Hindawi
Health & Social Care in the Community
Volume 2023, Article ID 8488615, 8 pages
https://doi.org/10.1155/2023/8488615

Research Article

"Winging It": An Exploration of the Self-Perceived Professional Identity of Social Prescribing Link Workers

Coco Moore,[1] **Peter Unwin**,[1] **Nick Evans**,[2] **and Frances Howie**[3]

[1]*School of Allied Health and Community, The University of Worcester, Worcester, UK*
[2]*School of Science and the Environment, The University of Worcester, Worcester, UK*
[3]*Three Counties School of Nursing and Midwifery, The University of Worcester, Worcester, UK*

Correspondence should be addressed to Coco Moore; coco.moore@worc.ac.uk

Received 25 January 2023; Revised 12 June 2023; Accepted 9 July 2023; Published 26 July 2023

Academic Editor: Tracy Collins

The practice of social prescribing (SP) has been rapidly expanding throughout the UK in recent years. The role of SP link workers (SPLWs) currently has no nationally prescribed requirements in terms of qualifications, background, or experience. This qualitative study of 13 SPLWs using semi-structured interviews is believed to be the first exploration of perceptions of their professional identity and the agency and structure within their roles. SPLWs reported feeling caught between biomedical and biopsychosocial models of health. Some identified with clinical healthcare teams, whilst others preferred non-medical and community-based identities. SPLWs valued professional flexibility and freedom, though were concerned this was becoming increasingly restricted. They reported filling gaps in the health system and absorbing more risk and complexity than they believed was reflected in their training or pay. Despite this, SPLWs demonstrated consistent core values of person-centredness, holistic practice, and a strength-based approach. A more consistent approach to professional identity is recommended as a way forward for SP.

1. Introduction

This paper explores social prescribing link workers' perceptions of their professional identity (PI) within one clinical commissioning group (CCG) in England in 2021. SP as a professional practice has been gathering momentum in recent years. The NHS Long Term Plan ([1], p.25) outlined an ambition to recruit over 1000 trained SPLWs by the end of 2021 and for more than 900,000 people to be referred by the end of 2024. Throughout the paper, the term "patient" is used to refer to recipients of SP intervention because this was the term most commonly preferred by study participants, although the authors recognise the contention related to such labelling of users of services.

1.1. Definition and Models of Social Prescribing. SP is generally agreed to be the practice of connecting people (usually primary care patients) with non-medical community sources of support [2]. This non-medical care can include, for example, linking patients with community groups to address loneliness or isolation; sports or fitness clubs; horticultural therapy; debt or housing support; adult education; or healthy living programmes. The practice aims to take a holistic approach to health and well-being [3]. It stems from the recognition that health is influenced by a range of social, environmental, and economic factors [4]. Modern advocates claim SP can treat biopsychosocial needs, reduce pressure on primary care services, and address health inequalities [5–7].

With increasing positivity surrounding using SP as a means of addressing non-medical health and well-being needs, it was more formally incorporated into NHS policy in 2019 with the publication of the NHS Long Term Plan (LTP) [8]. This introduced SP as part of the comprehensive model of personalised care [1] and created the NHS model of SP [9], which should be implemented, delivered, and accessed equally across the UK. The model involves patients being referred from primary care to an SPLW. Funding for SPLWs

was provided under the Additional Roles Reimbursement Scheme (ARRS) [10]. Primary Care Networks may either employ SPLWs directly or commission an external provider such as Voluntary and Community Sector (VCS) organisations. Therefore, SPLWs may be employed by the NHS or the voluntary sector, although the funding for all roles is provided through the ARRS.

The rollout of this model remains within its first three years of development, and it is yet unknown how uniformly it is being practiced across the UK, although local models had pre-dated this implementation. However, research carried out by the National Association of Link Workers [11] found that 29% of SPLWs studied were considering resigning in the next year due to a lack of support or supervision and felt unequipped for the role. They also perceived a discord with the GP surgeries they were linked to and often struggled to build relationships. This research was conducted at the outset of the implementation of the NHS model, and so it is unknown if support, training, and relationships have since improved. This research provides an early investigation of this new NHS model of SP within one CCG in England to ascertain the hetero- or homogeneity of practices and identity within a single commissioning area. It aims to gain an understanding of the experiences of SPLWs regarding their professional identities within their roles.

