Wiley
Health & Social Care in the Community
Volume 2025, Article ID 1517298, 23 pages
https://doi.org/10.1155/hsc/1517298

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Review Article

A Thematic Synthesis of the Experiences and Perceptions of Social Prescribing Among General Practitioners in the UK

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Received 21 October 2024; Revised 23 May 2025; Accepted 19 August 2025

Guest Editor: Qing-Wei Chen

Social prescribing (SP) is a way of addressing the "nonmedical" needs (e.g. loneliness, debt, and housing problems) that can affect people's health and well-being. The National Health Service (NHS) in England implemented SP link workers (LWs) in General Practitioner (GP) practices through its Long-Term Plan in 2019. While SP LWs facilitate the connection between patients and social prescriptions, GPs are often the ones responsible for the first stage in the SP pathway: identifying the need for SP and then referring the patient to a LW. While single studies have examined the perspectives and experiences of GPs with SP, they have not been reviewed and synthesized previously. Therefore, a thematic synthesis of qualitative studies was conducted to address the question *"What are UK GP experiences with and perceptions of SP?"* Seven databases and Google Scholar were systematically searched for references: Medline, PsycInfo, CINAHL, Embase, Scopus, ASSIA, HMIC, and ProQuest. Quality assessment was undertaken using the CASP tool. From 265 references, 57 potential papers were read in full, and 12 were included in the review. An overarching theme was identified as "the GP as a salesperson for SP." It was informed by the following three analytical themes: "belief in the product," "ability to sell the product," and "navigating market constraints." Data showed that GP engagement in SP is multifaceted, involving individual attitudes, medical culture, and systemic contexts. The review highlights the critical role of GPs as gatekeepers in SP, influenced by both intrinsic and extrinsic factors. To enhance SP's implementation, addressing these factors through education, policy, and community support is essential.

Summary

- What is known about this topic?
  - Social prescribing (SP) aims to address nonmedical issues of patients presenting to primary care services
  - The 2019 National Health Service (NHS) Long-Term Plan in England led to the introduction of link workers (LW) into primary care to facilitate SP delivery
  - Patients are often referred to a LW following a consultation with their General Practitioner (GP)
- What this paper adds
  - GPs serve an imperative role as "salespeople," often acting as a gatekeeper to a patient's entry into the SP pathway
  - GPs are influenced by an array of intrinsic and extrinsic factors which impact whether they refer patients to SP
  - More research is needed on alternative entry points into SP including other healthcare providers and patient self-referral

1. Background

Social prescribing (SP) has emerged as an innovative approach, deployed within the National Health Service (NHS) in England [1], which is used in several countries across the world [2]. While definitions of SP have varied according to context, a recent Delphi study established conceptual and operational definitions [3], defining SP as "a means for

trusted individuals in clinical and community settings to identify that a person has nonmedical, health-related social needs and to subsequently connect them to nonclinical supports and services within the community by coproducing a social prescription, a nonmedical prescription, to improve health and well-being and to strengthen community connections" [3]. At its core, SP exists to address social and structural factors (such as availability of resources, systemic barriers like funding, and organizational policies) that can affect people's health and well-being [2]. It involves the use of nonmedical interventions, such as advice services, cultural/creative groups or events, or physical activities, to support individuals in addressing their social, emotional, and practical needs. SP has been shown to improve the overall health and well-being of adults, particularly those with long-term conditions, by connecting them to community-based services and resources [4–6]. However, several reviews on SP have been conducted, and all highlight the need for further evidence to understand its delivery and impact [5–11].

Evidence around the effectiveness of SP is varied. Some research suggests it can support people's mental well-being in particular [4, 12–14]. However, trials on this topic are uncommon [6], as they are hard to operationalize for this complex intervention. Hence, other approaches to evaluation have been adopted, such as realist research, which has suggested that social SP can increase patients' social connections, augment their self-confidence and sense of hope, and allow for the provision of person-centered care [15]. In some cases, it may lead to people self-managing their health, but in other cases, it can lead to patients accessing their General Practitioner (GP) more because they are encouraged and facilitated to do so by a link worker (LW) [15].

Through the NHS Long Term Plan [1], SP was formally integrated into the NHS in England and introduced as part of its comprehensive model of personalized care [1]. NHS England initiated the rollout of SP by funding LWs in primary care; they play a key role in the delivery of SP, acting as a connector between primary care and community-based services and resources. LWs focus on identifying the nonmedical needs of patients and providing them with appropriate referrals to support such as social clubs, exercise classes, and financial advice [16].

LWs are core to delivering SP. However, evidence suggests that buy-in from healthcare providers plays a critical role in patients' acceptance of a referral to and engagement with LWs [11]. GPs are often referrers to SP in England, in essence acting as the entry point into the SP pathway. A survey on GP and healthcare provider perceptions of and engagement with SP revealed significant variations in practice between NHS staff and also noted that overall referral rates remained low despite mainly positive staff perception [17]. This survey highlighted that further training for clinicians is required to reduce variation and to ensure all patients have the same opportunities for referral to SP [17]. A lack of understanding about SP may prevent GPs from referring patients to it, even though it might be beneficial [11].

As GPs play a key role in introducing patients to SP, through identifying those who might benefit and creating referrals, a synthesis of their views and experiences is important to inform practice and policy. To our knowledge, there are no qualitative systematic reviews that focus on GP experiences and perceptions of SP, and no protocols are registered on this topic. It was anticipated that understanding GPs' perspectives on this topic would provide an insight into how to present the idea of SP to patients, highlight areas for GP education around SP, and identify future areas for research. Moreover, a recent systematic review was conducted on patient perspectives, which highlighted the need for referrers to gauge patient readiness for referral [18]. Thus, a thematic synthesis was conducted that aimed to answer the question: What are UK GP experiences with and perceptions of SP?

2. Materials and Methods

A thematic synthesis [19] was undertaken that involved systematically collecting, appraising, and combining data from existing qualitative literature about the experiences and perceptions of GPs in the United Kingdom with SP. Guidelines and criteria of the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement were followed [20]. The protocol for this thematic synthesis was registered through the International Prospective Register of Systematic Reviews (PROSPERO) (ID CRD42023447473).

