**Understanding how, why and for whom link work interventions promote access in community healthcare settings in the United Kingdom: A realist review.**

**Abstract**

Introduction: Inequity in access to healthcare in the United Kingdom can have a profound impact on people’s ability to manage their health problems. Link work interventions attempt to overcome the socioeconomic and structural barriers that perpetuate health inequalities. Link workers are typically staff, without professional clinical qualifications, who support patients to bridge the gap between services. Little is currently known about how and why link work interventions might be effective. This realist review attempts to understand the contexts and resultant mechanisms by which link work interventions affect access to community healthcare services.

Methods: The authors completed a systematic search of empirical literature in Embase, CINAHL, Medline, PsychInfo and SocIndex, as well as grey literature and CLUSTER searches. Context, mechanism, and outcome (CMO) configurations were generated iteratively in consultation with an expert panel and grouped into theory areas.

Results: 31 eligible manuscripts were identified, resulting in nine CMO configurations within three theory areas. These pertained to adequate time in time pressured systems; the importance of link workers being embedded across multiple systems; and emotional and practical support for link workers.

Conclusion: Although link work interventions are increasingly being utilised across community healthcare settings, the contexts by which they operate vary considerably, triggering a range of mechanisms. The findings suggest careful matching of resource to patient need and complexity, affording link workers the time to develop relationships with patients, embed themselves in local communities and referring teams, and develop knowledge of local challenges.

Patient or Public Contribution: The team included people with lived experience of mental health conditions and a carer, involved at all stages of the review.

Key words: Link worker, inequalities, healthcare, community health

**Introduction**

There is stark inequity in access to healthcare in the United Kingdom (UK). One of the core principles of the National Health Service (NHS) is equal access for equal need (1). However, there is ample evidence that this goal is not always met with the availability of medical care inversely associated with the needs of the populations served (2). Evidence points to multiple barriers in accessing adequate, appropriate, available, and timely health care for disadvantaged populations (3-5). Those most in need are likely to delay seeking treatment (6) and a socioeconomic gradient exists in waiting times for services (7). This is particularly important, as the most deprived are more likely to suffer ill health, earlier, for longer, resulting in gaps in life expectancy (8-10). There are concerns that existing inequity in access in the UK are worsening because of fiscal austerity measures and the COVID-19 pandemic (11).

The aim of link work interventions is typically to help individuals or families to overcome barriers to help-seeking that widen inequalities around health and wellbeing. Link workers are traditionally lay or non-clinical staff who provide practical support to bridge the gap between patients and clinical systems, services, and community organisations. There are many terms for link workers, including “social prescribers” or “bridging link workers”. Link work can be differentiated from other healthcare initiatives promoting access to services, such as referring and signposting, due to the hands-on nature of the work, often involving multiple contacts and a period of engagement (12). The link worker role is sometimes akin to that of support workers, without professional training or formal clinical qualifications, but with a focus on navigating services. Link work has been used across primary (13) and secondary (14) care services to facilitate access to a varied range of clinical services, community groups, and peer support. They can sit alone within purpose-developed services and initiatives or within broader social prescribing schemes. However, despite the varied nature of the link worker role, the objective is often the same; to support marginalised and disadvantaged populations to receive support that they would not otherwise receive.

There is emerging evidence that link work interventions can be effective in supporting access to services in currently under-served populations, such as people living in areas of multiple deprivation, or those living with complex physical and mental health difficulties. For example, it has been effectively used to facilitate dental appointments in families susceptible to poor oral health (15, 16) and diabetes screenings in marginalised inner-city communities (17). Despite its promise in improving outcomes, it is also apparent that the link worker role can be complex and challenging with high emotional strain and burnout for practitioners (18) and that there exist multiple systemic barriers to delivery (19). Little is currently known about the role that contextual factors play in determining the success of link work interventions in facilitating access, and the mechanisms by which they might operate across service settings. Understanding such processes may enable more effective and appropriate deployment of link work interventions. This is important as one of aims of the NHS Long Term plan is that over 900,000 people are able to be referred to a link worker by 2023/24 (20).

Realist reviews seek to make sense of complex interventions, offered across a variety of different contexts (21, 22). They attempt to understand contexts that trigger mechanisms underlying how interventions “work” by answering the question, “what works for whom, in what circumstances, how and why?” (23, p6). Realist reviews are often theory generating (rather than testing) and draw on a range of data sources to develop hypotheses or ideas that lead to programme theory development and refinement. Past reviews in this area have taken a broader focus on social prescribing more generally (24) or a narrower focus on the mechanisms which make link work interventions successful in primary care settings (25), rather than exploring community healthcare settings generally. There has been an unprecedented number of publications focusing on link work interventions in the past four years suggesting that an updated review is timely. The aim of this realist review was to identify the impacts of link work interventions on access to healthcare services and develop a programme theory to understand the underlying mechanisms that create these impacts, and the contextual factors that trigger these mechanisms to occur.

**Methods**

This review adheres to RAMESES published guidance for the reporting of realist reviews (26). The protocol was published online (PROSPERO: CRD42022302709). Programme theories were developed and refined across the following stages.

**1. Refining the scope of the review**

The scope of the review was refined by the research team (CL, JPC, FL, LL, RG, RH, VA) and informed by the main aims of the study; to identify the impacts of link work on access to healthcare services and understand the underlying mechanisms and contextual triggers. The focus was on link worker interventions defined as any intervention in which a patient is linked to/from a community healthcare service in the UK. Context included any relevant characteristics of the patient or organisational set up. Broader political and social context was not prioritised as it was recognised that this would be more difficult to change. The mechanism was defined as the response of any relevant stakeholder to the intervention, including the patient, link worker, staff etc. Outcomes focussed specifically on service access for patients as this is the main aim of the link worker role.

**2. Development of initial programme theories.**

Four authors (EE, JPC, RG, VA)conducted background scoping searches of relevant literature using Medline to begin to identify key literature and emerging programme theories. Subsequently, two authors (RG & JPC) held Individual, semi-structured meetings with four expert panel members to generate broad initial theories around how link work interventions support bridging between services across a range of contexts (27). The expert panel (AR, CC-G, LM, and MB) consisted of clinical academics specialising in primary and secondary care, and dentistry, known to the lead researchers through academic networks. All had expertise in, or knowledge of, link work interventions. The meetings were used to discuss the panel’s experience and knowledge of link working, and their perspectives on what makes link working successful, for whom and in what contexts. The authors used set questions and took detailed notes of conversations. The authors then analysed these notes to identify broad theory areas, which were then iteratively refined by the research team, including people with lived experience of mental health difficulties, and used as a framework to categorise context, mechanism, and outcome (CMO) configurations.

