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The experiences and perceptions of social prescribing: A qualitative study with people with long-term conditions, link workers and healthcare practitioners

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Abstract

Objective: To explore the experiences and perceptions of key stakeholders regarding social prescribing interventions.

Design: Qualitative study incorporating focus groups and semi-structured interviews. Data was analysed thematically to identify themes and sub-themes. The Consolidated Criteria for Reporting Qualitative Research was used.

Setting: Urban communities in The Republic of Ireland.

Participants: Participants included people with long-term conditions (n = 12), link workers (n = 9), healthcare practitioners (n = 17), and community service representatives (n = 6).

Intervention: Social prescribing interventions using community link workers

Main measures: Face-to-face focus groups were conducted with individuals with long-term conditions and online focus groups with link workers, healthcare practitioners, and community service representatives. Online semi-structured interviews were conducted with General practitioner.

Results: Transcripts were analysed using reflexive thematic analysis, using an inductive approach to develop codes, categories and themes. One overarching theme, three themes and six sub-themes were identified. The overarching theme 'Between Promise and Precarity' reflected the opportunities for growth, connection and sustainability alongside the challenges of implementing social prescribing. Theme 1 Promise had one sub-theme of empowerment and growth. Theme 2 was Fragmentation with two sub-themes of awareness and understanding. Theme 3 was Precarity with three sub-themes of workforce and resource insecurity, information gaps and evaluation shortfalls.

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Conclusion: Social prescribing has the potential to improve health and well-being by empowering individuals to grow through social connection. However, poor stakeholder understanding and collaboration coupled with unclear link worker roles and resource constraints threaten its sustainability. Streamlined workflows, clear guidelines and robust stakeholder partnerships are required to ensure social prescribing succeeds.

Keywords
Social prescribing, focus groups, semi-structured interviews, long-term conditions

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Introduction

Long-term conditions are defined as persistent non-curable health problems, which can lead to a decline in quality of life, well-being and physical ability.[1] Long-term conditions such as diabetes, asthma, cancer, chronic obstructive pulmonary disease and musculoskeletal diseases are often effectively managed with medication and other therapies[2] but tend to gradually worsen over time, resulting in diminished daily activities, social isolation, and the emergence of secondary physical and mental complications.[3] In response to this, national policymakers are adapting their health systems to increase support to those most in need, ensuring equitable access to appropriate services and resources.[4]

Social prescribing interventions are personalised care pathways targeting non-medical factors such as alcohol and drug misuse, poor nutrition, and limited physical activity that contribute to an individual living with a long-term condition's quality of life and well-being through interpersonal connectivity and relationship building.[5] Previous studies have reported improvements in social isolation[6]: mental health and psychological well-being[7] physical activity[8] and chronic disease-related outcomes.[9] Social prescribing has been adopted widely as a care pathway to improving unmet health and social needs in many countries.[10] The heterogeneity of social prescribing models; intervention delivery; absence of core outcome sets; and regional variations in health and social needs has hindered the development of robust research designs required to identify which approaches are effective and for which groups of people.[11] Qualitative research examining the experiences and perspectives of all stakeholders in social prescribing is limited, and there is little understanding of how these interventions operate across different geographical contexts and healthcare systems. In the United Kingdom, a recent study by Fattorini et al.[12] examined how social prescribing is understood by key stakeholders, including healthcare professionals, community representatives, link workers and patients. This and previous research[13,14] highlighted social prescribing as a complex interaction between service users and providers, shaped by the need for greater coordinated care, effective communication and improved collaboration among all stakeholders. It is currently unclear if other health systems outside the United Kingdom share similar experiences and perceptions. In Ireland, where this study was conducted, social prescribing has advanced considerably through the National Slaintecare Healthy Communities Programme even though robust evidence to supporting its implementation remains limited. To ensure sustainable development, future social prescribing providers must understand stakeholder experiences and priorities to inform the design of future interventions. The aim of this qualitative study was to explore the experiences and perceptions of service users, link workers, healthcare practitioners and community organisations to inform delivery of social prescribing interventions.

