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Research Article

"She's Been a Rock": The Function and Importance of "Holding" by Social Prescribing Link Workers in Primary Care in England—Findings from a Realist Evaluation

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Social prescribing link workers are recently introduced roles in English primary care. One of their intended functions is to support patients with conditions influenced by the wider, social determinants of health. Their main purpose is to connect people to community resources to meet their nonmedical needs. However, our research reveals that link workers provide not only connections but also what we have described as "holding" for individuals with complex needs, who lack informal networks of support or who are waiting to access services. We explore the concept of holding, its meaning and significance in this context, and consider its consequences. As part of a realist evaluation, we observed seven link workers in GP practices in England during focussed ethnographies over a 3-week period. We took field notes and interviewed 61 patients and 93 healthcare and voluntary sector professionals. Nine to twelve months later, we carried out follow-up interviews with forty-one patients, seven link workers, and a link worker manager. We identified four functions of holding: supporting patients waiting for services, sustaining patients as they prepare for change, reducing the emotional burden of primary healthcare professionals, and bearing witness to patients' distress. Holding appears to be a vital but often overlooked aspect of social prescribing. Patients benefit from having a reliable and consistent person to support their emotional needs. However, similar to the impact of holding on other primary care professionals, there are unintended consequences: some link workers exceed their capacity, become overburdened, experience burnout, and leave their job. Recognizing the importance of holding and understanding its role in link workers' primary care responsibilities are critical. If holding work is accepted as a role for link workers, providing training and support to them should be prioritised to ensure successful implementation and positive outcomes for patients, link workers, and primary healthcare staff.

1. Introduction

Social prescribing is a model of support that involves connecting people to a range of nonmedical community-based services, usually by someone called a link worker (other terms may be used like social prescriber, well-being coordinator, or community connector) [1]. Link workers are key to the delivery of social prescribing in the English NHS [2, 3], and their numbers are set to increase over the coming years [4]. They are employed to spend time talking to

patients about their nonmedical concerns, to identify relevant support or services that could help (often provided by the voluntary, community, or social enterprise sector (VCSE)), and to connect patients to such assistance.

The 2019 National Health Service (NHS) long-term plan rolled out social prescribing in primary care [3] and was accompanied by funding to primary care networks (PCNs) in England to employ link workers. This was a response to an increasing understanding that many health issues are social in origin [5, 6]. One of the ways social prescribing might work to address these difficulties is through enhancing social capital by assisting people to develop social connections and to access support including welfare benefits, access to housing, and activities to reduce loneliness [7]. It also aims to promote patient well-being through increasing self-determination and the adoption of healthy behaviours [8]. However, evidence for this primary care–based intervention is still emerging [9, 10].

While national guidance describes social prescribing as a "short-term intervention of 6–12 contacts over a three-month period" ([11] Section 4.2), there is wide variation across England in the duration of link worker engagement with patients [12]. The content and focus of social prescribing sessions also differ between programmes, with some prioritizing information-giving (simple signposting) while others address broader, holistic, and social issues [13, 14]. These differences are influenced by factors such as who employs the link worker, demand for the service, number of link workers in post, and availability of VCSE services. Critics argue that social prescribing may distract from capacity issues by keeping patients off waiting lists for statutory services such as mental health support [15]. Wider structural factors associated with health inequalities also affect the capacity of link workers to achieve desired outcomes for individuals they work with; this can create significant tensions in the role [16, 17].

To understand the delivery and implementation of the link worker role in primary care in England, a realist evaluation was undertaken, which built on findings from a previous realist review [7]. In this paper, we examine the concept of "holding," which was identified during data collection and analysis as a technique used by link workers in primary care to cope with tensions between supporting individual patient needs and managing constraints on their practice imposed by wider socio-economic forces and the limitations of support services.

Holding in primary care has been defined as maintaining a trusting, supportive doctor-patient relationship without expectation of cure [18]. It has also been referred to as the "doctor as a drug" [19], highlighting that the continued relational aspect of work with patients is an important and *active* ingredient of clinical interventions. Holding may allow space to consider social problems, and better support patient decisions and choices [20].

Holding is not a new idea in general practice but has for some time been a debated element of the GP's role [21]. Primary healthcare is distinct from other health services in providing ongoing provision to local populations, without the capacity to discharge patients. Within this context, making connections for patients and maintaining relationships with them is a core part of a GP's role. Some argue that this kind of support encourages patient dependency and reduces GP capacity [21–23], while those who see holding as a valuable part of the GP's role argue that the therapeutic relationship between clinician and patient is being eroded by performance targets and lack of time [18, 24, 25]. In the current context of long NHS waiting times, holding is recognised as an inevitable, if not always intentional, response. Falling GP numbers and backlogs due to Covid-19 may have contributed to unmet need, and patients who require emotional support may be overlooked or passed to other providers of primary care services.

