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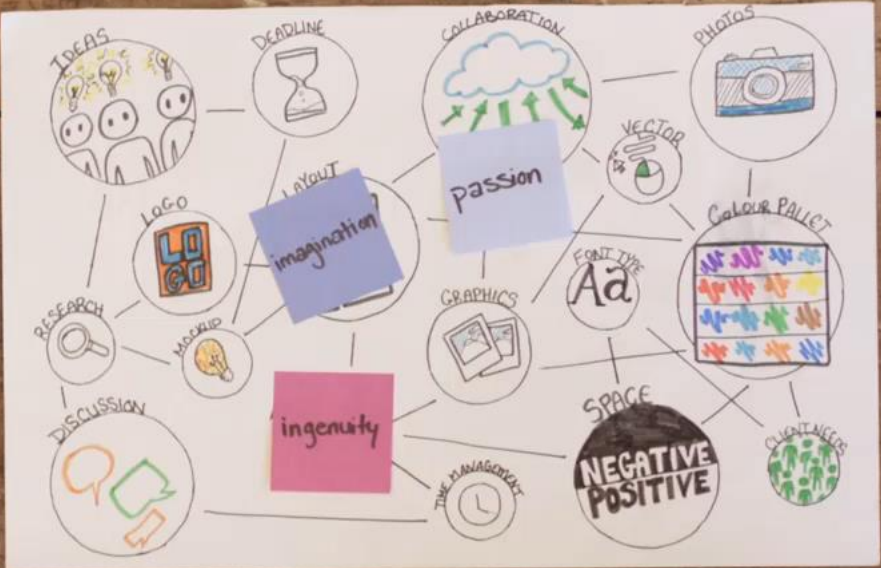
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Supplementary Materials 1

‘We are the eyes and ears of the community’: Reflections from social prescribing link workers during the real-world practice of a new community enhanced model.

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plan

creativity

communicate

efficiency

con

vestment




Community- Enhanced Social Prescribing

University of York

Cheyann Heap & Martin Webber

15th July 2022



What do you want
to learn / get from
today?

Agenda

**01. Introduction
discussions**

**02. A bit about social
prescribing context,
research and theory**

**03. Social
prescribing literature
'choose your own
adventure'**

**04. Adventuring and
applying the
literature to your
own case studies**

**05. End reflections /
review**



NHS Long Term Plan (2019)

- Universal Personalised Care which is aimed at 2.5 million patients – includes SPs, personal budgets & personal support plans
- Over 1,000 trained social prescribing link workers will be in place by the end of 2020/21 rising further by 2023/24
- Part of GP contract reform (i.e. part of the service model in the future)



United Nations Human Rights Council

- Mental health is a human right!
- Current mental health practices often based on power imbalance
- Need funding for psychosocial services and research –co-created with people themselves
- <https://digitallibrary.un.org/record/3873686?ln=en>
- <https://www.ohchr.org/en/health/mental-health-and-human-rights>

“States and other relevant stakeholders, including academic institutions, [must] recalibrate mental health research priorities to promote independent, qualitative and participatory social science research and research platforms, exploring alternative service models that are non-coercive” (p. 20)



‘Social prescribing’

Elliot et al. (2022)

- “There is no agreed definition of social prescribing, but it is generally understood to involve referral to non-medical resources in the community, with the goal of improved health and well-being. This typically involves a link worker, also known as a community connector or navigator, who works with the individual to identify their needs, coproduce goals and connect them to resources in their community.”

Spectrum from “light / medium” SP to “holistic” SP (Kimberlee, 2015)

Pescheny, Pappas & Randhwa (2018)

- 1. Info only service (advertise SP in primary care);
- 2. Info service & telephone line (SP advertised in primary care, leaflets / notice board);
- 3. Primary care referral (professional refers if needed)
- 4. Practice-based generic (clinics in GP surgery, health worker referral or self referral);
- 5. Practice-based specialist (works from primary care, direct advice / services e.g. Citizens advice, & signposting or self referral)
- 6. Non-primary care based (external referral centre with one-to-one facilitation)

National Association of Linkworkers - Educational Standards

<https://www.nalw.org.uk/education-standards/>

- **01. Promotion and understanding of population and community health and wellbeing, contributing to addressing wider and social determinants of health to reduce inequalities**
- **02. Linking and connecting with others**
- **03. Community development and integration**
- **04. Conduct safe and effective practice**
- **05. Upholding professional standards and maintaining professional integrity**





“ In small groups...

1. What does the word ‘research’ mean to you - What sorts of research do you already do in your job?
2. “Academic research has no use in the real world” - discuss

Research is the systematic collection of data to answer a specific question / explore a topic

To find out if your 'thing' makes a difference

Does it actually work / does something happen?

To test out practicalities

Can we actually do this? Is it cost-effective?

To explore people's experiences

To find out the 'how and why', the meaning people make of things.

To explore the process

Something might seem to work using numbers (e.g. an improved score on mood questionnaires). However, what was it like for people to do it? Or if something 'doesn't work', why not?

To compare different approaches

Find out what works better in what situation (e.g. telephone vs in-person support for people with chronic health issues)

To come up with, and test, theories

We know that something happens, but a theory tells us why it happens

To find out whether something is generalisable

Will this thing help the majority of people who use it?

To make sense of existing research

Can we bring everything together to look at the overall picture? Can we address gaps in existing knowledge?

Why theory?

Example: lipstick sales are up 20% since 2020.....