Methods

Study design

This study has received ethical approval from the Clinical Research Ethics Committee, University College Cork, Ireland (ref-ECM 5 (3) 12/09/2023).

This study has been reported as per the guidelines outlined in the Consolidated Criteria for Reporting Qualitative Research.[15] This study was conducted in urban Cork, Ireland, involving participants from socioeconomically disadvantaged areas where social prescribing has operated for over a decade, with mostly part-time link workers; common referrals included social isolation, mental health concerns, and low physical activity.

This study used a qualitative descriptive design with a pragmatic, naturalistic orientation, suited to health services research seeking a comprehensive, low-inference account of participants' experiences rather than theory-driven interpretation.[16] The aim was to generate a clear, clinically meaningful understanding of stakeholder views on social prescribing to inform service development and policy. Data were collected through focus groups and semi-structured interviews, enabling interaction and the exchange of diverse perspectives in participants' own language, and supporting identification of key themes[17]

Recruitment and sampling

A purposive sampling strategy with snowball effect[18] was employed to recruit eligible voluntary participants to enrol in this study. Previous research[19,20] was considered by the research team to identify an appropriate sample size of 8–12 participants per focus group. As the data sought from participants was not complex coupled with the focused research aim, the participants' specific knowledge and experiences with social prescribing we are confident that our data collection approach extracted relevant information, rich in detail and context to satisfy the aims of the study.[21] Forty-four (n = 44) eligible participants volunteered to enrol in four focus groups and 10 semi-structured interviews: Focus group 1 (Service user with a long-term condition, n = 12): Adults aged 18 years or older, living in middle-to-low socioeconomic areas, had at least one long-term condition, who were or had engaged with social prescribing interventions within the last 6 months and are able to communicate in English. Focus group 2 (Link worker, n = 9): Link workers who facilitated social prescribing services on behalf of a voluntary or governmental agency. Focus group 3 (healthcare professionals, n = 7): physiotherapists, occupational therapists and nurses who referred or previously referred patients directly to social prescribing services. Focus group 4 (community partners, n = 6): Existing or past community-based service providers who accepted people referred by link workers to their services. Semi-structured interviews: General practitioner, (n = 10): who have referred patients directly to social prescribing services. Those with severe mental illness, limited English for consent, or where participation could harm their health were excluded.

Service users with long-term conditions and link workers were recruited purposively via organisational 'gatekeepers' in management roles. Gatekeepers were emailed study details and asked to forward them to potential participants. Healthcare Professionals, community partners, and General practitioners were recruited through a formal introductory email and by word of mouth. Participants were screened for eligibility, given study information and consent forms, and invited to ask questions. Participation was voluntary. Topic guides were developed iteratively by the lead researcher with an experienced qualitative researcher, focusing on experiences, impacts and recommendations, with input from a link worker and a doctor to support content validity.

Data collection

Following consent procedures, three recorded online focus groups – Focus Group 2 (link workers), Focus Group 3 (healthcare professionals: physiotherapists, occupational therapists, nurses), and Focus Group 4 (community partners) – were conducted between April and October 2024. Two in-person focus groups with people living with long-term conditions (n = 7 and n = 5) were held in a community-based setting, audio-recorded and transcribed. General practitioners participated in online interviews due to time constraints within their clinical schedules, online interviews also enhanced recruitment feasibility. Field notes were taken after each session and shared with the team. Focus groups and interviews were recorded via password-protected Microsoft Teams, transcribed using its

native feature, anonymised and checked for accuracy.

Data analysis

Data were analysed using Reflexive Thematic Analysis. The lead researcher conducted line-by-line coding in Microsoft Excel, guided by the study aims, while a second researcher (Joseph McVeigh) independently coded selected transcripts to support reflexive dialogue rather than inter-rater reliability. The team met to compare interpretations, deepen analysis and challenge assumptions. A reflective diary and mind mapping supported reflexivity and awareness of positionality throughout. Codes were refined in Excel and organised into broader groupings using MURAL, before being developed into themes and sub-themes. An overarching theme captured the central narrative. Differences were resolved through discussion and reflexive consideration.