This context is important for understanding how social prescribing link worker holding is implemented in primary care. In this paper, we begin by reframing the concept of holding as it relates to link workers. We then explore why holding happens, for whom, and what are the consequences for both patients and link workers.

2. Methods

A protocol for the study has been published, delineating key procedures associated with the research. Ethics approval was granted by the East of England-Cambridge Central Research Ethics Committee (Ref: 21/EE/0118). RAMESES quality and reporting guidelines were followed when conducting and reporting on this study [26].

Realist evaluations can be used to explain why, when, and for whom an intervention or programme may or may not work. They support the identification of causal factors through the iterative development of a programme theory, which provides an explanation of how an intervention is thought to work. This usually involves developing micro-theories based on a heuristic of context-mechanism-outcome configurations (CMOCs) [27, 28]. Figure 1 provides an explanation of some key terminology in realist evaluations.

2.1. Data Collection. Focused ethnographies [30, 31] took place between November 2021 and November 2022. This involved generating data from seven link workers (cases) who worked in surgeries (sites) in different parts of England. Maximum variation was sought in link workers' experience in the role and areas they served (see Table 1).

Initially, researchers spent 3 weeks shadowing each link worker, going to meetings with them, and watching them interact with patients, other healthcare staff, and with VCSE organisations. Researchers made field notes during these observations: recording what they saw and making notes of their own and the link workers' reflections about what had happened during observations. They also took written notes at a daily debrief carried out with the link worker during the fieldwork period, in which they asked link workers to reflect on what they had done that day and patients on what they had seen. In addition to fieldwork, researchers interviewed 93 professionals: link workers, GPs, nurses, clinical pharmacists, care coordinators, health and well-being coaches, and VCSE managers and representatives (see Table 2).

Furthermore, 61 patients supported by link workers were interviewed (see Table 3). Interviews mostly took place via telephone/Microsoft Teams, but at some sites some interviews were in-person (e.g., sites 5 and 7). Interviews lasted between 20 and 65 minutes.

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Realist Term	Definition
Context	Describes the background of a programme and influences whether mechanisms are triggered or not. It can include structural factors such as social, economic, political and organizational aspects, but also individual factors such as cultural and social norms and relationships.
Mechanism	Generative mechanisms describe how programme resources and context lead to changes in the reasoning and behaviours of the individual and lead to certain outcomes. They are generally unseen and are responsive to institutional factors and powers. They include cognitive or affective responses that individuals may or may not be aware of (such as development of trust or increased awareness, or feeling safe).
Outcome	Mechanisms alter the behaviour of participants, leading to different outcomes within certain contexts. They can be intended, unintended and can occur at macro, meso and micro levels.
Context-mechanism-outcome configuration CMOC	This is a heuristic device used to explain how and why an outcome comes about. These are sometimes called "propositions" or micro-theories.

Figure 1: Key terminology in realist research (sources: [27–29]).

Follow-up interviews with patients and link workers were carried out 9–12 months after the first interview and were used to refine our programme theory, explore emerging insights, and validate our interpretations. Follow-up interviews lasted 10-50 minutes and were conducted via telephone or Microsoft Teams.

2.2. Analysis. Analysis was carried out in parallel with data collection. Data were initially coded thematically in the qualitative data management software QSR NVivo 12. Weekly researcher coding discussions helped us refine our coding framework; this framework included deductive codes from the original realist review [7] and inductive codes from our data. After coding data from the initial four sites, we refined the CMOCs developed from the review and created new ones to reflect new concepts developed from the primary data. Data from the remaining three sites were then coded using these revised CMOCs.

CMOCs were consolidated and labelled numerically. CMOCs relevant to holding are included in Table 4 and referenced in the findings section of this paper by number in this format: (CMOCn). We applied a range of realist reasoning processes within the analysis to explain why differences may arise across settings, and how and why identified outcomes occurred (or not) [27]. The concept of holding, which was related to existing theories of emotional containment and attachment for patients, and emotional labour for link workers emerged during this reasoning process.

Our development and refinement of the theory of holding were modified in consultation with a public involvement group (PPI), which met seven times during the study, and with link workers who were part of the study during knowledge exchange meetings. These stakeholders considered the relevance of this idea and helped us to develop CMOCs about holding. We designed diagrams to make sense of the data and to build a programme theory about holding and the consequences of regarding holding as part of the link worker role.

