Received: 4 May 2020 | Revised: 5 February 2021 | Accepted: 24 February 2021

DOI: 10.1111/hsc.13358

ORIGINAL ARTICLE

Health and Social Care in the community

WILEY

"It sounded a lot simpler on the job description": A qualitative study exploring the role of social prescribing link workers and their training and support needs (2020)

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Funding information
No external sources of funding.

Abstract

Social prescribing is an increasingly popular approach to promoting health and well-being, by addressing the wider determinants of health such as physical inactivity, social isolation and financial insecurity. Social prescribing link workers (SPs) connect people to local, non-clinical services. As part of the NHS Long Term Plan, NHS England aims to recruit 1,000 SPs across England by 2021. Understanding the role of SPs, including challenging aspects of the role and the types of training and support needed by SPs is crucial to optimising the effectiveness of social prescribing. Semi-structured qualitative interviews were conducted with nine SPs from five NHS and voluntary sector organisations in London to explore the role of SPs and identify SP training and support needs. Interviews were analysed thematically and three key themes emerged for which SPs needed particular support: defining and promoting their role; supporting clients with complex needs and coping with the emotional demands of their role. SP perceptions of training and future training needs is presented as a fourth theme. Most SPs felt that the initial training received for their role did not prepare them for the most demanding aspects of their roles. The findings of this study support the assertion that the social prescribing link worker role is complex and challenging. SPs are required to have in-depth knowledge of local services, which is built over time and makes retention in the role of high importance. Steps have been taken to develop online resources to support SPs, however, there may be a need for more comprehensive training, especially in mental health. SPs benefit from access to peer or one-to-one support to help them manage the emotional demands of the role and could benefit from the formation of local networks, especially for SPs working in isolation.

KEYWORDS

link worker, personalised care, qualitative methods, social prescribing, support, training

What is known about this topic?

- Social prescribing is a complex and demanding role.
- There is minimal evidence to support the development of social prescribing roles, specifically what training and support is needed.

- Research suggests that the initial training received by link workers may not adequately equip them for the role.

What does this study add?

- SPs reported the need for more comprehensive training, especially in mental health.
- Improvements in awareness of and understanding of SP roles among health professionals are needed to support SP role development and optimise the effectiveness of social prescribing.
- The development of local SP networks to provide peer-to-peer support could help SPs manage the emotional demands of their roles, particularly for SPs working in isolation.

1 | INTRODUCTION

Social prescribing is a novel approach to managing health and well-being in the UK. The aim of social prescribing is to improve health outcomes and reduce the burden on health services by addressing the social determinants of health, as well as empowering people to live more healthy lives (Kings Fund, 2017). Social prescribing may be carried out by any health professional. However increasingly, social prescribing link workers (SPs) are recruited from a variety of professional backgrounds and are employed to provide a holistic assessment and support clients to manage complex health and well-being needs. For example, a person with diabetes who is overweight and struggling with low mood could work with an SP to identify a range of factors affecting their health and well-being and co-produce a plan to address these. In this example, the SP may link the client to a local long-term condition support group and support them to attend a local exercise class. Although "social prescribing" is a relatively new concept in the UK, similar programmes can be seen internationally. Health Leads is a non-profit organisation in the US, which employs advocates to connect individuals with community organisations to address social issues, with the aim of improving health (Alderwick et al., 2018; Health Leads USA, n.d.)

There is limited evidence for the effectiveness of social prescribing and it can be a challenging intervention to evaluate (Gottlieb et al., 2017; Husk et al., 2019). However, a number of early evaluations have shown positive effects on reducing the number of general practice (GP) and emergency department visits in places where social prescribing programmes have been implemented (Bickerdike et al., 2017; Carnes et al., 2017; Healthy dialogues, 2018). Despite the challenges in evaluating the effectiveness of social prescribing, it has been noted that the skills and experience of SPs is central to the success of any programme (Skivington et al., 2018). Social prescribers need an in-depth knowledge of community provision in the local area and must be trusted by community organisations they refer on to (Wildman et al., 2019). Community integration develops with experience and time spent in the role, adding to the importance of providing training and support to retain SPs.