Researcher reflexivity and strategies for rigour

The lead researcher, a musculoskeletal physiotherapy lecturer with 26 years' clinical experience in biopsychosocial care, brought contextual insight but also potential bias, particularly regarding psychosocial factors and integrated care. Reflexivity was embedded through a reflective diary[22] and ongoing team dialogue. Researcher triangulation[23] at coding and theme development supported consideration of alternative perspectives and critical reflection. Member checking[24] enabled participants to confirm or refine interpretations. Trustworthiness was enhanced through strategies addressing credibility, transferability, dependability and confirmability[25] (Figure 1), with confirmability supported by clear data records and reflexive team discussions.

Results

Forty-four participants (M:20, F:24) were recruited purposively to satisfy the aims and objectives of this study. Thirty-four people participated in focus groups and 10 underwent semi-structured interviews with no dropouts occurring. The average time of focus groups and semi-structured interviews was 60 min and 25 min, respectively. All participants were sent a draft of their focus group or interview responses for member checking of which 13 participants responded and confirmed that the dataset represented the content of the focus group or semi-structured interview. Inductive data analysis using reflexive thematic analysis framework yielded one overarching theme, three themes and six sub-themes to represent the experiences and perceptions of key stakeholders of social prescribing (Figure 2).

***Overarching theme**: Between promise and precarity*

The analysis revealed an overarching theme of '**Between Promise and Precarity',** reflecting the dual nature of social prescribing interventions in this context. On one hand, there is clear promise captured through opportunities for participant empowerment and growth. On the other hand, the system exhibits precarity, manifested as structural fragmentation, gaps in awareness and understanding, and ongoing tensions related to resources, information flow, and evaluation. This framing highlights how the intervention holds significant potential while simultaneously operating within fragile and under-resourced structures, underscoring the need for strategic support to sustain its impact.

(Link worker-P4) 'I suppose the biggest threat would be they just pull the funding and that would be the end of that'

Theme 1: Promise

(Service user-P10) 'I can stand [on] my own two feet now. I don't have to rely on my family to help me. If I had to, I would ask for help…it has given me confidence again'

'Promise' captures the enthusiasm for social prescribing and its potential to address complex non-medical determinants of health, especially for those with long-term conditions, and its anticipated integration into healthcare and community systems.

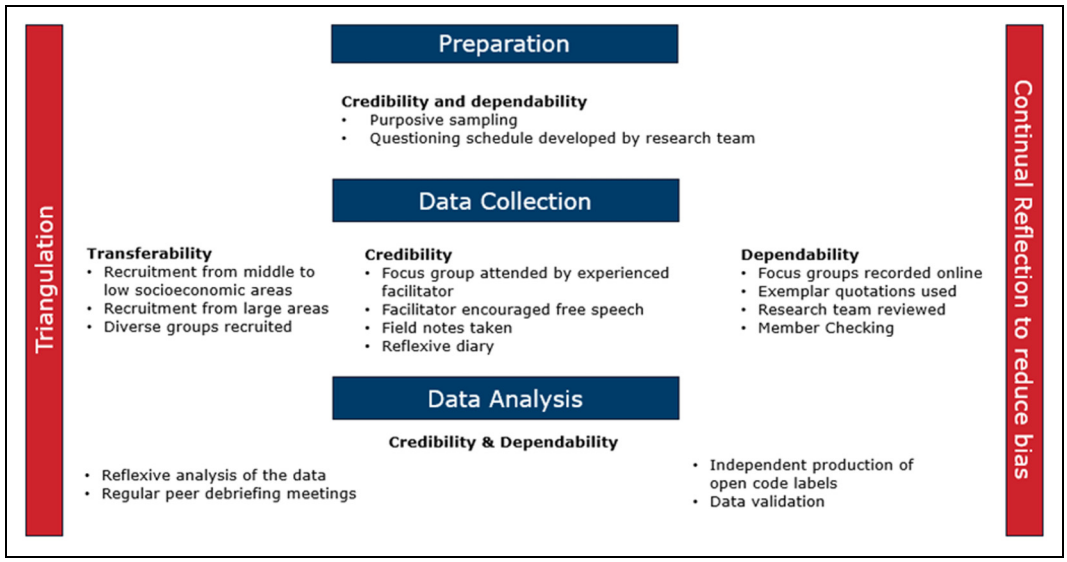

Figure 1. Measures taken to ensure trustworthiness and rigour.

