Northumbria Research Link

Abstract

For a social prescribing intervention to achieve its aims, clients must first be effectively engaged. A 'link worker' facilitating linkage between clients and community resources has been identified as a vital component of social prescribing. However, the mechanisms underpinning successful linkage remain underspecified. This qualitative study is the first to explore link workers' own definitions of their role in social prescribing and the skills and qualities identified by link workers themselves as necessary for effective client linkage. This study also explores 'threats' to successful linked social prescribing and the challenges link workers face in carrying out their work. Link workers in a social prescribing scheme in a socioeconomically-deprived area of North East England were interviewed in two phases between June 2015 and August 2016. The first phase comprised five focus groups (n=15) and individual semi-structured interviews (n=15) conducted with each focus-group participant. The follow-up phase comprised four focus groups (n=15). Thematic data analysis highlighted the importance of providing a holistic service focusing on the wider social determinants of health. Enabling client engagement required 'well-networked' link workers with the time and the personal skills required to develop a trusting relationship with clients while maintaining professional boundaries by fostering empowerment rather than dependency. Challenges to client engagement included: variation in the volume and suitability of primary care referrals; difficulties balancing quality of intervention provision and meeting referral targets; and link workers' training inadequately preparing them for their complex and demanding role. At a broader level, public sector cuts negatively impacted upon link workers' ability to refer patients into suitable services due to unacceptably long waiting lists or service cutbacks. This study

demonstrates that enabling client engagement in social prescribing requires skilled link workers supported by health-care referrer 'buy-in' and with access to training tailored to what is a complex and demanding role.

Key words: Behaviour/lifestyle interventions, chronic/long-term conditions, community interventions, complex interventions, patient engagement, social intervention

What is known about this topic:

- Social prescribing of non-clinical services is an increasingly popular strategy for tackling the burden of long-term conditions
- A 'link worker' facilitating client engagement is likely to be central to successful social prescribing

What this paper adds:

- Link workers with sufficient time and highly developed personal skills are vital for engaging clients facing complex challenges
- Bespoke training and career progression mechanism are needed to prepare and retain link workers in what is a demanding and highly-skilled role
- Spending cuts to voluntary and community services pose a grave risk to social prescribing

Introduction

Social prescribing enables primary-care practitioners to refer patients with long-term conditions (LTCs) into a range of non-clinical services within the voluntary and community sectors (South & Higgins, 2008). These interventions provide an individualised approach to health and wellbeing, with patients supported to identify and achieve personalised goals (Social Prescribing Network, 2016). Social prescribing interventions benefit patients by supporting them to address the wider psychosocial determinants of health, enabling better health-condition management and the adoption of healthier behaviours (Mossabir et al., 2015).

In a social prescribing intervention, patients must be 'linked' to appropriate groups and services, with the linkage route likely to influence service uptake (Husk et al., 2016). Linkage can be problematic (Dickinson & Glasby, 2010), with both practitioners and patients identifying a lack of time and knowledge in primary care to facilitate access to non-clinical resources (Wilson & Read, 2001). In addition, to effect change clients must be supported to maintain their involvement for an appropriate period of time (Brandling & House, 2009; Husk et al., 2016). For these reasons, social prescribing interventions frequently involve a facilitator link worker (alternative role titles include social prescribing co-ordinator, health trainer and community navigator) (Social Prescribing Network, 2016)). The level of link worker support varies between social prescribing models, ranging from 'light' (involving signposting to available resources) through to 'holistic' support that provides an intense level of link worker and service user interaction (Kimberlee, 2015).