Theory 1

- The mask mandates have been lifted

Theory 2

- People are spending on small luxuries instead of bigger items or holidays

Theory 3

- People are out socialising more

Theory 4

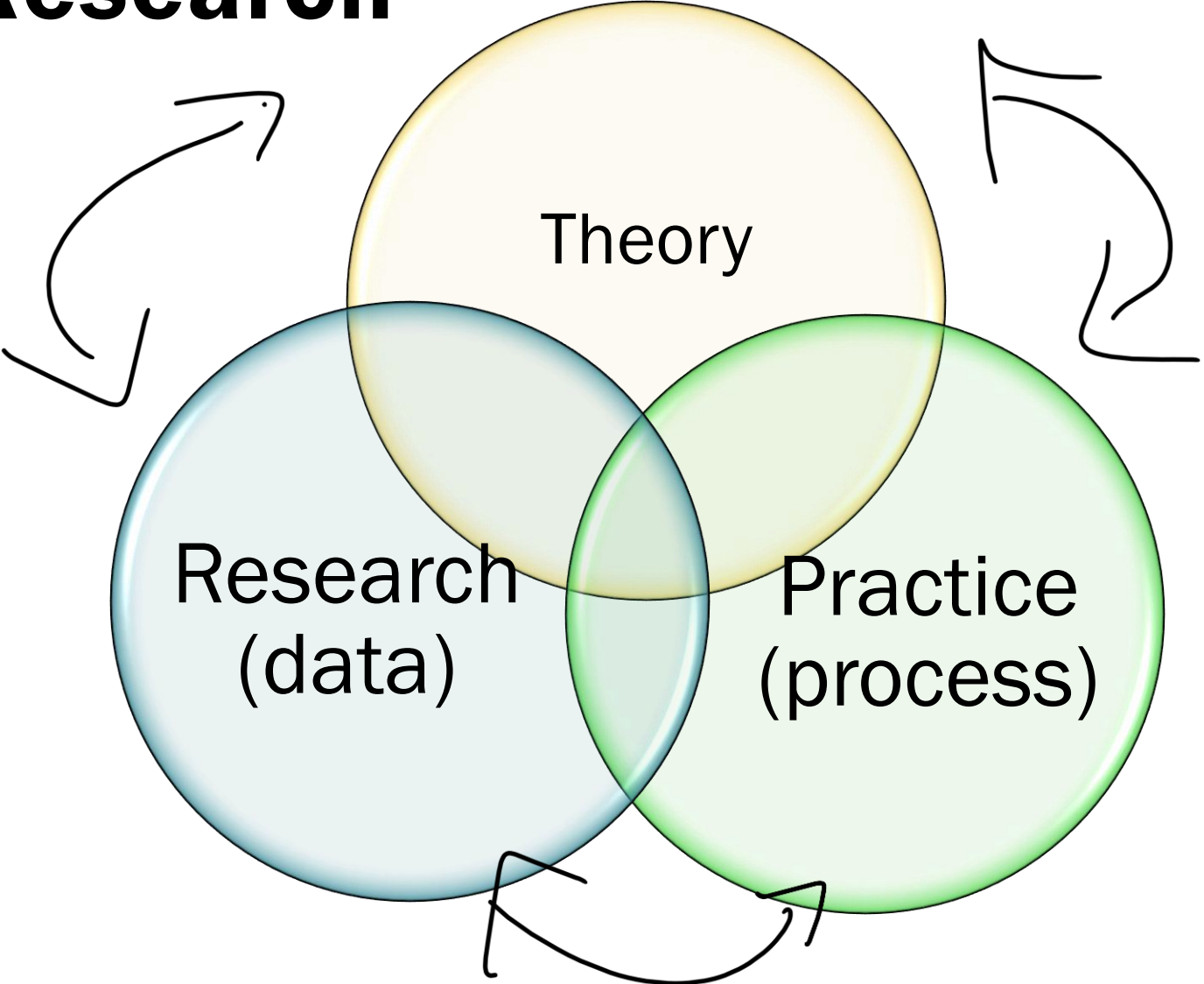
- TikTok's latest lipstick trend

Theory 5

- Increase in 'self care'



CESP Research



CESP Timeline

We are here



Jan 22 – first community panel

April 22 – research launch

June / July 22 – community survey launch

Oct / Nov 22 – CESP recruitment ends

Research follow ups (6, 12 months)

Community questionnaire repeat (April / May 23)