Sub-theme 1: Empowerment and growth. Service users engaging with social prescribing interventions spoke openly about the opportunity to connect with other people within their community and that this empowered them to forge new and meaningful relationships ***(Service user-P9) 'there was a fierce void in my life, and this took over, and I have to say I've never looked back'.*** In some instances, these experiences were transformative for the individual ***(Service user-P12) 'It's good when you look at her then and you see the difference, she's grown outwards, she's after showing us a transformation'.*** Being part of a group was seen as an enriching aspect of the social prescribing experience '**You're on a journey once you come in here' (Service user-P9),** highlighting the ongoing, supportive nature of group involvement. A sense of belonging was regarded as a key contributor to the formation of social bonds and shared identity. This was powerfully expressed by another participant who shared, '**Belonging is a good word, you know. I don't say I'm coming to do a course here. I say I'm part of the…, rather than just participating, you belong' (Service user-P11)**. Service users emphasised that flexibility and inclusiveness in delivering social prescribing resources was essential to its successful implementation as it suited their needs and comfort levels, '***You can just be by yourself, and you can still be a part' (Service user-P12),*** highlighting how participation could be tailored to individual preferences.

Theme 2: Fragmentation

A shared perception of fragmentation emerged from all stakeholders' limited awareness and understanding of each other's existence and the scope of services offered, leading to role ambiguity, and confusion around how a relatively new intervention like social prescribing aligns with, and integrates into, the broader framework of healthcare provision. The absence of shared knowledge among the professional stakeholders (link workers, General practitioners, healthcare professionals and community partners) hindered a cohesive approach to patient centred care ***(Community partner -P2)'I don't think people really know that it's there'.***

Sub-theme 1: Awareness. Service users showed limited awareness of social prescribing and link workers, often discovering the service informally through family, social media or community notices

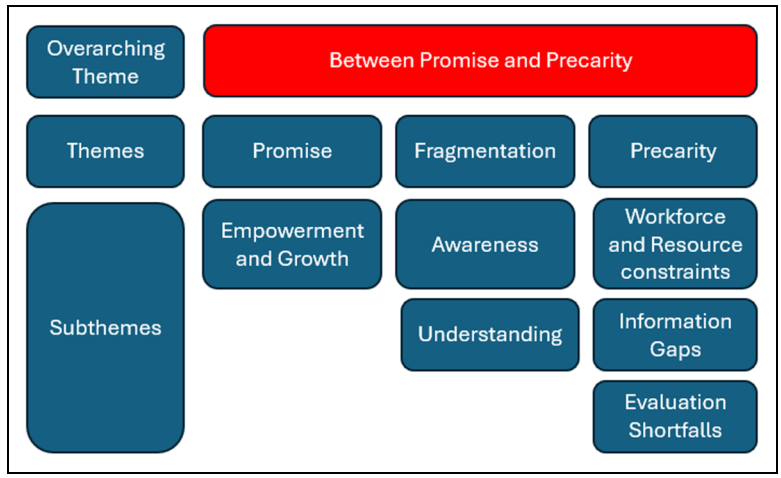

Figure 2. Overarching theme, themes and sub-themes.