In the UK, SPs can be employed by voluntary sector organisations and then commissioned to carry out work for the NHS or be recruited directly by the NHS and form part of primary care teams. SPs receive referrals from other health professionals such as GPs and self-referral is often available. In many areas SPs take part in multidisciplinary meetings in GP practices and have access to NHS patient records. As SPs work across health, social care and the voluntary sector, they have a vital role to play in the integration of health and social care (NHS England, 2019; Polley et al., 2017). Services vary nationally in the length and intensity of the support offered to clients ranging from telephone only support or sign posting to other services, to more holistic social prescribing (Kimberlee, 2015) which starts with a comprehensive assessment of need and may include face-to-face appointments offered over a number of weeks. There are different models of social prescribing ranging from simply signposting individuals to appropriate services (light) to working with clients over a number of sessions and weeks to empower them to work towards their health and well-being goals (holistic) (Kimberlee, 2015). Increasingly, it is noted that people who are employed in SP roles are using a holistic model with clients (Beardmore, 2019).

Moffatt et al., (2017) explored the client perspective of social prescribing and found that people accessing social prescribing often had multiple health conditions, mental health difficulties and were socially isolated, creating complex caseloads of clients for SPs. As well as addressing complex client needs, SPs are expected to network with community organisations, look for gaps in community services and work with organisations to fill those gaps (Skivington et al., 2018). The role of SP is complex and demanding (Skivington et al., 2018), in order to fulfil the requirements of the role SPs must have a breadth of knowledge and skills for which appropriate training should be developed. One recent study explored the experiences of SPs working in the role and found that many SPs brought years of relevant experience, however, gaps in training were highlighted to help them develop in their roles and careers; including people management and collaborative working skills (Beardmore, 2019). The aim of this study was to explore the challenges of working as an SP and their experiences of training and support received as they develop in this new and evolving role.

2 | METHODS

This study used an interpretative phenomenological approach to explore the lived experiences of individuals working as SPs (Smith et al., 2009). The primary researcher carried out in-depth semi-structured interviews with SPs working in NHS and voluntary organisations in Greater London.

2.1 | Recruitment and data collection

SPs were purposively recruited from a variety of NHS and voluntary sector organisations with the aim of gaining a rich view of social prescribing in different organisational, demographic and societal contexts. Recruitment began through the London Social Prescribing Network, attendance at related conferences and through other contacts previously known to the researcher. Snowball sampling led to the recruitment of a small proportion of the participants. Sampling was limited to organisations within the Greater London area due to time constraints placed on the research.

The interviews lasted 30–45 min and took place in person or via telephone. All interviews were audio-recorded and conducted by JR. A topic guide was developed following a review of the literature and refined after the first two interviews. Questions about initial recruitment and training for the role, role challenges and experiences of support were included. Space was provided for the participant to explore specific questions in more detail or discuss anything relevant but not previously defined in the topic guide.

2.2 | Data analysis

Interviews were transcribed verbatim and analysed thematically using the stages described by Braun and Clarke (2006). Particular thoughts, insights or ideas were coded and these codes were then organised into themes. One transcript was coded separately by SB to enhance the rigour of the analysis and coding approaches were discussed and refined. See Table 2 for the coding structure with illustrative quotes. NVivo 11 software was used to support the analysis.

2.3 | Ethical approval

Ethical approval was gained from the London School of Hygiene and Tropical Medicine Ethics Committee and Health Research Authority (Project ID: 263,270) approval was gained for interviewing NHS employees. For all non-NHS-employed participants, there were no formal local ethical approval requirements, therefore permission to approach and interview participants was gained from their line manager. Participants were provided with a participant information leaflet at least 24 hr prior to the interview, fully detailing the study procedures and explaining all aspects of participation including their right to withdraw from the research and issues surrounding confidentiality and data protection. Participants signed a consent form before the time of the interview. As the participants were discussing potentially difficult workplace issues, any participant who raised concerns about their own well-being were signposted appropriately.

3 | FINDINGS

Nine social prescribers were recruited to this study: seven women and two men, from three voluntary sector organisations and two NHS organisations in Greater London. Six SPs were employed by voluntary sector organisations, and three SPs were employed by NHS organisations. See Table 1 for details.