Qualitative interviews 2022/2023

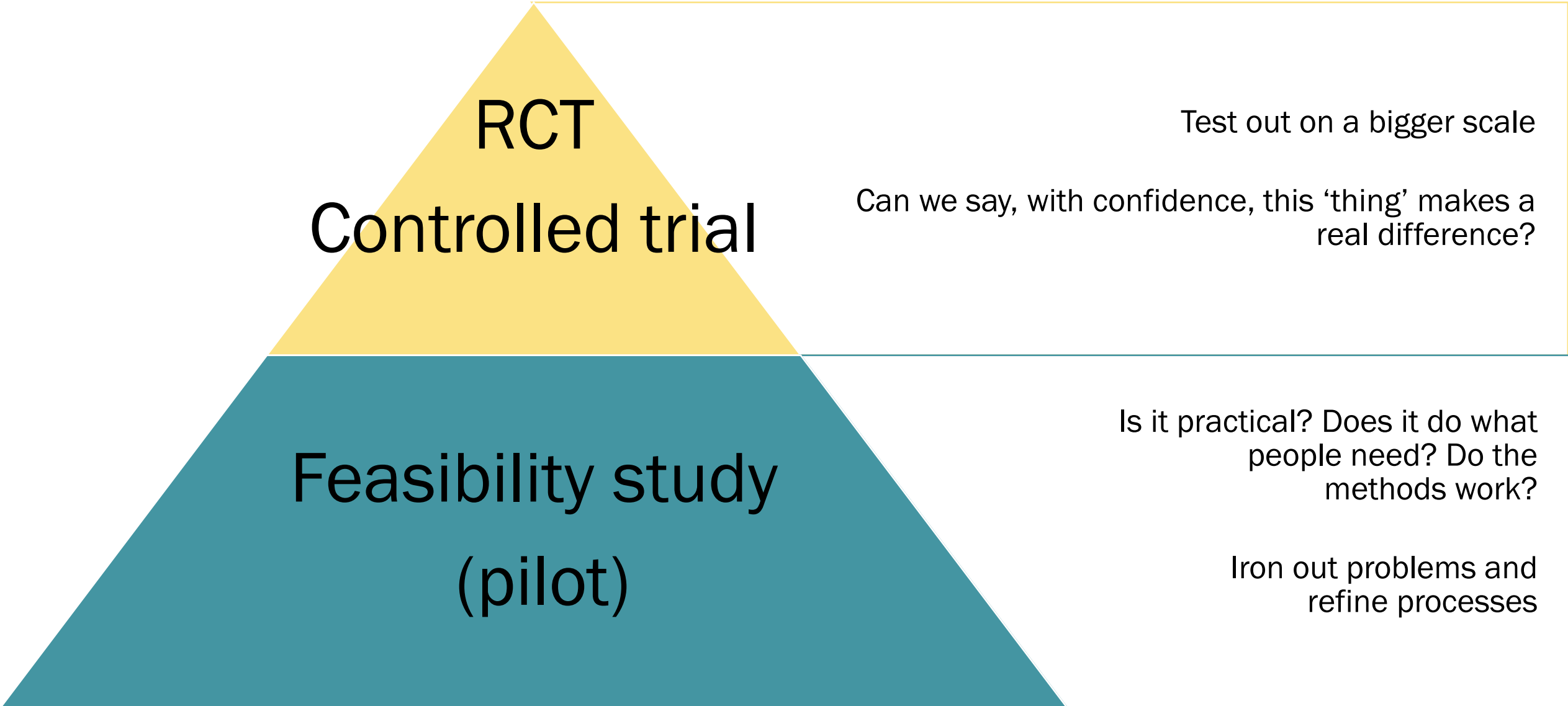


Developing a manual for other community panels



LEAP to participate in interview data collection

Where are we at?



“ Why is ‘the literature’ important in this?

- Make sure we’re talking about the same thing (‘social prescribing’)
- What other people have done
- What worked / what didn’t
- Which populations (groups of people) and types of services have been studied
- Like the community panel, researchers each have part of a ‘map’ – what’s weak, or missing
- **Literature reviews** bring together existing research



Home is where the
gaps are

“ Why is ‘the literature’ important in this?

- 20% of people contact their GP for social issues
- The wide variety of SP research is necessary: referrals are based on local need, services and resources
- **Difficulties** – ‘generalisable’ evidence, what is a ‘successful’ outcome, lack of control groups, researchers not being ‘independent’
- **Suggestions** – social prescribing is a whole system, each part needs its own evidence base (e.g. effectiveness, process..). MUST report context well in research reports.

Husk et al. (2019)



Home is where the
gaps are

So.. what does the literature mean by social prescribing?

Review of 89 documents / studies

Looked at the language ('discourse') used to understand SP in research.

Discourse 2. "From dependence to independence"

Most common rationale for design / measurements chosen in SP research. Services overstretched, people relying on public services too much. Barriers are individual e.g. confidence/ motivation, hence 'coaching', goal setting, motivation. Time limited, reduced "dependency" on link worker.

Discourse 1. Social prescribing as helping to overcome the social determinants of health

Most common rationale for the existence of SP. Social / medical treated as separate. Societal disadvantage causes health probs (yet is often not measured)

Discourse 3. Social prescribing as enhancing personalised care in general practice

Mostly qualitative studies. SP considered a "practice", and a care network (relationship and coordination between providers). People considered 'patients' with 'needs' – caring/ supportive / listening SP, contrasted to rushed impersonal GP. Could undermine / outsource GPs role in supporting people.

What makes a good social prescribing study? – a literature review

What was reviewed?

- UK social prescribing schemes 2000-2015.
- 86 schemes but only 40 evaluated primary data
- Arts, books, education, exercise, green gyms / ecotherapy, healthy living, signposting / information referral, supported referral, timebanks....

Key points in strong research

- Good to have mixed-methods
- Some studies lack data e.g. incomplete forms
- 17 different measurements
- Most quantitative analysis is for exercise on referral
- Overall lack of statistical testing
- Qualitative may be useful for 'how' and 'what kind' of changes happen

What else do we need?

- Impact on longer term health outcomes
- Amount of time / funding required
- Benefit from previous 'lessons learnt' about engaging communities

‘Choose your own adventure’ of studies...

1. Can Social Prescribing Foster Individual and Community Well-Being? (review – Loneliness based)
2. The aim and measurement of social referral programmes (review of evidence base)
3. What does successful social prescribing look like? Mapping meaningful outcomes (review)
4. Understanding the social prescribing process [through self-determination theory] (study)
5. The benefits of social connectedness on quality and effectiveness of care provision (study)
6. What approaches to social prescribing work, for whom, in what circumstances? (review)
7. Creating relationships between GP and voluntary services (study) / delivering social prescribing services (review) – both about facilitators and barriers
8. Supporting social prescribing in primary care by linking people to local assets (review)
9. Understanding the effectiveness and mechanisms of a social prescribing service (study)
10. Impact of COVID-19 on social prescribing across an Integrated Care System (study)

1. Can Social Prescribing Foster Individual and Community Well-Being?

Systematic review

Different levels of SP effectiveness on loneliness etc.