The presence of a facilitator to link clients to community services "has been identified time and again as key to successful social prescribing" (Keenaghan et al., 2012, p. 6). However, knowledge is lacking of the processes by which social prescribing achieve its aims and the specific mechanisms by which link workers successfully engage clients (Bertotti et al., 2017; Mossabir et al., 2015; Rempel et al., 2017). An exception to this is a recent realist evaluation of a social prescribing scheme, which found that a skill-mix comprising excellent listening and empathetic skills appeared to build trust between link workers and clients (Bertotti et al., 2017). A report by the UK Social Prescribing Network (2016) also identifies effective link workers with the right skills and appropriate training as key components of successful social prescribing. While these factors are likely to be important there remains a lack of evidence on the nature of the particular skills and training link workers need to effectively engage clients (Hutt, 2016). This study aims to address this critical knowledge gap by exploring link workers' definitions of their role in social prescribing and the skills and qualities they perceive to be essential for effective client engagement. This paper also explores threats to successful client engagement and the challenges facing link workers.

Background

The 'Ways to Wellness' (WtW) service has been delivering link worker social prescribing in West Newcastle upon Tyne, an inner-city area in North East England (population n=132,000), since April 2015. The area is ethnically diverse and ranked among the 40 most deprived areas in England (Department for Communities and Local Government, 2013). A higher-than-average proportion of the West-Newcastle population have LTCs, with over 27 per cent of residents reporting a limiting LTC

compared with an English average of 17.9 per cent (Public Health Profile, 2014). Rates of receipt of sickness or disability-related benefits are also high, with 8 per cent of residents claiming an incapacity benefit compared to a national average of 6.5 per cent (McInnes, 2016).

The WtW service was developed over a period of years by the Voluntary Organisations' Network North East with support from Newcastle West Clinical Commissioning Group and ACEVO (Charity Leaders Network). At the time this study was conducted, the service was delivered by four third-sector organisations who employ link workers and receive referrals from primary-care practitioners based in 17 general practices. The service is initially funded for seven years in which time it is expected to generate savings for the Clinical Commissioning Group through reduced health-care usage (Ways to Wellness Ltd, 2018).

In the WtW model, patients are referred by a primary-care practitioner to a link worker trained in behaviour change methods. Referrals are targeted at patients aged between 40 and 74 with one (or more) of the following LTCs: diabetes types 1 and 2, chronic obstructive pulmonary disease, asthma, coronary heart disease, heart failure, epilepsy, and osteoporosis, with or without anxiety or depression. Following primary care referral, link workers contact clients by telephone to arrange an initial appointment. This could be at the GP practice, a community centre, café or, infrequently, at a client's home. At their initial appointment, clients work with their link worker to complete a 'Wellbeing Star' ™. This a proprietary tool that identifies target areas for improvement across the following eight domains: 1) 'lifestyle', covering areas such as diet and

exercise; 2) ‘looking after yourself’, covering self-care and activities such as shopping; 3) ‘managing symptoms’, including pain management and medication; 4) ‘work, volunteering and other activities’; 5) ‘money’, covering debt management and welfare entitlements; 6) ‘where you live’, dealing with housing issues such as adaptations and improvements; 7) ‘family and friends’ covering personal relationships; and 8) ‘feeling positive’, covering mood and outlook. Clients identify their current level in each domain, ranging from 1: ‘not thinking about it’ to 5: ‘as good as it can be’. Having identified areas to target, a client works with their link worker to identify personalised, achievable goals. Link workers assist clients to access community groups and services that will support them in achieving these goals (e.g. weight-management groups, welfare rights advice, arts-based activities, volunteering opportunities and support to find paid employment). Progress and goals are reviewed every 6-months thereafter for the duration of a client’s engagement with the service. Clients remain with the service for up to two years or, with link worker discretion, longer if needed. Over the course of clients’ engagement with WtW, face-to-face contact is also supplemented by telephone, email or text, with meeting duration frequency decreasing or increasing depending on need.

Method

Ethical approval for the conduct of this study was secured from Newcastle University Faculty of Medical Science Ethics Committee (00868/2014).