The job titles of the participants included social prescriber, social prescribing link worker, locality navigator, community navigator and stroke care advisor. Three key themes emerged from the interviews for which SPs required training and support: defining and promoting the role, supporting clients with complex physical and mental health needs and coping with the emotional demands of the role. A fourth theme is also presented in which SPs consider how well their training prepared them for the abovementioned challenges and what their future training needs may be; perceptions of training received and training needs. Quotes illustrating these themes are presented in Table 2.

4 | DEFINING AND PROMOTING THE ROLE

Participants often felt that their job scope and remit had been poorly defined from the outset and it had *"sounded a lot simpler on the job description" (SP4)*. Participants also reported that their role was not well understood by external referrers such as GPs. It was reported that external referrers often had unrealistic expectations of what could be achieved by SPs, and in some cases were referring clients with complex needs that exceeded the remit of their role.

> "I would definitely say it's a pattern for GPs to refer clients to you that they don't know what to do with… they know the person can't be helped, and even for the social prescriber it's going to be a long hard path, and really social prescribing is meant to be a low level intervention" SP7.

Challenges were experienced by the SPs in defining and promoting the service to potential referrers and NHS colleagues. In some cases SPs were tasked with setting up the service and deciding *"how to promote your role, how to make people aware, how to articulate the role" (SP7)* without support or guidance. One SP experienced frustration while attempting to articulate to their colleagues that social prescribing is not *"only signposting" (SP7)*.

TABLE 1 Details of social prescriber participants and their organisations

Social prescriber (SP no.)	Employment	Time in role	Gender	Description of role and clients	Support available for SP
SP1	Voluntary sector	2 years	Male	Clients aged 65 + years in a team of SPs. Receives referrals from attending a multidisciplinary team (MDT) meeting weekly at a number of GP practices. Intervention time limited to 6 weeks. Mixed levels of deprivation in area covered. Appointments carried out in client homes or GP practices.	Support from VSO team manager, peer support within team of SPs.
SP2	Voluntary sector	2 years	Female	Clients of all ages in a team of SPs. Accepts self-referrals and referrals from healthcare professionals or through attendance at GP surgery MDT meetings. High level of deprivation throughout area covered. Time limited intervention 6–8 weeks, possibility to extend for some challenging cases. Appointments carried out at organisation base or GP practice.	Support from VSO team manager, peer support within team of SPs. SP receives monthly one-to-one support from a clinical psychologist.
SP3	Voluntary sector	2 years	Female	Clients of all ages in a team of SPs. Accepts self-referrals and referrals from healthcare professionals or through attendance at GP surgery MDT meetings. High level of deprivation throughout area covered. Time limited intervention 6–8 weeks, possibility to extend for some challenging cases. Appointments carried out at organisation base or GP practice.	Support from VSO team manager, peer support within team of SPs. SP receives monthly one-to-one support from a clinical psychologist.
SP4	NHS	1.5 years	Female	Clients aged 65 + years with complex physical health needs. Part of a team of SPs but often works in isolation as the team cover different geographical areas and hot desk to a number of bases. Work alongside NHS case managers, who also refer patients. Can also receive referrals from GPs and attend MDT meetings at GP surgeries. Appointments generally carried out in client homes.	Support from supervising health professional.
SP5	NHS	2 years	Female	Clients aged 65 + years with complex physical health needs. Worked in a team of SPs but often isolated in practice as the team cover different geographical areas and hot desk to a number of bases. Works alongside NHS case managers, who also refer patients. Can also receive referrals from GPs and attend MDT meetings at GP surgeries. Appointments in client homes.	Support from supervising health professional.
SP6	NHS	10 months	Female	Accepts referrals from a multidisciplinary team for clients of all ages with complex physical health needs. Does not work with other SPs. Time limited to 12 weeks. Appointments in client homes.	Support from supervising health professional.
SP7	Voluntary sector	1.5 years	Female	Clients of all ages. Accept self-referrals and referrals from healthcare professionals or through attendance at GP surgery MDT meetings. Works in a team of SPs. Mixed levels of deprivation in area covered. Weekly meeting with team of SPs for support. Appointments carried out in GP practices.	Support from SP team manager. Weekly peer support meeting with team of SPs.