Individual (51/51)

System (22/51)

Community (18/51)

Individual level

Loneliness (quality & quantity), isolation (frequency), wellbeing, connectedness (relating to others / belonging) – not everyone realises this. Connectedness/ loneliness often confused.

Only 5 ‘causal’ studies.

System level

Often service use e.g. health care. High variance e.g. 7%-68% reduction in GP use. Only 3 studies investigate social care. Mixed results.

Community level

No clear linkage between community resources and SP. Only 3 studies address community connectedness at all.

So what?

- We aren't sure of the answers
- We need a better theoretical framework/ outcome measures especially for community

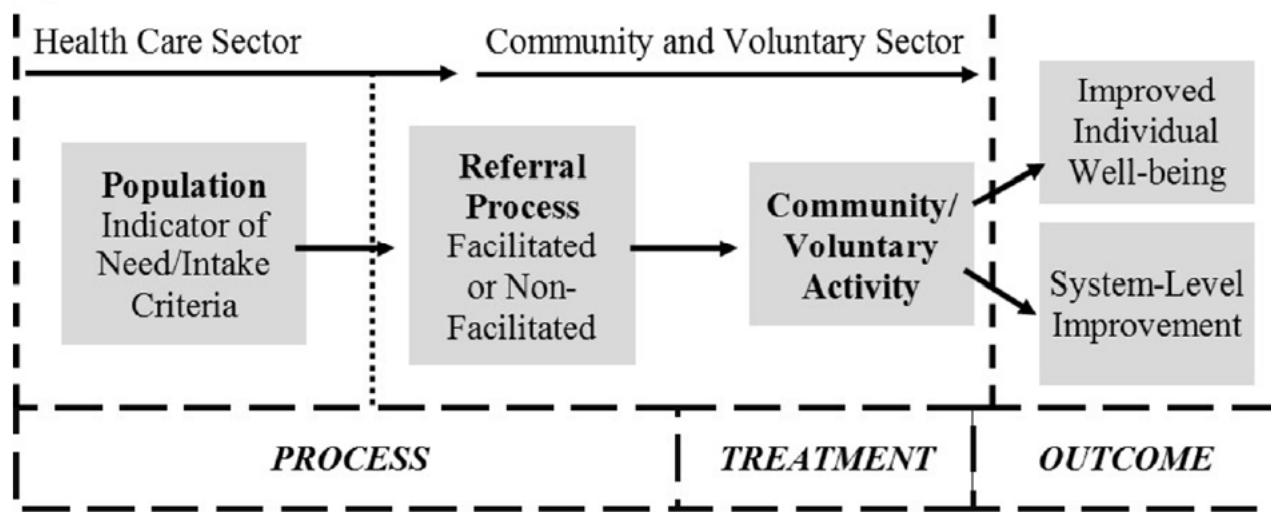
“The key aspect of any social prescribing programme is this interaction between the link worker and the individual (or a carer)”

2. A review of the aim and measurement of social referral programmes

- Literature review - 41 studies (38 were unique projects)
- No agreed definition of SP.
- Limited reflection on what SP is meant “to do”.
- Not enough research to establish effectiveness of SP
- None of the reasons for studies involved building stronger / more connected communities.
- Big variety:
 - 7 qual, 16 quant, 18 mixed-method.
 - 25 (out of 41) focused on “mental wellbeing”
 - Optimised service use (23)
 - Social wellbeing (21)
 - Physical wellbeing (16)
 - Cost savings was least common (6)

“definitive and systematic evaluations of social referral programmes are not possible while aims and measures are so inconsistent[...] we would argue that while aims and measures remain diffuse and the links between them undertheorised and underspecified that we actually *cannot* know that [effectiveness of SP] is the case”

2. A review of the aim and measurement of social referral programmes



Do you agree with where the arrows go?

3. What does successful social prescribing look like? Mapping meaningful outcomes

- There is a variety in research topics (literature review)
- 67 different outcomes - only 60% of these were measured
- Plus focus groups (n=31) led to 99 possible outcomes for social prescribing

| General | Physical | Psychological | Welfare | Spiritual | Social |
|----------------------|--|--------------------------------------|---|----------------------|---------------------------------|
| General wellbeing | Blood Glucose | Anxiety | Volunteering & employed | Sense of purpose | Reduced loneliness |
| Quality of life | Blood pressure | Depression | Education/ qualifications/ skills | Fulfilling potential | Reduced social isolation |
| Selfcare | Cholesterol | Self-esteem | Feel well informed | Relaxation | Increased independence |
| Social adjustment | CVD risk score | Confidence | Ability to access services | Broadening horizons | Increased social identity |
| Empowerment | Drug use: tobacco | Suicide ideation | Ability to do everyday activities | Enlightened | Builds self-worth |
| Social connectedness | Aches / pains | Trust | Housing / debts/ benefits | Inspired | Feeling supported & listened to |
| | BMI weight: waist circumference | Hope for future | Coping with bereavement/ separation | Enjoyment: happiness | Increased self-awareness |
| | Alcohol | Sense of control | Improved relationships; friendships; | | Builds knowledge |
| | Illegal drug | Anger | Concern about family/carers | | Friendship |
| | Prescription drug | Motivation | Sense of achievement | | Connectedness |
| | Quality of sleep/ less fatigue | Ability to concentrate | Better management/ coping with long term conditions | | |
| | Healthier diet | Personal resilience/ ability to cope | Ability to identify and address problems | | |
| | Physical activity: exercise activation | Positive decision making | | | |
| | Stamina | Feeling positive | | | |
| | | Cheerful | | | |
| | | Relaxed | | | |
| | | Absorbed | | | |
| | | Encouraged | | | |
| | | Pride in appearance | | | |

