**Link worker perspectives of early implementation of social prescribing: a 'Researcher-in-Residence' study**

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**Conflict of Interest**

The authors listed immediately below certify that they have no affiliations with or involvement in any organisation or entity with any financial interest, or non-financial interest in the subject matter or materials discussed in this manuscript:

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**Abstract**

Social prescribing (SP) is increasing in popularity in the UK and can enable healthcare providers to respond more effectively to a range of non-clinical needs. With the NHS commitment to establish an SP link worker in all GP practices, there is a rapid increase in the number of SP schemes across the country. There is currently insufficient evidence concerning the implementation and acceptability of SP schemes. In this paper, we report our analysis of the descriptions of the experiences of SP link workers, regarding the early implementation of SP link workers in two SP programmes in the South West. Data were gathered using the 'Researcher in Residence' (RiR) model, where the researcher was immersed in the environments in which the SP was managed and delivered. The RiR undertook

conversations with 11 SP link workers, 2 SP link worker managers, and 1 SP counsellor over six months. The RiR visited seven link workers at their GP practices (service 1) and four at their head office (service 2). The RiR met with the link worker managers at their offices, and the RiR spoke with the SP counsellor on the telephone. Data from these conversations were analysed using Thematic Analysis and six codes were constructed to advance our understanding of the components of early implementation of the SP programmes. Training (particularly around mental health), workforce support, location, and SP champions within GP practices were found to be key strategies of SP implementation, link worker involvement acting as a conduit for the impacts of these strategies. This paper suggests that the implementation of SP programmes can be improved by addressing each of these areas, alongside allowing link workers the flexibility and authority to respond to challenges as they emerge.

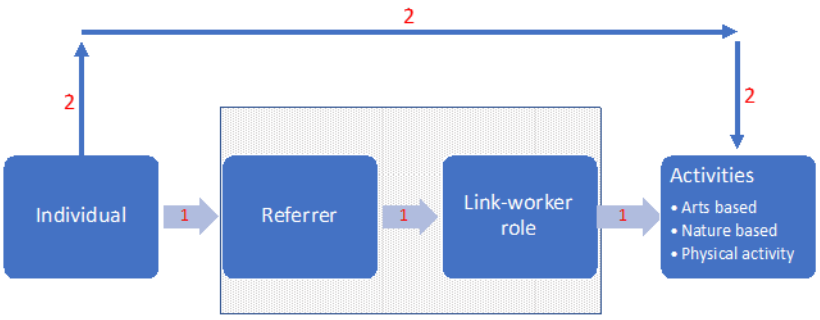
**Keywords:** Health services research; Primary Care; Social and Health Services

| | |
|---|---|
| What is known about this topic? | ● Social prescribing is a network of relationships rather than a single complex intervention<br>● Evidence relating to the impact on individual wellbeing is growing<br>● Lack of robust data relating to implementation and acceptability of pathways |
| What this paper adds | ● Link workers are central to developing and maintaining the network of relationships that allow social prescribing to function<br>● The needs of those accessing social prescribing are more acute and immediate than expected<br>● Allowing link workers the flexibility and authority to develop their own micro-solutions to problems as they emerge is paramount for effective social prescribing |

## INTRODUCTION

The prescribing of non-medical, community or social activities is scaling rapidly around the world as a way of helping people manage and prevent illness, improve their health and well-being and address the wider determinants of health and inequalities (Pescheny, Randhawa & Pappas, 2019). These approaches often labelled 'social prescribing', are designed to support the non-clinical needs of people who may need support with their mental health, who are lonely or isolated and who have long-term conditions or complex social needs that affect their wellbeing (Polley, Fleming, Anfilogoff & Carpenter, 2017; Polley, Bertotti, Kimberlee, Pilkington & Refsum 2017). They tend to comprise both a pathway through which individuals experience services (including, for example, self-referral, a referrer and link worker) and a set of activities or interventions, e.g. nature-based, art-based, debt and housing advice (see Figure 1) (Husk, Blockley, Lovell, Bethel, Lang, Byng & Garside, 2020).