**3. Identify relevant literature**

A systematic search of academic literature was conducted in October 2022 using PsychInfo, CINAHL, SocINDEX, Medline, and Embase, which was later updated in August 2024. Two groups of search terms were used: Group 1 related to link work interventions, and group 2 related to community healthcare services (supplementary material 1). These initial search terms were based on key definitions and terminology in the literature (e.g., 18, 28). The definition of link worker was broad and included advocates, health support workers, social prescribers, and support workers, where the aim was to support service access.

The authors conducted a concurrent search of the grey literature using Google, Trip, Allcatsrgrey, the National Institute for Health and Care Excellence (NICE) website, NHS England publications, Clinical Trials, ISRCTN registry, and the UK Government publications website. For each database, variations of the term “link worker” were entered to locate documents not available through traditional database searches, but containing information that could support programme theory generation. Grey literature is included and given particular emphasis in realist research as the aim of the review is to extract information that best answers the research question, regardless of where the data are sourced (29). Where search results were extensive, the authors screened the first 10 pages of the results from grey literature search engines. Following the main search, the authors employed a purposive CLUSTER approach to identify sibling research of the identified literature, which may have been missed in the original searches (30, 31). Titles of link work initiatives, based on findings from the initial search, were used to identify further reports (i.e. Rotherham Social Prescribing service (32), Glasgow Deep End Links Worker Programme (33), and Ways to Wellness Social Prescribing (34)) using the same grey literature databases.

*Inclusion and exclusion criteria*

Papers identified by the search were selected for inclusion based on the criteria in Table 1. In line with guidance around realist reviews (27, 35), literature was not excluded based on study design. Sources were required to provide insights into the mechanisms and contexts in which link work interventions help people to navigate or bridge the gap between clinical services. Within the literature, some authors used the terms social prescriber and link worker interchangeably, whereas others defined the former as a lighter touch intervention with a less hands-on approach, focusing on referring and signposting. For this review, it is acknowledged that the social prescriber role is broader, but the authors accepted reports where the described role approximated that of a link worker. On some occasions, the term wellbeing coordinator was employed instead of link worker, but again the roles were felt to be analogous by the authors.

Two authors (RG & EE) screened the titles and abstracts of the identified empirical papers, before reviewing the full manuscripts against the inclusion and exclusion criteria. Following this, the lead author screened the reference lists and citing articles of relevant literature to identify any further eligible research. For grey literature, in the absence of an abstract, two authors (RG & KV) screened whole reports and searched for references to link work interventions. Included sources were required to provide insights into the mechanisms and contexts in which link work intervention help people to navigate or bridge the gap between clinical services. This process involved reviewing the literature against the published standards of relevance, richness, and rigour, to ensure that the data were relevant to the topic area, contextually and conceptually rich, adding a depth of understanding and meaning to theory development, and rigorous in its methodology, with a sense of coherence and transparency apparent in its theory development (27, 35, 36). Grey literature with no reported methodology was assessed for rigor based on the trustworthiness of the source and credibility of findings (36). Research with low relevance, richness, and rigour, particularly where there was insufficient information to identify CMOs were excluded.

*Data extraction*

Data extraction focused on using abductive and retroductive reasoning to identify CMO configurations, to develop programme theories relevant to each broad programme theory area. Each paper was read in depth, and any data relevant to understanding any aspect of a whole or part of a CMO configuration were extracted and coded into the most relevant programme theory area. This was done using Microsoft Excel and allowed multiple coders to contribute to the process.

*Analysis and synthesis processes*

JPC, RG, and FL completed the analysis, meeting regularly to discuss findings and identify underlying and recurring CMO configurations (demi-regularities; 37). The authors then reviewed the configurations and clustered them into groups of theory areas for reporting. Within the analysis, there was particular emphasis on key contextual factors as it was felt this would facilitate knowledge exchange, highlighting the things that services can act upon to enhance the effectiveness of link worker outcomes in improving access to services.

**4. Use of formal theory.**

The authors attempted to identify how formal theory had been applied to link work interventions and trigger mechanisms in specific contexts. It was hoped that they could facilitate further in-depth understanding of the underlying mechanisms by which link worker interventions can improve access. Formal theories were identified by reviewing the identified literature for mention of theories or models that explained how a link worker intervention might work. We considered the relevance of these theories and applied them to our own emerging understanding of CMOs and resultant programme theories.

**5**. **The voice of people with lived experience.**

The research team included two people with lived experience of mental health difficulties and a carer. They were involved in all aspects of the review, including the conceptualisation, funding acquisition, analysis, and write-up. The lived-experience voice was central to creating and understanding emerging theory areas and CMOs.

**Results**

*Initial programme theory generation*

Expert interviews and scoping searches identified preliminary theory areas, which were developed, expanded, and refined through the identification of empirical and grey literature. Initial broad theory areas included ideas around the importance of engagement with communities, training and supervision needs, and effective information sharing between parts of the system.

*Refinement and development of programme theory*

Electronic database and grey literature screening yielded 31 reports. (Figure 1). Twenty-eight eligible reports were peer-reviewed articles and three were grey literature (33, 38, 39). 28 papers linked from primary care (including one literature review paper that included one study which involved a Community Mental Health Team), two papers from secondary care, and one paper concerning the Childsmile programme linking community nurses to dental services. Table 2 summarises the included reports.

During the realist synthesis process, the authors iteratively developed nine CMOs centred around three theory areas: 1) Matching resource to complexity in insecure systems; 2) Blended embeddedness; 3) Supporting those supporting others. The three theory areas represent a refinement of ideas from the initial expert interviews. For example, blended embeddedness was thought to better capture the literature than engagement with communities. Together, the CMOs make up the programme theory. Table 3 displays the CMOs, organised into their respective theory areas, and with example quotes supporting each configuration. The CMOs are all interlinked and should not be taken in isolation; it is the combination of these theory areas and CMOs that make link working successful and ultimately lead to better access to services for patients.