3. What does successful social prescribing look like? Mapping meaningful outcomes

- 37 priority outcomes were linked to social factors in health (i.e. meaningful).
- Green = rarely/never reported, orange = qualitative only, yellow = often reported.

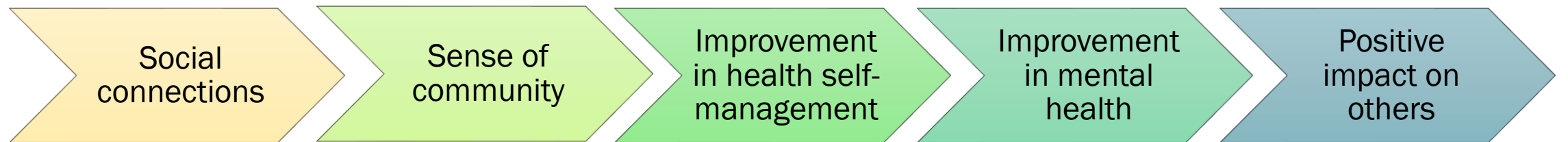
| Work and volunteering | Social | Education and skills | Crime | Housing | Legal | Income | Welfare |
|---------------------------|---------------------------------|----------------------|------------------------------|--------------------------------|------------------------|----------------------------------|----------------------------|
| Volunteering | Loneliness | Qualifications | Fear of crime | Housing conditions | Accessing legal advice | Reviewing and accessing benefits | Access to welfare advice |
| Employment / unemployment | Social isolation/connectedness | Skills acquirement | Effect of criminal behaviour | Home safety | Wills | Debt | Access to welfare services |
| Self-employment | Independence | Parenting skills | Anti-social behaviour | Home adaptations | Probate | Loan sharks | |
| | Social adjustment & functioning | | Disclosure of domestic abuse | Nuisance neighbours | | Increasing income | |
| | Social identity | | Gangs | Ability to pay rent / mortgage | | Fraud avoidance | |
| | Carer and family support | | | Fuel poverty | | Adversity and hardship | |
| | Friendships & relationships | | | Relocation | | | |
| | Intergeneration engagement | | | | | | |

3. What does successful social prescribing look like? Mapping meaningful outcomes

- Themes from focus group: measurement / monitoring, using holistic approach, relationship between SP & community [capacity to connect, creating connections, work capacity and sustainability]
- People felt that the impact of social prescribing on a community is not valued in same way as medical outcomes
- SP schemes start with assets (available resources) - impact of austerity & need for sustainable funding model in voluntary sector
- **Travel and transport are crucial**
- ‘Deprivation status’ of participants is a missing an outcome measure??
- Are we measuring the right things e.g. consider “becoming employable” (inc. psychological, skills-based, physical and social barriers) vs “employed” (jobs might not be available in the area)

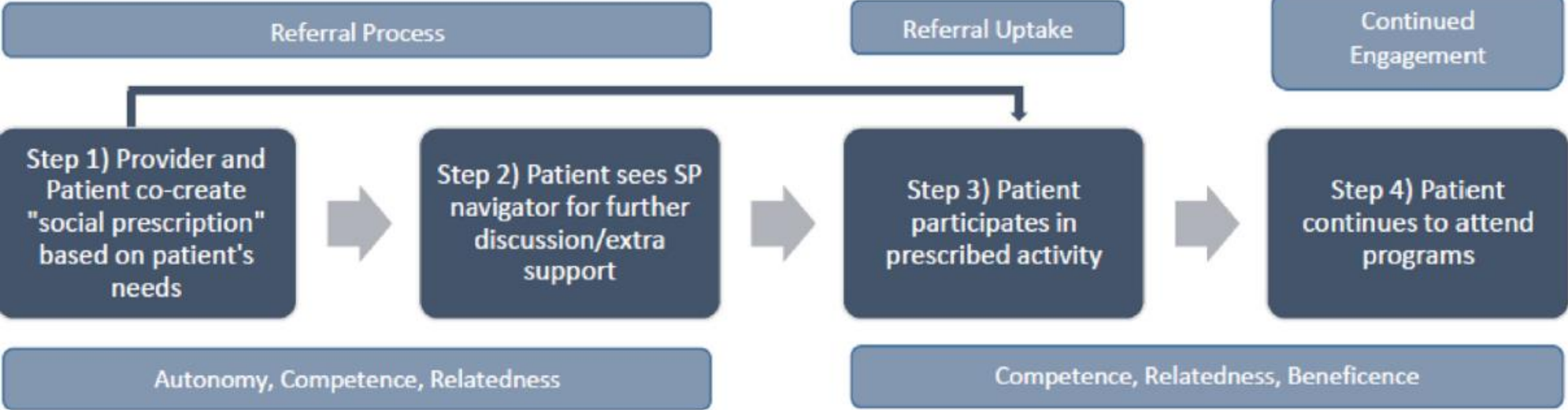
4. Understanding the social prescribing process

- Self-determination theory (greater belief in one's ability to make choices / have control = greater motivation to take action).
- But several psychological needs must be met first (autonomy, competence, relatedness, beneficence).
- 8 interviews, 88 people in focus groups (Canada). Most participants female.