Data collection

Fieldwork was conducted in two phases between June 2015 and August 2016. The WtW service commenced in April 2015 and in this study's first phase link workers had been in-post for between 2 and 4 months. Immediately prior to the commencement of this study, link workers had completed a 10-day training programme, comprising an established Health Trainer National Vocational Qualification, training in the use of the 'Wellbeing Star' ™, motivational interviewing, and understanding of LTCs and mental health issues. The study's first phase aimed to capture link workers' early experiences of delivering what was a very new service and their perceptions of the recently-completed training. The second-phase explored how link workers' perceptions of how both the service and their role within it had developed over the course of a year. In the initial phase (June to September 2015), all link workers (n=15) employed by the four service-provider organisations were invited to take part in focus groups. All agreed to participate, resulting in five focus groups (total participants n=15). Following the focus groups, each participant was invited to participate in a one-to-one interview, which covered perceptions of their role and their behaviours in delivering the intervention. Individual interviews (n=15) were conducted to capture personal experiences free from the presence of group dynamics that may have influenced focus group responses.

In the second phase in August 2016, all link workers employed by the four service providers (n=17) were again invited to participate in focus groups. This resulted in four focus groups (participants n=15). Four link workers who participated in the first phase also participated in the second phase. One-to-one interviews were not conducted in the follow-up phase due to resource constraints and link worker time constraints.

In both phases, fieldwork was conducted at provider organisations or on University premises. Informed consent was collected prior to participation. Participation was entirely voluntary and link workers were reassured that declining to participate would not affect their employment with WtW. First-phase focus groups were conducted by LP. Individual interviews were conducted by LP, MS and KB. Second-phase focus groups were conducted by MS and CH.

Transcription, Data Management and Analysis

First-phase focus groups lasted between 58 and 87 mins (average 75 mins) and one-to-one interviews lasted between 16 and 79 mins (average 41 mins). Follow-up focus groups lasted between 75 and 92 mins (average 84 mins). All transcripts were digitally recorded and transcribed verbatim. Transcripts were anonymised, checked for accuracy and entered into NVivo10 software (NVivo 10, 2010) to support data management. Thematic analysis was used (Green & Thorogood, 2014). In phase one, following close reading of the focus group and individual interview transcripts by all members of the research team, a common coding scheme was developed, which contained a-priori themes based on the topic guides as well as further themes which emerged from the data. The coding scheme captured data relating to the role of the link worker; intervention delivery; and the intervention's context and resources. The coding frame was reviewed by all team members and modifications agreed and made before being applied to all interviews. Phase two analysis proceeded in the same way, with the development of the coding scheme to capture developments over time. In both phases, line-by-line coding and constant comparison were used to code the entire

dataset (Glaser & Strauss, 1967; Silverman, 2000). Deviant case analysis, where opinions were sought that modified or contradicted the analysis, was used to enhance validity (Barbour, 2001).

Findings

Participant characteristics in each phase are described in Tables 1 and 2. In both phases, the majority of link workers were female. Employment tenure by phase two ranged between 1 and 16 months, with an average tenure of 7.5 months.

[Table 1 about here]

[Table 2 about here]

Two key themes emerged from data analysis: 1) the realities and complexities of the link worker role; and 2) barriers to performing the role. Analysis of data from the study's first and second phases demonstrated how link workers' perceptions of their role and its challenges had changed over time.

The link worker role

The WtW service specifies the importance of trusting link worker/client relationships in order to motivate and encourage. Participants in the first phase recognised that their role was fundamental to the service's success, explaining that the presence of a link worker acted as a "*linchpin … the person [clients] come back to*", offering "*consistency*" (P9, Interview, Phase 1) over the period of clients' engagement with the programme. Link workers stressed the importance of delivering a non-directive service, viewing

their role very much as co-producers of change: "*It's an agreement between two people … It's not an 'us and them' it's an 'us', it's got to be together*" (P14, Phase 1, Interview, Phase 1). To achieve this non-directive enabling of goal-setting and behaviour change, link workers identified the need to be empathic, non-judgemental and use active listening skills to build trust and encourage honest self-reflection.

