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OXFORD SOCIAL PRESCRIBING RESEARCH NETWORK

Understanding the implementation of link workers in primary care in England: An overview of findings from a realist evaluation

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Executive summary

Primary care in England has seen the incorporation of social prescribing link workers to address patients' non-medical issues. They were one of the early posts that formed part of the Additional Roles Reimbursement Scheme (ARRS). Understanding link workers' implementation into primary care is important to ensure that social prescribing is acceptable and sustainable in this setting. This summary provides an overview of research findings and recommendations from a study, funded by the National Institute for Health and Care Research (NIHR), that addressed the question:

When implementing link workers in primary care to sustain outcomes – what works, for whom, why and in what circumstances?

Data collection involved observing and interviewing link workers, patients, primary care staff and voluntary-community sector representatives. Patients completed questionnaires on well-being and self-efficacy. In addition, data on patient contact with a general practitioner (GP) before and after being referred to a link worker were collected. Key findings from these data included:

Holding – link workers are the intervention

Observations undertaken during fieldwork, and interview data, revealed that the relational practices of link workers with patients were an important but overlooked element of the role. Link workers were depicted as a consistent source of support, attuned to an individual's emotional situation, who enabled patients to deal with feelings they experienced as overwhelming. This relates to the idea of 'holding' – a role that our data suggested link workers often provided. Holding was particularly used when it was not possible to 'fix' social issues that contributed to patients' ill health (e.g. around housing or employment). We identified four functions of holding: a) supporting patients waiting for services; b) sustaining patients as they prepared for change; c) trying to reduce the emotional burden of health professionals; d) bearing witness to patients' distress when unable to find solutions to (or 'fix') a patient's difficulties.

Micro-discretions – the flexibility link workers are afforded to impact outcomes

The term 'micro-discretions' identifies actions link workers undertook in their role based on personal judgment; 'micro' was used because this discretion tended to relate to interpersonal interactions – with patients and primary care staff. Micro-discretions were expressed by link workers in areas such as how long they spent with patients, how they identified organisations within the community, how they accepted referrals, training they accessed. Micro-discretions enabled link workers to use their skills and knowledge to best support person-centred care – increasing job satisfaction. We also identified boundaries that constrained the micro-discretions of link workers, and how having too much scope made some unsure about the remit of their role, prompting them to consider leaving their job. This was particularly the case if lacking clear or supportive management structures.

Being an anchor point – link workers' ability to prompt patients to take steps towards change

Data highlighted how link workers had to be skilled in putting people at ease, creating an atmosphere in which patients felt able to open up. Talking to a link worker could unlock a range of issues that a patient required support with to reach a state of equilibrium before moving forwards. Patients we interviewed described how link workers gave them hope by proposing potential solutions they could draw on for support. However, link workers had to be careful in how they encouraged different people to take steps to connect to external support; whilst some patients welcomed goals and being gently pushed to try things, others said this was inappropriate, especially in the early stages of their interactions with a link worker, when what they needed was space to think more clearly.

A continuum of embeddedness – differences in link workers connections with and within primary care

Based on the data we collected, we identified a continuum of how far link workers were embedded (or not) within primary care. At one end of the continuum, link workers were 'bolted on' – brought into primary care without much consideration of how the role would work alongside existing provision. In a central position within the continuum was 'fitting in'. This is when there was some attempt to bring link workers into a practice but this could be uncomfortable if they felt their role was not really understood or appreciated. At the other end of the continuum was 'belonging', which involved some negotiation and potential adjustment by the link worker and the practice as they worked together to offer the best support possible to patients. A sense of belonging was important to help with job satisfaction among link workers. It could also help with moving towards a boarder view of factors affecting health within primary care – bringing into consideration patients' social, economic and environmental circumstances.

Our findings demonstrate that flexible link workers are an integral part of social prescribing in primary care; they require support from practices, peers and their managers for this to happen and to feel embedded.

Our recommendations include clearly defining what the role entails in a local setting, in order to be appropriately resourced and understood, and to enable social prescribing to de-medicalise non-medical issues affecting patients' health.