***Theory area 1: Matching resource to complexity in insecure systems.***

The theory area with the most evidence was matching resource with complexity and need. Resource could take many forms, including the length of sessions, the duration of interventions, the number of practitioners, the size of caseloads, and the availability of services in the local area. Patient and community level complexity could act as a major barrier to link working, which could be exacerbated by inappropriate resource allocation. If resource was inappropriately matched, this was felt to contribute to burn out and fatigue in link workers, making them less effective in their roles around supporting service access. Conversely, providing link workers with the capacity and space to work with complexity empowered them to overcome barriers to accessing services. There are three CMOs within this broader theory area.

* 1. *Time in time pressured systems.*

*CMO: If link workers are afforded time, this provides opportunities to build relationships and trust between link workers and service users, which better allows them to collaboratively work towards service access.*

Time had multiple meanings including the number of sessions, the length of sessions, and the duration of the intervention, which needed to be appropriate for and tailored to the linked population. It was felt that link workers were able to spend significantly more time with patients compared to other healthcare professionals, which was often seen as a major strength of these interventions. In addition to time availability, efficient time use was also seen as important with more effective and experienced link workers appropriately pacing interventions to meet the needs of patients, whilst achieving the desired outcomes around access. Appropriate time allocation allowed link workers to build relationships and rapport with patients, and better understand them as individuals. This in turn helped patients to trust their link workers, giving them confidence in their advice and recommendations. Trust was seen as integral when working closely and collaboratively together, especially when encountering challenging and emotionally demanding barriers to access.

*‘There is the sense, both from patient and [link worker] interviews, that much of the work actually involves one-to-one support over a period of time rather than simply linking patients to community resources… There was something about the un-conditionality and continuity of support from [link workers] that was valued by patients.’* ***33, p58***

Inadequate time and capacity to work with patients was also seen as an obstacle to the success of link work interventions, particularly within the context of complexity and systemic pressures. Link work became more challenging when the practitioner felt forced to pick up a large caseload with multiple needs, but without the capacity or time to sufficiently address their presenting issues. Link workers sometimes described how they had to hurry people into services without building in time to support them to facilitate changes. This led to link workers becoming burnt out and exhausted, making it hard for them to meet the needs of their patients.

*‘An increase in referral rates by follow‐up had created new challenges. Link workers reported tensions between achieving what were viewed as high referral targets and their ability to deliver the holistic, intensive support their clients needed… Link workers felt they lacked the capacity and/or expertise to offer these clients the high‐intensity, specialist support they needed’* ***40, P5.***

*1.2. Open doors, open now.*

*CMO: If there are few or inadequate local services, this leads to disillusionment in both link workers and patients, who view the service access as an impossible task, causing both to disengage.*

There was a strong suggestion in the identified reports that the success of link work interventions was contingent on the availability of local services, which were often impacted by local funding limitations and cuts (39, 41, 42). Access problems included long waiting times, changing service remits, financial barriers, and service closures. Although challenges around transport could sometimes be addressed during the intervention, this was sometimes seen as a barrier to progress being maintained once the link work intervention had finished.

*‘Of particular value was the potential to be engaged with the service for up to 2 years. Due to the long-term and complex nature of conditions which often fluctuated, participants recognised that a shorter-term approach would be inadequate… “It’s the kind of thing if you need them, you phone them and they’ll get straight back to you. They’re there, I know they’re there.” [patient speaking about link worker].’* ***28, p6.***

Reports highlighted the benefits of having multiple onward referral options so that they were able to tailor their offer to the person’s interests and needs (28, 41). This was particularly true of link work within the context of social prescribing schemes where patients were referred from NHS services to local charities, support groups, and societies, which appeared to be instrumental in generating enthusiasm and interest from referrers and patients for the linking process.

*‘The availability of services varied greatly across localities. For example, a link worker operating in an affluent area in the South of England discussed the abundance of community activities in their local area: [quoting participant] ‘There’s groups for everything, you know. Everything I thought of which would make an idea for a group, there's a group out there…’* ***41, p1540.***

*1.3. The sustainability of the service offer*

*CMO: If there is uncertainty in the service offer of link work interventions, link workers feel undervalued and underappreciated, which leads to staff vacancies and the intervention to break down.*

Although less supported in the empirical literature, some sources of information raised the possibility that the stability of link worker service provision and investment in link worker interventions determined their success (38, 43). In the absence of long-term funding commitments and job security, link workers felt stressed and underappreciated within the navigated systems. Some link workers saw their roles as precarious and voiced concerns that rates or conditions of pay and job roles might alter with changes in contracts or service providers. This was further compounded by uncertainty in career progression and how people felt that they could build on the link worker role. Service level uncertainty also appeared to affect referrers trust in link work interventions, as referrers were reluctant to refer patients due to uncertainty around how long the intervention would be in place, and therefore of how much benefit it would be to patients, resulting in fewer referrals over time.

*‘In all three schemes, there were uncertainties about future funding of both social prescribing schemes and third-sector organizations. As one Link Worker explained, ‘We really don’t know what that’s going to look like ahead, unfortunately, we just don’t. And that’s a huge, huge worry’.’* ***44, p675.***

***Theory area 2: Blended embeddedness.***

A second theory area concerned the idea of blended embeddedness; the need for link workers to be seen to have roots both within referring services and the communities that they served. Within this were ideas around being perceived as a member of the team by referrers, and this being integral to building professional trust and respect. However, link workers were also expected to be situated within and belong to the local community, which was important for building a sense of togetherness and understanding with patients. The success of link work interventions was therefore contingent on the link workers ability to concurrently embed themselves into and navigate these two social spaces. There were four CMOs within this theory area.

*2.1. Co-location and understanding.*

*CMO: If link workers are embedded in referring services, this fosters a sense of teamwork, mutual appreciation, and joint working, which streamlines working processes vital to facilitating access.*

Reports highlighted the importance of placing link workers within referring services, emphasising the need for a perceived and real presence within teams (13, 43, 45, 46). If link workers could incorporate themselves into services, this elicited good information sharing and communication. It enabled link workers to formally and informally advise and liaise with staff on possible referrals and update them on the work completed. This in turn helped to build a sense of collaboration and togetherness with referring clinicians, which produced greater numbers of appropriate referrals, with clear goals and targets for the link work intervention, resulting in improved outcomes.