3. Results

3.1. Holding as an Active Process in Social Prescribing. Link workers are tasked with enabling patients to understand and address their health issues by connecting them with nonmedical support. This requires them to develop trust so that patients open up about their wider concerns, while simultaneously discouraging dependence and promoting self-management. Across the study sites, we found giving advice and connecting patients to services, activities, and experiences was only part of what link workers did. They also addressed broader social and emotional needs through a holding process, although they did not always label it as such.

> "I make them feel they are being listened to, acknowledge their difficulties . . . if you focus on them and allow them to talk . . .I think it's important to make them feel supported just by understanding what they're going through." (Site01_LW01)

Holding required link workers to build a reliable relationship, in which patients felt safe and unhurried, and could therefore unburden their worries (CMOC 1).

> It was good, anyway, just to be able to talk to someone about it that had time to listen, and even if she couldn't have really helped me much, it was still someone you can offload onto. (Site03_P08)

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Table 1: Characteristics of link workers (cases) at first interview.

Characteristics/sites	Site 1	Site 2	Site 3	Site 4	Site 5	Site 6	Site 7
Link worker time in role at first interview	24 months	2 months	16 months	8 months	32 months	31 months	38 months
Was the link worker leading a team?	No	No	No	No	Yes (officially)	Yes (officially)	Yes (informally)
Number of sessions with patients	Up to 6	Up to 6	Up to 6	Open ended	6–8	Open ended	Open ended
Deprivation in area served[$]	Medium	Low	Low	Medium	Medium	High	High
Location of site in England	South	Midlands	South	Midlands	South West	North	North West
Employment of link workers	Funded by primary care but subcontracted to, and managed by, VCSE	Funded by primary care but subcontracted to, and managed by, VCSE	Funded by primary care but subcontracted to, and managed by, VCSE	Funded, contracted, and managed by primary care	Funded, contracted, and managed by primary care	Funded by primary care but subcontracted to, and managed by, VCSE	Funded, contracted, and managed by primary care
Who set up the link worker service	VCSE, GP and link worker	GP led	VCSE and link workers	Mainly link workers	Practice manager and link workers	VCSE and link workers	Link workers

[$]Please see the following blog describing our definition of deprivation (Westlake et al., 2023).

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Table 2: Characteristics of professional interviewees.

Work roles Participants were anonymised using these acronyms followed by an allocated number: link worker (LW), healthcare professional (HCP), and voluntary and community sector employee (VCSE)	Link workers (includes our seven cases and other link workers working alongside them) (LWs)	12
	VCSE staff and managers	20
	GPs (including trainees)	19
	Practice managers/operations managers	11
	Nurses (including advanced practitioners)	10
	Care coordinators/health and well-being coaches	6
	Reception staff	5
	Clinical pharmacists	2
	Mental health practitioners	2
	Dietician	1
	Occupational therapist	1
	Paramedic	1
	Physiotherapist	1
	Other	2
Ethnicity	White British	71
	Asian (including British Asian or Indian)	7
	White (non-British)	5
	Mixed ethic groups	4
	Afro Caribbean/black British	3
	Chinese/Chinese Hong Kong	2
	Missing	1
Gender	Female	70
	Male	23
Age	Range	20–66 years
	Mean (standard deviation)	43.3 years (SD 12.2)

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Table 3: Characteristics of patient participants.

Involvement in the study Patient participants (P) were anonymised using an allocated number	Observation only	23
	Interview only	49
	Interview and observation	12
Ethnicity	White British	62
	White (non-British)	6
	Asian (including British Asian and Indian)	5
	Afro Caribbean/black British	5
	Mixed ethnic groups	3
	Others	3
Gender	Female	55
	Male	29
Age	Range	19–86 years
	Mean (standard deviation)	49.3 years (SD 19.5)
Number of times spoken to/met with the link worker (in-person or remotely)	Range *(Eight people said they had seen the link worker "multiple times" rather than a specific number, and for three people this information was missing because they could not remember. One participant was interviewed as a member of the practice patient participation group (PPG) and had not seen a social prescriber as a patient, which is why the range here starts from 0.)*	0–30 times
	Mean	4.1 times (SD 4.9)

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Table 4: CMOCs related to holding.