**Figure 1 – simplified social prescribing pathways**




(1) – Social prescribing through primary care referral routes
(2) – Social prescribing through self-referral/community routes
Shaded box – health service 'scaffolding'

Adapted model from (Husk, Blockley et al. 2019)

Social prescribing has become a key component of Universal Personalised Care in England and there is now a financial commitment for every General Practice to have access to a social prescribing 'link-worker' by 2023 (NHS England, 2019; NHS England, 2018). Denmark, Sweden and Canada are among other countries trying the approach out (Alliance for Healthy Communities, 2020; Rayner, Muldoon, Bayoumi, McMurchy, Mulligan & Tharao, 2018). Interest in the approach is based on the belief that the approach may enable healthcare providers to more effectively respond to a range of non-clinical needs, extend traditional boundaries of primary care and facilitate contact with professionals who can provide longer consultations with knowledge of local social activities. The range of activities is such that diverse mechanisms of action might be activated through being with people, cognitive

stimulation or identity generation (Husk et al, 2020; Bertotti, Frostick, Hutt, Sohanpal & Carnes, 2018).

As a complex intervention, comprising pathways, activities and a network of relationships across multiple sectors, social prescribing projects are more difficult to evaluate than traditional public health interventions that focus on specific proximate and individual-level risk factors (Husk, Elston, Gradinger & Callaghan, 2019). There is emerging literature relating to the impacts on individual health through participation in such programmes as exercise, nature-based activities, and arts on prescription for example. Several studies have suggested that social prescribing has modest but significant effects on people's ability to manage and prevent illness and improve their health and well-being (Tierney, Wong, Roberts, Boylan, Park, Abrams, Reeve, Williams & Mahtani, 2020; Munford, Panagioti, Bower & Skevington, 2020; Chatterjee, Camic, Locker & Thompson, 2017; Loftus, McCauley & McCarron, 2017; Pescheny et al., 2019; Pilkington, Loef & Polley, 2017). Fewer studies have assessed impacts on service use, some reporting a reduction in demand for GP services, A&E, or secondary care use where social prescribing is adopted, others seeing an increase where unmet need is being addressed (Elston, 2018; Polley et al., 2017).

Less is known about how implementation impacts on quality of delivery (Polley, Whiteside, Elnaschie & Fixsen, 2020). Our previous work has examined the complexities of the social prescribing pathway experienced by individuals before accessing activities (Husk et al., 2019). As social prescribing comprises both a pathway and a series of relationships and these need to function to meet the patient need (any disruption to this series of interactions potentially limiting the ability of services to deliver effectively), embedded qualitative research is required which allows the detail and complexity of the functioning of these relationships to be explored in differing contexts.

In this paper, we report analysis of rich descriptions of the early implementation of link worker social prescribing, to assess *how* this series of relationships functions and the key barriers and facilitators experienced on the ground. While social prescribing programmes are tailored services to local contexts, the lessons learned around the functioning of relationships along the pathways would, we hope, have broader applicability and assist others in implementing new services proliferating with the rapid expansions through Primary Care Networks.

## METHODS

### *Researcher in Residence*

We collected qualitative data relating to link worker experiences of implementing new social prescribing programmes, which were collecting using a 'researcher-in-residence' (RiR) approach to data collection as described by Gradinger, Elston, Asthana, Martin & Byng R (2019). RiR approaches site researchers in delivery organisations and uses the data and perceptions gained through the lived experience of the RiR, who becomes immersed in the environments in which SP services are managed and delivered.

This approach combines service evaluation with collaboration in researching aspects of the service alongside the stakeholder organisations that seek to inform the implementation and development of that service. One of the key enablers of successful RiR activity is the development of trusting relationships between the RiR and organisations, alongside an openness to be led by those organisation(s) regarding researching salient aspects of the service (Gradinger et al., 2019). This approach differs from more traditional evaluator roles and encourages joint ownership of the evaluation and service development.