*‘A positive feedback cycle occurred when link workers became integrated into primary care teams, with productive case discussions* also leading to increased trust and generating further liaison opportunities’*… Productive clinical case discussions were reported to be the key to both link worker integration and better outcomes’.* ***45, p5.***

Conversely, if link workers and referrers were seen as outsiders, it could be difficult for them to build relationships and sell the benefits of their intervention. This was particularly true of primary care settings where General Practitioners did not see engagement with link work interventions as a core part of their role (19, 40, 44, 46). In turn, this could lead to feelings of disconnection and detachment between referrers and link workers, which led to fewer referrals and limited ability to bridge between services. In some instances, link workers who had been unable to develop links with referrers felt despondent and a sense of failure.

*‘…staff referred to changes in joint working that had a negative impact on the service: ‘‘Co-location increases understanding but…recently [the link worker] feels more isolated... is [now] in a room on [their] own.”’* ***46, p32.***

*2.2. Commonality of experience*

*CMO: If link workers are seen as part of the communities they serve, this leads patients to believe in them and their intervention, allowing them to take supported and scaffolded steps towards access.*

Initial expert interviews highlighted the importance of link workers belonging to the same communities as patients, which was then supported by several academic articles across multiple settings (14, 28, 47). Embeddedness was helped by recruiting link workers from similar backgrounds, who knew the local language, values, and culture. It was felt that this commonality of experience afforded link workers greater empathy, understanding, and compassion towards their patients. In turn, when this passion was visible, it facilitated trust and confidence in patients, which allowed them to take steps towards accessing services that were previously unavailable, scaffolded and supported by somebody that they knew and trusted.

*‘These kinds of experience helped Link Workers to sit with whatever was brought to the session and relate to the patient… Empathy and the ability to listen empathetically was widely regarded as an essential skill as were other personal attributes like the ability to be non-judgemental and persevere to build trust.’* ***48, p410****.*

* 1. *Knowledge of the local services*

*CMO: If link workers develop knowledge of the local challenges and the area, patients and referrals have more faith in their ability to help and are more likely to want to work with them around service access.*

Link workers who were embedded in an area were viewed as having insider and rich knowledge of local systems and services. This afforded them a practical advantage in finding places to refer to, but also gave stakeholders confidence in their ability to facilitate bridging between services. At times, this local knowledge highlighted to referrers the advantages of using the link worker, rather than making referrals and bridging services themselves, contributing to a throughput of referrals and the success of the intervention. There was some acknowledgement that acquiring local knowledge was time consuming and required the researching and scoping out of services, linking to CMO 1.1. During expert panel interview 6, it was discussed that unfortunately, disruption caused by the COVID pandemic was seen to have broken down ‘internal maps’ of services meaning that link workers had to relearn the local context all over again.

*‘The Wellbeing Coordinators suggested that they had worked consistently to build a presence in various geographical areas, building relationships with a number of different services and organisations and understanding the local offer in communities and neighbourhoods… The approachability, trustworthiness and communication skills of the Coordinator were crucial and often results in individuals feeling valued and listened to… The interpersonal qualities of the Wellbeing Coordinator were raised as a key factor in service users engaging with the social prescribing service.’* ***49, P7****.*

*2.4. An ethos of relationship building.*

*CMO: If link work interventions include a focus on relationship building, this will lead to greater trust, confidence, and sense of agency in patients, enabling them to engage with the intervention.*

Multiple reports stressed the importance of relationship building within link work interventions, rather than being entirely task focused. Again, this was closely associated with time allocation (see CMO 1.1), but also related to an ethos and directive from management and supervisors on how link workers should conduct their sessions. Furthermore, it was reliant on the link workers interpersonal effectiveness, experience, and passion for the area. If link workers prioritised and effectively built relationships with patients, learning their stories, backgrounds and presenting problems, this instilled confidence, trust, and a sense of agency in patients, which in turn empowered them to engage with the intervention. This had to be a whole team approach to function well.

*‘Such workers demonstrated genuine passion and drive, fostered through previous community-based roles, and utilised innovative strategies to address gaps in community infrastructure… In common with other research into the importance of the link worker role in developing relationships, engaging service-users and ultimately improving outcomes’* ***41, p1542.***

***Theory area 3: Supporting those supporting others.***

The third theory area focuses on the importance of effective and standardised training and supervision to help link workers to feel competent, confident, and focused in their roles, but that emotional support was equally as important. Link workers were seen as susceptible to emotional burnout, isolation, and role drift making it particularly important that they received the right support when they needed it. There are two CMOs within this theory area.

* 1. *Training and supervision to maintain hands-on focus.*

*CMO: If link workers receive appropriate support and training, they feel confident and clear about their roles, enabling them to become more competent practitioners, which is important for the promoting focused outcomes around access.*

Supervision and training were seen as integral to the success of link work interventions, which sometimes included behavioural-change strategies, cognitive behavioural techniques, and motivational interviewing. This had the benefit of empowering link workers to be more hands-on in their roles, elevating interventions from lighter-touch forms of signposting, to engaging and comprehensive support. Supervision was also seen as important for overcoming the multifaceted and complex barriers to access, which required collective thinking and creative problem solving.

*‘[quoting participant] we’re almost like social prescribing but we also would provide intervention… around behavioural change as well. Because the idea being that these might be repeat presenters to their GP. They’re not just going to go somewhere because you tell them…’* ***19, p4.***

Link workers came from a variety of backgrounds, including housing support, debt management, exercise, health coaching, and counselling. Although diversity of experience was considered a strength of the workforce, some reports suggested the risk of *role drift*, where both link workers and referrers were confused about the nature and purpose of the intervention, leading to inappropriate referrals and varied outcomes. Structured training and supervision helped link workers maintain focus in their work leading to better outcomes around access, rather than getting lost in the complexity of their caseloads.

*‘While this variation in skillset and expertise within teams was highlighted as a positive aspect, it also raised concerns that it could affect the consistency of offer across areas, meaning that signposting and other aspects of the role were undertaken differently by different professionals’.* ***19, p6.***

*3.2. Combating isolation with emotional support.*

*CMO: If link workers experience isolation, they become burnt out and fatigued, making their roles untenable. Conversely, emotional support can protect link worker wellbeing, facilitating their ability to facilitate the link worker role.*

Several reports emphasised the importance of formal and informal emotional support for link workers. It was clear that link working could, at times, be challenging and demanding for the practitioners themselves, affecting their wellbeing and mental health. Link workers often operated independently in the community and/or part of small teams, which could be isolating. This increased the need for regular emotional support from peers, families, and supervisors. Frequent informal, empathic conversations were seen as paramount to protecting link workers from fatigue, exhaustion and burn-out, which could affect their ability to work effectively and therapeutically with patients, making the role ultimately unmanageable.