No.	CMOC
1	When patients offload their troubles during meetings with a link worker they trust (C), they feel their emotions are more manageable (O) because it helps them to feel unburdened (M)
2	When link workers work with a patient who has multiple problems which are challenging to solve (C), they appreciate being able to share their problems with the link worker (O) because this puts their concerns into perspective and helps to diffuse some of their distress (M)
3	When patients reach a tipping point of multiple problems that lead them to seek help (C), link workers may adopt a step-by-step approach (peeling back layers) (O) so the patient can focus on one problem at a time and does not feel overwhelmed (M)
4	If link workers prioritise relationship building in initial sessions and make patients feel emotionally contained (C), patients are more receptive to suggestions about connecting to services and activities (O) because the link worker has built up their trust (M)
5	When patients who are not able to progress with a link worker's suggestions are held by the link worker (C), they may become more able to move forward later on (O) because whilst being held they have the space to increase their self-confidence and motivation (M)
6	If link workers are perceived as calm and empathetic by patents (C), they feel comfortable and safe in opening up to them (O) because they have been made to feel emotionally contained (M)
7	When a link worker consistently actively listens and appropriately responds when patients share their concerns/problems/issues (C), the patient develops trust in this person (O) because they regard the link worker as reliable and compassionate (M)
8	When the location or medium (e.g., face to face or phone call) for a meeting between patient and a link worker is in some way inappropriate (C), then either patient or link worker may not fully engage (O) because they find they are unable to focus or build a relationship (M)
9	Patients who are unable to share their concerns with family or friends in their social network (C) can feel overwhelmed (O) because they feel alone with their problems (M)
10	When a link worker is sensitive to whether patients are ready to make changes (C), patients continue to engage with this person (O) because they do not feel pressured (M)
11	If link workers are not able to connect patients into a follow-on service or activity (C), they may consider holding the patient (O) as they feel responsible to do something to prevent the patient returning to the referrer (e.g., general practitioners) (M)
12	When patients are being held by a suitably skilled link worker or primary care professional (C), this protects patient and practitioner well-being (O) because the task is being done by an individual with the appropriate skills (M)
13	When link workers receive timely support and supervision from the wider primary care team (C), they are better able to manage patient risk and their own well-being (O) because they are not carrying the risks and emotional burden alone (M)
14	If link workers are not able to connect patients into a follow-on service or activity (C), they may consider holding the patient (O) to do something to help and so patients do not feel alone with their problems (M)
15	When the link worker helps to make people feel they matter through holding (C), patients are more willing to try new things (O) because they develop a sense of inner confidence (M)
16	When a patient is informed they can contact the link worker directly themselves or be re-referred (C), they feel reassured (O) because they have a safety net if they need more help (M)
17	When link workers hold patients over an extended period (C), they may find the patient is unwilling to stop being seen (O) because the patient has become dependent on the link worker's support (M)
18	If the link worker does not have sufficient time (C), then they are likely to have an incomplete understanding of a patient's needs—including any risks (O) because they are unable to delve down into the patient's problems (M)

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Table 4: Continued.

No.	CMOC
19	When link workers allocate time to holding patients rather than connecting them into other experiences, activities, or services (C), this leads to a reduction in their capacity to see other patients or investigate community resources (O) because holding patients is a time-consuming process (M)
20	When a link worker is holding a patient and cannot see any progress (C), they can feel despondent or frustrated (O) because they feel they are not achieving what is expected of them (M)
21	When link workers are holding patients (C), they are at risk of burnout (O) because they are engaging in work which is emotionally burdensome (M)
22	If holding is explicitly communicated to link workers as a valued part of their role by their managers (C), link workers feel they have the flexibility to hold patients when needed (O) because they know it is a legitimate part of their role (M)
23	If resources and time for appropriate training and supervision for holding are allocated (C), link workers feel supported and their emotional burden is reduced (M). So they are more able to sustain this part of their role and less likely to leave their job (O)
24	When GPs (and managers) appreciate the benefits of link workers being there to hold patients who cannot be "fixed" with medical interventions (C), they will give support for link workers to do so (O) because they believe it is useful to them and the patient (M)

However, holding involved more than just listening; it called for link workers to create space for patients to gain a sense of perspective and help to diffuse patients' distress, which could otherwise result in feelings of overwhelm (CMOCs 2, 3). This was described by some interviewees as helping individuals to see "the wood for the trees" (Site04_P03; Site05_HCP01).

Holding could involve ongoing support over several sessions—even if this was through short infrequent contacts. Yet, some patients could experience holding after a single appointment.

> You do make a difference sometimes with just one phone call—just talking. Even if they rant and rave, they feel better. You feel you haven't done much, but you have if they talk for half an hour. (Site05_Meeting notes during fieldwork: link worker team meeting)

Some sites had boundaries around the number of sessions that could be offered, which were then followed up by review phone calls. These might be short, monthly calls (sites 3, 5, and 6) which reassured patients and served as a "check-in" for link workers who remained concerned about a patient and were reluctant to close a case.