2.1. Search Strategy. An information specialist helped devise a search strategy to locate data relevant to the review question. The search was conducted in July 2023 and updated in January 2025 on seven databases covering a mixture of health and social sciences literature and including qualitative research (see PRISMA [21] diagram in Figure 1). An example search can be found in Supporting file 1. Google Scholar was also used for the search; we used the first 15 pages of results to identify records that had not been identified in other databases.

Search terms used on databases and with Google Scholar were related to the key components of our research question; based on the SPICE framework [22], they are presented in Table 1.

2.2. Study Selection. Screening of papers was recorded in the online tool Rayyan; two reviewers (AK and TF) screened the title and abstract of the articles blindly and then discussed and resolved any disagreements. Following this, AK reviewed all papers that were screened as full texts. As the NHS Long-Term Plan in 2019 [1] increased the profile of SP as part of patient care, and professionals' interactions with and understanding of it, we looked for literature published from 2019 onwards.

2.3. Inclusion Criteria

- Studies or peer-reviewed evaluations for which a full text is available in English

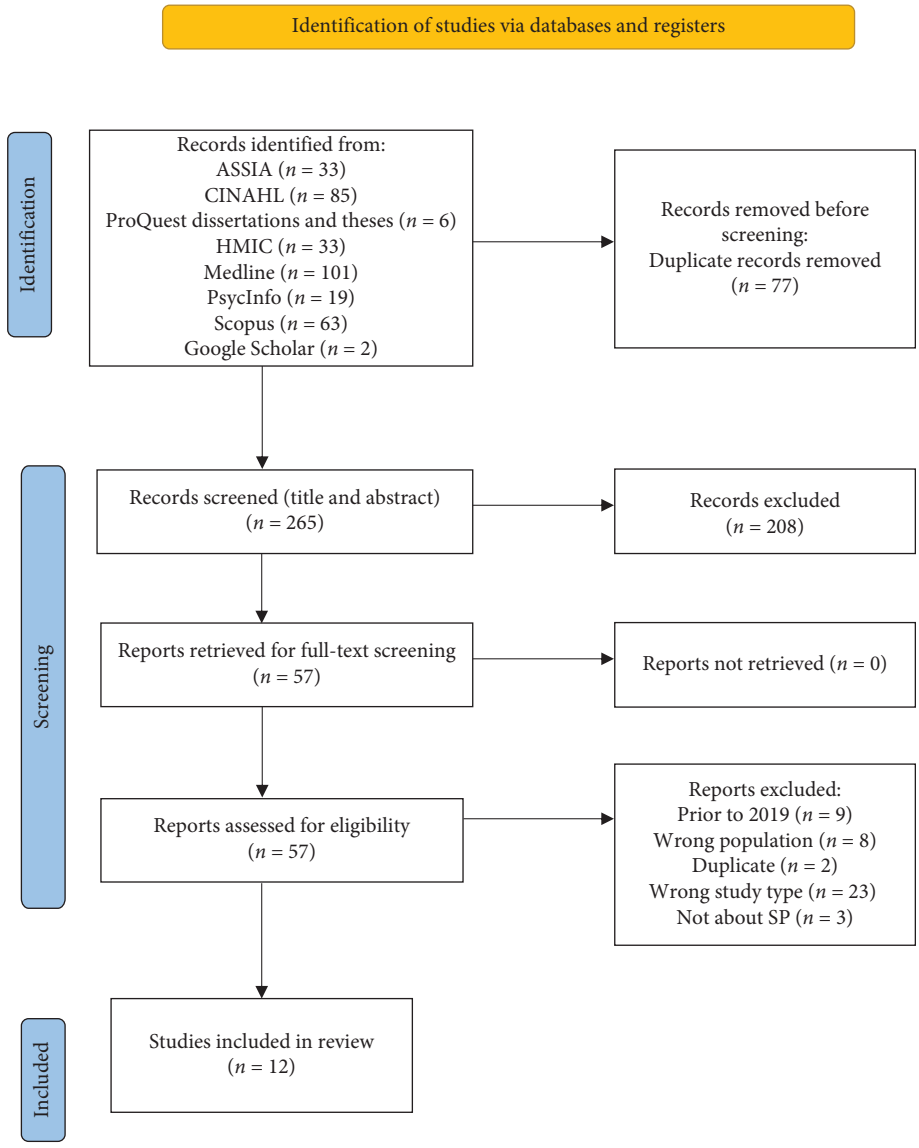

Figure 1: PRISMA diagram.

Table 1: SPICE framework criteria.

Setting	The UK primary care
Perspective	GPs
Intervention	Social prescribing
Comparison	Not applicable
Evaluation	First-hand experience or perceptions from qualitative research

- Includes qualitative data (e.g., from semistructured interviews, focus groups, or observations) and a qualitative approach to analysis
- Mixed-methods studies if qualitative data/component reported separately from the quantitative
- Focus on GP perspectives or with a clear section on GP perspectives

2.4. Exclusion Criteria

- Quantitative studies including questionnaires
- Conference abstracts, editorials, letters, and commentaries
- Papers or evaluations where the views of GPs were not reported separately from those of patients
- Papers or evaluations without clear sections that related to GP's views or experiences
- Papers or evaluations published prior to 2019

2.5. Quality Appraisal. AK evaluated the quality of included papers, using the Critical Appraisal Skills Programme (CASP) guidelines for qualitative research. This tool is often used to ensure that methodological rigor and ethical

standards have been met in papers included in a thematic synthesis [23]. The CASP tool appraises the study's results and their applicability to other populations, contexts, and a specific research question. Each article was reviewed in line with the 10-item CASP checklist (Table A1). Given the small number of studies retrieved, we did not use this tool to exclude studies based on perceived low quality but used it to be transparent about strengths, limitations, and perceived quality of included studies.