Introduction

Primary care in England has seen the incorporation of social prescribing link workers to address patients' non-medical issues. Those undertaking this role come from a range of backgrounds; they may have worked in healthcare (e.g. as an occupational therapist or healthcare assistant) or within the voluntary-community-social enterprise (VCSE) sector. Link workers help patients to identify non-medical issues affecting their health and well-being; for example, loneliness or housing problems may affect people's mood and willingness to self-manage existing long-term health conditions. Link workers can connect patients to support or services (often in the VCSE sector) that can help with these non-medical issues.

Link workers form part of the Additional Roles Reimbursement Scheme (ARRS) in primary care in England; since 2019, it has seen the introduction of a range of additional roles as a direct response to pressing concerns facing primary care, including the escalating prevalence of long-term conditions, the increasing incidence of general practitioner (GP) burnout, overprescribing of medication and the growing recognition of the impact of social determinants of health. The NHS Long Term Plan stated that by 2023/2024, 900,000 patients would have been referred to social prescribing (NHS England, 2019), and its Long Term Workforce Plan (NHS England, 2023) projects that the number of link workers in 2022, which was 3,000, would rise to 9,000 by 2036/2037.

Despite the current drive in England for social prescribing within primary care, and the link worker role as part of this, a consistent theme from systematic reviews has been a need for more high-quality research to support current policy (Bickerdike et al., 2017; Chatterjee et al., 2018; Polley et al., 2017). This includes an improved understanding of how, why, and under what circumstances social prescribing pathways can be optimally delivered. A previous realist review we conducted (Tierney et al., 2020) was a step towards addressing this knowledge gap. It drew on 118 documents about the link worker role. By triangulating qualitative and quantitative findings from these documents, we made a series of knowledge claims regarding how link workers work, for whom, in what circumstances and why.

Our realist review highlighted the following:

- **Engagement is key**, with success dependent on 'buy-in' (from patients and health professionals) to: a) social prescribing as a viable addition to traditional clinical care, and b) an individual undertaking the link worker role (i.e. seeing them as credible and reliable).
- **VCSE organisations buy-in to the role**; feeling able to work in partnership with a link worker, if adequately supported (financially) and if not overstretched.
- **Connections are key to buy-in**, through relationship building between the patient and link worker, link worker and primary care staff, link worker and the VCSE sector.
- **Link workers facilitate the mobilisation of patients' social capital** (i.e. resources accrued by patients from connections with others, such as a sense of belonging, improved self-confidence, access to advice).
- **People can be prompted to invest in their health through an upsurge in their social capital.** This could mean they rely less heavily on medical professionals for assistance or, conversely, that they contact their GP more as they seek to better manage their health.

This previous realist review (Tierney et al., 2020) highlighted gaps in knowledge including how link workers established themselves as credible and reliable members of a primary care team, how they promoted buy-in to their role from patients, and what factors prompted change to a patient's situation following social prescribing. This led to our decision to conduct some follow-up primary research to build on and advance findings from our realist review.

7 Link Workers

22 Months of Data Collection

154 Interviewees

What we did

This report is based on a realist evaluation (see Box 1 for a definition). It addressed the question:

When implementing link workers in primary care to sustain outcomes – what works, for whom, why and in what circumstances?

Data were collected between November 2021-August 2023 around seven link workers based in different parts of England. They were purposively sampled to vary in: a) geographical location; b) how they were employed - through primary care or a VCSE organisation; c) the population they served; d) the amount of time they had been a link worker. Researchers spent three weeks in situ with each link worker, going to meetings with them, watching them interact with patients, with primary care staff and with VCSE organisations. During this time, researchers had a daily debrief with each link worker, inviting them to reflect on their working day, and they collected relevant documents (e.g. job descriptions, information on social prescribing given to patients). In addition, data on patient contact with a GP before and after being referred to each link worker were collected from practices.

Researchers also interviewed 93 professionals (VCSE staff, GPs, link workers, practice managers, nurses, care coordinators, health and well-being coaches, reception staff and allied health professionals) and 61 patients; 41 of these patients were re-interviewed 9-12 months later. As part of interviews, patients were asked to complete questionnaires on their well-being (Tinkler and Hicks, 2011) and self-efficacy (Schwarzer and Jerusalem, 1995).