> . . .even though you know the guidelines are six appointments, maximum of six appointments. . . he had carer burnout and it was checking in with him, making him feel— "cause sometimes I didn't really feel I was doing very much apart from just ringing him, but he did say, and I know he's said to the GP several times, just knowing that there's somebody who cares and listens; it helps." (Site03_LW01)

At sites 4, 6, and 7, there were no set boundaries about the number or length of sessions and the timeframe of engagement with the link worker, allowing for more intensive and prolonged holding.

> I always get texts off her. She's ringing me all the time, checking if I'm alright and things like that. She's just really accessible in any sort of way that I need her, to be fair. . . sometimes it will be like a 10 second phone call where she'll say, "You alright? Do you need anything. Are you struggling for anything?" (Site07_P03)

3.2. What Is Needed for Holding to Take Place? Link workers needed to be flexible in addressing a wide range of patient concerns during initial appointments and often focussed on building a personal connection *with* patients, rather than connecting them *to* external resources (CMOC 4). The link worker was then better positioned to connect patients to community support in subsequent sessions (CMOC 5).

Patients found certain link worker characteristics and behaviours allowed them to open up and trust them with their story: these included empathy and using nonverbal cues such as body language, facial movements, and a gentle tone of voice to create a sense of reassurance and calm (CMOC 6, 7).

The setting and environment for patients to feel held was important. For some, this was a meeting in their own home, or on the phone, while for others this was a neutral place that felt safe to them—like the GP surgery. Link worker flexibility to create this safe environment, by giving choices, was important for holding work.

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Where it was not possible to offer options, this could create barriers to patients opening up and engaging with the link worker (CMOC 8).

> . . .unfortunately, it was over the phone and I said when I started, I don't like—and I know it sounds a bit rude—but I don't like speaking to people over the phone because in my head I feel like that person is not taking it in, not listening, because you could literally be: "yeah I'm listening" and in my head, they probably are listening, but (. . .) I don't think they are. (Site02_P01)

3.3. Holding Candidates. Our data showed that holding was not enacted for all patients; individuals with discrete needs or concerns could be supported by more transactional forms of support (e.g., completing benefit forms or referrals to relevant services). However, there were some patients for whom holding work was more likely to occur. These were typically individuals who had multiple concerns, including complex socio-economic, mental health, and physical problems, which were unlikely to be easily "fixed" by primary healthcare solutions (CMOC 2). Patients requiring support from a link worker had often experienced dramatic and simultaneous life changes by the time they sought assistance, leading to feelings of overwhelm.

> Well my mum was taken ill just before COVID, [. . .] and then when COVID was just about to come into its force whereby we got lockdowns etc., etc., she passed away. . .then we had COVID and then my wife left me and then my sister died and it's just been one thing after another, and I find myself now, I sort of lock myself away. I'm in a small flat on my own. . .I've suffered with depression for many years, and things got really bad. . .I feel very isolated, lonely, I lost confidence. . . (Site06_P08)

Some had reached a "tipping point" (Site04_LW01) resulting in deteriorating mental health and suicidal thoughts or attempts. Link workers also provided holding support to isolated patients with limited social networks, or those reluctant to seek family support due to caregiving responsibilities or family conflicts (CMOC 9). In these circumstances, the neutrality of the link worker was key.

> I thought she doesn't know me, it's not like it's a personal friend, and I thought it's nice in an anonymous kind of way. . .things that I could tell her, you know, about my family life, my feelings about my mum, you know, things like that what I probably wouldn't have been able to speak to somebody if they'd just been a friend. (Site06_P05)

3.4. Functions of Holding in Social Prescribing Work. Our analysis identified four functions of holding: supporting patients while they waited for services, sustaining them as they prepared for change, reducing the emotional labour of healthcare professionals, and bearing witness to patients' distress.

3.4.1. Holding While Waiting. Holding was often used to fill the gap whilst patients waited for mental health services or other interventions, including housing and social services provision. Many services were unable to accept referrals or had long waiting lists.

> I would say especially we hold in terms, like I said with waiting lists as well, if they've got no support at the moment, they're on a waiting list for mental health support, they don't feel like they can engage in the community until they've had the mental health support. So, we might kind of do some check-in calls. They're kind of on our books but they're kind of being held I guess. . . (Site06_LW01)

This was vital during COVID lockdowns when link workers could not connect people to community activities, and for some continued post-pandemic.

3.4.2. Holding for Change. Link workers engaged in emotional holding of people who were currently unable to take up offers of support within the community because of circumstances such as a physical or psychological difficulty, caregiving responsibilities, or socio-economic factors. This might mean the link worker did not expect the patient to be able to engage in connecting activities without considerable support.