2.6. Data Synthesis. The selected articles were imported into NVivo for analysis using thematic synthesis, which is a flexible approach to qualitative evidence synthesis, designed to combine and explore perspectives and experiences [19, 24]. We chose this approach as it allowed us to draw together data from several papers to create overarching results. We used the three-step approach to thematic synthesis [19]: (1) line-by-line coding of text; (2) developing descriptive themes while remaining close to the primary text; and (3) generating analytical themes by adding new interpretative constructs [19]. The first reviewer (AK) carried out each phase, with input from ST and MW for the creation of descriptive and analytical themes and refinement of the paper. The synthesis process began with line-by-line coding of relevant data segments in all the included papers. These segments typically contained context details, quotes from GPs, and the authors' interpretations; they were drawn from the results and discussion sections of the papers included in this synthesis. Each segment underwent inductive coding based on its content and meaning, generating new codes to represent emerging concepts until all segments from all studies were coded. After coding, an iterative approach was taken to manually group the codes with similar meanings into broader categories, which were refined into descriptive themes on a virtual whiteboard. Following this, analytical themes were generated by considering how the descriptive themes related to the original research question [19]. This step involved grouping the descriptive themes to form analytical themes to synthesize new conceptualizations and explanations across different studies. As the team discussed the results, the analytical themes were refined to better reflect the data and to inform the creation of an overarching theme.

In terms of reflexivity and perspective, our team covered expertise in SP as well as in models of healthcare delivery, which collectively enriched our understanding and interpretation of the literature. We engaged in frequent discussions at each point in the analysis, which allowed comparison and interrogation of diverse perspectives.

3. Results

3.1. Screening. Searches and screening were undertaken at two time points (July 2023 and January 2025), as by the date of submission, additional research was published. Through the screening process outlined in Figure 1, we identified 342 articles for review. After removing duplicates, 265 references proceeded to title and abstract screening and 57 to full text screening. The most common reasons for exclusion were a lack of qualitative data or a focus on healthcare professionals other than GPs. Twelve papers (two of which were located at the second search time point—January 2025) were included in the final review, as displayed in Table 2.

3.2. Characteristics of Included Studies. The 12 papers were published between 2019 and 2024 (though the second search was undertaken in January 2025, no papers were published in 2025 at this time). They included data from a total of 90 GPs, though other healthcare providers were also included in most studies. Studies collected data using interviews ($n = 12$); some utilized focus groups ($n = 4$) in conjunction with interviews. Most studies analyzed data thematically ($n = 9$), and the rest used grounded theory ($n = 1$), template analysis ($n = 1$), and a framework approach ($n = 1$). Table 2 presents the characteristics of studies included in the review.

3.3. Quality Appraisal. Results from using the CASP tool are presented in Table A1. The most common problem identified within papers was not reporting the relationship between the researcher and participants.

3.4. Data Synthesis. Three analytical themes were produced during the synthesis process. These themes have been organized around the multiple factors that impact GPs engagement with SP—from a personal to a broader systemic level. Together, all three of these factors—which could be defined as personal, interpersonal and structural—impact whether or not a GP makes a SP referral for a patient and informed the overarching theme of the GP as a salesperson. Data suggested that GPs are pivotal in SP as advocates and referral facilitators, shaping who enters the SP pathway. Their role in this respect was influenced by their knowledge and understanding of SP, their capacity to identify individuals in need of SP, and being able to convince patients of its benefits. This is illustrated in Figure 2, which brings together these various elements of our findings. Table 3 summarizes the main themes from the review with example codes and illustrative quotes.

3.5. Overarching Theme: GP as a Salesperson. This metaphor of the GP as a salesperson underscores the multifaceted nature of their involvement in SP. It highlights the complexity of their role, where they must "sell" the value and benefits of SP to patients, despite systemic challenges and varying levels of community support. Their ability and capacity as a salesperson appeared to be shaped by two factors: (i) buy-in to the product of SP and (ii) their skills in promoting the value of SP to patients. However, there were limitations to the power GPs had over the end product of SP after making a referral. The following analytical themes explore these issues in more detail and expand on the key roles and challenges faced by GPs.

3.5.1. Theme 1: Belief in the Product (Understanding and Perceiving SP). This theme highlights that GPs must develop

Table 2: Characteristics of included studies.

Author	Year	Research type	Qualitative methodology	Participants	Analysis	Location
Aughterson et al. [12]	2020	Qualitative	Interviews	17 GPs	Reflexive thematic analysis	Wales, East of England, West Midlands, South West England, South East England, London
Brunton et al. [25]	2022	Qualitative	Semistructured interviews	3 GPs, 31 others	Template analysis	Greater Manchester
Chng et al. [26]	2021	Qualitative	Focus group discussions, email surveys, in-depth interviews midimplementation, and in-depth end-of-evaluation interviews in four phases	Unclear, 64 total participants for focus groups and interviews with GPs included in each	Framework approach	Glasgow, Scotland
Fixsen and Barrett [27]	2022	Qualitative	Interviews	6 GPs, various others	Inductive thematic analysis, grounded theory aspects	Glasgow area, rural Scotland, and North of England.
Fixsen et al. [35]	2021	Qualitative	Semistructured interviews	5 GPs, various others	Inductive thematic analysis	Glasgow and Western Isles of Scotland
Fixsen et al. [28]	2022	Qualitative	Semistructured interviews	5 GPs, various others	Inductive thematic analysis, grounded theory aspects	Glasgow and the Western Isles (Scotland)
Fixsen et al. [29]	2020	Qualitative	Semistructured interviews	2 GP, various others	Modified grounded theory	Shropshire (West Midland)
Kellezi et al. [30]	2019	Mixed-methods but paper focuses on the qualitative data	Semistructured interviews	I7 GPs (referring into the pathway), 3 health coaches (HCs), 6 link workers (LWs) (involved in pathway delivery), and 19 patients	Thematic analysis	Unclear
Norman et al. [31]	2021	Qualitative	Focus group discussions, email surveys, in-depth interviews midimplementation, and in-depth end-of-evaluation interviews in four phases	11 GPs, various others	Thematic content analysis	North East and North Cumbria regions of England, focusing on practices in areas of blanket deprivation in North East England
White et al. [32]	2022	Mixed-methods but paper focuses on the qualitative data	Focus groups and semistructured interviews	14 GPs, various other stakeholders	Thematic analysis, combined inductive/deductive approach	Urban area of Northern England with higher-than-average social deprivation indicators
Ajibade et al. [33]	2024	Mixed-methods (online survey, written responses, semistructured interviews)	Semistructured interviews and narrative written responses	GPs: Online survey ($n = 102$), narrative written responses ($n = 55$) and semistructured interviews ($n = 8$)	Thematic analysis	Unclear
Watkins et al. [34]	2024	Mixed-methods but paper focuses on the qualitative data	Semistructured interviews	12 GPs	Reflexive thematic analysis	In and around a city in the South of England

