to social prescribing services, and to relevant VCS services.

Husk et al. (2020, p.319) suggest that social prescribing is dependent upon:

A series of relationships, between referrer and patient, patient and link worker, link worker and activity and patient and activity, all of which need to function to meet patient need.

Our findings suggest that these relationships also need to be grounded in the provision of what we have termed 'personal support' (referred to by participants as 'hand holding', and Bertotti et al. (2018) as 'intensive coaching-style interventions') to enable individuals to progress to the next stage of their journey. This is consistent with Watt (2019, p.274) who observed that self-help and self-management are *destinations, not starting points, for many, and are only achievable after time is taken to build knowledge, confidence, and agency.* Personal support was required for complex reasons including lack of confidence and social anxiety, sometimes underpinned by complex underlying psychological issues, often not identified or diagnosed. These could include autism spectrum disorders, attention deficit hyperactivity disorder, chronic anxiety, and chronic, persistent, effects of grief or trauma.

Especially in older generations, such issues may have gone long unrecognised, but even mild forms can contribute to loneliness, isolation and reduced wellbeing (Barkley, 2018; Silberman 2015).

Two key areas of personal support were highlighted as important; in-depth LW support and support to enable clients to access new services, including entry into and beyond social prescribing services.

Our findings support previous research (e.g. Carnes et al., 2017; Skivington et al., 2018; Wildman et al., 2019), which highlight that Link Working is a skilled role that often requires time: it includes information provision; in-depth work to 'dig deep', explore client needs and priorities and develop motivation; establishing trusting working relationships; introducing clients to new forms of support. Some clients may benefit from brief information provision and signposting (Bertotti et al., 2018), which act as catalysts for change, however, others desire and benefit from gradually tapering longer-term provision. Without this, those in greatest need may be inadvertently excluded from social prescribing support. Longer-term LW support has resource implications, yet, there is some evidence to suggest that higher levels of LW contact are correlated with greater levels of uptake of community services (Mercer et al., 2019) potentially promoting better client outcomes.

Working in this context requires that LWs have the skills, training and supervision to enable them to maintain professional boundaries, manage client expectations and endings, and foster community links, reducing the risk of dependency (Wildman et al., 2019; Foster et al., 2020; Teirney et al, 2020; Rhodes & Bell, 2021). LWs themselves may experience dissonance between the role as commonly described and as experienced in practice, and a disconnect between the 'picturesque' training they receive, and their experiences of clients with more in-depth needs (Rhodes & Bell, 2021; Wildman et al., 2019).

Clients indicated that they lacked confidence when meeting new practitioners, agencies and groups and appeared to require more than signposting (see also Bertotti et al, 2018). However, while some practitioners recognised the importance of referral, and actively referred if judging this necessary, others appeared reluctant. This may reflect the effort required to make a referral; however, there was also a suggestion of moral judgements, and that those who would not or could not refer themselves lacked the motivation to engage with support, thus wasting practitioner time. Yet it appears that, for some, referral is an important element of the social prescribing journey, without which they will be unlikely to engage further. The importance of practitioner referral has been reinforced through the study of other services, including domestic abuse services; psychological therapies; exercise programmes. Their findings indicate that practitioners may underestimate the challenges of self-referral, perceiving that this demonstrates motivation and ownership of the recommended intervention, while clients perceive referral as legitimating their difficulties and as enabling, although some prefer a less directive approach, highlighting the importance of individualised responses (Carstairs et al., 2020; Roy et al., 2021; Thomas et al., 2019). These findings lend further support to the argument that practitioner referral can facilitate attendance, especially for those in challenging personal circumstances. The need for an individually and momentarily appropriate balance to be struck between support and dependency is a common issue in much work with clients.

Our findings on personal assistance has resonance beyond accessing social prescribing (and other services). The increased emphasis within health and social care on personalisation and individualised sources of funding is intended to enable individuals to create innovative sources of support which meet their needs and circumstances. While personalisation has delivered positive outcomes for some, it also relies on individuals' self-reliance and enterprise and may therefore deliver the greatest benefits to those best able to navigate the challenges of self-management, who have family members able to provide support, or who are able to draw on personal contacts (Scourfield, 2007; Southall et al., 2020, Turnpenny et al., 2021). Together our findings on social prescribing journeys and those from research and commentary on personalisation highlight the importance of ensuring that individuals have the assistance they need to identify and access community resources which meet their needs, and that concepts such as choice, independence and empowerment are not over-simplified with the consequent risk that individuals are disempowered through a lack of support and a misplaced overemphasis on self-reliance. Further research is needed within social prescribing (and other services) to gain quantitative insights into the numbers of people requiring 'more than signposting', and how practitioners make decisions about which approach to use.