As this was a realist evaluation, we set out to test (confirm, refute, refine) the programme theory we developed from our previous realist review; our programme theory set out to understand and explain how and why link workers produced specific outcomes in certain contexts. To do this, our analysis explored connections between contexts, mechanisms and outcomes to explain how, why and in what circumstances the implementation of link workers might be beneficial (or not) to patients and/or healthcare delivery.

Box 1: A summary of realist evaluation

Realist evaluations (Pawson, 2013) build from an initial programme theory about how an intervention (e.g. social prescribing) is thought to work, for whom and how. Through data collection and analysis, the initial programme theory is revised and refined. Data are drawn upon to develop explanations that focus on mechanisms producing outcomes, and contexts required to trigger these mechanisms. Realist evaluations aim to "open up the 'black box' of the policy intervention to understand why the observed outcomes occurred and to explore the interplay of stakeholders, resources, beliefs, outcomes and circumstances. This can help to develop the evidence base around a policy area and pave the way for the generalisation of the programme" (HM Treasury, 2020: 6-7).

Summary of findings from the research

We developed the following key concepts from the data; we see them as a useful way of expressing different stakeholders' experiences of having link workers in primary care, and they allow conclusions to be drawn about the best ways to implement and support the role.

Holding – link workers are the intervention (see Box 2 for related data extracts)

Our data highlighted that sometimes link workers engaged with patients in a way that was not always working towards a particular goal or connecting individuals to external support; rather they sought to contain the patients' emotional difficulties by making space for them to express their needs.

They did this by providing patients with a safe space where they could acknowledge their difficult circumstances and feelings. We described this as 'holding' – an element of the link worker role that several patients said was key when asked about the benefits of social prescribing. Data suggested holding was particularly critical in areas of high socio-economic deprivation, where it may not be possible to 'fix' many of the social issues experienced by patients contributing to their ill health (e.g. housing problems, lack of employment). However, interviewees noted that holding undertaken by link workers was not necessarily recognised by managers and funders.

We identified four functions of holding by link workers:

a) supporting patients waiting for services;

b) sustaining patients as they prepared for change;

c) reducing the emotional burden experienced by primary care staff;

d) bearing witness to patients' distress.

Data highlighted potential negative consequences of holding, such as link workers taking on too many complex cases and becoming burnt out. We concluded that if link workers engage in holding, they should receive adequate training and supervision, to highlight its legitimacy as part of their job.

Box 2: Data extracts related to the concept of holding

> *"…in a dream world, people would come – we'd talk about something – and I'd refer them straight to an organisation, but it doesn't always work like that – sometimes, you have to hold people's hand a bit more, and that's okay as long as the motivation and understanding of the process is there. If people are expecting a 'quick fix…it's not gonna work."*
>
> Site 4 link worker 01

> *"Sometimes you feel like you are holding people emotionally while they're waiting for – even though you're not mental health or a psychologist, you're there just basically being someone who can listen to them and someone to check in on them really and for them to check in with. Sometimes that can feel quite a lot."*
>
> Site 3 link worker 01

Micro-discretions – the flexibility link workers are afforded to impact outcomes (see Box 3 for related data extracts)

We used the term micro-discretions to depict the local flexibility afforded link workers at a micro level – exhibited during interpersonal interactions with patients and primary care staff (e.g. in time spent with patients and where individuals were seen, referral types). Our data highlighted that having the scope to engage in micro-discretions allowed link workers to be person-centred and to shape what they provided to an individual's needs and situation.

Outcomes of link workers engaging in micro-discretions included feeling like trusted and respected employees, who could make a valued contribution to primary care by using their skills and knowledge to best support patients and their diverging needs This could foster job satisfaction. Conversely, too much discretion could lead to link workers feeling unsupported and overwhelmed, resulting in job dissatisfaction and the risk of them leaving their job.