For patients lacking motivation or confidence, holding served as a transitional step, allowing them to regain confidence in a supportive environment. Understanding their life circumstances, acknowledging their challenges and limitations, and providing hope for change were essential aspects of this process (CMOC 5).

> They're there and just waiting for me to find the confidence to contact somebody and get involved in a group- . . .in the meantime, I'm in that sort of—don't know how to describe it. I call it mid-state. I'm nearly there, I've nearly got the confidence, but I'm just not quite there yet. . . it's like I'm stuck in a void between yes and no. (Site05_P03)

Patients appreciated that link workers did not pressure them to participate in activities or meet specific goals, and commented that this prevented them from feeling overwhelmed or withdrawing (CMOC 10).

> I don't think putting pressure on me would have been any good anyway, cause I probably would have just left it and not had another appointment. (Site05_P05)

However, link worker sensitivity to varying personalities and their readiness for change was paramount since some patients benefitted from having goals.

> . . .one of my favourite things was having goals. . . I could really feel like I'd achieved something by the next time I spoke to her. (Site04_P08)

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Link workers often adopted a step-by-step approach; addressing areas of concern which could be more easily resolved, then holding the patient with less frequent contacts until the individual was ready to make more substantial changes—for example, in lifestyle or socialising (CMOC 3).

> you've got some that you're actually working with intensively now and then you've got others that . . .you're not working as intensively with but you haven't completed, you haven't closed the cases 'cause they still either want that contact or you're still checking in with them or you're waiting for various developments that you've kind of put in train. (Site03_LW01)

3.4.3. Holding to Reduce Healthcare Professionals' Emotional Labour. Link workers felt a responsibility to prevent patients from returning to a practitioner who had referred them to social prescribing (CMOC 11) and this was valued by primary care professionals.

> Having a social prescriber has been really helpful because a lot of it is social in General Practice—there's lots of things that we can't fix, but actually having someone talking is really helpful to someone. Sometimes, people have no-one else to talk to, so they come to the GP for problems that we can't fix, but having someone they can actually offload to, even, helps. . . (Site 03_HCP06)

Healthcare professionals noted that having a link worker capable of addressing specific patient needs relieved them of emotional burden during consultations, enabling them to concentrate on their expertise in clinical aspects of patient care. They also acknowledged that, reluctantly, they had sometimes medicalized issues due to their lack of capacity to provide the necessary support or holding for patients.

> I think as a GP I've always been doing social prescribing. . .I spent a longer time with patients trying to [. . .] link them up with the voluntary sector to. . .support them but obviously that took a lot of my time. . .I'd just go that extra mile but after a while that wasn't feasible or sustainable, so you ended up not doing it and therefore medicalising patients because you didn't have the time or resource. . .to really address their real core issue. . . (Site01_HCP01)

For some patients who had multiple social or mental health concerns, co-holding (or shared holding) was described, whereby primary care team members distributed and coordinated patient care. At sites 3 and 5, multidisciplinary team meetings incorporated link workers and ensured that the emotional labour was shared (CMOC 12). Co-holding also enabled shared management of patient risk (CMOC 13).

> And having a lovely big team and everything. . . cause you've always got the GPs around you to manage that (risk). (Site05_LW01)

3.4.4. Holding as Bearing Witness. Many patient concerns could not be readily "solved" by social prescribing. Socio-economic factors, including poor access to housing and impacts of the cost-of-living crisis, were frequently raised in link worker appointments but were not within their scope to alter.

> We had a spate last year of when we were doing our team meetings. . .everybody was a bit, I suppose feeling frustrated and hopeless doing housing, because with housing there's not a lot you can do. . .Certainly, some of us had to point out to GPs that we couldn't wave a magic wand and solve a patient's housing needs which is kind of what. . .GPs say, "oh yes, go and see the social prescriber and they'll sort you out, and find you a new house". . .(Site03_LW01)

This could be difficult to balance for link workers, who were often solution-focussed. Some link workers felt that they were "not doing much" (Site03_LW01) by holding people. However, for patients, creating a sense of not being alone with their difficulties was important, even if the link worker could not change the fundamental circumstances (CMOC 14).

3.5. Impact of Holding on Patients. We have shown that one of the key benefits of social prescribing to patients was in providing a space to safely unburden their frustration, sadness, and feelings that were hard to contain (CMOC 1). This made their feelings more manageable and allowed them to adopt a more hopeful mindset (CMOCs 2, 3, 5, 6).

> So, I was very happy to have the chats with (link worker) because I felt so much better and I also felt like I had hope in my life. (Site03_P09)

Having a witness to their distress made patients feel that they had worth and mattered to someone. This in turn increased their confidence to try new experiences or make lifestyle changes (CMOC 15).