The two organisations described here stated that it would be useful to investigate the early implementation of link workers in order to map their activities and to identify challenges which could then be addressed in real-time. The RiR undertook structured conversations with social prescribing link workers (see Figure 1) and link worker managers in two geographic areas delivering SP programmes in the South West of England (Service 1 and Service 2). This work was conducted after the link workers had been in post for 6 months, relating to their experiences of SP and their role in the pathway. Embedded counselling coordinators providing workforce support were also included.

Conversations were loosely directed by a topic guide and link workers were encouraged to digress beyond the conversation topic guide to surface issues that were pertinent to them. Handwritten field notes were recorded by the RiR detailing the information shared by the link worker, throughout the conversation. Field notes can help the researcher record valuable contextual information (Phillippi & Lauderdale, 2018), therefore, the RiR was also able to record their observations such as their own experience of the setting (e.g. whether the link worker was able to display information about the SP service in the waiting room). The focus of these field notes was to describe what the link worker said to the RiR, in order to

capture the experiences and views of the link worker. This encouraged freedom of direction of the conversation, allowing rich descriptions to emerge from participants.

***Ethics***

Ethical approval for the synthesis of the two included service evaluations was obtained from the University's Faculty Ethics Committee and conforms to recognised standards concerning the ethics of research on humans, approval number: FREIC1920.40 Invitations to take part in these conversations were emailed to link workers by the link worker managers. And verbal, informed consent was taken immediately before each conversation.

***Analysis and synthesis***

We analysed collected qualitative implementation data using Thematic Analysis (TA) as described by Braun and Clarke (2006). Here, the coding and the development of codes are driven by the content of the data, i.e. capturing and reporting what participants 'said', rather than seeking to interpret what was 'meant', and 'how' it was said. This study acknowledged that data were analysed from an experiential perspective, i.e., that the researcher 'learned' about the views and experiences of social prescribing, from their exposure to, and consultation with, participants, rather than interpreting the data of those

participants to elicit their ‘reality’, in a constructionist way. Our analysis iteratively examined data throughout the data gathering period. After each conversation with the link workers, link worker managers and the counselling coordinator, the RiR reviewed the field notes that were recorded during the conversation, and constructed codes that described the salient points of the conversation. This process was repeated after each conversation and as the data set increased, codes from each new conversation were compared with codes that had already been identified and examined for commonalities and differences in order to start to develop early, 'fledgeling' themes. We did not, however, develop these further into full TA themes as we wished to extract useful data that would remain specific in order to feedback to the SP services.

We took care to structure our data and analysis around concrete concepts that resonated with our participants. Initial codes were thus presented back to link workers, managers, and the counselling coordinator. Those who had been unable to take part were invited to contribute at this point if they felt that there were gaps in the data or if they felt that what was presented did not represent their experiences of social prescribing. Amendments were incorporated into the final dataset.

***Settings***

*Service 1*

The first SP scheme was delivered via a consortium of 6 VCSE partners and led by a large voluntary sector organisation with objectives to develop social capital and the wellbeing of individuals and communities. The consortium covered an adult population of 221,673 across a large geographical area with many isolated and remote locations (NHS Digital, 2017). Link workers were based at GP practices across the area, with most working at several locations on different days. This cohort of link workers did not regularly return to a single central 'base' and, because of the wide geographical area, often worked in remote locations away from colleagues and their employing organisation.

In Service 1, interviews were conducted with seven SP link workers and one link worker manager. Where workers were based across multiple practices the most convenient for the link worker was selected. Meetings were held at individuals' place of work for two reasons; first, as outlined workers did not often return to a single base, it would have been time-consuming for them to meet as a group. Second, this process enabled the RiR to experience the environment in which each link worker

practised first-hand and gain a sense of how integrated the link worker and the service was.