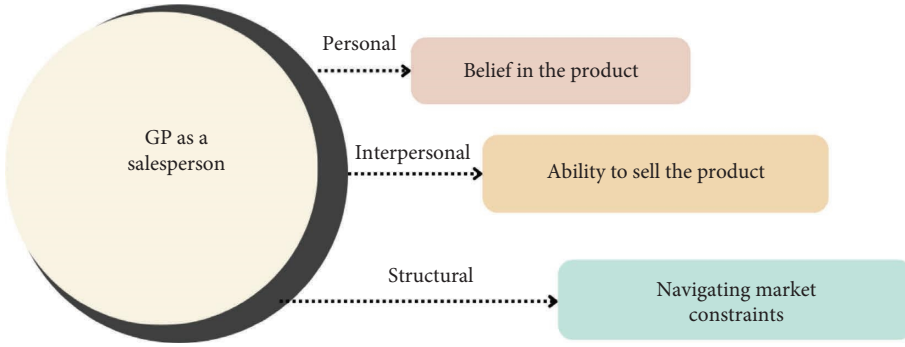

Figure 2: Model illustrating themes.

foundational knowledge of and conviction in SP to effectively advocate for and "sell" it to their patients. This belief can be shaped by continuous education, regular feedback loops, and the influence of their personal and professional experiences.

3.5.1.1. Knowledge Shaping Buy-In. Data showed that buy-in to SP required understanding of it and the value it might bring to patients [12, 25, 27, 28, 32–34]. In the absence of appropriate educational opportunities and evidence of the value of SP, this was difficult [26], as GPs did not know whether they could trust the process [29, 30]. Positive associations with holistic care and understanding the limits of the biomedical model contributed to GPs seeing the value of SP [12, 29, 32]. In one reviewed paper, a GP emphasized the need for this shift, saying, "As a GP for 30 years, I am very conscious that there a lot of people that I cannot help with these skills and training that I have received so far as a doctor" [12]. This highlights how some GPs reached a point in their patient interactions where they felt they could appreciate the limits of biomedical approaches. This was often influenced by a GP's personal encounters with accessing community resources, participation in recreation activities [27], or their own experience of illness. As one GP noted, "So, I was ill myself probably about seven or 8 years ago. And at that time, I was struggling to work, so what I did was I went to an art class. . .And I think certainly for patients of mine with mental health problems or even actually things like chronic pain or breathlessness or any of those things being able to focus on an activity, I think is really helpful for them" [12].

3.5.1.2. Evidence and Feedback Loops: Feedback Mechanisms. GPs' understanding of SP was critical and often stemmed from interactions with LWs and patient feedback. Regular contact with LWs reinforced the value of SP and kept it relevant in their daily practice [22, 23, 27]. As one GP stated, "you have to constantly communicate, and recommunicate, and remind practices and staff it [SP] is there" [29]. Regular and constructive feedback from patients and LWs reassured GPs of the positive impacts of SP; it served as a motivational tool that encouraged continued engagement and investment in the process [12, 29, 32]. Conversely, "GPs shared feelings of discouragement, as they were often unaware of the outcomes of their referrals" [33]. Formal evidence also played a vital role in GPs ascribing value to SP. As one GP noted, "We want to try and have some evidence to prove that patients are benefiting, so that we can go on employing somebody in this role and applying for funding. . ." [12]. Some GPs emphasized the importance of early collaboration and greater involvement in the SP process by allied stakeholders, stating the need for "more feedback from LW regarding the progress of people they had referred into the scheme and working more closely with our health colleagues" [29]. However, as the goal of SP is to be tailored and individualized to patients, this poses difficulty in building the type of evidence that GPs would like. As one GP noted, "it is like the art therapy, we know it is making a huge difference and we can do surveys or different things, but does it really capture that it is actually reducing, improving well-being?" [12] This proved to be difficult due to a lack of consistent and easy to use monitoring tools [26].

3.5.2. Theme 2: Ability to Sell the Product (Engaging and Motivating Patients). The second aspect of the GP role in SP that we identified from the data was the GP's ability to motivate or "sell" its value to their patients. This hinged on GPs' buy-in (see above). It was also impacted by their ability to build a long-lasting and trusting relationship with patients, their ability to listen to patients to fully understand their nonmedical needs, and their skills at motivating patients to try a potentially less familiar route to managing their problems. This theme explores the strategies and interpersonal skills that GPs utilize to effectively communicate and promote the benefits of SP, focusing on building trust, empowering patients, and overcoming the challenge of shifting away from the biomedical model.

3.5.2.1. Building Trust and Effective Communication. Trust and communication formed the cornerstone of effectively selling SP to patients [12]. Building trust required long-term relationships and a personalized approach to patient care. One GP stressed the importance of rapport, stating "I have been there for 14 years, so I have got a group of patients that I know very well, I have got a rapport with, I feel if I suggest something to them, they will generally think it might be a good idea, and try and follow through" [12]. This trust-based relationship enabled GPs to suggest SP,

Table 3: An illustration of the qualitative synthesis: analytical themes, descriptive themes, codes, and illustrative quotations.

Analytical theme	Example descriptive themes	Example codes	Example quotes for illustration
Belief in the product	Understanding of SP and LW roles	GP lacks understanding of SP pathway	GPs also discussed concerns about referring due to limited knowledge and understanding of the pathway and poor feedback on their referrals (all of which could influence the referrers' willingness to continue engaging with the pathway [30]
		Training	Some GPs felt that when they did have teaching related to this area, it was treated as somewhat of an "add-on," secondary to the biomedical and clinical teaching: "*it's always thought of as a little asterisk. . .it gets thrown in on the side like oh, don't forget about social prescribing*" [12]
		GP lack of trust in LW training and skills	Both the GPs and practice manager knew of doctors who resisted any directives coming from authorities other than the CCG and who had doubts about the skills and training of the link workers. Even where staff within practices were more engaged, *"you have to constantly communicate, and recommunicate, and remind practices and staff it [social prescribing] is there"* [29]
	Value assessment of SP by GP	GP personal connection with SP and community	*"So, I was ill myself probably about seven or 8 years ago. And at that time I was struggling to work so what I did was I went to an art class. . .And I think certainly for patients of mine with mental health problems or even actually things like chronic pain or breathlessness or any of those things being able to focus on an activity I think is really helpful for them"* [12]
		Understanding and appreciating wider determinants of health	Nevertheless, working in an area of high social and economic deprivation in Scotland, this GP recognized the complex social and domestic problems many of her patients faced [28]
		Skepticism about SP	GP perceptions of the value of social prescribing also appear significant; whilst some appeared to have positive perceptions, others were skeptical*: "I've managed up until now and I still am, simple as that. . .. That's just one more "do-gooding" type of thing. . .coming [patient's] way)*" [32]
		GP more likely to use SP if evidence to show it is helping	*"We want to try and have some evidence to prove that patients are benefiting, so that we can go on employing somebody in this role and applying for funding and stuff*" [12]
	Data collection and feedback loops	Lack of feedback to referrers	When asked what might encourage staff to refer more people to a link worker, more feedback from link workers regarding the progress of people they had referred into the scheme, and "working more closely with our health colleagues and being part of that promotion and preventative role," were advocated. These responses highlight the desirability of early collaboration and greater involvement in the social prescribing process of allied stakeholder buy-in [29]
		Difficulties in recording and monitoring SP	*"it's like the art therapy, we know it's making a huge difference and we can do surveys or different things, but does it really capture that it's actually reducing, improving well-being? Those kind of things, without stifling the organizations, or the patients with survey after survey, or questionnaire"* [12]