Box 3: Data extracts related to the concept of micro-discretions

> *"…because of the wide range of people coming in and their backgrounds, we don't all start on a level playing field, which actually isn't the worst thing, because actually, like I say, we can adapt our role to ourselves."*
>
> Site 2 link worker 01

> *"I think social prescribers…have a little bit more flexibility in the work they do, so that they can tailor their intervention to the need of the client, which is never the same. It's just one by one."*
>
> Site 3 voluntary sector 08

> *"Not every social prescriber is gonna have a finger on the community pulse and know exactly what support is available…but you'll find some that go above and beyond the rest and are amazing at what they do, and take away a lot of the burden from doctor staff…"*
>
> Site 4 health professional 07

Being an anchor point – link workers' ability to prompt patients to take steps towards change (see Box 4 for related data extracts)

Link workers had to be skilled in putting patients at ease, creating an atmosphere in which individuals felt able to open up about their non-medical issues. Their consistency and reliability encouraged patients to do so. Having the link worker to talk to helped patients to think more clearly about how non-medical issues they were facing could be addressed. Patients talked about experiencing a sense of hope through the trust they developed in a link worker; this trust was established through the communication skills and knowledge demonstrated by a link worker. Link workers also fostered a sense of hope by proposing different potential solutions in the community that patients could draw on for support. Link workers had to approach this task of connecting patients to external support sensitively, taking into consideration how ready someone was to move forward; this was shaped by a patient's motivation but also their capacity to make changes given other demands in their life (e.g. caring responsibilities). Connecting patients to external support could be affected by structural factors outside a link worker's control (e.g. a lack of housing options or employment opportunities).

Box 4: Data extracts related to the concept of link workers being an anchor

> *"You feel like, 'Oh, wow, somebody here listening to me, somebody here to help me.' Yeah, you're not alone…Somebody there if you need some help…"*
>
> Site 1 patient 06

> *"She pointed me in different directions of, you can look in this place or you can look in that place, and you can talk to this person…it's all of those little things that were little nuggets that helped me."*
>
> Site 2 patient 03

> *"I don't see my GP as much now because I know I've got someone else [a link worker] to talk to, so I'm therefore saving the NHS time for other people…"*
>
> Site 3 patient 14

> *"Talking to her [link worker]…made me see that everything is brighter, that there was stuff waiting for me in various social settings if I wanted to…rather than everything feeling a bit bleak…"*
>
> Site 4 patient 05

> *"I'm looking forward to go and see her and we can track my progress…She'll give me information…of what she thinks I need to do next, what sort of steps I need to take…"*
>
> Site 5 patient 03

> *"…because she's helping me with my personal things, you know, and with the finances, improving the finances, I think she's took that worry off me, so I'm not as bad as what I used to be."*
>
> Site 6 patient 12

> *"…she helped me talk about some of the things I was dealing with and look at what some of the options were… it was so spot on…things I didn't even know I needed, you know were being brought to the forefront and into the discussion for me…"*
>
> Site 7 patient 07

A continuum of embeddedness – differences in link workers connections with and within primary care (see Box 5 for related data extracts)

Data highlighted the varying ways in which link workers were incorporated into primary care. These data related to issues around power, organisational culture, professional identity and establishing impact, all of which were informed by the strengths or weaknesses of the infrastructure provided around the role in a setting.

Terms like 'fit in', 'embed', 'integrate' and 'part of' were used throughout interviews when referring to the implementation of link workers in primary care. This prompted us to develop a continuum to explain the differing ways in which link workers might experience being introduced into primary care.

At one end of the continuum, link workers were 'bolted on' – brought into primary care without consideration of how the role would work alongside existing provision, how their skills and knowledge would be used, or what additional support and training they required. This could leave link workers feeling isolated and overwhelmed and considering leaving their job.

In a central position along the continuum was 'fitting in'; some attempt was made to integrate link workers into a practice (e.g. providing an induction, inviting them to team meetings), but their role was not really understood or appreciated. Consequently, they were asked to do things outside of their remit or skill set (e.g. seeing patients with significant mental health problems).