> "They (link workers) actually came into that dark room and took me out of that dark room. So, they didn't ask me to come out on my own. They came and they fetched me out from there. I think for that I'm like you know truly, truly grateful. I mean I don't even think I would have had the courage you know to even do certain things, and yet I've done it, and they applaud me for that. And I'm nobody, and yet they make me feel like I'm somebody." (Site05_P06)

Patients regarded the link worker as a "rock" (Site05_P06) to which they could tether themselves at a challenging time when they could easily feel adrift or overwhelmed. Being approachable and accessible to patients was key to feeling held; when patients could contact the link worker directly, rather than going back through the GP referral system, patients felt reassured that a safety net was available once allotted sessions were completed (CMOC16).

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What was a nice part about it was I know I could have messaged her, sent her a text message, an e-mail, or rang her if I felt I couldn't cope. (Site06_P05).

Healthcare professionals and link worker managers were concerned about dependency, especially for patients who were not ready to make changes and when the wait for some services was undefined. Where there were no limits on the number and frequency of sessions patients could have, this reliance could be fostered, such that link workers became a substitute for other healthcare support (CMOC 17).

I know that some very difficult patients that I looked after over the years and found difficult have latched on, sorry, that's a bit derogatory, but that's what they do. They've latched on to the girls (link workers), so they are providing the service that the NHS used to provide previously. (Site07_HCP04)

While link workers were aware of these dangers and sought to encourage self-reliance where appropriate, they also felt responsible to support people who might not meet eligibility criteria for other services. They acknowledged the impact of socio-economic factors, recognizing that achieving independence could be difficult, or impossible, for certain patients due to a multitude of complex issues, especially in sites where deprivation was high.

3.6. Impact of Holding on Link Workers. Some link workers were initially surprised that emotionally supporting patients was part of their role, assuming social prescribing would primarily involve signposting to external groups and activities. Those with a background or training in counselling emphasised the importance of holding for patients, albeit recognizing their limitations in the link worker role.

I can signpost people, and that's what expected of me, and I'm expected to talk to people and ask good questions, but also, I can push the boundary a little bit in that I can bring in my therapeutic skills, not obviously give therapy, but have more therapeutic conversations and use therapeutic worksheets and things and actually push the boundaries. (Site02_LW01)

There were potential tensions when managers' expectations of how link workers should deliver their role (as a signposting service) were at odds with holding. At one site, the link worker was training in listening skills. Data showed her patients appreciated this expertise. However, an emphasis on throughput (number of patients seen) from the primary care clinical lead limited her time with each patient, reducing her capacity to build a relationship and fully explore individuals' needs. This caused role frustration for the link worker (CMOC 18).

In a similar way to primary care colleagues, link workers were balancing time and caseload with patient need. They recognised that holding patients could lead to a reduction in their own personal capacity, and that of the system, to see more patients (CMOC 19).

. . .the more established members of the team said be careful that you don't end up having a caseload actually 'cause we're not really supposed to be having a caseload . . . So be aware of it. (Site03_LW01)

Interview data from healthcare professionals highlighted the importance of link workers having time in their consultations to fully explore patient concerns. However, competing demands were in danger of jeopardising this principle (CMOC 18). Containing patient emotions while they waited for services, or while the patient was preparing for change, could result in frustration for link workers about apparent lack of progress with making connections for them (CMOC 20).

Link worker managers were concerned about emotional labour [32, 33] and potential burnout, due to the increase in referrals of people with many complex needs (CMOC 21). One GP supervisor reflected on the need for more protective boundaries around link workers.

I think it's that because they care and because they love their jobs that they are holding more risk than they ought to. . . it's about being able to say no, it's about remembering you've got a family life. I think it's a service that should grow in some respects, but it needs to be boundaried so that they don't end up being overwhelmed and burnt out. (Site07_HCP12)

Some link workers struggled to set boundaries because they felt a strong responsibility to assist those in need. This could lead to them taking on excessive risks to help patients, especially when waiting lists for services left them without support. In some instances, link workers were responsible for patients they felt had been "offloaded" by referrers: "Thank goodness for that, I've got somewhere to put them now" (Site07_HCP12).

Protective boundaries, clinical supervision, and peer support were recognised as approaches for link workers to manage the emotional labour associated with holding. However, line management providing access to supportive resources varied across our sites. For example, link workers at sites 1, 2, 3, and 6 were employed by larger voluntary sector organisations that provided external clinical supervision and peer support. This was not available at all sites.

Primary care practitioners acknowledged that staff self-care was not prioritised in their work setting, and that embedding link workers in this culture was not conducive to encouraging them to support their own well-being.