Table 3: Continued.

Analytical theme	Example descriptive themes	Example codes	Example quotes for illustration
Ability to sell the product	GP PT communication regarding SP	Motivating patients to try SP	There seems to be a "motivational threshold" that patients have to surpass in order to agree to engage with social prescribing, then actually turning up for a group or activity, and then continuing to show up: "One of my concerns is around how to help patients get over the threshold, so the threshold in terms of actually signing up and the threshold of actually joining the group" [12]
	Role of GP in referral	GPs referring psychosocial needs to SP	GPs we interviewed regarded their links worker as valuable in supporting them and their patients, in particular those who came with psychosocial needs or who you "didn't know what to do with" [28]
	GP relationship building for SP	GP face to face contact with a LW	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: *"…having a Links Worker role who is practice-attached [to the GP surgery], who became a trusted member of the practice team, so you could very much say [to a patient], 'Listen, I know the person that can help you, their name is x, they're just down the corner here, I'll come and introduce you to them now"* [35]
Navigating market constraints	Impact of GP workload and burnout on SP	GPs lack time for SP	*"[Prescribing medication] is easiest way out. You don't have to have that big conversation about what a social prescriber is or start delving into lots of social stuff or lots of mental health stuff. You know, if I wanted to, that would be the easiest thing to do. Would be to just do a prescription and be done and dusted"* [34]
	Influence of social deprivation on SP uptake	Social deprivation makes buy-in of SP from patients	Staff interviewed from these sectors agreed that, in principle, social prescribing was a great idea, but motivating people in an area of high deprivation was a big challenge: "*We want it to work but [it's a big task]…the North West of Shropshire is one of the most deprived areas of the county, there are a lot of people who have got compromised health or disabilities because of their level of income opportunities, health…*" [29]
	Navigating infrastructural and systemic challenges	Time-bound nature of SP activities	Patients might become reliant on community groups or activities for their health and well-being, and so there was also concern from GPs about the time-bound nature of certain community activities and projects: "*they would have some support, but it would finish after the prescribed amount of time. So, I had one patient who was invited to a gardening project, he was given 16 sessions. And actually, ended up in hospital when that provision was taken away because I think that the contrast between having activity and having some social support and then having it removed was almost worse, for him, than having nothing at the beginning*" [12]

particularly in areas where the community might have preconceptions of what medical care looks like and, therefore, suggesting SP might impact the doctor–patient relationship [12, 27, 31]. As one GP noted "they might kick up a fuss if I sent them to the social prescriber when they wanted pain relief" [34].

A strong relationship between GPs and LWs was also essential in the "sales" process. GPs with regular contact and mutual trust with LWs felt that they could better convey the benefits of SP to patients. GPs viewing LWs as valuable in supporting patients [12, 27, 28, 31, 32, 35] was often achieved through physically having a LW in their space [12, 31, 32, 35]. One GP described the benefit of regular interaction with a LW who was a part of the practice team "so you could very much say [to a patient], 'Listen, I know the person that can help you, their name is *x*, they are just down the corner here, I will come and introduce you to them now" [35]. This ongoing dialog sustained GP enthusiasm and belief in SP. However, the absence of appropriate educational opportunities and evidence of SP's value could challenge GP buy-in. One GP trainee expressed skepticism about SP due to a lack of education on it, saying, "It is always thought of as a little asterisk. . . it gets thrown in on the side like oh, do not forget about SP [12]."

A lack of GP understanding of the role sometimes led to LWs being a catch-all solution for psychosocial needs. This occasionally resulted in "reverse signposting" [25, 28, 29, 31] back to GPs. One GP admitted, "Those who came with psychosocial needs or who you did not know what to do with (were often referred to LWs)" [28]. This reflected a potential overestimation by GPs around the extent to which LWs could help patients [25] and the importance of clear communication and mutual understanding between GPs and LWs and the role of SP in practice.

3.5.2.2. Personalization and Patient Empowerment: Customizing the Sales Approach. GPs strived to empower patients to take an active role in managing their health, often needing to shift their focus from medication to more holistic approaches as offered through SP [12, 27, 29, 31, 32]. One GP emphasized the importance of finding the "right fit" for each patient, stating, "For me, the biggest thing is more around what people want because it is not my choice at the end of the day, it is the patient and what they want and what they think will be helpful to them" [12].

GPs believed that many patients focused on medication as the solution to their difficulties, posing challenges for GPs in promoting SP [12, 28, 31]. As one GP highlighted, "Our patients are so conditioned that they think sometimes medications will fix their problems, but we create more problems like what we know from the States. . . [we] know from the figures in the UK as well that painkillers are much more often prescribed in deprived areas and we see our patients being dependent on opioids" [27]. Encouraging patients with multiple problems to consider alternatives, like exercise or creative experiences, was seen as difficult as patients might believe this is minimizing their issues [27, 35]. Furthermore, some GPs perceived that referring patients to SP might not be useful if the patient was not already motivated: "If they do not want to take that step to contact the service, it is unlikely they are gonna get much from it, they do not really have the motivation" [32].