1.2. Defining Professionalism and Professional Identity. There is no universal agreement regarding what it means to be a professional, although there are key components. The literature identifies four main aspects, with overlap within themes and no resource containing all [12]. The first relates to specialist knowledge and formal training, yielding professionals who possess exclusive ownership of knowledge not widely known or accessible to the layperson ([13], p.56; [12, 14]). The second characteristic of professional status, closely related to the first, is the barrier to entry or professional certification which is required to practice within the profession [12, 15, 16]. The third characteristic is belonging to a professional group with which a person shares commonly understood roles [12–14]. These groups also share common values, beliefs, and attitudes and are often guided by their own code of ethics [17]. Fourth, there is the characteristic of serving the public or performing a public service [14, 17].

According to Schein [18], PI relates to how people define themselves in a professional role due to their relatively stable and enduring collection of attributes, beliefs, values, motives, and experiences. Subsequent delineations have included the meanings attached to a person by themselves and others [19].

1.3. The Development and Value of Professional Identity. PI has been shown to be beneficial for both the professional and the profession [20]. Relating to the former, a strong sense of PI has been found to improve professional resilience and career longevity [20] and professional fulfilment [21]. Wilding and Whiteford [22] described practice settings which had ambiguity regarding PI and roles which led practitioners to adopt other professions' techniques and languages.

One mechanism considered highly influential for developing PI is through formal training institutions. Trede et al. [23] conducted a systematic literature review which concluded that health professionals' immersion in a professional training programme builds their PI.

2. Methods

In order to illuminate the dynamics of the new and emerging role of SPLWs, an explorative case study [24] of a CCG was seen as an appropriate method to adopt. The study location covered a range of city, urban, and rural environments, although it was more rural and less ethnically or socioeconomically diverse than the national average. Interviews were conducted with practicing SPLWs within the CCG, whether they were in direct employment or commissioned via a SP provider. Data were transcribed verbatim and thematically analysed [25] using NVivo 12 software. Ethical approval for this project was granted by the College of Health, Life, and Environmental Sciences Research Ethics Committee, University of Worcester.

2.1. Interview Design. This study was part of a larger project exploring perceptions of, and engagement with, SP across three main stakeholder groups: primary care referrers, SPLWs, and patients. This required a qualitative approach with a smaller number of participants and a method which allowed for probing, building of rapport, and the ability to qualify or explain questions or ask the participant to elaborate. Therefore, semi-structured interviews were seen as the most appropriate method [26–28], and a schedule was developed using knowledge of existing evidence, the research priorities set, and findings from Moore et al. [29] in their survey of referring healthcare practitioners.

2.2. Recruitment and Interview Process. In the absence of readily available data, the exact number of SPLWs working within the CCG is unknown. However, recruitment aimed to achieve the maximum number of participants possible and so used multiple means to advertise and promote the study. This included promoting the research through SP steering meetings, newsletters, and snowball sampling. Managers within SP services were also contacted and requested to deliver invitations to their employees. Therefore, reach was dependent upon managerial cooperation with the research and communication with SPLWs. Responses were sporadic, and persistence was required to encourage dissemination of the invitation. All SPLWs who responded and showed initial interest agreed to be interviewed in depth. They were offered the choice of location for the interview to take place, to decrease any inconvenience of participation and encourage greater response rates. Nine chose to hold the interview using video conferencing, two in local cafes, and one in a hospital location. They were offered the choice of their own

pseudonym in order to provide anonymity whilst maintaining ownership of their interview data.

3. Results

Interviews with thirteen practicing SPLWs across the CCG were carried out in autumn/winter 2021/2022. Of these, nine were employed through VCS SP providers commissioned by PCNs, two by a GP federation, and the remaining two employed directly by their PCN. Their practice locations included city centre, edge of city, small town, and rural areas. Length of practice experience ranged from four months to four years in this setting, although one participant who had been employed for just under four months had worked for six years as an SPLW in another location. Four of these had joined when the SP scheme was piloted or initiated, which pre-dated the NHS LTP. Six themes were developed regarding SPLWs' perceptions of their role and PI: entry, training, and registration; relationships with medicine and clinical teams; core values; agency and structure; role boundaries; and risk, pay, and impact on SPLWs.