*‘Where [social prescribers] were unable to find support from another [social prescribers], they felt increased anxiety regarding their ability to fulfil their role and cope emotionally as others' understanding of the role was perceived to be limited… [social prescribers] working for this organisation all commented that they would find the role untenable without this support.’* ***18, p342-3.***

**Identification and discussion of formal theory**

Within the literature, there was scarce use of theory to interpret and understand the contexts, and resultant mechanisms, in which link work interventions might operate. The most relevant was the application of Social Capital Theory and Patient Activation Theory by Tierney and colleagues (25) who previously reviewed link work interventions in primary care. The authors outlined how link work interventions can facilitate social capital, which relates to resource from the connections that form between people, and can reduce isolation, generate meaning in life, and act as a conduit for advice. Applying Patient Activation Theory, they suggest that social capital can result in patient activation (i.e. increased confidence, motivation, and ability): small successes that build into higher levels of achievement. Our emerging programme theory proposes a similarly important role for relationship building and further elucidates the structural antecedents that allow this to occur (e.g., matching of resource allocation to complexity and need, embeddedness with communities, provision of training and supervision). Whereas Tierney and colleagues (25) propose a role for reducing isolation in patients, our programme theory suggests that social embeddedness and tackling isolation in link workers are key factors in determining whether these interventions can promote access for people in under-served groups.

Mercer and colleagues (33) created a programme theory of change to underpin the Glasgow Deep End Links Worker Programme. This highlighted the resources and actions available at a patient, practice, and community level that could facilitate short, medium, and long-term outcomes. One-to-one individual support was theorised to lead to skills, information, and support acquisition, resulting in better self-management of health conditions, systems, crises, and challenges. This in turn was hypothesised to result in better relationships between patients and professionals, and enhanced patient wellbeing in the long term. The proposed activities at a practice level to promote staff wellbeing are consistent with CMO 3.1, which highlight emotional support as a key context. Similarly, the idea of link workers gathering ‘intelligence’ (p.16) on available resources is akin to knowledge of local services (CMO 2.3). The programme theory also highlights the importance of blended embeddedness calling for integration of link workers into community hubs.

Aughterson and colleagues (47) mapped qualitative interview data to the capability, opportunity, and motivation domains of the COM-B model to understand barriers and enablers to GPs utilising social prescribing interventions, like link work. Their data suggested that link work interventions could facilitate relationship building and community integration, enhancing all domains of the model. Two reports (48, 50) mentioned psychological theories, namely social learning theory (51) and attachment theory (52), to explain the mechanisms by which relationships might foster behaviour change; through patients modelling of link worker behaviour and the creation of secure relationships that allow a person the freedom and confidence to navigate their environment, which are pertinent to CMO 2.4.

**Discussion**

The aim of this review was to explore the mechanisms by which link work interventions affect service access in community healthcare settings, and the contextual factors that trigger these mechanisms to occur. Expert interviews identified initial programme theories, which were subsequently developed and refined through the identification and analysis of 31 reports. The analysis suggests that link workers require time resource matched to levels of complexity and need, stable service provision, places to link to, and emotional and practical support. Their success is also contingent on link workers’ ability to embed themselves into multiple systems, within the communities they are serving, with the freedom to build relationships and knowledge of the local service offer. These in turn, can build trust, self-confidence and understanding of the link working process in both patients and referrers, and appear vital for facilitating positive outcomes around access.

The authors hypothesise that link work interventions must be appropriately resourced and supported to match complexity and need to enable access, which should be considered in the face of long-term fiscal challenges in the NHS. Link workers require the time, flexibility, and permission to emphasise relationship building with patients. As the NHS adopts short-term interventionist models of healthcare, there is a risk that longer-term enablers of change are deemphasised in policy, service design, and commissioning. However, our findings suggest that relationship building should not be overlooked in favour of brief practical solution-based interventions. Indeed, one framework applied to link work interventions was attachment theory, which suggests that formation of secure relationships is essential for allowing individuals to explore and navigate their social environments (52). Indeed, there is some evidence that secure attachment can lead to a better therapeutic alliance between clinicians and patients in health and social care settings, and engagement with services (53).

The current analysis highlights the importance of link workers maintaining a dual role as a professional and as a member of the local community, demonstrating shared experience, to build trust and respect over time. Therefore, link workers may have to engage both individuals and their communities, whilst also managing their role within teams. Wildman and colleagues (40) refer to the need for ‘well-networked’ link workers, which they acknowledge are harder to recruit, but integral to the successful delivery of these interventions. Other authors have also highlighted the importance of link workers utilising their life experiences in their roles to build relationships (48), which resonates with literature around the potential benefits of lived experience and peer support (54). However, in this review, the authors failed to identify any research that had formally used peer support workers as link workers.

The programme theory suggests that link work interventions require adequate provision around training and supervision, affording clear direction and focus to avoid role drift, and emotional support. Without this, link workers themselves are vulnerable to isolation, anxiety, and burn-out, which are associated with high staff absenteeism and turnover, and worse patient safety (55). One hypothesis from the data was that if link work interventions lack focus, this can lead referrers to disengage from the process, which could have ramifications for their delivery in practice.

Realist reviews can ‘open the black box’ (27) of interventions, illuminating how these work, for who, and in what contexts. It is vital that the findings are recognised as theories and subject to the interpretation and experiences of the authors, shaped through reflection and feedback from the expert panel. These theories need further testing and refinement through the evaluation of specific link worker programmes. Most reports identified in this review of link work interventions were published recently, in the past four years, suggesting that this is an emerging and relevant area of investigation. The authors identified little grey literature in this area (*n*=3) and more might have strengthened the emerging programme theories. Most link worker interventions were situated in primary care. Only two studies explored link work in the context of secondary mental health services (14, 45) and one, albeit large, evaluation of link work in an oral health pathway (56); the contexts and mechanisms by which link work interventions act on access in these areas may be under-represented in the current analysis and require further consideration and theorising. All studies were based in the UK and therefore the applicability of the theories beyond this context is limited.

**Conclusion**

Link working is a complex intervention operating in complex systems. This review has attempted to understand what makes community link working successful in increasing access to services for patients in the UK. Based on our evidence-led conclusions, the authors advise that, when developing and designing community link work interventions, consideration is given to the topics raised in this review with particular emphasis on the adequate training and supervision of link workers, who must be embedded in local communities and referring teams. The authors also advise that resource is matched to the local populations need, affording link workers enough time to develop positive relationships with patients, to support them to access appropriate services.