3.5.3. Theme 3: Navigating Market Constraints (Systemic and Community Factors). We found that despite a GP's buy-in and ability to sell as a salesperson, they were affected in their role in the SP pathway by several external factors. This theme reflects the broader context in which GPs operate. It is the point at which the GP has fulfilled their role and hands over to the LW. This theme suggests that SP is shaped by what is available in terms of community resources and services (and whether or not those resources are sufficient to resolve a patient's nonmedical issues), as well as GPs' perceptions of the effectiveness of these resources in helping patients.

3.5.3.1. Socioeconomic Barriers and Resource Availability. GPs noted that in areas of high deprivation, limited resources made SP seem impractical [26, 28, 31, 35]. GPs named larger structural barriers such as socioeconomic deprivation and limited resources as deterrents from referring patients to SP; they were concerned about the limitation of SP to address the most imperative needs for patients such as housing, food insecurity, and unemployment. In more deprived areas, patients were described as expecting traditional medical approaches and GPs feared disrespecting and losing trust with patients [12, 27, 31, 35]. GPs felt that referral to SP activities for these patients might be perceived as frivolous: "patients' notions about the role of the GP role as there to prescribe medications were deeply entrenched in western society, hence being offered advice on physical exercise as a drug-free alternative was not always greeted with enthusiasm" [27].

The transient nature of community resources posed significant barriers to establishing stable SP pathways. GPs highlighted the instability of community resources as a deterrent for referral [12, 28, 31]. They also noted the time-bound nature of SP and how potentially providing and then taking away an activity might be harmful to a patient: "I had one patient who was invited to a gardening project, he was given 16 sessions and actually ended up in hospital when that provision was taken away because I think that the contrast between having activity and having some social support and then having it removed was almost worse, for him, than having nothing at the beginning" [12]. Although the role of connecting to community resources is that of the LW, and GPs found it hard keeping up-to-date with available community services [12], having some sense of the resources available and a feeling of community connectedness increased GP receptivity to SP [12, 26, 29]. Practices that had a stronger presence in the community and valued holistic care facilitated GP engagement with SP [23, 35] and encouraged GPs to see SP as an integral part of healthcare [12, 26, 29]. In contrast, practices with limited community connections struggled to establish relationships with local organizations [12, 29].

3.5.3.2. Influence of Organizational Factors. GPs felt that NHS structures and systemic barriers made it challenging for them to effectively refer patients to SP services. They noted that high staff turnover rates and the reliance on part-time and locum GPs curtailed the trust and continuity necessary for motivating patients" [27]. Additionally, inadequate IT systems and time constraints limited GPs' ability to explore nonmedical solutions [32]. One GP stated, "It is easier to give prescriptions and say off you go . . . rather than taking some time and say look, I do not think there is anything medically we could do for you, these are the things that we can do that might take a bit more time and effort as well . . . it is not always possible in GP surgeries sometimes, they just want to move on" [32].

4. Discussion

4.1. Summary of Findings. The thematic synthesis revealed that GPs play a critical role in the SP pathway, influenced by a complex array of personal, interpersonal, and structural factors. Three main themes were produced: "Belief in the Product," "Ability to Sell the Product," and "Navigating Market Constraints." The overarching theme of the GP as a salesperson underscored the multifaceted nature of their involvement in SP, highlighting both the challenges and opportunities in effectively implementing SP.

4.2. Relation to Existing Literature. Previous research has highlighted how personal interest and level of understanding of SP among GPs can drive or hinder buy-in to it, which formed the basis of the review's first analytical theme. For example, Tierney et al. denoted buy-in as existing at two levels—to the idea of SP as a means of supporting patients alongside biomedical care, and buy-in to the LW responsible for delivery of SP in a practice—seeing that person as competent and credible [11]. This is in line with our findings which highlight the importance of GP education to increase the palatability of nonmedical interventions and training to see LWs as skilled and valuable members of the team.

Bickerdike et al. found that visibility of the LW and a good working relationship between LWs and GPs can increase referrals to SP [5]. Similarly, Griffith et al. showed how LWs help bridge the gap between healthcare providers and community resources, emphasizing the importance of LWs being well embedded within Primary Care Networks (PCNs) to ensure effective and sustainable SP [36]. Kiely et al. examined the impact of LWs on health outcomes and costs, finding that well-integrated LWs can significantly enhance the delivery of SP, particularly in primary care and community settings [6]. Emphasizing continuity and relationships, South et al. found that GP referral to a single LW increased trust in the process [37]. This previous research relates to the second analytical theme from the review, which focused on the importance of interpersonal connections for GPs to be able to sell the idea of SP to patients.

The critical role of community resources and infrastructure in enabling effective SP underpinned our third analytical theme and is well documented in existing research on SP [38]. For example, Sandhu et al. noted that investment in community-based organizations and wider public services is crucial to both the long-term effectiveness and the sustainability of SP [39]. This challenge has also been noted with regards to other additional roles in primary care [40, 41]. In line with our findings on the availability of resources, Pescheny et al. found that a lack of partnership and service level agreements and reduction in available and suitable service providers in the third sector were barriers to implementing SP [10].

4.3. Implications for Practice. While previous research has highlighted the salience of the connector role in SP [11], our review highlights the need to better understand the referrer role in the SP pathway. Findings from this review support research showing that the introduction of new healthcare roles within primary care often burdens the new workers with selling themselves for successful uptake [42]. This is reflected in research undertaken in England [43] surrounding the implementation of additional or extended roles into PCNs through the Additional Roles Reimbursement Scheme (AARS) scheme; one of these being LWs [43]. An evaluation by Baird and colleagues on the implementation of these roles revealed that a lack of effective and supported implementation meant that the core needs of individuals working in ARRS roles—autonomy, belonging, and contribution—were not being met in many cases [44]. This evaluation raised some ambiguity among GPs about the strategy of implementation and what multidisciplinary working means in practice [44]. Variability in ARRS implementation highlights the importance of structured support and training for GPs to effectively promote SP to patients. Checkland et al. also emphasized the role of organizational factors in the success of SP programs. Their study found that effective implementation of new roles, including those related to SP, requires substantial organizational support and alignment with broader healthcare strategies [41].