At the other end of the continuum was 'belonging', when the practice worked with the link worker to set up the role in a way that best served patients and reflected the link worker's expertise. It might involve some negotiation and potential adjustment by the link worker and the practice to enable the former to make a positive contribution in primary care by having the scope to use their skills and knowledge appropriately.

Data highlighted that buy-in to and acceptance of the link worker role could be shaped by feedback to practices around how patients had been supported through social prescribing. This could be challenging in terms of what measures to use, and the reluctance some link workers expressed in relation to collecting data using standardised questionnaires, which they felt failed to reflect how they supported patients. Furthermore, there was not necessarily a system in place for a feedback loop whereby others in primary care got to hear about outcomes for patients from social prescribing.

Box 5: Data extracts related to the concept of micro-discretions

> *"…if you're working ten minutes and the person next door to you is doing one hour and two [patients] don't turn up you can then start having that resentment of 'Why are they here?'… then you feel they're not a member of the team…I think both sides are right because GPs are 'Well, you know that's not fair'. And then link workers 'We need to spend time with them'."*
>
> Site 1 health professional 01

> *"I think they [link workers] need a really good induction, so they need to know who they're working with, how the system works in individual practices…they need a good interaction with the people who they're working with so that they can build rapport…so the staff know who they can refer to them and vice versa…"*
>
> Site 2 health professional 03

> *"If you provide no training and then you dump on them a bunch of people's problems…and you don't have resources that people can use, then obviously it's going to be really difficult. They don't do that for doctors and they don't do that for nurses, so why are we doing this with other people who are involved in the healthcare of our patients?"*
>
> Site 4 health professional 07

> *"Sometimes it's closed minds, so we just need to open some of the minds a little bit and realise that actually, some of this social stuff can be really effective in getting your patients back up and running quicker."*
>
> Site 6 health professional 14

Factors affecting outcomes associated with the link worker role – programme theory

A key aim of our research was to present a programme theory (a proposition about how an intervention is thought to work, under what conditions) to inform and understand the implementation of link workers in primary care. The four concepts outlined above highlighted new outcomes that were not in the review's (Tierney et al., 2020) programme theory – person-centred care, link worker job satisfaction, and increased self-confidence and hope in patients. The revised programme theory, which incorporates these outcomes, is presented in Figure 1.

Figure 1 shows how buy-in to social prescribing as a concept and an individual link worker is essential. This can be fostered through connections developed by link workers with different stakeholders (primary care staff, VCSE representatives, patients). Buy-in and connections can affect (and be affected by) how far link workers are integrated (embedded) into a primary care setting.

When link workers have scope to practice in a flexible manner, including being able to 'hold' patients when necessary, it can facilitate delivery of person-centred care, encouraging patients to feel more hopeful about their future as they start to consider alternatives to medication to address their non-medical issues. It can also foster job satisfaction among link workers as they are able to use their discretion and skills to best support patients. When link workers are perceived to be a reliable source of support they can assist patients in reaching a point where they can start to move towards accessing solutions to their non-medical issues.