As found elsewhere (Bertotti et al., 2018; Wildman et al, 2019) GP referrals into the service were lower than anticipated (although some self-referral may reflect GP signposting). Scepticism about the value of social prescribing; the volume of information GPs need to remember (and the consequent risk of overlooking social prescribing); the prominence of the medical model, and a lack of feedback to reinforce the value of the approach were all cited by participating GPs. A need for 'buy-in' by GPs and other professionals has been identified as a necessary element in ensuring the delivery of the intended benefits of social prescribing, in addition to patient and VCS buy-in (Bertotti et al., 2018; Tierney et al., 2020, Fixsen et al., 2020). In contrast, social work/social care accounted for considerably more referrals. However, the connections between social work and social prescribing have received little attention, although Fixsen et al. (2020: 7) notes social work 'success stories'. Further work to explore social workers' understanding and use of social prescribing, and the extent to which they can refer to social prescribing services (many of which are based within primary care) is needed, as well as research to further explore the apparent reluctance of GPs to refer.

Strengths and limitations

The findings of this paper support previous social prescribing research, while also presenting new findings. These include a focus on social work involvement in social prescribing, which is currently neglected in the literature; additionally, the findings further develop our understanding of the relative merits and limitations of referral and signposting.

Throughout the research there were difficulties recruiting clients. This has been a feature of other social prescribing studies (Bertotti et al., 2018; Carnes et al., 2017), and suggests a need to explore approaches which best support client participation, especially when clients are socially reticent. The perspectives of those who do not attend initial appointments are important for inclusion in future research, to further identify barriers to accessing support, and the assistance and information that might increase participation.

The research took place within a single urban-based social prescribing service; therefore, the findings may not be generalisable to all settings, given the diversity among services.

Repeat interviews were undertaken with long-term managers and LWs. This enabled us to track some significant developments in the service, such as the increased offer of buddying. However, COVID-19 restrictions also impacted on the work of the service (leading to reduced referrals, the replacement of face-to-face contact with phone support), and limited the extent to which long-term developments could be identified.

Conclusion

This study considered the social prescribing journey and the 'personal support' required by some to enable them to access support throughout. Key elements of this support included referral into and onwards from social prescribing services (in addition to signposting), longer-term LW support, and buddying. The balance between empowerment and dependency featured in practitioner responses, and a need for good support and supervision for LWs to enable them to provide support while minimising the risk of client dependency was highlighted. Unusually in this service, social workers were key referrers and there is a need to both explore the role of social prescribing in UK social work practice, and to explore why GP referrals can be lower than anticipated, and how this might be remedied.

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Tables

Table One: Participant groups and areas explored in data collection

Participant group	Areas explored within interviews/focus groups
Social prescribing managers	▪ Their role ▪ Service aims ▪ Service operation ▪ Patient journeys into and out of the service ▪ Difficulties and challenges ▪ Evidence of impact
GPs and social work practitioners	▪ Professional role ▪ Whether they have referred or signposted to social prescribing service, and why ▪ How/why they choose between formal referral or signposting ▪ Outcomes for clients/patients ▪ Any difficulties ▪ If they have not referred/signposted, reasons for not using the service
Link Workers	▪ Key elements of their role ▪ How they work to support clients ▪ Key issues people need support with ▪ Networking with potential referrers/the VCS ▪ Outcomes for clients ▪ Difficulties, challenges and successes
Clients	▪ How they came into contact with the service (referral/signposting/self-referral) ▪ Reasons for getting LW support ▪ Experiences of working with the LW ▪ Whether they went on to get support from the VCS ▪ Outcomes and changes experienced
VCS practitioners	▪ Their role ▪ Purpose and aims of their organisation/group ▪ Routes into their organisation from social prescribing ▪ Benefits of the social prescribing service for their organisation/the local area ▪ Any changes/developments required

Table Two: themes identified through qualitative analysis

Theme One	Accessing Link Worker Support
Theme Two	The Nature and Value of Link Worker Support
Theme Three	Getting on: Accessing Support in the Community
Theme Four	Perceived Benefits of Social Prescribing
Theme Five	Working to Deliver Social Prescribing

Table Three – Participant Groups

Participant group	**Individual participants***	**Total number of data collection activities**
Key Stakeholders	2 KSHs – single interview 1 KSH – 3 interviews	5 individual interviews
Referrers	13 GPs – focus groups 1 GP* – single interview 7 social work practitioners – single interviews 2 social work practitioners – joint interview 12 social work practitioners – focus group	4 focus groups 8 individual interviews 1 joint interview
Link Workers	2 LWs – single interview 3 LWs – 2 interviews each	8 individual interviews
Clients	5 clients – single interviews 2 clients - survey	5 interviews 2 surveys
Community Agencies and Groups	6 practitioners – individual interviews 2 practitioners – joint interview	6 individual interviews 1 joint interview
	Total participants: 57*	**Totals:** 32 individual interviews 2 joint interviews 4 focus groups

**One GP participated both in a FG and a follow-up interview.*