The WtW service is a holistic intervention (this is reflected in the varied domains covered by the Wellbeing Star ™). Participants in the first phase focus groups judged that the multiple challenges many clients' faced meant that physical health problems formed a relatively minor part of a role that centred on supporting clients in dealing with the economic, social and environmental determinants of health. By follow-up, link workers' experiences supported the contention that simply signposting to activities (the principle underlying 'light' social prescribing (Kimberlee, 2015)) would be ineffective in engaging clients and much more intensive support was required:

> *The work that we do is quite in-depth with the client … Some people say, "Well we should just be signposting and that's it." But actually we know that our clients, if we did that, they're not going to engage … So really we are quite intense. (P2, FG1, Phase 2)*

In the first phase, some link workers reported that training had increased their confidence in performing the role and their knowledge of areas such as confidentiality and safeguarding. They particularly welcomed the opportunity to study for a formal qualification. However, for others, early experiences of the role indicated that the

generic health-trainer training had inadequately equipped them with the practical skills and knowledge required to fully implement what was a highly complex role. This was confirmed at follow-up. A number of participants described their initial training as overly theoretical and lacking the more practical elements that may have better prepared them for the range and severity of the issues their clients faced:

> *The training that I did, I thought it was very 'picturesque': "Let's talk about the traditional female who sits at home and bakes. She would like to go to the gym or join a walking group to have a couple more friends. Her health's good but it's not great." You're not talking about 'Sally' who lives in a flat where the room's caving in, she's got no money and she's got loads of family. You're not actually talking about real poverty, which is what we deal with on a daily basis … (P3, FG4, Phase 2)*

The intensive levels of support required by some clients before they could focus on health improvements, meant that by necessity, providing initial support relating to the social determinants of health was proving to be a key part of the link worker role:

> *[We are] support workers more than link workers … I think you find when you go in with a client and they've got massive problems, like they've got no money for food, you can't just say, "Do you fancy going to the gym?" We have to look at the problem that's affecting them at the moment. (P2, FG4, Phase 2)*

By follow-up, link workers had identified a number of further training needs, including an increased focus on the wider determinants of health (e.g. giving advice on benefits and housing), further training on behaviour-change tools such as motivational interviewing and in-depth training on mental health issues and LTCs. Community development training to improve knowledge of the availability of community resources and how to access them was identified as particularly important.

Prior to their employment with WtW service providers, many of the participants in this study had been working in support and advocacy roles. First-phase participants reported that, beyond their formal training, valuable sources of knowledge and peer-support came from their wide range of professional backgrounds that included family, mental health and addiction support work; health training; and housing, welfare and debt advice. By this study's commencement, this knowledge resource was already being captured in a database by link workers in one provider organisation.

At follow-up, link workers continued to stress the benefits stemming from a range of previous experience. For example, prior experience in youth work and weight-management provided valuable motivational skills, while experience of support work was proving useful as it closely matched the link workers' role 'on-the-ground':

> *Personally, with my support worker background, I feel like that has helped me in a lot of ways, like just building up a rapport with people and managing to achieve things … So that for me has developed my ability to be compassionate*

but also to say, "I know you're feeling like this, but what can we do to solve things?" (P1, FG1, Phase 2)

Varying skill-sets also enabled link workers to try different approaches with difficult-to-engage clients. Mechanisms for career progression that recognised link workers' abilities and credited their prior experience were identified as vital; for example, the development of a supervisor role into which experienced link workers could progress.

Barriers to performing the role

Referral challenges

In WtW, and many other social prescribing initiatives, primary-care referrals are the first link in the social prescribing chain. At this study's commencement, WtW was a new service and link workers reported some general practices as more engaged than others. This resulted in considerable variation in the number and suitability of referrals. In this study's first phase, link workers identified three barriers to referral: firstly, high primary-care workloads leaving little time for referral; secondly, uncertainty over whom to refer; and thirdly, frustration with the WtW referral criteria precluding referral of patients who practitioners felt could benefit from social prescribing but were ineligible (for example, those outside the 40-74 age range). Due to the low referral rates from some GP practices, link workers had to take an active role in recruiting clients. A number felt uncomfortable with, and unprepared for, this aspect of their role, while others felt it prevented them focussing on engaging with clients

I didn't anticipate there being a slow start in terms of GPs referring and that's been difficult because it meant that marketing, promotion, selling, that has become quite a big part of the role … it's frustrating … it's like the quality of the work with the clients is running parallel and sometimes is side-lined by this panic of getting referrals. (P13, Interview, Phase 1)

An increase in referral rates by follow-up had created new challenges. Link workers reported tensions between achieving what were viewed as high referral targets and their ability to deliver the holistic, intensive support their clients needed.