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**Tables and Figures**

|  |  |
| --- | --- |
| People with a health condition who are linked to/from a community health service (including primary and secondary care). | Link between social care or charity sector services only (i.e. no healthcare setting)  |
| Relate to the United Kingdom.  | Link between inpatient wards. |
| Focus on a link work intervention.  | Non-English language source. |
|  | Published prior to 1990  |

Table 1. Inclusion and exclusion criteria.

Figure 1. Flow chart showing screening of reports.

Reports identified from grey literature search (*n* = 3)

Duplicate reports removed (*n* = 375)

Reports identified from main search (*n* = 1383)

**Identification**

Reports excluded due to not meeting inclusion/ exclusion criteria (*n* = 784)

Reports screened at title and abstract level (*n* = 1008)

Reports sought for retrieval (*n* = 224)

Reports not retrieved (*n* = 29)

Reports excluded (*n* = 169):

 No focus on link work (*n* = 108)

 Not based in the community (*n* = 2)

 Not healthcare setting (*n* = 6)

 Not based in the UK (*n* = 4)

 RRR\* (*n* = 47)

 No specified health condition *(n =* 2*)*

**Screening**

Reports assessed for eligibility at full article level (*n* = 195)

Reports identified through reference list / citation checking (*n* = 2)

**Included**

Reports included in review (*n* = 31)

\*RRR: Relevance, Richness, and Rigour

Table 2. Characteristics of included reports

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| First Author, Year | Document Type | Study Design | Sample / Population | Data Collection | Services linked to / from |
| Aughterson, 2020 (47) | Academic Article | Primary QualitativeStudy | 17 GPs. | Qualitative interviews | GPs to community groups and activities.  |
| Bertotti, 2018 (50) | Academic Article | Primary Realist Evaluation | 17 patients, 3 community organisations, 3 social prescribing coordinators, 2 commissioners, and 2 GPs.  | Qualitative interviews | GPs to community groups and activities.  |
| Brunton, 2022 (19) | Academic Article | Primary QualitativeStudy | 34 varied staff members around GP surgery.  | Qualitative interviews | GPs to voluntary, community and social enterprise sector services. |
| Bush, 2014 (17) | Academic Article | Primary Quantitative Randomised Controlled Trial | 2680 patients. | Attendance at screening dates. | GPs to diabetes screening clinics. |
| Byng, 2008 (45) | Academic Article | Primary Qualitative Realist Evaluation | 21 GPs, 10 varied practice staff, 16 mental health staff.  | Qualitative interviews | GPs to CMHTs. |
| Calderon-Larranaga, 2024 (65) | Academic Article | Primary Qualitative Case Study | 35 primary care clinicians, link workers and local VCS organisations. | Qualitative interviews, ethnographic observations, and documentation about the local SP scheme and VCS organisations. | GPs to VCS organisations. |
| Chng, 2021 (13) | Academic Article | PrimaryQualitative Process Evaluation | 121 GP practice staff, and community organisation workers.  | Qualitative focus groups, email surveys, qualitative interviews.  | GPs to community resources |
| Cooper, 2023 (61) | Academic Article | Systematic Review | 6 papers. | Systematic Review | Included studies were UK based social prescribing services in adults.  |
| Craig, 2008 (58) | Academic Article  | Primary Mixed Methods Process Evaluation Framework | 100 patients with tuberculosis diagnosis, and interviews with professionals from 8 care providers. | Qualitative interviews and outcome measures | Tuberculosis outpatient clinics to community organisations. |
| Dayson, 2020 (14) | Academic Article | Primary Qualitative | 2 commissioners, 9 service providers, 9 patients accessing social prescribing. | Semi-structured qualitative interviews | CMHTs to community-based activities. |
| Department of Health & Social Care, 2023 (38) | Government Report (Grey Literature) | Primary Mixed-Methods | 165 link workers, 104 green activity providers, 16 stakeholders, and 7 health leads. | Semi-structured qualitative interviews, surveys, literature review | Primary care to community green and nature-based activities. |
| Fixsen, 2020 (57) | Academic Article | Primary Critical Systems Thinking | 10 service users, 7 key staff (including 2 link workers), and 8 other stakeholders. | Qualitative interviews | GPs and external organisations to voluntary sector services and community organisations. |
| Fixsen, 2021 (43) | Academic Article | Primary Qualitative Interviews | 5 managers, 5 GPs, 4 link workers, 3 researchers, 3 community navigators, 2 volunteers, 1 social prescribing advisor. | Qualitative Interviews | GPs and community centres to community organisations.  |
| Fixsen, 2021b (44) | Academic Article | Primary Qualitative Interviews | 5 managers, 5 GPs, 3 link workers, 3 community navigators, 3 researchers, 2 community volunteers, 1 social prescribing advisor. | Qualitative Interviews | GPs and community centres to community organisations. |
| Frostick, 2019 (48) | Academic Article | Primary Qualitative | 13 link workers. | Qualitative interviews and focus groups | Primary care to community organisations. |
| Griffith, 2023 (60) | Academic Article | Primary Ethnography | 20 link workers. | Demographic questionnaire and shadowing of link workers | Primary care to community organisations. |
| Hazeldine, 2021 (64) | Academic Article | Primary Qualitative ‘Researcher-in-Residence’ Approach | 11 link workers, 2 managers, 1 counselling service manager. | Qualitative data gained through the lived experience of the ‘Researcher-in-Residence’ | GPs to voluntary service organisations. |
| Holding, 2020 (41) | Academic Article | Primary Qualitative | 15 link workers and 9 volunteers. | Qualitative interviews | Community bases to community organisations. |
| Huddart, 2006 (46) | Academic Article | Primary Qualitative | 23 pupil support staff and integration officers. | Qualitative interviews | Primary care and CAMHS staff in a local hospital to community CAMH services.  |
| Kellezi, 2019 (42) | Academic Article | Primary Mixed-Methods | 7 GPs, 9 healthcare providers, 19 service users, 630 patients. | Semi structured qualitative interviews and longitudinal survey. | GPs to relevant third sector groups. |
| Macpherson, 2010 (56) | Academic Article | Primary Mixed-Methods | All eligible children in Scotland. | Monitoring data collected on dental visiting and qualitative work. | Link workers (assuming health visitor role) to dental practices. |
| Mercer, 2017 (33) | Report (grey literature) | Primary Quasi-Experimental Outcome Evaluation | 84 GP practice staff, 12 patients, 7 GPs, 7 practice managers, 6 link workers. | Mixed methods – qualitative interviews and questionnaires. | GPs to community services. |
| Moffatt, 2017 (28) | Academic Article | Primary Qualitative | 30 service users. | Semi-structured qualitative interviews | GPs to community, voluntary and NHS services. |
| Morris, 2022 (63) | Academic Article | Primary Qualitative | 8 service managers, 5 link workers and 44 clients. | Semi-structured qualitative interviews | GPs to community services. |
| Rhodes, 2021 (18) | Academic Article | Primary Qualitative | 9 link workers. | Semi-structured qualitative interviews | GPs and other healthcare professionals to community services. |
| Skivington, 2018 (59) | Academic Article | Primary Qualitative | 6 community links practitioners and 30 representatives of community organisations. | Semi-structured qualitative interviews | GPs to community organisations. |
| Tierney, 2020 (25) | Academic Article | Secondary Realist Review | 118 documents relating to social prescribing. | Literature review | Social prescribing services in GPs and community centres to community organisations. |
| White, 2010 (39) | Report (grey literature) | Primary Mixed-Methods | 12 patients, 6 managers, 3 GPs, and 1 nurse practitioner. | Routinely collected data, qualitative interviews, and a focus group. | GPs to community services. |
| Wildman, 2019 (62) | Academic Article | Primary Qualitative | 24 service users. | Semi-structured qualitative interviews. | GPs to community services. |
| Wildman, 2019b (40) | Academic Article | Primary Qualitative | 15 link workers. | Qualitative focus groups and semi-structured interviews. | GPs to community services. |
| Woodall, 2018 (49) | Academic Article | Primary Mixed-Methods | 436 service users. | Semi-structured qualitative interviews and quantitative questionnaires. | Primary care to community services. |