*Service 2*

Link workers in Service 2 were employed by a single Community Development Trust with an annual turnover of £1.2m and a trading surplus of over £150k which is used to support community projects. The local City Council are the Trust's major partner, and the Trust has a population coverage of approximately 46, 000. Whilst this cohort also delivered the SP service from GP practices they were, in contrast to Service 1, based at a single site with a shared office and were in close contact with colleagues regularly. The RiR was invited by the link workers and their manager to meet with them as a group of five at the Trust head office as that was deemed the most convenient. Service 2 also provides an in-house counselling service which operates from the main community hub and is available to both users of the SP service and the SP workforce; the counselling service manager was included but separate to the group conversation.

**RESULTS**

Following repeated engagement with the resulting data, we constructed the following codes to contribute to our understanding of the components of early implementation of

these programmes. Here, we describe the codes and report exemplar descriptions of where schemes were working 'well' and where there was a need for further development to allow the implementation to be successful.

**Mental health severity (1)**

Individuals reported a proliferation of referrals where those referred were experiencing moderate to severe mental health problems that were outside the remit of the link worker. "*Many referrals could be considered "inappropriate" on the surface of it, although if some of the initial issues are addressed then that person may become open to Social Prescribing activities...Have had people in psychosis. Quite a few referrals who disclose suicidal ideation or attempts"* (RiR notes, Link Worker 4, Service 1). At times, such referrals included individuals who presented in psychosis and those reporting suicidal ideation. Link workers discussed this aspect of social prescribing in terms of "*picking up people who have fallen through the gaps*" (RiR field notes, link Worker 1, Service 2) and some referrals made by GPs as "*a last-ditch attempt*" (RiR field notes, link Worker 2, Service 2).

It was not necessarily clear to link workers from the referral information that they received, that these individuals were experiencing serious mental health problems. However, upon meeting in person and talking with them at the first

appointment it would become clear that serious and enduring mental health problems were significant. Link workers talked about having to make decisions not to complete the SP scheme outcome measures with individuals who had presented to them with significant mental health problems, in case the taking of these measures triggered an escalation of their poor mental state at that time. "*The outcome measures are not always appropriate and not always understood. ONS Q1-3 can be triggering for someone in poor mental health. People scoring themselves is not always welcome and can ruin the flow of the appointment."* (RiR field notes, Link Worker 7, Service 1.)

**Training (2)**

Link workers' expressed concerns that more training should be available to equip them to manage the individuals who were referred to them with moderate to severe mental health problems appropriately and effectively. *"Link worker dealing with a lot of mental health and would like further training so that they feel confident in the work that they are doing with individuals with mental health issues."* (RiR field notes, Link Worker 7, Service 1.) Where mental health issues manifested during the first hour-long appointment, the link worker had to manage the rest of that meeting in a manner that would do no harm.

There were differences in how confident and competent link workers felt in managing their interactions with individuals who were presenting with moderate to severe mental health problems. Link workers who had previously worked in a mental health profession (which was not a requirement for the post) or those who had a background that included mental health training (again, not a requirement of the post), discussed feeling confident and able to make decisions about whether and how they continued to work with that individual. *"Link worker sees predominantly mental health referrals, including those with severe and enduring mental health needs. Link worker is mental health trained and, therefore, feels trusted by the mental health team to work with these individuals."* (RiR field notes, Link Worker 3, Service 1). Link workers without a professional background in working with individuals with mental health talked about managing those interactions in the way that they thought was best, however, lacked confidence in those decisions. Link workers expressed the need for training so that they could feel confident in those interactions and to protect both themselves and the individuals that they were working with.

Link workers also discussed training of other professionals that were involved with the SP pathway, as a tool for improving the SP referral process. Link workers felt that if professionals who

formed part of the SP pathway received training about what SP could and could not do, this would help to make the referral process more appropriate and informative. *"Link worker thinks meeting with medical staff to train/discuss: who is the LW? What are they doing? would work. This supports GP understand of the role, which impacts on quality of referral."* (RiR field notes, Link Worker 5, service 1.) *"Referrals would be better (quality) if LW was more integrated with the surgery. GP surgeries training around Social Prescribing would help matters."* (RiR field notes, Link Worker 8, Service 1).