At follow-up, some also noted that increasing targets were pressuring their employing organisations to accept clients who were not necessarily ready to engage. Link workers also reported increasing numbers of referrals of clients with complex physical and mental health needs combined with multiple financial and social issues. These clients could be at crisis-point at referral. Link workers felt they lacked the capacity and/or expertise to offer these clients the high-intensity, specialist support they needed. In response to managing increased targets, the four service provider organisations had adopted a 'triage' process where link workers differentiated between 'heavy' and 'light' and touch service users, respectively requiring more or less intensive support.

Onward referral challenges

Bertotti et al. (2017) and Skivington et al. (2018) identify the lack of availability of suitable onward referral services as a barrier to social prescribing . These deficiencies were frequently highlighted by link workers, in both phases of this study, who

identified that *"a massive barrier is other services' capacities*" (P1, Interview, Phase 1). Specific gaps in onward referral services included a lack of affordable and accessible groups and services for adults in their 40s and early 50s, especially those in employment who did not qualify for cost concessions and needed after-work services. Also lacking were flexible services that could be accessed on a drop-in basis according to clients' fluctuating health status and services tailored to the specific needs of Black and Minority Ethnic clients. Public-sector funding cuts had reduced funding to the voluntary and community sectors, leaving many services with reduced capacity to cope with social prescribing referrals. Where good-quality popular services were available for onward referral, link workers expressed concerns about services becoming over-subscribed.

As reported above, before they could focus on their clients' LTC management needs, link workers often had to deal with crises around welfare benefit appeals, evictions and debt. High demand coupled with decreasing capacity in services such as mental health support, welfare rights and housing advice meant many clients found themselves referred onto waiting lists in order to access services. At follow-up, lengthy waits to access specialist support services meant that link workers were frequently providing direct support with tasks such as welfare and housing applications. As their case-loads increased over time, dealing with the intensity of client's needs could place link workers under strain:

You've got medical assessments for benefits, it's a massive time consuming exercise. It's mentally draining. You've got two hour appointments. You've got elderly people who are facing homelessness because they've lost their benefit when they were getting disability [benefits]. (P4, FG4 Phase 2).

Boundary setting

In both phases of the study, link workers reflected that the intense support required by some clients meant that it was vital to set boundaries around expectations of the nature of support on offer. Perhaps the trickiest and most sensitive aspect of boundary-setting was managing clients' expectations around relationships. A strong, supportive link worker/client relationship is vital for successful social prescribing (Moffatt et al., 2017). Nevertheless, relationship boundaries were not always easy to set and required careful management, with link workers describing "*a bit of a balancing act*" between being a "*friend but not a friend*" (P13, Interview, Phase 1). A useful strategy for managing client dependency involved referring clients to specialist services and utilising the multi-agency approach suggested in the link worker training.

By follow-up, link workers had established relationships with some clients over a period of months. Dependency continued to be identified as an issue, with link workers expressing concerns both over the risk of client dependency and of themselves becoming "*too emotionally involved*" with clients who "*are not seeing you as their professional worker but as their friend*" (P2, FG3, Phase 2). Additional strategies for maintaining appropriate boundaries had been developed over time, including regularly reminding clients of the limits of the link worker role, creating

distance by doubling-up, swapping link workers or running group activities and reasserting the importance of empowerment rather than dependency.