(Continues)

TABLE 1 (Continued)

Social prescriber (SP no.)	Employment	Time in role	Gender	Description of role and clients	Support available for SP
SP8	Voluntary sector	2 years	Female	Clients of all ages. Works in a team of SPs. Accepts self-referrals or referrals through GP MDT meetings. Supervisory responsibilities. High level of deprivation throughout area covered. Time limited intervention 6–8 weeks, possibility to extend for some challenging cases. Appointments carried out in GP practices.	Peer support within team of SPs. SP receives monthly one-to-one support from a clinical psychologist. Also provides managerial and pastoral support to a team of SPs
SP9	Voluntary sector	2.5 years	Male	Clients of all ages. Works in a team of SPs. Supervisory responsibilities. Accept self-referrals and through attendance at GP surgery MDT meetings. Mixed levels of deprivation in area covered. Appointments carried out in GP practices.	Weekly peer support meeting with team of SPs. Provides managerial and pastoral support to a team of SPs.

Participants reported that being viewed only as a signposting service could be frustrating and devalue the contribution of SPs who often use a range of skills to help clients connect with services and address a complex variety of issues affecting their health and well-being.

5 | SUPPORTING CLIENTS WITH COMPLEX PHYSICAL AND MENTAL HEALTH NEEDS

One of the greatest challenges discussed by SPs was providing support to a caseload of clients with a range of complex physical, mental health and social needs. SPs reported that clients often disclosed serious mental health problems, including suicidal ideations. It was reported that the philosophy of social prescribing practice created opportunities for mental health to be discussed more openly:

> "I just find that sometimes, when you are working in a more holistic way, people are more open to bringing things up and I think that when you are suicidal you are desperate to tell somebody how you are feeling…our appointments are one hour long and someone can feel more comfortable and at ease talking to somebody to sort of raise their concerns and about suicide" SP7.

Participants reported that their way of working contrasted to that of GPs and other health professionals, who often have short appointment times or only allow for a single issue to be discussed, making it unlikely that a mental health issue will be raised. SPs working in NHS services often found it was challenging to meet the needs of clients who were physically disabled or housebound due to the lack of services available to assist them in leaving the house, which severely limited the services SPs were able to link to:

> "disabled people who cannot leave the house because they do not have a care worker…we just have no one to support them to go to these groups, I guess it's not that they don't want to attend activities, it's that they don't have the means to do it" (SP6).

6 | EMOTIONAL BURDEN AND COPING

SPs spoke of the emotional burden associated with working in the role, at times feeling unable to help within the limits of their personal resources and at risk of burn-out:

> "often you think you're managing fine and that you've done it, sorted it out yourself, but then it actually does take a toll physically, or on you" SP4.

SPs coped with the emotional burden in a variety of ways. Participants felt that having a safe space to debrief their experiences was particularly important to support their health and well-being. SPs discussed one-to-one supervision and peer support as particularly valuable:

> "having a team of social prescribers… just to organise your thoughts with or have some reflective time with, you know, another social prescriber can be really valuable" (SP8).

Not all SPs worked in teams and getting appropriate professional and personal support when professionally isolated was reported as a challenge. Where SPs were unable to find support from another SP, they felt increased anxiety regarding their ability to fulfil their role and cope emotionally, as others' understanding of the role was perceived to be limited. The importance of support which was quick and easy to access on an informal basis was discussed by several SPs, which may also make working in isolation as an SP more challenging. SPs working in voluntary sector organisations in this study spoke of having organised mechanisms of peer or one-to-one