**Workforce support (3)**

Frequently in discussions, individuals surfaced the importance of workforce support and supervision in the SP scheme. This reflected their experiences of working with a caseload that included mental health difficulties and enduring social and health problems. All link workers and the counselling coordinator talked about the need for comprehensive and well-embedded workforce support, including one-to-one clinical supervision that was a "*confidential safe space*" (RiR field notes, Link Worker 7, service 1).

There was considerable variability in the workforce support according to site. Where the SP scheme was managed by one organisation (Service 2), link workers experienced consistent

workforce support structure comprising of monthly manager supervision, informal peer supervision via the shared office base and group peer discussion at meetings. Where necessary, additional support was available from the in-house counselling service based at the Trust. Service 2 link workers reported feeling well supported.

In Service 1, where link workers were employed by six partners across a wide geographical area, there was greater variability in workforce support. While some felt well supported and able to access their own support structure (at times independently), *"Link worker does feel supported in role, however, is supported by her own mechanisms for clinical supervision"* (RiR field notes, Link Worker 4, Service 1); some reported feeling not wholly supported in some key aspects of their role, particularly around clinical Where link workers had reported a support structure this was often because they were able to access clinical supervision from their employing organisation (not the SP programme organisation), or through personal contacts with expertise in mental health supervision *"Link worker attended supervision provided once but did not feel it was suitable for needs as it was general reflective practice, had sourced own support from psychologist friend."* (RiR field notes, Link Worker 7, Service 1). This was starting to change at the time of writing

as the consortium's lead organisation had arranged clinical supervision for the link workers.

**Location (4)**

There were two main components to the fourth code: *the role of GP practices* (**4a**) and *accessing SP activities* (**4b**).

GP practices (**4a**) either acted as facilitators of the smooth running of the SP scheme or, at times, inhibitors. For some link workers, GP practices were open and receptive environments to the SP scheme; they were provided with good facilities such as a practice room in a suitable location, access to the rest of the practice to speak to practice staff, inclusion in practice meetings, access to practice resources such as WiFi, patient information systems, email and printing, and advertising in the foyer or waiting room. *"All surgeries are active supporters of the social prescribing link worker, providing a practice space, advertising space and actively referring people. Link worker has had people self-referring from the large display in. Practice manager supportive"* (RiR field notes, Link Worker 4, Service 1.) Other practices were less receptive and access to the same facilities was not made available. "*Surgery has not provided space for the Link Worker who now hires [a location] at [a location], twice a week.*" (RiR field notes, Link Worker 1, Service 1).

In terms of accessing SP activities (**4b**), even when link workers had identified appropriate activities and referred individuals, there were often challenges around those individuals accessing activities. In Service 1 there was great variability between locations in terms of the number of activities available and their accessibility. In remote locations, there were problems of access amongst the very elderly and/or frail, those who did not have a car or did not drive, and those who did not have access to regular or affordable public transport. *"Barriers to people up taking activities are poverty, transport and access."* (RiR field notes, Link Worker 6, Service 1). It was therefore difficult for link workers to engage these groups or those who were socially isolated, without home visits. *"Surgery stated to link worker that if the link worker cannot do home visits, then the role will not be successful."* (RiR field notes, Link Worker 7, Service 1.)

**Social prescribing champions (5)**

The fifth code highlighted the pivotal role of social prescribing 'champions' in successfully implementing and embedding SP in their GP practice*. "Link worker very well supported by practice with GP champions. The community maker attends the MDT meetings."* (RiR field notes, Link Worker 2, Service 1.) These individuals were often practice staff who had an in-depth understanding of SP and the role and remit of the link worker,

and who looked to embed both in their practice. SP champions acted as facilitators, allowing the link workers to access practice meetings more easily, or aiding in training sessions, making referrals, and encouraging colleagues, ensure appropriate and useful referrals, enabling access to resources, and raising the visibility of schemes. *"90% of referrals are made by the GP and the forms are designed by link worker in collaboration with the GP surgery to make sure that the information that link worker receives is comprehensive."* (RiR field notes, Link Worker 5, Service 1).