3.1. Entry, Training, and Registration. Previous careers and experience were found to have been diverse and included managerial; social work; social support, families, community, or youth work; benefits, homelessness, or housing work; mental health work; police service; VCS work; and administration. Twelve interviewees had experience with client-facing or support roles. Most SPLWs reported no formal qualifications relating to the role. One person reported a psychology and sociology degree and one reported a counselling degree. Questions were asked to all participants regarding previous qualifications and potential relevance to their SP role, though no others reported formal higher education. Emily described relying on training received in her previous mental health career to manage her role. She reported that colleagues without this experience were leaving their role as an SPLW due to the numerous crises calls and complex cases.

Regarding motivations to become an SPLW, all participants expressed the desire to help or support others and saw SP as a way of doing this. Elizabeth perceived the role as having a wider remit and greater flexibility than previous support work. Rachael felt the flexibility of the role would enable her to help more patients than within her previous position as a social worker. Francesca had been working in higher managerial roles and wanted to return to direct client-facing work before retiring. Emily, who had previously worked in mental health, wanted to continue helping people but perceived SP as making fewer demands on her. Respondents also reported low salaries and a lack of progression opportunities.

3.1.1. Training. Variations in training were evident amongst the interviewees. Some, such as "Bee," felt unequipped for the role. He stated that:

> *"I think the training issue is it is definitely something that's a bit of a gap. . . I wouldn't have said the training was very specific or very in depth. I think one of the weaknesses really is that there is*n't *very much professional development training."*

"Emily" reported:

> *"We have like all the basic training, so we had like safeguarding and all that kind of stuff. We didn't actually have any specific kind of social prescribing training."*

However, most SPLWs reported having access to national or external training, such as through E-learning for Healthcare [30], the NHS e-learning platform. They also reported mandatory basic training, such as data protection, safeguarding, health and safety, and Making Every Contact Count (MECC). Three interviewees explained that training has improved since the lack of initial training they experienced when they started the role. For example, "Judy" did not have much training when she began as: "*we were the sort of pathfinders really. We were finding our own way and setting up systems*."

This suggests SP is moving away from the fringes of primary care and towards integration into mainstream practice, with associated education, although not all SPLWs feel they have received adequate training.

3.1.2. Professional Registration. As highlighted in Section 1.2, an important aspect of professionalism has been argued to be the "barrier to entry," or the professional registration, that is required to practice within the profession [12, 15, 16]. Interviewees demonstrated conflicting views regarding whether or not SP should become a regulated profession.

The most common reason for supporting the idea was the perception that a regulated title would increase their legitimacy in the eyes of other practitioners and afford them greater respect than they currently received. Elizabeth felt this would cause her to be "*recognised as more professional*" [by the GP practices]. Rachael explained she often felt that she did not receive the same professional respect as achieved by an OT or social worker. The issue was also raised by Bee who believed referrers may be hesitant to refer their patients to somebody "*effectively unqualified*." Another reason to support professional registration was provided by Elizabeth who felt this would enable a more equitable access to SP, as patients would be accessing the same service wherever they were in the country. Indeed, this would be more in-keeping with the top-down approach of the NHS model and improve uniformity of practice. The pre-registration process, normally involving in-depth training at a university or similar, would help to build this consistency, along with strong PI. As Trede et al. [23] and Matthews et al. [31] claimed, such an educational process assists with PI development. Alternatively, five main arguments against professional registration were presented. First, Elizabeth and Rachael felt that it would make the role more restricted and remove their individuality. Elizabeth felt flexibility was an important aspect

of SP success. Second, it was argued that increasing professionalism by registration would be a negative result; Judy reported:

> *"I get on well with people. They relate to me as well. Because-and I make sure of this-I am different to the GP. They see me as professional but not a 'Professional.' I'm more like them."*

Third, Bee believed that the more qualified SPLWs were, the more pressure there would be to see more patients in less time, removing the one of the main strengths of SP: the ability to give people more time. Fourth, Judy felt a barrier to entry would impact recruitment, which was already difficult, and that she would not be doing the role if a degree was required. Fifth, four respondents (Judy, Elizabeth, Barry, and Emily) discussed their view of SPLWs having low wages and would expect these to be increased if they were professionally registered.