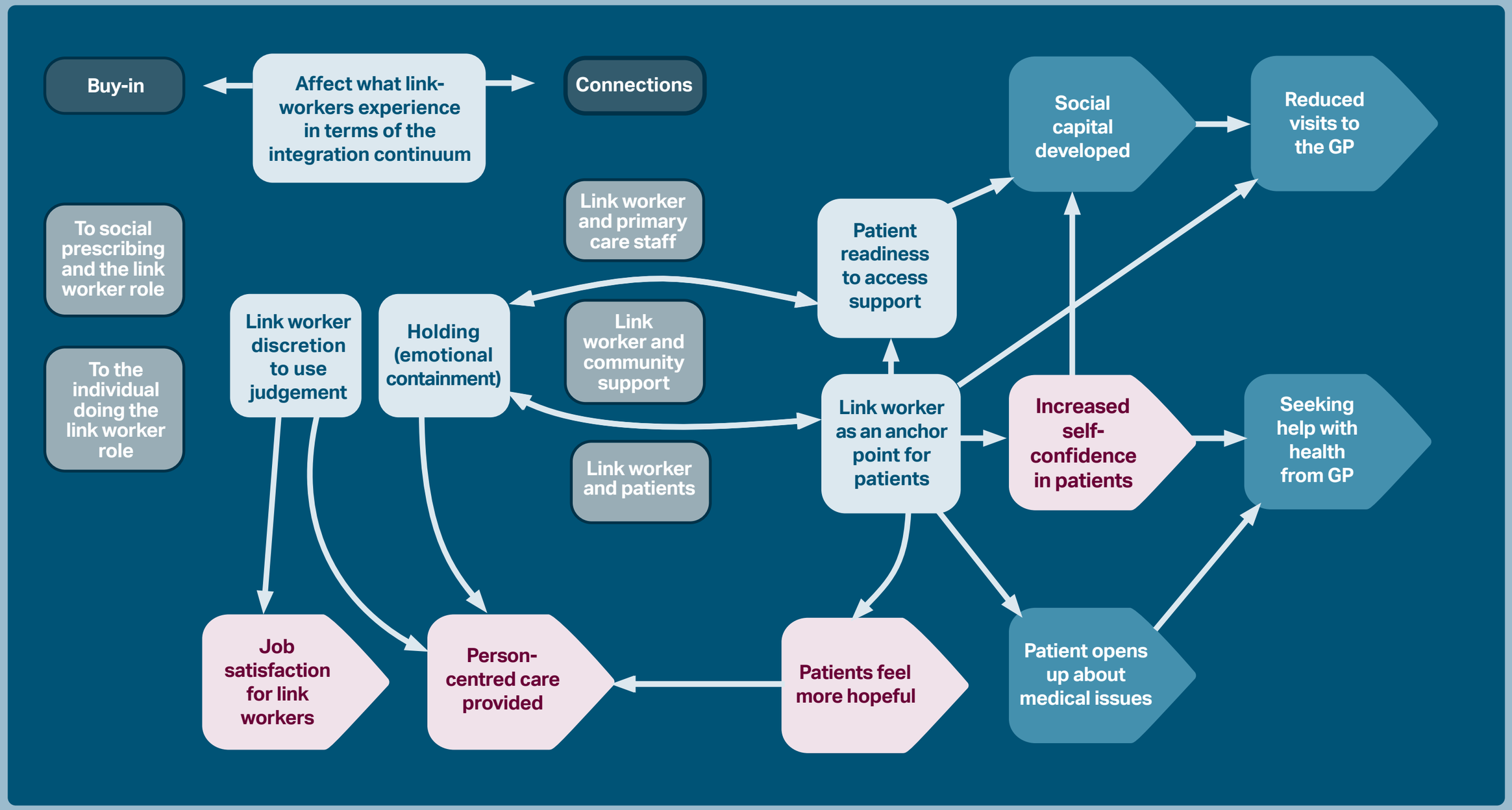
Patients' movement towards change can stem from them developing self-confidence as they encounter a sense of safety from the anchoring provided by a link worker. This allows patients to start making connections in the community, thereby building their social capital. Having a broader social network may mean that patients are less prone to turn to their GP when encountering non-medical issues.

Likewise, knowing they have a link worker who is supporting them can make patients less likely to contact their GP. However, seeing a link worker, in some cases, may increase patient contact with their GP; the link worker may pick up medical issues requiring attention, after gaining the trust of the patient, or through becoming more confident, the patient may wish to take steps to better self-manage their health, seeking advice from their GP on doing this as a consequence.

Figure 1. Programme theory

This builds on the figure we developed from our previous realist review (Tierney et al., 2020), which was amended based on learning from the realist evaluation.

- key concepts from the realist review
- key actors associated with these concepts
- new concepts from the evaluation
- outcomes from the original review
- new outcomes added to the model which came from the evaluation



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Implications of the findings

The research showed diverse ways in which link workers have been implemented into primary care in England. This included variation in: a) the number of patients seen, and frequency and length of contact with them; b) how link workers were employed (e.g. through primary care or not); c) whether they were part of a bigger social prescribing team; d) their backgrounds (professional and personal experiences); e) how much time they had in their working week to develop connections with VCSE organisations. Our findings highlighted the challenge of scaling up and rolling out a new role in an established institution like the NHS. We would argue that some of our findings are relevant to other ARRS posts introduced into primary care. This is reflected in a report on such posts by the King's Fund (Baird et al., 2022), which described a lack of shared vision and buy-in to these roles by Primary Care Networks (PCNs) due to time or capacity constraints.