**The individual as a conduit (6)**

The experiences, skills, knowledge, and behaviour of the link workers crosscut the other codes and acted as a conduit for their impacts. The codes that emerged during the data collection and analysis were largely the result of external environmental factors. However, link workers were able to overcome these in novel and inventive ways. Where, for example, referrals were initially slow, strategies were developed which addressed rates such as a 'prescription pad', a bright, easy to complete and colourful pad that was put on the desk of each clinician, which subsequently increased referrals. *"Initially referrals were a bit slow but then the Link Worker developed an SP prescription pad that sits on the desk of all of*

*the clinicians.*" (RiR field notes, Link Worker 4, Service 1). This link worker was also involved in the rolling development and maintenance of community directories of activities and resources, in order to make referrals to providers and activities that had been quality assured by the service.

Where SP was working well and exceeded the capacity of the link worker, one individual had worked collaboratively with the practice to set up a weekly group meeting where those on the waiting list could meet until there was the capacity for their face-to-face meeting and referral onto individual activities.

As with the mental health code discussed above, the professional background of link workers influenced aspects of their approach to their role, and their confidence in developing and implementing novel solutions to the challenges that they faced.

## DISCUSSION

### *Social prescribing implementation*

As we argued at the outset, social prescribing is not a single complex intervention but a series of relationships all of which need to function to meet individuals' needs. We wanted to supply rich descriptions of how the early implementation of two new SP services was experienced from the perspective of one of the key actors in the pathway, the link workers. Much of the

previous research that we have discussed has been conducted externally to the services and has frequently been rudimentary. The methodological approach of the RiR allows immersion in the service that gives the RiR insight into the highs, lows and everyday workings of the service. The detailed and rich conversations with the link worker allowed the link worker to surface things that were important to them and describe them in detail.

Our analysis resulted in six codes, which help us understand how areas of focus may improve implementation. First, it is important to consider the level of severity of mental health difficulties that are referred through to the link workers. Cohorts, where there are acute difficulties, influence the link worker's ability to link to appropriate community assets and can have impacts in other areas of the pathway. Robust dialogue between referrers and link workers about the suitability and limitations of those referred is important.

Linked to this, and an area of much debate in the field is the level and access to training in mental health for new and existing link workers. Posts are advertised at varying grades depending on the funding source, but even the new NHSE link worker job specifications do not require mental health training (NHS England, 2019). Programmes are locally addressing this

issue by beginning to provide access to training, but this is on an ad hoc and locally costed basis. There is some indication that this issue has been hidden in the past owing to the experiences and expertise of the individuals who have been recruited (those with MH experience).

Perhaps unsurprisingly, coordinated, and comprehensive support to the new workforce ensures that these individuals feel supported and able to engage with the role more effectively. Our findings here indicate that where this is done centrally, rather than in a more devolved or practice-based way, workers feel more supported.

We found here that the location of SP activities and the location of the link worker contributed to the successful delivery of the SP service. Where link workers were well established in the GP surgeries they reported the SP service working well. Husk et al. (2018) previously found that the co-location of link workers in GP practices means that ensuring these are open and receptive environments is important to managing SP effectively, something echoed in other areas of healthcare. Practical and personal approaches impact on the ability of link workers to take, link and engage with people throughout the pathway, and minor changes such as WiFi or access to printing can go a long way towards helping. Our findings indicated that activities

varied in number and accessibility. Some link workers reported a wide variety of activities in their area, whilst some reported very few, often in rural areas where transport presented a barrier to access. The location of social prescribing activities themselves such as arts or nature-based activities impacts on the linking that is possible – something noted before (Husk et al., 2020). Again, the provision of practical assistance such as reduced cost or free, timely transport can impact significantly across the whole pathway.