4. Understanding the social prescribing process

Final theory / model from the data:

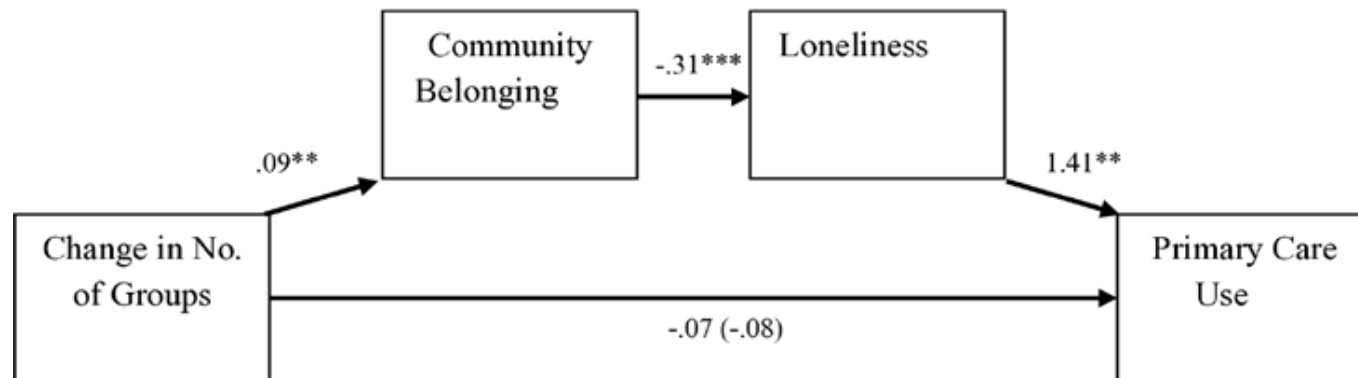


- Supported in having a voice, co-made prescriptions, trusted staff.

- Satisfying need / developing skill, r'ships with other participants & sense of community, used their experience to help others.

5. The benefits of social connectedness on quality and effectiveness of care provision

- East Midlands social prescribing project - chronically ill patients experiencing loneliness
- Quantitative survey (n=630; baseline, 4 months, 6-9 months). Plus interviews: 19 patients, 7 GPs, 3 health coaches, 6 link workers.
- Significant reduction in primary care service use (by 25%) & increased group memberships
- community belonging, loneliness etc. not expected to change, but are the 'active ingredients' (process) through which increase in group memberships predicts reductions in service use
- Group attendance needs to be positive and meaningful, welcomed
- **Being accompanied to the first meeting was important for people with social isolation and health problems.**



“our social group memberships (e.g. family, community, volunteering group) are consequential for our social life, health and well-being, but only if we identify with them (ie, feel a subjective sense of group belonging” (p. 3)

6. What approaches to social prescribing work, for whom, in what circumstances?

Wide definition of SP – “transfer between primary care and community-based activities”

Enrolment (agreeing to referral)

- **IF** the patient believes the social prescribing will do them good **THEN** they may be receptive.
- **IF** the referral is presented in an acceptable way and matches patient needs and expectations **THEN** they may be receptive.

Engagement

- **IF** the activity is accessible to the patient **THEN** they are more likely to attend.
- **IF** transport to first session is supported **THEN** the patient may be more likely to attend