Discussion

Hutt (2016, p. 94) observes that "if social prescribing is to be successful, it is imperative that learning from projects is shared". This study is the first to explore link workers' perceptions of their role and its requirements. Broad definitions of the link worker role and its requisite skills have been identified (for example, Brandling & House, 2007; Keenaghan et al., 2012). This study makes clear what the role entails 'on-the-ground'. To foster the trust and open communication required for identifying and setting client goals, link workers needed highly-developed interpersonal communication skills. Indeed, the skills and qualities link workers identified as important in this study are an excellent fit with Brandling and House's (2009, p. 15) description of the putative 'ideal' link worker as "someone with highly developed interpersonal communication and networking skills, with a motivating and inspiring manner to encourage clients to make brave decisions or take up new opportunities". There is a high degree of fidelity between WtW link workers' accounts of their role and skills and the accounts of service users in an earlier study (Moffatt et al., 2017; Wildman et al., 2018). Specifically, clients identified a close client/link worker relationship and link worker continuity as important factors in service engagement and in making and maintaining lifestyle changes (Moffatt et al., 2017; Wildman et al., 2018). In this study, we identify a risk of dependency arising from this close relationship, with link workers sharing a range of strategies developed over time to mitigate this risk.

355 It is argued that linkage underpins successful social prescribing. Our findings support
356 the contention that the presence of a link worker is necessary for effective social
357 prescribing (Keenaghan et al., 2012; Whitelaw et al., 2017). Primary-care appointments
358 in the UK are routinely allocated only 10 minutes (Oxtoby, 2010) and practitioners,
359 therefore, lack the time to support patients dealing with complex problems beyond
360 health. In contrast, link worker appointments tend to be considerably longer (WtW
361 initial appointments are around one-hour, with appointment length then varying
362 according to clients' needs), with link workers explicitly tasked with helping clients
363 identify and address issues beyond their physical health. Further, link workers were
364 clear that social problems were a severe impediment for many clients, preventing
365 them from effectively managing their physical and mental health. Without holistic and
366 intensive link worker support, clients could not engage effectively with the
367 intervention. Moreover, the rationale behind the link worker role is that identifying,
368 navigating and accessing community services can be extremely challenging, especially
369 for patients in socio-economically disadvantaged areas (Mercer et al, 2017). Primary-
370 care professionals are unlikely to have knowledge of the full range of community-
371 based resources and this study confirms that effective linkage requires link workers'
372 comprehensive community knowledge.
373
374 This study also identifies impediments to the effectiveness of the link worker role. Our
375 findings confirm the importance of primary-care practitioners' engagement with social
376 prescribing (White et al., 2010)(Whitelaw et al, 2017). In common with other studies
377 (Bertotti et al., 2017; Brandling & House, 2009; Mercer et al., 2017), we find that link
378 workers' experiences of primary-care engagement with social prescribing indicate that

379 practitioners can be both slow to identify patients who may benefit from social
380 prescribing and to refer. We identify as an additional issue the referral of patients with
381 severe and complex social problems who may be unable to engage with social
382 prescribing. Link worker capacity is also an important consideration, requiring realistic
383 referral targets that take account of the complexity of cases.
384
385 Onward referral groups and services are a further vital link in the social prescribing
386 chain. Our study supports the suggestion that access to high-quality and continuously-
387 funded community resources is central to the success of social prescribing (Whitelaw
388 et al., 2017). Areas of high-socioeconomic deprivation have been disproportionately
389 affected by prolonged austerity around public spending and the resulting cuts to
390 services in the public and voluntary sectors (Bambra & Garthwaite, 2015). This may
391 present an existential threat to social prescribing.
392
393 This study highlights the challenges and complexities of the link worker role and
394 suggests that both initial and on-going training should be a particular focus. In
395 common with a previous study (Bertotti et al., 2017), we identify the value of link
396 workers with backgrounds in health training, welfare rights advice and support work.
397 However, the development of 'bespoke' link worker training, perhaps including
398 elements to enable career progression and/or give credit for prior skills and
399 experience, could help to clarify and support the link worker role, enhance its status
400 and ensure service fidelity and consistency. As an additional benefit, standardised link
401 worker training would help to simplify at least one aspect of the complicated task of

evaluating the effectiveness of link worker social prescribing programmes (Rempel et al., 2017).