3.2. Relationship with Medicine and Clinical Teams. There was a polarised difference in how closely linked to medicine and the clinical team SPLWs perceived themselves to be or wanted themselves to be. On the one hand, some SPLWs wished to express a closer relationship with primary care teams and medicine; on the other hand, some were keen to distance themselves from clinical practice. They employed strategies such as seeing patients in non-medical environments to reinforce this, especially so that patients would differentiate between them and the medical team.

Elizabeth identified with being an NHS practitioner within the primary care service and wanted consultations to be held in the surgery to emphasise this, rather than feeling like a worker who would be external to the surgery. She declared that it was her role to build the relationship with surgeries, although acknowledged that this could be difficult. The above evidence suggested that there was a disconnect between the SPLW and the surgery within which they are based.

3.3. Core Values. Despite large differences between models of practice, relationships with medicine, and the medical model of health, greater cohesion was apparent within the SPLWs' core values. Five core values were identified in this research by those interviewed: belief in SP; holistic practice; person-centredness; empowering and enabling; and a strength-based approach.

First, participants expressed a love for SP and belief in the potential it holds. According to Sarah, all the SPLWs she knew joined the role because they wanted to help others and believed SP would enable them to do this. Others described belief in the efficacy of this non-medical support. Second, holistic practice was often highlighted, which mirrors the holistic model of SP. Five respondents reflected that they had the opportunity to help patients with a range of issues whilst they awaited formal mental health support.

A third core value was a commitment to person-centredness. According to NHS England and NHS Improvement ([8], p.3), SP is a component of personalised care, which should be delivered based on individual strengths and diverse needs. Five SPLWs emphasised the importance of identifying what works for the patient. Five SPLWs reported adapting the location of consultations to increase patient-centredness. This included being the most comfortable place for the patient (4); giving the patient choice of location (2); and considering where would be accessible for the patient (2). This is exemplified by Seyla when discussing farming communities. Many farmers would not want to take time out of their normal day or go to a place where they would have to get "dressed up," so she attended "milk meetings," described as gatherings of dairy farmers to increase engagement. Further person-centredness was demonstrated by Molly who had helped to create a project in a social housing area where the residents created a play park for the children. In contrast, Bee described how council schemes had failed in the past by not taking into account what works for the people it was designed to help. These views demonstrate a highly person-centred approach of the SPLWs, aligning with the values and aims of the innovation. Person-centred perspectives were further demonstrable with five SPLWs stating they will endeavour to match activities and links to patients' budgets. Three recognised that people do not want to be seen as "poor" and will avoid anything seen as "charity."

Fourth, the core value of empowering and encouraging was evident. Ten SPLWs reported that their role was to empower the patient to be independent, with eight stating they should motivate and encourage. Fifth, strength-based practice was described by SPLWs who reported facilitating their SUs to volunteer or use their skills to assist their own communities.

3.4. Agency and Structure. The agency experienced within the SPLW role was discussed positively by the majority of interviewees. There was a clear perception that they enjoyed greater freedom than other NHS or clinical professionals. This enabled them to be more person-centred and to develop the role themselves; the latter was often part of the initial attraction to the role. However, the agency experienced was sometimes too broad, resulting in them being unsure of their remit. SPLWs discussed the increased person-centredness that their agency enabled. "Francesca" stated:

> *"I think we've got more freedom. . . We have up to an hour. We can see them for up to 10 sessions. I think we're very different to mainstream NHS staff and social care staff in that respect."*

"Steve" reported that his agency allowed him to tailor intervention to each patient, and Elizabeth explained that what she loved about SP was that she was not confined in the ways in which she could support people, so that SP was not prescriptive.