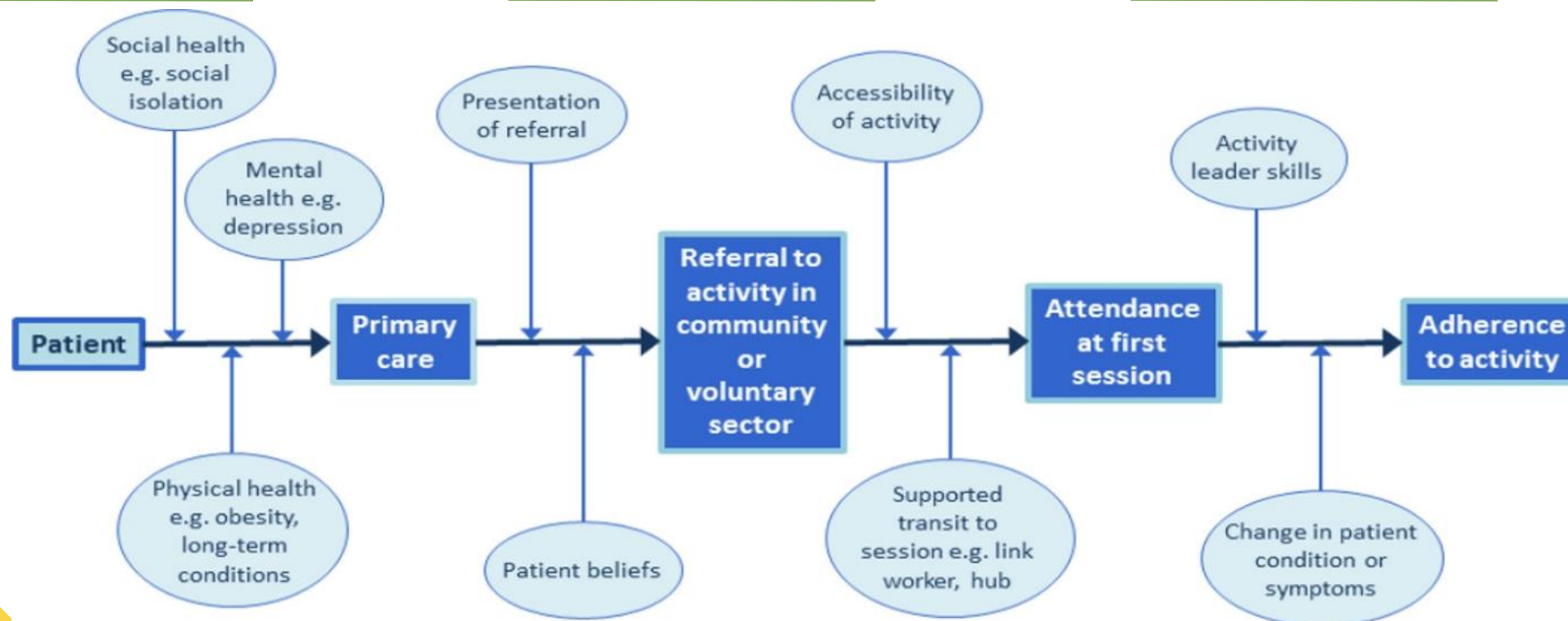
Adherence

- **IF** the activity leader(s) is/are skilled **THEN** the patient is more likely to maintain Adherence.
- **IF** there is a significant change in patient condition or symptoms **THEN** this may affect Adherence.

Activity leaders need interpersonal skills: “non-judgemental concern, compassion, personal attention and advice”

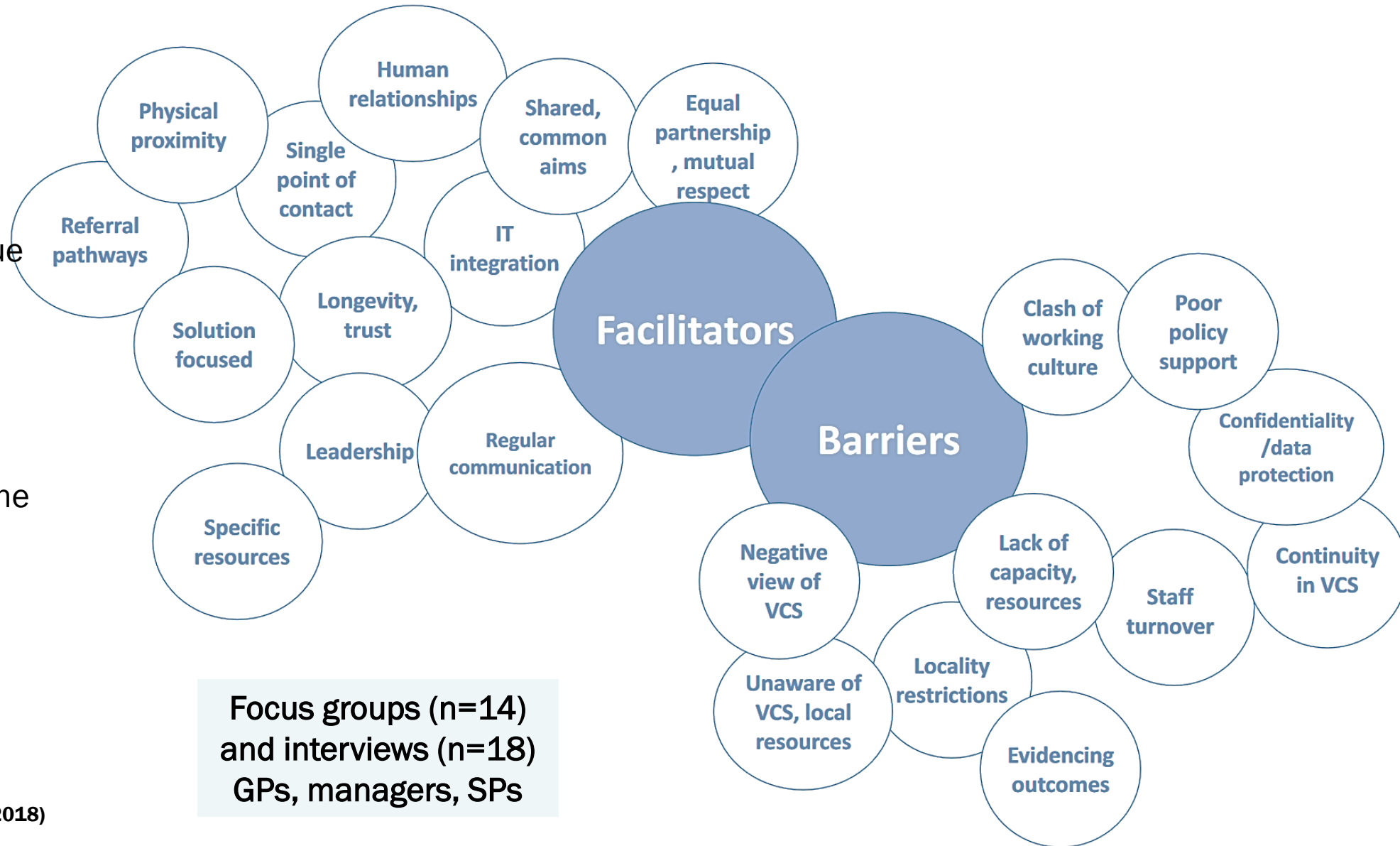
Cost and transport are very important issues!