It is well known that the engagement of social prescribing champions encourages spread and uptake of programmes (the NHS and RCGP both have SP champions, as increasingly are medical schools), (Mulligan, et al., 2019). However here we note the local-specific impact of such champions (also noted by Greenhalgh et al. in their NASSS framework). Arguably, the ability to get 'buy-in' from one or more individuals within a practice goes a long way to addressing the majority of the previously noted issues. The fact that these champions do not have to be specific roles, such as practice managers, or GP partners, is important and the spread of behaviours through locations is key.

Last, and with greatest links to the existing literature, the impact that the skills, knowledge, characteristics, and approach

the link workers posses as individuals are difficult to exaggerate. As noted in the NASSS implementation of digital technology health framework (Greenhalgh et al., 2018), allowing frontline staff the flexibility and authority to make minor adaptions can make marked impacts on the uptake and success of changes.

**Strengths and limitations**

The strength of our approach is that we adopted an innovative model of research, the RiR model. This embeds the researcher within services delivering programmes and allows real-time observation of the functioning and evolution of those services, alongside the challenges services that those services meet with. The RiR model, furthermore, allows the researcher to feedback evaluation findings to services in order to optimise the delivery of the service.

The limitations of this approach are the potential challenge for the RiR of reporting evaluation outcomes that may indicate occasions when the service has not been functioning optimally, or where implementation has proved different. For the services described here, however, where the RiR identified aspects of the services which had faced challenges to implementation, the services reported that this was useful as it supported their anecdotal findings and supplied a rationale for further development of that component of the service.

In addition, our data do not allow us to make assertions as to whether services are effective or have an impact on health as is intended. We can certainly infer that if programmes are functioning well then, they have better reach, scope, and acceptability to those who they are looking to engage; but further quantitative work would be needed to definitively answer this question.

**Comparisons with existing literature**

Although our study focussed uniquely on the barriers and facilitators experienced by link workers and their managers, our study adds value because of the RiR model of research employed and builds on the work of Gradinger et al. (2019) in examining the implementation of SP from the perspective of front-line staff rather than being effectiveness or outcome-based. In agreement with recent literature, this study found that the link worker model is a key component in successful SP schemes in allowing the support offered to be personalised by responsive adaptation to challenges presented by environmental factors (Chatterjee et al., 2017; Loftus et al., 2017; Husk et al., 2020; Moffatt et al.,2017).

**Recommendations**

The evidence presented here implies that those looking to implement SP in new programmes, or at scale, would benefit

from focusing on some core areas. 1. Link workers should be offered a focused programme of training that reflects the more complex needs that are being referred to them. 2. All GP practices should facilitate information and training sessions for all employees about the roles, remits, and processes of the social prescribing service. 3. Workforce support to link workers in all services should be provided. This support should provide link workers with the opportunity for a confidential discussion about any concerns or queries that they may have about individuals that they are working with, or about other aspects of their role. This could form part of one-to-one clinical supervision or as a separate offer from the link workers' organisations if clinical supervision is not available to them. 4. Mangers of SP programmes should be aware of geographical variations in accessibility to activities and take active steps to improve access for referred individuals (e.g., by subsidising travel costs) or tailoring new and local solutions.

**Conclusions**

Social prescribing is proliferating, and all new Primary Care Networks will be recruiting new link worker roles in the immediate future. Implementation of programmes can be improved by focusing on fully embedding social prescribing services within GP practices, including securing link worker

access to all the practical resources that facilitate the work of the link worker, and ensuring their inclusion in practice/team meetings to support the maintenance of ongoing GP practice engagement with the social prescribing service. Crosscutting all the codes that have been described here, the link worker is a conduit for the impacts of external environmental factors and, therefore, understanding the role of the individual and allowing them the flexibility and authority to develop micro-solutions to problems as they emerge is paramount.

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