Increased agency was seen as enabling SPLWs to develop the role in whichever way they wanted. Rosie discussed how SPLWs in her team each manage their own caseloads and are "*pretty much. . . left to kind of develop the role.*" They develop their own leaflets for their service and are encouraged to "think outside the box." She did feel she had not been constrained in the role and explained how enjoyable she found this, as it enabled her to be more relaxed and spend more time with people. "Francesca" *had had* "*total freedom to do things how I want*." This was also perceived as a positive aspect by "Catherine":

> *"So I applied, got the job. And so they said to me. . . just set it up and make it whatever. So it was literally just winging it."*

Bee also discussed heightened agency, though was less positive, saying lack of training meant "*it's then fairly much up to you how you tend to carry the role out*." These findings demonstrate non-adherence to a top-down NHS model, with each SPLW creating and maintaining diverse roles and PI.

Instances of structural constraints were highlighted by respondents who generally felt that these were increasing. One example was the inability to transport patients in the SPLWs' cars. This frustrated Francesca because it had restricted patients accessing groups on several occasions. The notion that the role was subject to increasing constraints was emphasised by Judy and Bee. Judy explained that whilst she was previously able to attend groups with patients, especially for their first attendance, since the pandemic she has been encouraged by her managers to refer people to the group and "*move on*." Further, Bee stated he felt the role was becoming more bureaucratic, with continuously changing goalposts. This indicates some movement towards increased uniformity, as each service begins to align itself with the directives set out within the NHS model, and with related requirements and funding initiatives. Yet this undermines the freedom of the role which is highly valued by the SPLWs in this study.

3.5. Role Boundaries. The most common concern expressed by SPLWs was that they felt they expected to "fill a gap" when specialist services either did not have the capacity to support patients early, or when the GP had exhausted all other options, referring to SP "as a last resort." Eight respondents explicitly stated receiving referrals because there was nowhere else to send them. The majority of these were due to a lack of mental health provision. For example, Judy explained the Cognitive Behavioural Therapy (CBT) waiting list was more than 18 months long. The term "*desperation*" was used by "Molly" when describing why GPs referred patients who she believed were not appropriate for SP, as they had nowhere else to send patients. The result is that SPLWs reported that they felt they were working with issues far above that expected of their role.

"Emily" discussed the sort of people SPLWs work with—frequent attenders at A&E and people with complex backgrounds, and explained how she had many patients who:

> *". . .have got quite significant mental health problems. But then they've also got substance misuse problems. They won't be accepted by mental health teams because of the substance misuse problems, and they won't engage with substance misuse services because they find them quite punitive and paternalistic."*

These people are then referred to SP as there are no other options. Exceeding the parameters of the role seemed to occur frequently. This was often due to concerns that if not, the patient would be inadequately supported because no other professions would deviate from their role boundaries. Molly discussed arranging multi-disciplinary team (MDT) meetings for patients who seemed to have a multitude of professionals involved, yet she witnessed little evidence of communication between them. She was unsure if this was a correct expectation of her role, but she did it anyway as nobody else would otherwise. In a similar way, "Francesca" took on the role of mediator between patients and social care, which she stated: "*I don't think is the social prescribers' role-But that's what I was doing*."

3.6. Risk, Pay, and Impact on SPLWs. The above issues have led to SPLWs dealing with a greater degree of risk than they originally expected. SPLWs did not feel it was adequately reflected in their pay, or how valued they feel. Elizabeth discussed feeling that she was poorly paid, and Emily explained that the role deserved to be financially respected due to the level of complexity involved. She also reported that there was a high level of risk involved, which she did not feel she should be taking. "Molly" felt again that her role was more demanding than the level of pay received. These issues impacted upon the SPLWs, who often did not have adequate supervision and support to process them. "Barry" felt that the things he hears from patients causes him fatigue, which he does not know how to deal with and makes him feel "*rubbish*." "Catherine" felt the need to be a "*tough person*" to deal with the things heard. Bee felt that he needed more time to decompress between patients. "Emily" and "Catherine" referred to the difficulty of retaining staff under such circumstances, noting a high turnover.