Finally, if, as suggested, "the link worker has arguably the most important role in social prescribing", the role must be valued appropriately (Social Prescribing Network, 2016). A number of social prescribing schemes use volunteers as link workers. However, the high levels of skills and knowledge required and the role's demands indicate the necessity of a paid link worker role with career progression. A recent Social Prescribing Network report (2016) identifies the challenges in finding skilled and networked link workers, observing that, while the link worker person specification is demanding, the pay is relatively low. Robust cost-effectiveness studies of social prescribing are lacking (Polley et al., 2017) but are needed to identify the costs and benefits of link workers as it may be the case that the role justifies higher remuneration, greater professionalisation and scope for career development.

Strengths and limitations

The longitudinal nature of the data collection is a strength of this study. Two phases of data collection captured link workers' initial perceptions of the role and the nature and extent of changes over time. The participation in phase one of all link workers employed by the WtW service and the participation in phase two of a majority of link workers means that the sample is a good reflection of link workers' views. In the first phase, individual interviews conducted after the focus groups allowed us to explore link workers' views free from the influence of group dynamics. The study is limited by the lack of individual interviews at follow-up.

Conclusion

As social prescribing becomes more widespread, knowledge is building on the components of effective practice. This study adds to the evidence base by reporting the experiences of link workers delivering a social prescribing scheme during its first and second years. Link workers were central to client engagement, demonstrating reflective practice, willingness to learn and to share their learning, and commitment to a complex role they performed with skill. This study's findings also provide direction for commissioners and practitioners interested in developing link worker social prescribing schemes. Firstly, perhaps most important is a properly funded voluntary and community sector. Equitable allocation of resources between all the links in the social prescribing chain will be vital for the long-term sustainability of social prescribing (Bertotti et al., 2017; Brandling & House, 2007; Keenaghan et al., 2012). Progress is being made in this area, with the Department of Health announcing a scheme to provide grant funding directly to voluntary and community sector organisations to develop social prescribing programmes (NHS England, 2017). Funding will only be provided to schemes involving link workers in recognition of the pivotal role of link workers in social prescribing. Secondly, although social prescribing is becoming increasingly popular, there is still some uncertainty in primary care (Harrison, 2018). Further research into the reasons for differing levels of GP engagement with social prescribing is required. Finally, training and career development are likely to be central to recruiting and retaining link workers. Work is being undertaken to identify core competencies required by link workers. These competencies are intended to inform the development of a bespoke qualification that builds on and develops existing skills

(Health Education England, 2016). This is likely to be essential for developing high-quality link worker social prescribing to be delivered to people with complex needs.

References

Bambra, C., & Garthwaite, K. (2015). Austerity, welfare reform and the English health divide. *Area, 47*(3), 341-343.

Barbour, R. S. (2001). Checklists for improving rigour in qualitative research: the case of the tail wagging the dog? *British Medical Journal, 322*, 1115-1117.

Bertotti, M., Frostick, C., Hutt, P., Sohanpal, R., & Carnes, D. (2017). A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. *Primary Health Care Research and Development*. doi: 10.1017/S1463423617000706

Brandling, J., & House, W. (2007). Investigation into the feasibility of a social prescribing service in primary care: a pilot project: University of Bath and Bath North East Somerset NHS Primary Care Trust.

Brandling, J., & House, W. (2009). Social prescribing in general practice: adding meaning to medicine. *British Journal of General Practice, 59*(563), 454-456. doi: 10.3399/bjgp09X421085

Department for Communities and Local Government. (2013). The English Indices of Deprivation 2010.

Dickinson, H., & Glasby, J. (2010). Why Partnership Working Doesn't Work. *Public Management Review, 12*(6), 811-828.

Glaser, B., & Strauss, A. (1967). *The Discovery of Grounded Theory.* Chicago: Aldine.

Green, J., & Thorogood, N. (2014). *Qualitative Methods for Health Research*. London: Sage.

Harrison, K. (2018). Social Prescribing: let's not lead in without the evidence. *BMJ, 362*.

Health Education England. (2016). Care Navigation: A Competency Framework. London.