While SP has the potential to alleviate GP pressures in the long term, it demands initial investment in time and effort, creating a paradox requiring short-term investment in terms of GP time for long-term benefits for both GPs and patients. This highlights the need for appropriate training—potentially as part of medical education—to equip GPs with the skills to support patients effectively and efficiently in accessing SP. We found continuous education and regular feedback loops to be crucial in shaping GPs' beliefs about SP. This finding is supported by Bickerdike et al. who noted that visibility and good relationships with LWs can significantly increase GP referrals to SP [5]. Evers et al. found that while most GPs across Europe were aware of SP, there were significant variations in their understanding and implementation of SP practices [45]. This variability underscores the need for a standardized educational framework to enhance GPs' belief in and engagement with SP and for SP to be integrated into medical training and continuous professional development.

SP is currently being integrated into UK medical schools through the Social Prescribing Student Champion Scheme, a peer-assisted learning approach that aims to teach students about SP and the social determinants of health. It empowers

students to become advocates and educators of SP within their institutions and communities [46, 47]. However, during medical training, students may benefit from spending time in community organizations to learn about the potential health and well-being benefits they can bring for patients. With regards to curriculum, we believe any educational framework would need to be adaptable and responsive to local contexts. Rather than proposing a rigid, standardized approach, the framework could offer core principles and flexible components that account for variations in service provision, funding, and delivery models across different areas.

4.4. Implications for Research. Our thematic synthesis highlights the crucial role GPs play in the SP pathway, acting as gatekeepers who significantly influence whether patients engage with SP services. Future research should explore several key areas to further enhance the effectiveness and reach of SP. First, there is a need for studies that investigate alternative entry points into SP, such as self-referrals and referrals from other healthcare providers, which could alleviate the burden on GPs and promote more equitable access to these services. Additionally, research could examine the effectiveness of various training and educational interventions aimed at improving GPs' understanding of SP, particularly in diverse healthcare settings. The role of community resources is another critical area for investigation. Research should examine how variations in the availability and stability of these resources, particularly in socioeconomically deprived areas, affect the success of SP initiatives, and, therefore, GP buy-in to it. This could include exploring strategies for strengthening community infrastructure to support SP. Without sufficient investment in voluntary sector services, there is a risk of these organizations becoming overwhelmed or unable to meet demand, which could undermine the effectiveness SP. This creates broader implications for policymakers, as funding these services is integral to ensuring the sustainability and success of SP initiatives.

Comparative studies across different healthcare systems and cultural contexts could provide valuable insights into how the role of GPs and other referrers into SP varies internationally, offering lessons that could inform the global implementation of SP models.

4.5. Strengths and Limitations. This thematic synthesis is the first to our knowledge to systematically review and integrate qualitative research on the experiences and perceptions of GPs with SP. It provides an understanding of the multifaceted nature of GP engagement in SP, which has not been previously synthesized in this manner. The conceptual framework presented in the review helps in understanding the critical factors influencing GP referrals to SP and offers valuable insights into the personal, interpersonal, and systemic factors that impact GP engagement in SP.

A key limitation of this review is it relied heavily on the reported experiences and perceptions of GPs, which may not capture the full complexity of SP implementation. Additionally, the landscape of SP and related policy is rapidly evolving, which can make findings time sensitive. Changes in SP policies, funding, and practice models could impact the relevance of the review's conclusions over time.

Our review focuses on the entirety of the UK, although SP implementation differs between England, Scotland, and Wales [48]. We would like to add that SP was rolled out across England in primary care as part of the NHS Long-Term Plan [1]. Hence, the LW role is mainly funded through this, although there are also examples of funding for the role through charities or local authorities. In Wales, funding of the LW role is more varied; it can come through the Welsh Government or through other routes (e.g., local health boards, primary care, public health, and local authorities). In Scotland, community LWs facilitate SP within primary care but how they are employed varies; some are employed through health and social care partnerships, others directly by health boards [48]. A more nuanced understanding of variations between devolved nations would require further research and targeted exploration.

Relatedly, our review may not fully capture the nuances between urban and rural settings. The experiences and challenges faced by GPs in different geographical locations might differ, and this synthesis does not provide a comparison between these contexts. Another key limitation was the lack of rich qualitative data available in the included papers, something highlighted in other reviews on SP [49]. Quotes presented in the findings above were taken mainly from those papers that were richer and focused more on the GP perspective. We believe there is a need to explore further the extent to which GPs' beliefs and experiences influence how they refer or signpost patients in practice.

5. Conclusion

Findings from this thematic synthesis revealed that while GPs hold a pivotal role in SP, it is contingent upon their belief in the product, their ability to engage and motivate patients, and the support of a well-resourced community infrastructure. Understanding these dynamics can inform future research, practice, and policy to enhance the effectiveness and sustainability of SP in primary care. Recommendations for practice include the integration of SP education into GP training and ongoing professional development and for policymakers to focus on supporting community resources. Further research is needed to explore other entry points into SP, aside from referral from a GP. Exploring what happens across different countries in this respect could be useful in understanding the benefits and drawbacks of varying entry approaches for patients into SP.

Appendix A

Table A1: CASP quality appraisal.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[12]	Aughterson et al.	2020	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	This study elucidates the barriers and enablers to social prescribing for patients with mental health problems, from the perspectives of GPs. Recommended interventions include a more systematic feedback structure for GPs and more formal training around social prescribing and developing the relevant interpersonal skills. This study provides insight for GPs and other practice staff, commissioners, managers, providers, and community groups, to help design and deliver future social prescribing services

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[25]	Brunton et al.	2022	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	This study provides new insights from staff stakeholder perspectives into the challenges of integrating signposting into general practice and highlights key factors affecting the success of signposting in practice. Clarity of role purpose and remit (including resolving tensions inherent the dual aims of "active signposting"), appropriate training, and skill development for role holders and adequate communication and engagement between stakeholders/partnership working across services, are required to enable successful integration of signposting into general practice The study addresses an important topic related to the integration of signposting into general practice, which can have implications for healthcare delivery and policy
[26]	Chng et al.	2021	Yes	Yes	Yes	Cannot tell	Yes	No	Yes	Yes	Yes	Provides valuable insights into the implementation of a social prescribing initiative in primary care practices in areas of high socioeconomic deprivation. It sheds light on the challenges and factors influencing successful implementation, which can be useful for similar initiatives in the future