4. Discussion

The findings presented in this paper describe a diverse range of backgrounds and experience across the SPLWs interviewed. No SPLWs reported any formal qualifications gained, or required, for the role. Formal training, once employed, is often minimal, inconsistent, and non-standardised. Some SPLWs felt they had not received adequate training. Educational programmes are considered a strong contributor to PI [23, 31] and an essential aspect of professionalism ([12], p.56; [15, 32]). However, they are currently not a requirement of employment as a SPLW. This also poses a question of enhanced risk, as SPLWs do not feel appropriately qualified to navigate through the complexities of patients referred to them. Some manage this by relying upon training from previous careers, although they did not

feel the job's complexities were reflected in the pay received. These findings reflect the report published by the National Association of Link Workers [11] which described how many SPLWs were planning to resign from their role due to the lack of support and training and were being compelled to manage highly complex cases and medical or mental health issues.

Findings suggested that there was a disconnect between the SPLW and the surgery within which they are based. This is despite the NHS guidance for SP to "*be embedded within the PCN's Core Network Practices and be fully integrated within the multi-disciplinary team*" ([8], p.7).

SPLWs wish for greater legitimacy in their practice, a higher degree of uniformity and equitable services, and a reduction of poor practice. However, they are concerned this will restrict their professional agency and the informal way they are able to interact with patients, differentiating them from clinical professionals. The agency experienced by SPLWs was much appreciated as they believed this enables them to practice in a way which adheres to their core values. They feel they have been able to develop their role and devote greater time and flexibility to their patients than other healthcare professionals. This is reported as a factor which attracts workers to the position and helps with employee retention.

There were reports of SP being used to "fill gaps" in the health service. As cautioned by Fortune [33], "filling gaps" is an identified risk of having unclear PI in newer professions. Stronger and more homogenous PI, which is communicated to referrers, is likely to reduce this. However, if people are being referred to SP when there are no other options, this is clearly a matter for concern.

This heterogeneity undermines the argument that the NHS model has provided uniform service provision, though this research notes that the model remains in the first few three years of development and is not yet fully incorporated. If a reduction or elimination of variation in practice is aimed for within the top-down NHS model of SP, the NHS must train SPLWs to manage the level of risk and complexity referred to them or discontinue involving them in complex cases. However, additional training would be expected by SPLWs to be reflected in their salary, as some reported low salaries and a lack of progression opportunities despite guidance that SPLWs may earn "around £27,000 per annum," equivalent of a band 5 NHS worker (such as a newly qualified nurse) [1].

Their differentiation from clinical professionalism is appreciated by some SPLWs but not by others. Those wishing to distance themselves believed this enabled greater rapport building with patients and emphasised how they are "not medical" and also did not want to be seen as a social worker or therapist. Alternatively, some SPLWs feel closer relationships with primary care are required and employ strategies such as meeting patients in GP practices to reiterate and validate this viewpoint. This demonstrates a division between those associating with the medical model of health and those adhering to a more biopsychosocial model. There must be greater clarity on which perspective of health the NHS model expects workers to adopt in order to prevent continuing divergence between these two "camps" of SPLWs. Despite the ambiguity within PI and models of health discussed above, there was consistent evidence of commitment to core values such as person-centredness and holistic practice. According to NHS England and NHS Improvement ([8]; p.3), personalised care should be delivered based on individual strengths and diverse needs, and therefore SPLWs demonstrated adherence to this. There was also evidence of compliance with Kimberlee's [34] holistic model of SP, in which the SP provider works to address all health and well-being needs and goals rather than just the aspect the referrer has identified.

5. Limitations

This research was based within one CCG in England, with a relatively small number of individuals. There is likely to have been an element of selection bias as those who volunteered to participate may have held more partisan views than those who did not respond. The CCG of interest is less ethnically diverse than the national average and participants were primarily white British; therefore, there is a lack of profile of ethnic minorities within the findings. Whilst transferability was not the aim of this qualitative piece, the emergent findings do correlate with previous reports of the training needs of SPLWs [35]. Therefore, the work does contribute to this existing pool of knowledge. It also provides a base of themes to be explored in other areas to ascertain if these findings are shared across a wider population.