Husk, K., Blockley, K., Lovell, R., Bethel, A., Bloomfield, D., Warber, S., . . . Garside, R. (2016). What approaches to social prescribing work, for whom, and in what circumstances? A protocol for a realist review. *Systematic reviews, 5*(93), 1-7. doi: 10.1186/s13643-016-0269-6

Hutt, P. (2016). Social prescribing: A new medicine? *InnovAiT*.

Keenaghan, C., Sweeney, J., & McGowan, B. (2012). Care Options for Primary Care: The development of best practice information and guidance on Social Prescribing for Primary Care Teams.

Kimberlee, R. (2015). What is social prescribing. *Advances in Social Sciences Research Journal, 2*(102-110).

McInnes, R. (2016). ESA and incapacity benefits – constituency statistics for Great Britain. London.

Mercer, S., Fitzpatrick, B., Grant, L., Chng, N., O'Donnell, C., Mackenzie, M., . . . Wyke, S. (2017). The Glasgow 'Deep End' Links Worker Study Protocol: a quasi-experimental evaluation of a social prescribing intervention for patients with complex needs in areas of high socioeconomic deprivation. *Journal of Comorbidity, 7*(1), 1 - 10.

Moffatt, S., Steer, M., Penn, L., & Lawson, S. (2017). What is the impact of 'social prescribing'? Perspectives of adults with long-term health conditions. *BMJ Open, 0:e015203. doi:10.1136/bmjopen-2016-015203*.

Mossabir, R., Morris, R., Kennedy, A., Blickem, C., & Rogers, A. (2015). A scoping review to understand the effectiveness of linking schemes from healthcare providers to community resources to improve the health and well-being of people with long-term conditions. *Health & social care in the community, 23*(5), 467-484. doi: 10.1111/hsc.12176

NHS England. (2017). VCSE Health and Wellbeing Fund 2017-18: Social Prescribing. London: Department of Health.

NVivo 10. (2010). Computer Assisted Software for Qualitative Analysis. Retrieved 20.3.07, 2007

Polley, M., Bertotti, M., Kimberlee, R., Pilkington, K., & Refsum, C. (2017). A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications. London: University of Westminster.

Public Health Profile. (2014). Newcastle and Gateshead health and care economy five year strategic plan 2014/15 – 2018/19. London.

Rempel , E. S., Wilson, E. N., Durrant, H., & Barnett, J. (2017). Preparing the Prescription: a review of the aim and measurement of social referral programmes. *BMJ Open, 7*. doi: 10.1136/bmjopen-2017-017743

Silverman, D. (2000). *Doing qualitative research*. London: Sage.

Skivington, K., Smith, M., Chng, N. R., Mackenzie, M., & Wyke, S. (2018). Delivering a primary care-based social prescribing initiative: a qualitative study of the benefits and challenges. *British Journal of General Practice, 68*, 487-494. doi: doi: https://doi.org/10.3399/bjgp18X696617

Social Prescribing Network. (2016). Report of the Annual Social Prescribing Network Conference. London: University of Westminster.

South, J., & Higgins, T. J. (2008). Can social prescribing provide the missing link? *Primary Health Care Research and Development, 9*, 310 - 318.

Ways to Wellness Ltd. (2018). Ways to Wellness. Retrieved 25/10/18, from http://waystowellness.org.uk/

White, J., Kinsella, K., & South, J. (2010). An evaluation of social prescribing health trainers in South and West Bradford. Leeds: Leeds Metropolitan University.

Whitelaw, S., Thirlwall, C., Morrison, A., Osborne, J., Tattum, L., & Walker, S. (2017). Developing and implementing a social prescribing intitiative in primary care: insights into the possiblity of normalisation and sustainability from a UK case study. *Primary Health Care Research and Development, 18*, 112-121.

Wildman, J. M., Moffatt, S., Steer, M., Laing, K., Penn, L., & O'Brien, N. (2018). *Service-users' perspectives of link worker social prescribing: a qualitative follow-up study*. Under review.

Wilson, J., & Read, J. (2001). What prevents GPs from using outside resources for women experiencing depression? A New Zealand study. *Fam Pract, 18*. doi: 10.1093/fampra/18.1.84

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