Key:

CAMH – Child and Adolescent Mental Health Service

CMHT – Community Mental Health Teams

GPs – General Practices

LWP – Links Worker Programme

SP – Social Prescribing

VCS – voluntary and community sector

Table 3. Supporting context-mechanism-outcomes for theory areas

|  |  |
| --- | --- |
| Theory Areas / CMOs | Supporting quote(s) |
| 1. Matching resource to complexity in insecure systems. |
| * 1. Time in time pressured systems.

*If link workers are afforded time, this provides opportunities to build relationships and trust between link workers and service users, which better allows them to collaboratively work towards service access.* | *‘Whilst CMHTs in some areas are able to refer patients to existing primary care-based schemes, the extent to which this is happening is unclear, and it is arguable that social prescribing services offering a ‘lighter’ model of provision… would not be able to provide the level of support required by secondary mental health patients.’* ***14, p1.****‘As a whole, the users we interviewed appreciated the person-centred approach of the service and contrasted this with the brief time afforded by GP appointment slots. “How often do you get offered an hour’s chat about a particular problem with a doctor in the medical centre? You don’t, and I have to say that was really quite an incentive”’.* ***57, p8***‘*Agencies reported that a major advantage of the post was the additional time, intensive support that the TBLW [Tuberculosis Link Worker] was able to offer patients, sharing of information and raising awareness of the disease.’* ***58, p419.*** |
| 1.2. Open doors, open now. *If there are few or inadequate local services, this leads to disillusionment in both link workers and patients, who view the service access as an impossible task, causing both to disengage.*   | *‘Unlike most health professionals they can spend more than 5-10 minutes with patients (first appointments were for one hour), visit them at home if need be, can accompany them to activities and can see them several times over a number of weeks (usually up to six times per client) … None of the patients interviewed thought they would have made the progress they did without the support of the SPHT ... ‘I just felt relaxed. There’s no pressure and it’s up to me, they’re not pushing me to do anything I don’t want to do… she seems understanding.’’* ***39, p28.****‘Some link workers had been successful in sourcing sustainable transport for service-users so they could continue to attend activities at the end of the intervention. However, community transport varied across localities, again reflecting the importance of local infrastructure for the success of social prescribing services.’* ***41, p6.****‘“[The link worker] said that both of us could go to [the group] the first time, so that she could help me make sure I was comfortable and that I had what I needed to do the class. She spoke to [the instructor] and introduced me to her. I felt a lot happier knowing I had someone I knew to go with me. [lines omitted] If someone had just told me to go, I don’t think I would have gone.”’* ***42, p5.****‘“[…] There’s a really bad barrier with the BMI. So, if their BMI doesn’t reach a certain level, they can’t get onto these weight management programmes, but they’re still quite high with their weight, and it’s affecting their diabetes risk. So, what I’ve started to do is try and refer them over to the diabetes centre, for the classes that they do over there, but then they’re limited with what they can do as well. […] So, unless someone’s doing like some healthy eating cooking classes and stuff, but that’s not going on right now. So, that is quite hard […] but I keep trying” [LW 02.5].’* ***65, p4.*** |
| 1.3. The sustainability of the service offer. *If there is uncertainty in the service offer of link work interventions, link workers feel undervalued, underappreciated, and stressed, which leads to staff vacancies and the intervention to break down.*   | *‘When a link worker leaves, they take with them tacit knowledge of local, reliable [service] providers, and relational links. Consequently, improvements made by the service may temporarily decline as a new link worker is installed and has to create positive connections with a range of stakeholders.’* ***25, p7.****‘”Funders don’t like funding existing work, they like funding new stuff. So you’re in that dilemma where you know the funder will say ‘we’re not gonna fund you just to carry on doing what you’re doing’. So then people doing the work on the ground, they have to change what they’re doing to make it look like a new project and in some cases that changes the whole ethos of the work. And although they might be more successful getting the funding it changes the, you know, the whole dynamic of the delivery.”’* ***38, p31-32.****‘[quoting link worker] “It’s a little bit unsettling, that’s the truth . . . when you start bringing organizations in who are tending for contracts and there’s a worry about your terms and conditions of contract, if they’re going to change your pay and all that type of thing, it’s unsettling”.’* ***43, p9.*** *“'Everybody's chasing some sort of money. Like the women's centre I'm talking about, they're - they don't know if they're gonna be here in a year's time. They're chasing funding.' [CLP4]” [Community links practitioners].* ***59, p491.*** |
| 2. Blended Embeddedness |
| 2.1. Co-location and understanding*If link workers are embedded in referring services, this fosters a sense of teamwork, mutual appreciation, and joint-working, which streamlines working processes vital to facilitating access.*   | *‘The difference between practices was also apparent in relation to community networking activities. Only in [fully integrated practices] were [link workers] enabled to be proactive and strategic, by, for example, making time each week to interact with staff in community organisations, and facilitating links between community organisations and staff in the practice. These activities were highly valued by the [link workers] in [fully integrated practices]’* ***13, p917.***‘*‘To those with investment in practice-attached schemes, having the link worker ‘embedded within the practice’ with ‘open lines of communication with the GPs in the practice’, was seen as of high importance. Not only did this mean less delay for the patient between GP referral and meeting with the links worker, but also it helped to create a sense of trust for all concerned. These productive discussions about individual clinical cases manifested themselves in different ways in different contexts, and performed a key function of the intervention, in terms of the liaison process.* ***43, p5.****‘This focus on referrals and assessments shaped organisational priorities and made it harder for link workers to engage with complexity and offer the intensive support they felt come clients needed … ‘that imbalance is a result of structural strategic issues rather than patient need and is incredibly frustrating to me. I’ll leave it like that’ (Sam\_Focus Group) … Ultimately, link workers increasingly had to secure their own referrals to meet targets … the whole process was time-consuming and left less time to spend with clients who were increasingly followed-up over the telephone, rather than face-to-face contact.* ***60, p286.*** |