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[27]	Fixsen and Barrett	2022	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Findings support the premise that time spent in open green spaces can alleviate some of the negative mental health effects compounded by the pandemic. However, the creation of healthy environments is complex with population health intrinsically related to socioeconomic conditions. Social disadvantage, chronic ill health, and health crises all limit easy access to green and blue spaces, while those in the most socially economically deprived areas receive the lowest quality of healthcare. Such health inequities need to be borne in mind in the planning of schemes and claims around the potential of future nature-based interventions to reduce health inequalities
[35]	Fixsen, Barrett, and Shimonovich	2021	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Offers valuable insights into social prescribing during a global health crisis, providing recommendations for greater coordination and communication between stakeholders and emphasizing the importance of adaptability and resilience in social prescribing schemes

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[28]	Fixsen et al.	2022	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Concerns included identifying and digitally supporting disadvantaged and vulnerable individuals and reduced capacity statutory and third-sector services, obliging link workers to assume new practical and psychological responsibilities. Social prescribing services in Scotland, we argue, represent a collage of practices superimposed on a struggling healthcare system. Those in need of such services are unlikely to break through disadvantage whilst situated within a social texture wherein inequalities of education, health, and environmental arrangements broadly intersect with one another. Semivaluable provides anlaysis but fails to make policy recommendation
[29]	Fixsen et al.	2020	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Those implementing social prescribing in different localities inevitably face hard choices about what and whom to include. Research on the sustainability of social prescribing remains limited; studies are required to ascertain which “holistic” models of social prescribing work best for which communities, who are the main beneficiaries of these approaches, and how “buy-in” is best sustained

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[30]	Kellezi et al.	2019	Can't tell	Yes	Yes	Yes	Yes	No	Cannot tell	Yes	Yes	Results healthcare providers recognized the importance of social factors in determining patient well-being, and reason for presentation at primary care. They viewed SP as a potentially effective solution to such problems. Patients valued the different social relationships they created through the SP pathway, including those with link workers, groups, and community. Group memberships quantitatively predicted primary care usage, and this was mediated by increases in community belonging and reduced loneliness. Conclusions methodological triangulation offers robust conclusions that "social cure" processes explain the efficacy of SP, which can reduce primary care usage through increasing social connectedness (group membership and community belonging) and reducing loneliness. Recommendations for integrating social cure processes into SP initiatives are discussed

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[31]	Norman et al.	2021	Yes	Yes	Yes	Yes	Yes	No	Cannot tell	Yes	Yes	This paper adds important context to the quantitative data on excess morbidity and mortality in deprived populations during the COVID-19 pandemic. We identify mechanisms through which socioeconomic deprivation exposes both patients and healthcare providers to an increased risk of COVID-19. We also add to the literature on the harms associated with some public health measures by highlighting the role of primary care in addressing the social determinants of health and the ways in which the pandemic is likely to worsen existing deprivation. We also highlight the work done by district nursing and social prescribing link workers during the pandemic. Finally, we contribute to the conversation around the move to remote consulting in primary care by identifying the potential risks that the drive to digital-first care poses to the provision of primary care in areas of deprivation. Provides insights into the challenges and experiences of primary care practitioners working in deprived areas during the COVID-19 pandemic, contributing to the understanding of the impact of the pandemic on primary care delivery in such areas

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[32]	White et al.	2022	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	This study considered the social prescribing journey and the "personal support" required by some to enable them to access support throughout. Key elements of this support included referral into and onwards from social prescribing services (in addition to signposting), longer-term LW support, and buddying. The balance between empowerment and dependency featured in practitioner responses and a need for good support and supervision for LWs to enable them to provide support whilst minimizing the risk of client dependency was highlighted. Unusually in this service, social workers were key referrers and there is a need to both explore the role of social prescribing in UK social work practice and to explore why GP referrals can be lower than anticipated, and how this might be remedied

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[33]	Ajjibade et al.	2024										This study provides one of the largest published set of responses from GPs on the topic of attitudes to using SP in their practice. Therefore, it provides a unique perspective on the facilitators and barriers to effective implementation of SP, in the context of the ongoing debate around lack of high-quality evaluative evidence in this field. While previous research has focused on the effectiveness of social prescribing, emphasizing its aims and barriers, this study has focused on the attitudes and experiences of GPs toward using social prescribing as a treatment option. These data contribute a new insight into the relationship between GPs' opinions on social prescribing and their intended future use of it in their practice

Table A1: Continued.

Citation	Author	Year	CASP-A-1. Was there a clear statement of the aims of the research?	CASP-A-2. Is a qualitative methodology appropriate?	CASP-A-3. Was the research design appropriate to address the aims of the research?	CASP-A-4. Was the recruitment strategy appropriate to the aims of the research?	CASP-A-5. Were the data collected in a way that addressed the research issue?	CASP-A-6. Has the relationship between researcher and participants been adequately considered?	CASP-B-7. Have ethical issues been taken into consideration?	CASP-B-8. Was the data analysis sufficiently rigorous?	CASP-B-G. Is there a clear statement of findings?	CASP-C-10. How valuable is the research?
[34]	Watkins et al.	2024										This is the first study that has sought to explore the interface between SP referrals and prescriptions of medication. Given the impact of pharmaceuticals on water quality and the associated carbon footprint as well as the negative health impacts of overprescribing and problematic polypharmacy, reductions in prescribed medication are increasingly being mooted as an outcome that should be embedded within evaluations of SP

Data Availability Statement

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study.

Conflicts of Interest

The authors declare no conflicts of interest.

Author Contributions

Stephanie Tierney: writing–review and editing, validation, supervision, and conceptualization. Marta Wanat: writing–review and editing, validation, and supervision. Arisha Khan (lead): writing–review and editing, writing–original draft, project administration, investigation, formal analysis, and conceptualization. Stephanie Tierney and Marta Wanat are joint senior authors.

Funding

This research was primarily conducted by Arisha Khan as part of her doctoral work funded by the Rhodes Trust.

Acknowledgments

We would like to thank Nia Roberts, librarian and information specialist, for her valuable assistance with developing the search strategy and supporting article extraction. We also thank Tori Ford for serving as the second screener during the first round of article screening and for reviewing the final manuscript. This research was primarily conducted by Arisha Khan as part of her doctoral work funded by the Rhodes Trust.

Supporting Information

Additional supporting information can be found online in the Supporting Information section. *(Supporting Information)*

Example search strategy.

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