'***a poster up in the church' [Service user-P3]*** rather than via healthcare professionals or formal referrals. Some service users joined community services independently, underscoring uncertainty around referral routes and the clarity of social prescribing pathways. While most general practitioners demonstrated a general awareness of social prescribing, primarily acquired through postgraduate in-service training, this understanding did not consistently translate into clinical practice, as their consideration of social prescribing in patient management appeared limited or absent ***(General practitioner-P3) 'I'm not sure that it's always first in my list of referring so I suppose it's that constant reinforcement from my point of view, you know, if I want people to change, I have to change also'***. Healthcare professionals and community partners expressed concerns over the awareness of social prescribing ***(Community partner -P2) 'I think there's a huge lack of awareness that the service even exists'***. Link workers, by contrast, saw themselves as playing a supportive role to General practitioners ***(Link worker-P1) 'Cutting down on General practitioner visits was supposed to be one of our original targets….***, yet this aim was hindered by the General practitioners' lack of awareness of their presence ***(Link worker-P1) …when we started the General practitioners didn't even know we were there' (Link worker-P3).***

Sub-theme 2: Understanding. A key finding of this study was the gap between the job description for prospective link worker roles and the actual responsibilities of the role in practice ***(Link worker-P9) 'the job description isn't reflective of what the role actually is… situations vary from person to person'.*** Understanding of social prescribing varied among stakeholders, except Link Workers, reflecting ambiguity around the term within the healthcare system ***(Service user-P5) 'Well, before you come in, you wouldn't know what you're gonna get anyway, so you have to experience it first'.*** There was a mixed sense among all stakeholders that the term implied a medical model of care, as one link worker noted, '***I feel like that's probably why people think I'm a doctor of some form because you're saying prescription' (Link worker-P6).*** There was also evidence that senior organisational leadership did not understand the nature of the link worker role leading to frustration among link workers ***(Link worker-P2) 'Senior health promotion officer doesn't really get my job or what I do, even though I report directly to them'.*** Referrers to social prescribing interventions expressed a need for enhanced communication from link workers to '***know the process better' (Healthcare professional-P7)***, including concrete examples that illustrate how, for whom and under what circumstances social prescribing is effective ***(General practitioner-P7) 'You don't want to***

overload anyone with referrals, so it would be great to know what they want to see and or when they see it'. However, despite these concerns, professional stakeholders expressed trust in link workers' expertise in facilitating connections between service users and community partners ***(Healthcare professional-P11) 'I would feel quite confident to sending people to speak to her'.***

Theme 3: Precarity

Precarity surrounded the daily operation of social prescribing. Insecurity around resources, poor collaboration and frustration with evaluation procedures were seen to influence the effective delivery of social prescribing interventions **(Link worker-P1) '*everyone [is] just making it up literally as they go along and that's pretty much it'*.**

Sub-theme 1: Workforce and resource constraints. Low morale displayed by link workers in the focus group stemmed from the discrepancies in the terms and conditions of employment contracts provided by the funding agencies. Variations in remuneration packages ***(Link worker-P6) 'everyone was really angry about the how the role was going in terms of contracts and nothing was long-term, everyone's pay was so different',*** no access to pension plans left link workers feeling undervalued and worried for their future, ***(Link worker-P6) 'I can't worry about my job every like 10 months down the line'*** encouraging link workers to seek secure employment elsewhere **(Link worker-P1)*'There is a fair amount of turnover, but to be honest with you, it's more to do with the conditions'.*** Many link workers expressed frustration over the regional disparity in administrative duties and sought guidance on vague key performance indicators ***(Link worker-P7) 'I meant to have 60 referrals in because I'm part time in a 12-month period, …I find it hard to understand how 60 is the magic number'.*** There was also a sense of disapproval from professional stakeholders that the introduction of social prescribing was duplicating services that already existed ***(Community partner -P4) 'I swear straight up I think they copied my role with social prescribing…. it's like it's what I do every day'.*** Service users acknowledged the correlation between funding and the availability of community-based services ***(Service user-P2) 'depends on the funding as well'*** but ***(Service user- P5) 'a lot of the funding has been stopped'.***