6. Conclusion

This paper has explored SPLW perceptions of their professional identity. Thirteen practicing SPLWs openly discussed their role and provided clear narrative in terms of how they perceive themselves, the role of SP, and the challenges they face in practice. Clear themes were developed, and innovative discussion has been explored regarding the professional identity of SPLWs. There are many different interpretations in the area studied of what SP is and how it should be delivered.

To realise the ambition for SP set out in the NHS Long Term Plan, this research suggests that further work is needed to embed the role within the NHS career frameworks. One way to resolve these issues would be through formal qualifications and role clarification.

The future direction of SP has been laid out with policy directives that suggest further standardisation in terms of the SPLW role and SP practice. A course has been set for greater professionalisation. It will be valuable for future research to follow the development of SP and how the national move towards homogeneity, professionalisation, and uniform protocols is able to meet SU needs alongside the impact it will have on recruitment, job retention, and job satisfaction for SPLWs.

Data Availability

The data used to support the findings of this study are available from the corresponding author upon reasonable request.

Conflicts of Interest

FH is currently employed as a public health consultant in one of the counties where the study took place and was instrumental in the development of the social prescribing pilot, which was part-funded by the Public Health ringfenced grant.

Authors' Contributions

CM conceptualised and designed the research with support and supervision from PU, NE, and FH. CM carried out all interviews, transcription, and thematic analysis of data. CM drafted the manuscript. All authors discussed the results and commented on the manuscript. PU, NE, and FH edited the manuscript and provided expert guidance.

Acknowledgments

This research was funded through a University of Worcester PhD studentship.

References

[1] National Health Service England, "Social prescribing and community-based support: summary guide," 2020, https://www.england.nhs.uk/wp-content/uploads/2020/06/social-prescribing-summary-guide-updated-june-20.pdf.

[2] M. Brown, L. Friedli, and S. Watson, "Prescriptions for Pleasure," *Mental Health Today*, pp. 20–23, 2004.

[3] National Health Service England, "Social prescribing," 2021, https://www.england.nhs.uk/personalisedcare/social-prescribing/.

[4] Public Health England, "Social prescribing: applying all our health," 2019, https://www.gov.uk/government/publications/social-prescribing-applying-all-our-health/social-prescribing-applying-all-our-health#fn:1.

[5] C. Drinkwater, J. Wildman, and S. Moffatt, "Social prescribing," *British Medical Journal*, vol. 364, no. March, pp. 1–5, 2019.

[6] M. Polley, J. Fleming, T. Anfilogoff, and A. Carpenter, "Making sense of social prescribing," 2017, https://westminsterresearch.westminster.ac.uk/item/q1v77/making-sense-of-social-prescribing.

[7] M. Redmond, "Light in dark places": exploring qualitative data from a longitudinal study using creative arts as a form of social prescribing," *Arts & Health*, vol. 11, no. 3, pp. 232–245, 2019.

[8] National Health Service England and National Health Service Improvement, "Social prescribing link workers: reference guide for primary care networks," 2020, https://www.england.nhs.uk/wp-content/uploads/2019/07/pcn-reference-guide-social-prescribing.pdf.

[9] A. Jani, H. Liyanage, U. Hoang et al., "Use and impact of social prescribing: a mixed- methods feasibility study protocol," *BMJ Open*, vol. 10, no. 9, pp. 1–9, 2020.

[10] H. Alderwick, "The NHS Long Term Plan," *British Medical Association*, vol. 364, p. 184, 2019.

[11] National Association of Link Workers, "Care for the Carer: social Prescribing Link Workers views, perspectives and experiences of clinical supervision and wellbeing support," 2020, https://www.nalw.org.uk/wp-content/uploads/2020/07/NALW_Care-for-the-Carer_-Report_8th-July-2020-Final.pdf.

[12] A. Fitzgerald, "Professional identity: a concept analysis," *Nursing Forum*, vol. 55, no. 3, pp. 447–472, 2020.