TABLE 2 Themes, codes and illustrative quotes from semi-structured interviews

Theme	Description of theme	Codes	Quotes
Defining and promoting the role	Participants' experiences of working in an evolving role, making sense of the role for themselves and others. Needing to promote the role to raise awareness and promote the status of social prescribing link workers. Negotiating client and professionals' expectations.	Defining role for self, client expectations, evolving role, not just signposting, others' expectations and communicating role to others	*"GPs were giving the wrong information about the extent of what we can do", "There needs to be some clear cut guidance on what a link worker is allowed to do and what's not to do, a clear defined job role" (SP2) "I'm trying to help patients with X,Y,Z and they [patients] don't know what they can ask us, or ask us to do, they don't seem to understand" (SP4)*
Supporting clients with complex physical and mental health needs	Participants' sense of their caseload and how it is evolving as services develop.	Every client is different, increasing complexity, complex mental health, quality of training, peer support and shadowing	*"I kind of noticed how the caseload has been getting bigger and bigger and how people are coming with more complex issues", "the number of people coming in who are feeling suicidal or have suicidal thoughts is quite great" (SP3) "I find it most challenging when we see complex patients " (SP7)*
Coping with the emotional demands of their role	Participants explore the most challenging aspects of the role. The effect on their mental well-being and the strategies they use to manage this. Types of personal support received were discussed.	Need to offload, self-protection, staff retention, emotional labour, peer support, clinical supervision and coping strategies.	*"It's all about how you relate, don't take stuff home with you and be professional, don't get tangled up and keep boundaries and all that stuff that's important", "It can be quite isolating, I was for the first year on my own" (SP9).* *"If you're seeing five people a day, four days a week then there's a lot of problems and issues that are coming up and maybe even triggers for you in your own personal life" (SP7)*
Perceptions of training and future training needs	Participants talk about their experiences of training in the role, what was most useful to them and unmet need for training in certain areas.	Mandatory/statutory training, online training, role shadowing, mental health training, feeling under prepared, need to be proactive and lack of funds for training	*"Sometimes, like domestic abuse, the online module was absolutely disappointing, it was 20mins and it was literally just facts and statistics, no practical help at all" (SP2)* *"The training I received was a lot of online training, things like data protection and adult safeguarding…but it doesn't tell you how to be an effective social prescriber, it doesn't tell you about the challenges you will face, it doesn't talk about support mechanisms, who to go to for support"(SP3) "There wasn't really much training, it was just shadowing, I had to be active in finding my own training online or with different organisations" (SP7)* *"There are quite a few obligatory training courses that you need to do and there are some other ones you can choose from so I just did as much as I could" (SP1)* *"There was one we all wanted to go to* [social prescribing event/conference] *but we couldn't go because it cost too much money…they wouldn't allow it"(SP4)*

support, in the case of one organisation, monthly *"clinical supervision"* (SP2) with a clinical psychologist. SPs working for this organisation all commented that they would find the role untenable without this support.

Understanding how to keep a professional distance and being aware of boundaries was reported as being a vital coping mechanism.

> "We deal with some really intense stuff…I used to take the client emotions home, you know…you need to learn to take a step back in a way that you think is right" SP1

Maintaining professional boundaries was linked to the ability to set expectations with the clients early on about what could be achieved through social prescribing which some of the prescribers found challenging when new to the role:

> "when I started here I was raring to go and your expectations often exceed reality you know, you want to help everyone and you want to do what you can but then you sort of realise that the money isn't there and the resources aren't there and sometimes it just isn't possible." SP1.

When it came to managing their own health and well-being, SPs felt that receiving appropriate training helped them to cope with the demands of their role:

> "I actually felt that when I started using those techniques [from training] I felt a lot less burden!" (SP2)

7 | PERCEPTIONS OF TRAINING AND FUTURE TRAINING NEEDS

Participants reported a need for training beyond what was perceived as core skills, all the SPs working for the NHS entered the role after going through the statutory and mandatory training for the NHS trust (including topics such as infection prevention, data protection and adult safeguarding) and reported that the best way to learn the job was through shadowing others:

> "I think going out with other care navigators was most helpful, because the training was quite generic, not specific to social prescribers" (SP4)

SPs felt that more specific initial vocational training would help them to understand the role and develop boundaries for themselves and others:

> "it would be beneficial if there was some kind of social prescribing guide or training to say you know, this is the dos and don'ts and to…learn about boundaries and patients and about the social issues that can affect their health, you know, and training all about social prescribing would be beneficial" (SP7).

SPs who worked for voluntary services covered the same mandatory aspects of training but then reported having choice in future training needs, which was in contrast to SPs employed by NHS organisations in this study who spoke of a lack of funding or lack of understanding from their managers regarding what training was required:

> "what I'm interested in is motivational training and I've been told it's not a priority. They thought that benefits was the priority" (SP6)

A preference for face-to-face learning was expressed by participants. Online modules for important issues such as domestic violence were felt to be *"a tick box kind of thing"* (SP2) that did not equip the SP with the practical skills they needed to support clients who might be living in a high-risk situation. The need for training on issues such as housing and benefits, immigration, addiction and domestic violence was closely related to the levels of deprivation in the areas they worked. Many SPs in this study reported that high-quality mental health first aid and suicide awareness training were vital for the role and that this should be prioritised for face-to-face training:

> "What I have done online [training] is going to go out of my head but the two day [face to face] suicide training, that's completely in my head and I've got a resource, I'm confident" (SP2).