Sub-theme 2: Information gaps. Most social prescribing referrals involved mental health, social isolation or physical activity, originating from General practitioners, nurses, social workers and occupational therapists. The referral process was seen as problematic ***(Link worker-P2) 'a bit time consuming'*** and ***(General practitioner-P10) 'cumbersome'.*** The absence of clear guidance on appropriate referrals is causing link workers to rely heavily on their prior experience and training. Link workers spoke about knowingly accepting inappropriate referrals due to the pressures of reaching the key performance indicators imposed by their funding authority ***(Link worker-P4) 'So a lot of times they [referrals] are inappropriate but then you have to reach your KPIs, you know, which is kind of wrong for everybody'*** and expressed a desire to have their responsibilities standardised to avoid ***(Link worker-P9) 'going the wrong way here and staying in my lane'.***

Community partners pointed out that link workers sometimes made referrals without a clear understanding of their service boundaries ***(Community partner -P5) 'there's possibly potential for a little bit more of a link there'.*** General practitioners and link workers expressed a desire that referrals be digitalised through bespoke email services ***(General practitioner-P5) 'If it was something where I could do it on the computer and send it off, I probably do it more often'.*** All stakeholders expressed positivity towards the importance of feedback having made a referral ***(Healthcare professional-P8) 'Yeah, I'll be very interested to get feedback, you want to know what works well for your patients and what doesn't work well'*** but not everyone was receiving feedback from those services ***(Healthcare professional-P11) 'I haven't really gotten a response after doing it, so I don't know'*** and only knew of progress when they saw them again.

Sub-theme 3: Evaluation shortfalls. Stakeholders expressed differing views on the need for evaluating

social prescribing interventions, with perspectives often shaped by their professional role or underlying belief systems. Link workers had very strong opinions ***(Link worker-P5) 'Frustration is probably the right word, but I just think the KPI's we use, I just don't think they tell us anything, so I just think they're pointless'*** and reported not receiving support from the health service on what they should be evaluating (***Link worker-P6) 'We need something, and I didn't get anything back yet through the framework, like what I should be doing in terms of evaluation stuff'.*** There was a shared perception among some stakeholders that the outcomes of social prescribing interventions were difficult, if not impossible, to measure. As one general practitioner remarked, '**I don't think you can actually measure the outcomes of the referral' (General practitioner-P1).** Collecting health-related quality of life outcome measures in social prescribing posed significant practical challenges at the initial appointment ***'[the participant] don't trust you enough to show their vulnerability, which I really understand' (Link worker-P1)***, highlighting the relational barriers to early data collection and follow-up compounded by natural disengagement that occurs as participants improved '***it's really tricky to get the end one, because when people feel good, they disengage' (Link worker-P7).*** Service users with long-term conditions also expressed scepticism about the accuracy and usefulness of standard outcome measures '***If you came to me at some point last week, you'd be getting a very different answer than today' (Service user-P11)***. Another reflected on the experiential nature of the intervention, stating, '***You have to feel the experience to know what it feels like – I don't know how to word it' (Service user-P12)***. There is also evidence that outcome measures were abandoned due to concerns over potential harm in certain contexts ***(Link worker-P5) 'I don't like these KPIs and I don't do it on some people…it's a reminder to some people about how really shite their life is'.***

Discussion

This study explored experiences and perceptions of social prescribing among people with long-term conditions, link workers, healthcare practitioners and community organisations to inform future delivery. Data from 44 participants suggest social prescribing has the potential to address non-clinical needs such as social isolation, inactivity and poor mental health by fostering community connection and personal growth. Service users described belonging and personal change through group participation, consistent with Social Identity Theory.[26] However, delivery was constrained by organisational fragmentation, limited awareness and role confusion, alongside inequities in link worker employment, insecure funding, weak interprofessional collaboration and limited evaluation, all of which threaten sustainability. A central theme from this study was the fragmentation in the provision and integration of a new social prescribing initiative within existing health services. Previous research[27] has identified 'organisational readiness' as a requirement to the successful implementation and delivery of social prescribing services. This study revealed a strong sense that social prescribing initiatives were not effectively introduced to their intended audiences. Consistent with previous research,[12] this study found that limited stakeholder awareness coupled with workload pressures, part-time constraints and funding limited link workers' ability to improve their visibility. Although general practitioners understood social prescribing, it was rarely prioritised possibly reflecting limited awareness of local services or lack of formal training.[28]