| 2.2. Commonality of experience*If link workers are seen as part of the communities they serve, this leads patients to believe in them and their intervention, allowing them to take supported and scaffolded steps towards access.*   | *‘[quoting participant] Individually and collectively they [Wellbeing Coordinators] have worked really hard to get foot hold in their areas, becoming part of forums, neighbourhood networks, health and wellbeing partnerships…’* ***49, p7.*** *‘Link worker Lucy, had her own experience of ill health … “I would send them to someone who was going to give them the time and take them … I feel quite strongly about this” … she had been instrumental in establishing a local community group that allowed different clients to meet and chat. She often had informal contact with clients, perhaps to remind them of a meeting at the job centre or to turn up to an appointment.’* ***60, p288.****‘“where I’m living in Tower Hamlets there are lots of takeaways, food, confectionary. […] So I see the challenges for other people too [LW 02.3]” ... “I’m from a South Asian country, I know […]” [LW 02.8]. Yet, practitioners’ opportunities to apply and act upon this relatability varied depending on the context.’* ***65, p4.*** |
| 2.3. Knowledge of the local services. *If link workers develop knowledge of the local issues and the area, patients and referrals have more faith in their ability to help and are more likely to want to work with them around service access.*   | *‘The SPLW service was embedded within both the community and local hospital multi-disciplinary teams, and SPLWs attended regular meetings for clients who had more complex needs so that they could be referred to relevant services more quickly, to prevent crisis and avoid duplication of care.’* ***19, p7.****‘'The link worker’s role was therefore considered of fundamental importance in building the relationships with community groups, and enabling effective social prescribing' (p7) “she (the link worker) was a brilliant point of contact just to get plugged into that side of things. Because to be honest, before GP I was completely oblivious to all this stuff (p9). Link workers were also seen as the key ‘bridge’ between the GP and community, where previously GPs were limited by the number of relationships they could build with the different community groups.'* ***47, p13.******‘****Where service users felt they were referred to a service for activities that did not meet their needs or preferences, naturally they did ‘not feel positive about the social prescribing pathway’... Themes within studies strongly suggested that service users engagement hinged on whether referrals met their mental health needs or not, as this directly influence the way they would interact with services.’* ***61, p140-141.*** |
| 2.4. An ethos of relationship building. *If link work interventions include a focus on relationship building, this will lead to greater trust and confidence in patients, enabling them to engage with the intervention.*   | *‘…having the space and time to explore the context of patient’s lives and asking what they thought might help them… It’s not, “You should do this”. It’s about empowering them to make the decision for their own welfare and wellbeing”.*’ ***48, p408-409.****‘The quality of the relationship between the service user and the link worker was considered essential in six of the included studies. Service users reported 'feeling at ease and relaxed' and 'well-matched' with their link worker… Having both trust and openness enabled service users to settle into socially prescribed activities and benefit from support that is tailored to their mental health needs.’* ***61, p140.****‘Participants favourably contrasted their relationship and interaction with their link worker to their interactions with healthcare professionals, which were often characterised as impersonal and too rushed to properly address the breadth of their social problems.’* ***62, p6.****‘The continued link worker relationship was key for Gill [a client receiving the link worker support] in a time of traumatic disruption, and the intervention she received was person-centred, holistic and consistent’.* ***63, p8.*** |
| 3. Supporting those supporting others.  |
| 3.1. Training and support to maintain hands-on focus. *If link workers receive appropriate support and training, they feel confident and clear about their roles, enabling them to become more competent practitioners, which is important for the promoting focused outcomes around access.*   | *‘There is an important coaching element to the role with some patients and those Link Workers with a background in counselling spoke of being tempted to work in greater depth with some patients whilst at the same time realising this was not possible.’* ***48, p409.****‘Link workers expressed the need for training so that they could feel confident in those interactions and to protect both themselves and the individuals they were working with.’* ***64, p1848.*** |
| 3.2. Combating isolation with social support. *If link workers experience isolation, they become burnt out and fatigued, making their roles untenable. Conversely, emotional support can protect link worker wellbeing, facilitating their ability to facilitate the link work role.*   | *‘An environment offering supervision or peer support allows anxieties or difficulties**associated with the role to be shared and explored. Problems arise when the link worker’s capacity and capabilities are overextended, especially if HCPs refer complex cases because (a) they believe the link worker can cope and (b) there is a lack of immediately accessible alternatives (due to long waiting lists for statutory services). The link worker may become so overstretched that they leave their post.’* ***25, p7.****‘Whilst Link Workers were often passionate about their work, all agreed on the need to be supported in this frontline role where complex and unexpected issues could present themselves without warning… the most important form of support was that of clinical supervision and the safe space it provides to offload and discuss difficult patients and challenging situations…. “we’ve recently started Clinical Supervision. And I had my first one and it was absolutely amazing… I came out feeling really kind of a weight taken over, a weight that I didn’t realise I had had.* ***48, p410.*** |