6. What approaches to social prescribing work, for whom, in what circumstances?



Phase 1. Reviewed 109 papers to make a theory.
Phase 2. 34 high quality studies to clarify 'how' success is achieved, & consulted people with lived experience.

7. Creating relationships between GP and voluntary services



- Personal r'ships key
- Burden on showing value can sometimes fall with voluntary sector
- 'Policy' support inc. regional and national
- Trust takes time
- GPs need to attend to the 'status gap'
- Understanding wider voluntary sector
- Clear & regular mutual feedback

7. Facilitators and barriers of implementing and delivering social prescribing services: a systematic review

Pescheny, Pappas & Randhwa (2018)

8 papers total

Barriers

- **Leadership / organisation** (lack of partnership agreement between SP service and hosting GP surgery, turnover, lack of project management).
- **Implementation approach** (rushing before building r'ships, "go live" dates).
- **Economic climate / funding** (of SP).
- **Shared understanding** (of SP service and pathway, among all stakeholders).
- **GP staff engagement** (lack of, e.g. trust / time).
- **Staff turnover** (high).
- **Patient engagement** (new way of working, confidence, money, scepticism).
- **Infrastructure** (services and activities).

Facilitators

- **Implementation** (phased roll out inc meetings with GP practices); organisation (workshops / briefings before SP rolled out; steering groups, training for referrers)
- **Shared understanding / attitudes** between clinical / non-clinical staff & partners.
- **Relationships and communication** reciprocity & trust between SPs and partners. Structured regular communication, feeding back SP patient progress.
- **Organisational readiness.**
- **General practice staff engagement** e.g. attending staff meetings, letters back to referrer.
- **Support / supervision** (via manager).
- **Infrastructure** (of community).

8. Supporting social prescribing in primary care by linking people to local assets

Review of 118 documents – primary care based

- **Concept 1: Creating and sustaining ‘buy-in’.**
- Legitimise SP, not another gimmick; clear information; easy to refer, include voluntary sector in discussions; GP referral ‘validates’ SP.
- Belief in individual link worker (from referrer & patient). Skills / attitude, small wins, need for time & longer term input. SP workload should reflect the significant requirements of the role.

Concept 2: Establishing and maintaining connections.

Meaning and hope – action plans, safe to disclose, trust & conversations, making new connections in community

Support the supporter (training & manageable workload for SPs).

Key identified linkworker skills: “active listening, being non-judgmental, motivational techniques”

SPs “help patients to access support to meet their ‘non-medical’ needs by linking them to local assets”

9. Understanding the effectiveness and mechanisms of a social prescribing service

Plus a survey of patient outcomes pre/post 6 sessions (total n= 436)

- Wellbeing significantly improved
- Gender made no difference but being younger did
- Reduced anxiety and depression
- Half increased networks, 25a% reduced/no effect

Primary care based SP. Focus group with staff (n=17) and interviews with 'patients' (n=26).

- Flexibility of sessions perceived as positive ve (although only 6 total)
- Shared experiences with others = hope.
- New activities = purpose and independence.
- The SP service benefitted from well-established community relationships, joining networks and partnerships.
- Available community services need good compatibility with service user needs
- Particularly helpful for men to open up with SP (maybe cos the social practitioners were women)
- Study notes GP use may go *up* as a result of SP!

10. Impact of COVID-19 on social prescribing across an Integrated Care System

- Online survey (52 SPs), Interviews (57 link workers, plus community builders, managers etc), researcher notes.
- 2020, voluntary and PCN employed link workers (131 GP practices in PCN)

Access

- “Access shift” and “role drift”.
- Referrals down in lockdown, then up
- PCN had broader remit

Practitioner assets

IT & supervision were helpful. PCN - contracted felt they weren't incorporated into team & some teams didn't know they employed SPs. Generally most SPs got equipment to work remotely, this was a little slower in PCNs.

Activities

- Fewer due to pandemic.
- Appeared more difficult for PCN services to adapt.
- SPs used their own skills and experience to manage the needs of their patients / clients / people

About the SP role

- More clarity needed over SP role, especially “open” or “boundaried”
- Explicit contracting needed – shared and agreed
- Employing organisation has big influence on objectives / outcomes of SP service
- ‘Good’ / holistic SP needs to be balanced with burnout

“The workforce, or practitioner, is an essential asset, enabling this pathway through their skills and experience”



“ Overall take-homes

- No one model or job description of SP
- Getting other people to understand what SP means is often difficult
- Also, SP services do different things and serve different populations
- Evidence currently is a little patchy and lacking in systematic, causal data
- The voluntary sector / community may be under-valued when strict medical models dominate
- We need better theories and outcome measures
- Relationships are important at all levels



How does this chime with
your own experiences?

What would you like to
see researched?

What's
important?

Reflection

What's missing?



Impact on your practice in
the future?



Any surprises?

Other resources about social prescribing

Social prescribing. NHS England (2019)

<https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/public-and-partners/social-prescribing/>

The economic impact of social prescribing (report)

<http://shura.shu.ac.uk/29932/>

Official government training on social prescribing for other professionals

<https://portal.e-lfh.org.uk/Component/Details/571333>

Making sense of social prescribing (2017)

<https://westminsterresearch.westminster.ac.uk/item/q1v77/making-sense-of-social-prescribing>.

The King's Fund: social prescribing explainer

<https://www.kingsfund.org.uk/publications/social-prescribing>

National Academy for Social Prescribing summary of the evidence

<https://socialprescribingacademy.org.uk/our-work/evidencing-social-prescribing/social-prescribing-the-evidence/>