8 | DISCUSSION

In this study, we explored the main challenges of working as an SP and the experiences of training and support of SPs employed by NHS and voluntary sector organisations. This study supports findings from previous research describing the role of SP as a *"big ask"* (Skivington et al., 2018, p. 491). Participants in this study stated that the role exceeded their expectations in complexity and generally felt that training had inadequately prepared them for the role. This echoes findings by Wildman et al., (2019) who interviewed social prescribing link workers in the north east of England in one of the early social prescribing schemes. Link workers interviewed by Wildman et al., (2019) received general health trainer training and after some time working in the role felt that this did not prepare them for the complex social and mental health needs of their clients.

Wildman et al., (2019) recommended that bespoke training be developed to support link workers in their role. Since the date of the interviews for this study, Health Education England (HEE) released an e-learning package of study for SPs working in primary care networks in the NHS (Health Education England [HEE], 2020). The content of the online training provided by HEE aligns with recommendations made by Wildman et al., (2019) and many of the needs expressed by participants in this study. The online training modules are rated highly (4–4+/5) by those who complete them (HEE, 2020). Development of this training is a significant step forwards to ensuring that SPs are supported to develop in their roles, however, given the preference for face-to-face training expressed by participants in this study, monitoring the usefulness of e-learning as initial training after SPs have worked in the role for an extended period of time may be an important part of future research.

A notable omission from the HEE initial e-learning training is mental health first aid or suicide awareness and prevention training. SPs in this study reported that supporting clients with mental health needs, particularly those experiencing suicidal thoughts, was the most challenging aspect of their role and it was reported that the number of people with complex or undiagnosed mental health issues was increasing on their caseloads. Mental health services have been chronically underfunded for a number of years (Docherty & Thornicroft, 2015). Despite more recent prioritisation of mental health in policy and funding, waiting times for mental health input continue to be unacceptably high in some areas (Baker, 2020).

Given that the need for mental health services has been rising (Baker, 2020), it is likely that people who would ordinarily have been managed by mental health services will continue to be referred to social prescribing services. Furthermore, given the holistic approach taken by SPs and longer appointment times available than to other health professionals, clients are more likely to disclose mental health issues or suicidal thoughts. To prevent distress for both clients and SPs, it is essential that SPs have the training to recognise when they are able to support clients with mental health needs through social prescribing and when more specialist input is required. Online training in suicide awareness and mental health first aid has been found to be almost as effective or as effective as a more blended approach to training (Reavley et al., 2018; Stallman, 2020), however, participant satisfaction was reportedly lower with online training (Stallman, 2020). The findings from this study support making high-quality mental health and suicide awareness and prevention training available to all SPs, it is important to note that mental health training provided in the abovementioned studies was comprehensive and consisted of modules completed over a number of weeks. Co-production of tailored mental health training for SPs could be an important area for future research.

SPs in our study reported the importance of personal and professional support to help them carry out their role successfully and cope with the emotional burden of the role. NHS England have created a learning network of professional development resources for use by SPs (NHS England,n.d.) and have also created an online network where SPs can share resources and gain peer support. These resources will be valuable, especially for SPs who are working in isolation. There is limited research exploring health professionals' understanding of the role of SPs. A recent qualitative interview study by Aughterson et al., (2020) explored the barriers for GPs carrying out social prescribing and reported that GPs had highly varied knowledge and understanding of social prescribing and the role of the social prescribing link worker. Given that GPs are professionals who have had most exposure to the role of SP, it is not surprising that health professionals in other areas are still developing their understanding of the role. Embedding SPs in multidisciplinary health teams such as community rehabilitation teams or integrated care teams could be a valuable area for innovation and expansion and offer SPs a chance to specialise in working with populations with more specific challenges, however, appropriate guidance and training needs to be available for health professionals to support SPs working in these settings. Findings from this study and by Aughterson et al., (2020) support further research exploring health professionals' knowledge and understanding of the role of SP to ensure SPs working in all settings can access appropriate personal and professional support. SPs employed by the voluntary sector in this study were supervised by other, more experienced SPs who had carried out the role previously and had a clear understanding of support needs. To improve support for SPs who are isolated or working in health services, local networks of SPs working in the area could be established as a source of peer support, which was considered valuable by participants.