[13] K. Adams, "Investigating the factors in- fluencing professional identity of first-year health and social care students," *Learning in Heatlh and Social Care*, vol. 5, no. 2, pp. 55–68, 2006.

[14] J. Evetts, "The sociological analysis of professionalism: occupational change in the modern world," *International Sociology*, vol. 18, no. 2, pp. 395–415, 2003.

[15] Y. Dikmen, "The level of professionalism of nurses working in a hospital in Turkey," *Journal of Caring Sciences*, vol. 5, no. 2, pp. 95–102, 2016.

[16] P. Elliott, *The Sociology of the Professions*, Macmillan, London, UK, 1972.

[17] C. McCully, "The School counselor: strategy for professionalisation," *Personnel & Guidance Journal*, vol. 40, no. 8, pp. 681–689, 1962.

[18] E. Schein, *Career Dynamics: Matching Individual and Organizational Needs*, Addison-Wesley Publishing Company, Boston, MA, USA, 1978.

[19] V. Gecas, "The self-concept," *Annual Review of Sociology*, vol. 8, no. 1, pp. 1–33, 1982.

[20] S. E. Ashby, J. Adler, and L. Herbert, "An exploratory international study into occupational therapy students' perceptions of professional identity," *Australian Occupational Therapy Journal*, vol. 63, no. 4, pp. 233–243, 2016.

[21] L. S. Cowin, "The psychometric properties of five professional identity measures in a sample of nursing students," *Nurse Education Today*, vol. 33, no. 6, pp. 608–613, 2013.

[22] C. Wilding and G. E. Whiteford, "Language, identity and representation: occupation and occupational therapy in acute settings," *Australian Occupational Therapy Journal*, vol. 55, no. 3, pp. 180–187, 2008.

[23] F. Trede, R. Macklin, and D. Bridges, "Professional identity development: a review of the higher education literature," *Studies in Higher Education*, vol. 37, no. 3, pp. 365–384, 2011.

[24] R. Yin, *Case Research*, Sage, Thousand Oaks. CA, USA, 2003.

[25] V. Braun and V. Clarke, "Reflecting on reflexive themaic analysis," *Qualitative Research in Sport, Exercise and Health*, vol. 11, no. 4, pp. 589–597, 2019.

[26] A. Bolderston, "Conducting a research interview," *Journal of Medical Imaging and Radiation Sciences*, vol. 43, no. 1, pp. 66–76, 2012.

[27] S. Jamshed, "Qualitative research method-interviewing and observation," *Journal of Basic and Clinical Pharmacy*, vol. 5, no. 4, pp. 87-88, 2014.

[28] R. Dowling, K. Lloyd, and S. Suchet-Pearson, "Qualitative methods 1: enriching the interview," *Progress in Human Geography*, vol. 40, no. 5, pp. 679–686, 2016.

[29] C. Moore, P. Unwin, N. Evans, and F. Howie, "Social prescribing: exploring general practitioners' and healthcare professionals' perceptions of, and engagement with, the NHS model," *Health and Social Care in the Community*, vol. 30, no. 6, pp. 1–10, 2022.

[30] Elearning for Healthcare, "Social prescribing-learning for link workers," 2022, https://www.e-lfh.org.uk/programmes/social-prescribing/.

[31] J. Matthews, A. Bialocerkowski, and M. Molineux, "Professional identity measures for student health professionals: a systematic review of psychometric properties," *BMC Medical Education*, vol. 19, no. 308, pp. e5176–e5185, 2019.

[32] W. Hughes and C. Hughes, "Professionalism and professional institutions in times of change," *Building Research & Information*, vol. 41, no. 1, pp. 28–38, 2013.
[33] T. Fortune, "Occupational therapists: Is our therapy truly occupational or are we merely filling gaps?" *British Journal of Occupational Therapy*, vol. 63, no. 5, pp. 225–230, 2000.
[34] R. Kimberlee, "What is social prescribing?" *Advances in Social Sciences Research Journal*, vol. 2, no. 1, 2015.
[35] L. H. Spencer, M. Lynch, and A. Makanjuola, "Qualifications and training needs of social prescribing link workers: an explorative study," *Lancet*, vol. 400, p. S79, 2022.