Through the research, we have brought to the surface nuances and variations associated with the link worker role that may be hidden or not discussed explicitly; these are areas we feel need to be given consideration by those planning, delivering and funding social prescribing (see Figure 2).

Recommendations we developed from the research relate to:

- The importance of defining the role
- Allocating adequate resources
- Addressing non-medical elements of health and well-being

The importance of defining the role

Our research showed that a shared understanding of the link worker role is not automatic. Hence, a clear definition should be created, at a local level, involving key stakeholders (link workers, primary care staff, VCSE and patient representatives). There should be opportunities for these stakeholders to review and revise the role definition at regular timepoints, as this may need to alter due to factors that are local (e.g. changes in demographics of an area), national (e.g. due to cost of living difficulties) or international (e.g. due to a pandemic). The role must be defined and understood in the context of the changing wider primary care workforce (e.g. the addition of further new/extended roles). In particular, agreement is needed at a local level on:

- How much discretion link workers have around: a) how often and how long they spend with patients; b) where patients are seen; c) type of referrals accepted; d) training provided/accessed; e) feedback and data collected and shared.
- Whether it is acceptable/appropriate for link workers to support patients for a prolonged time (i.e. to assume a holding role). If so, this should be communicated when they take up their post and considered in terms of supervision provided.
- How much time link workers can spend in the community, researching what is available to connect patients to, and developing provision when required. Our previous review and this realist evaluation emphasised the importance of having scope in the role for link workers to undertake community development activities.

Allocating adequate resources

Our data highlighted that investing time in planning was essential when implementing link workers into primary care. Clarity on who will offer link workers supervision and how needs to be in place. Link workers require supervision around patient cases but also their own well-being. Supervision should include opportunities for link workers to reflect on their training needs and to access training when required. Practice resources should include space for link workers to see patients or to have private conversations with them. Ideally, this should be a non-clinical space, to reflect the type of support provided by link workers.

Addressing non-medical elements of health and well-being

Addressing non-medical factors affecting health is central to social prescribing. Link workers' presence in primary care should help to challenge simplistic views of health as separate from patients' socio-economic circumstances. Social prescribing brings to the fore wider determinants of health and illness. It can rebalance an overemphasis on the medicalisation of patients' difficulties. For this to transpire, link workers need adequate time to develop connections with VCSE organisations that they can refer patients to. As noted by some participants in our research, the constant state of flux and financial instability experienced by VCSE organisations can make its ability to underpin social prescribing uncertain.

More specific recommendations related to each of the concepts presented above can be found in the papers we produced from the research, which are listed on the study's webpage:

https://socialprescribing.phc.ox.ac.uk/research/projects/understanding-the-implementation-of-link-workers-in-primary-care-a-realist-evaluation-to-inform-current-and-future-policy

Figure 2: Key considerations for optimising delivery of social prescribing in primary care

Leadership and governance

- Ensuring a supportive environment for link workers
- Permitting some autonomy for role discretion
- Championing of social prescribing from local clinial leaders and patient groups

Planning and commissioning

- Acknowledging link workers may provide a 'holding' service due to service gaps
- Building in time for link workers to connect with local community services
- Moving beyond the role being seen as solely an approach to reducing GP workload

Workforce development

- Providing regular supervision for link workers to allow for safe patient care and workload management
- Valuing and recognising the impact of link workers for retention and team integration
- Training for link workers being given priority

Digital and technology

- Developing a digital directory of available services in the community
- Training for link workers in primary care IT systems to facilitate joint communication
- Tracking patient engagement and outcomes with social prescribing activities

Evidence and impact

- Gathering data on services gaps within the community to reduce 'holding'
- Creating feedback loops on outcomes to those referring to social prescribing
- Creating opportunities for link workers to share success stories with primary care teams

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