In our study, SPs were employed by different organisations and posts were funded in different ways; some SPs were employed by voluntary sector organisations and funded by the local NHS commissioning group (some with joint funding from the local authority) and some SPs were employed directly in NHS posts (embedded in multidisciplinary health teams working with adults with a range of long-term conditions). How SPs were funded and employed affected their experiences of training; SPs employed by NHS organisations reported completing NHS mandatory training on commencement of the role, addressing topics such as infection prevention, data protection and safeguarding vulnerable adults. Although this training will be relevant to the role, participants reported it to be *"generic, not specific to social prescribers"* (SP4) and shadowing was found to be the most useful way of understanding the role. For some SPs working in the NHS, shadowing was challenging because they did not always work with other SPs, so they shadowed health professionals, which sometimes led to conflict between the SP's and health professional's vision of the role and what training opportunities might be most appropriate. Participants employed by NHS organisations reported limited access to training opportunities, priorities for training conflicted with manager expectations and a lack of available funding was reported. SPs working in voluntary sector organisations in this study also completed a level of mandatory training in similar areas to SPs employed by NHS organisations, but were able to shadow other experienced SPs and then accessed training from a range of sources, including online training, private companies and had access to local authority training in areas such as housing and benefits. Even when training was highlighted as important by managers to SPs employed by the NHS it was reported that this was difficult or impossible to access as it was delivered by the local authority. Overall SPs working in voluntary sector organisations reported being well integrated with local authority, health and other voluntary sector organisations, whereas SPs employed by the NHS reported barriers to accessing training from other sources, even when highlighted as a priority by their managers. For the participants in this study, an integrated model of funding appeared to work well in terms of training and support and allowed SPs to work in an integrated way across health, social care and the voluntary sector.

9 | STRENGTHS AND LIMITATIONS

The sample size for this study was relatively small due to time constraints placed on data collection, however, efforts were made to ensure participants were recruited from a variety of NHS and voluntary sector organisations to explore a variety of SP experiences. Participants had been in their roles for between 10 months and 2 years, which was an appropriate length of time for them to be able to reflect on their initial training and evaluate the impact of this training on their ability to carry out their role.

Interviews were limited to SPs working in the Greater London area, and further research with SPs working in other locations would

be valuable to gain insight into any different challenges they may experience. The findings from this study, due to the small sample size and recruitment from an urban setting, are limited in transferability beyond urban areas, particularly outside of London.

10 | CONCLUSION

The findings of this study support the assertion that working as a social prescribing link worker is a complex and demanding role. SPs are required to have in-depth knowledge of local services, which is built over time and makes retention in the role of high importance. Steps have been taken to develop online resources to support SPs, however, there may be a need for more comprehensive mental health and suicide awareness training. SPs benefit from access to peer support to help them manage the emotional demands of the role and could benefit from the formation of local networks, especially for those SPs working in isolation. Where SPs are embedded in multidisciplinary health services, more guidance and training on the role of SPs could be made available for health professionals so they are able to support SPs to develop in their roles. Careful planning of the availability of training from all sectors is needed to ensure that SPs can work in an integrated way across health, social care and the voluntary sector.

ACKNOWLEDGEMENTS

I would like to acknowledge the contribution of Dr Dagmar Zeuner, Dr Mohan Sekeram and Barry Causer for providing me with links to my first participants and valuable practical support along the way. Thank you to colleagues and managers of organisations who either gave their permission for me to interview their employees or introduced me to potential participants. Thanks to all the social prescribers for their time and contribution to the study.

CONFLICTS OF INTEREST

No conflicts of interest declared by either author.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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How to cite this article: Rhodes J, Bell S. ''It sounded a lot simpler on the job description'': A qualitative study exploring the role of social prescribing link workers and their training and support needs (2020). *Health Soc Care Community*. 2021;00:1–10. https://doi.org/10.1111/hsc.13358