Professional stakeholders in this study expressed a strong belief in the value of social prescribing for managing long-term conditions reinforced by the high regard for link workers. Their expertise and trusted status enhanced credibility and positioned them as key contributors to integrated care. However, previous research indicates link workers often feel marginalised due to poor communication and limited networking opportunities[29] and simultaneously general practitioners seek more supports for patients with non-medical needs.[30] It is apparent that there is a need for these services to work together within an integrated model; however, further research is needed to evaluate their impact on practice, care delivery and patient outcomes.

Service users reported a strong sense of belonging, often through relationships extending beyond group sessions, alongside personal growth described as 'threshold moments'.[31] Consistent with Self-Determination Theory,[32] participants experienced empowerment through autonomy in shaping their involvement, supported by empathetic coordinators and safe environments. Link worker dissatisfaction with employment conditions emerged as a key issue. Employed on short-term contracts without recognition or career progression,[33] link workers felt undervalued contributing to turnover, loss of expertise and challenges to the sustainability of social prescribing services, as seen in the UK,[34] suggesting the current employment model may be unsuitable and warrants a comprehensive review. Like previous research,[35] all stakeholders highlighted that inadequate funding reduced service availability, limited training for link workers and constrained the capacity of community organisations which may reflect caution in investing in services not fully evaluated for effectiveness.[36] Consistent with previous research,[37] referral processes also posed challenges. Professional stakeholders reported frustration with paper referral forms and called for digitised, integrated systems. Unclear referral guidance and funding targets led link workers to manage cases beyond their training, creating risks like mismatched needs and blurred professional boundaries for practitioners, link workers and service users. Evidence from medical referrals highlights the importance of clear communication and training in referral protocols.[38]

In our study, feedback was reported as sporadic due to administrative burdens and high dropout rates. Professional stakeholders emphasised that feedback must be timely, concise and focused. General practitioners valued outcome measures but questioned its accuracy for complex needs, a view echoed by service users who saw engagement itself as success. Link workers were frustrated by unclear guidance, measurement challenges and unsuitable tools, highlighting the need for systematic development and evaluation of complex interventions to ensure effectiveness and scalability.[39] Although commonly used in social prescribing health-related quality of life measures rarely inform clinical decision-making and lack sensitivity to meaningful change.[40] A revised approach, using tailored core outcome sets has been proposed[5] and future research should examine how outcomes measures are shaped by practitioner–patient relationships.

A limitation of this study is that the question schedules were reviewed by only one link worker and one doctor, which may have limited how well they reflected other stakeholders' priorities. The exclusion of commissioners, policymakers and family members may also have reduced insight into relational and equity issues. Purposive sampling limits transferability, and one-off data collection restricts understanding of how experiences change over time. As with all qualitative research, there is potential for researcher bias, though reflexive practices were used to support transparency and credibility.

This is the first Irish qualitative study to include all key social prescribing stakeholders. It showed that social prescribing can foster connection, belonging and personal growth, but its place within existing healthcare remains uncertain. Fragmentation, driven by limited awareness and poor understanding, emerged as a key barrier to communication, engagement and collaboration, constraining impact. Implementation was further challenged by workforce pressures, resource constraints, referral issues and weak evaluation. Future research should identify the key elements of effective social prescribing interventions.

Clinical message

- Clinicians should recognise connectedness as a central mechanism of social prescribing, ensuring patients are actively linked to community resources that enhance belonging, purpose and social support
- Clinicians should address fragmented awareness among stakeholders by promoting shared understanding, as misalignment can impede communication, engagement and collaboration, and reduce intervention effectiveness.

- Clinicians should support the sustainability of social prescribing by advocating for adequate funding and workforce resources, while contributing to clear referral and evaluation processes through strengthened interprofessional collaboration..

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Supplementary information

Supplementary information can be found at the following link: https://10.6084/m9.figshare.30276160

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