. . .we're not good in primary care it's a real generalisation but doctors are hopeless, nurses are almost as bad and it's too late by the time we go on and seek help for ourselves. . . (Site07_HCP04 (GP)

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It was recognised by link workers that they needed to develop their own support mechanisms, which often derived from previous workplace experience.

> . . . I've learnt probably in the police and other jobs . . . You have to learn to kind of put it to the side and go home, otherwise you'll never be able to cope with it. (Site05_LW03)

At Site 5, the lead social prescriber (PCN employed) implemented a supportive structure for her link worker team, including line management, supervision, staff wellness plans, and end-of-week team meetings. This was in response to her own challenging experiences of handling distressing calls when she was a lone link worker, carrying the emotional burden over the weekend and into the evenings.

3.7. Link with Existing Theories. Existing psychological theories of emotional containment and attachment can help us understand the positive impact of holding work performed by link workers with patients. In the psychological literature, holding involves a practitioner providing active support to patients facing difficult feelings [34] and operates both psychologically, through empathetic and non-judgmental attitudes, and physically, through making the timing and location of sessions reliable and the setting feel safe and comfortable [35]. Containment assists individuals in handling challenging emotions and avoiding overwhelming feelings, enabling them to gain perspective on their circumstances. Containment and holding are beneficial to both the practitioner and patient in preventing overwhelm [35, 36]. This concept aligns with Bowlby's attachment theory [37], which highlights the importance of maintaining close, consistent contact and offering a secure base in therapeutic relationships [38]. In our research, participants frequently depicted link workers as a steadfast and dependable presence, comparing them to a "*rock*" they could anchor to during uncertain and challenging times.

The impact of holding work on practitioners can be analysed through the concept of emotional labour [32, 33]. Hochschild observed that when employees' actual emotions do not align with required emotional display, like feeling sad or overwhelmed while needing to appear enthusiastic or supportive, two strategies are commonly used to align actions with display rules: employees either overtly express desired emotions, while suppressing genuine ones, or subtly manage emotions during interactions. Regulating emotions in this way can lead to negative impacts on employees' well-being [39] and clinical supervision may be required to manage difficult feelings that arise [40, 41]. This is an important issue for link worker managers to consider: while holding is beneficial for patients, it is not currently an explicitly discussed element of the link worker role and therefore its potential negative consequences are not recognised or supported.

3.8. Programme Theory: The Consequences of Recognizing Holding as a Legitimate Role for Link Workers. The theories of psychological containment, emotional labour, and attachment, combined with the CMOCs in Table 4, have been integrated into our programme theory (Figure 2).

Holding was an active and purposeful practice by link workers. It was highly valued by patients, providing them with support while they awaited other services or prepared for life changes. However, its significance was not generally acknowledged by link workers or healthcare colleagues.

Holding goes beyond waiting for services or witnessing distress; it can contribute to patient-centred outcomes by building confidence and motivation. Our programme theory proposes that if holding were recognised as a legitimate, valuable activity for link workers in primary care (CMOC 22) and if resources (clinical supervision, peer support, and adequate line management) and risk-sharing among professional teams were provided, positive outcomes could occur (CMOCs 12, 23, 24). This would safeguard practitioners from negative consequences of emotional labour and excessive risk management (CMOC 13), enhance job satisfaction (CMOC 22), and ultimately lead to better patient care (CMOCs 1, 5).

Our theory suggests that if holding work is deemed inappropriate for link workers and lacks proper support and supervision, several negative consequences may occur. Some of these potential consequences, shown in Figure 2, are expressed as *negative* CMOCs, which mean these are CMOCs from our analysis that has not been activated. Patients might feel rushed, unprepared for change, and pressured to achieve connecting goals (CMOC10 not activated). Link workers might feel compelled to close their sessions with patients as they are not "achieving" anything (CMOC 22 not activated). Link workers would experience capacity issues, frustration, burnout, and reduced job satisfaction (CMOCs 18, 20, 21). If holding work is *not* acknowledged as a valid part of the link worker role, patients are likely to return to primary care professionals for emotional support, confounding one of the primary objectives of the link worker role in primary care, which is to reduce inappropriate healthcare appointments (negative case of CMOC 11). This programme theory has implications for practice which are summarised in Table 5:

4. Discussion

This study has made visible the common practice of link worker holding for patients facing multiple challenges who have little existing support. Having a reliable, trusted person to hold them was a key benefit of social prescribing; it enabled patients to feel contained and reassured during "tipping points," while they were preparing to make changes in their lives or waiting for services to respond. However, link workers and their colleagues often overlooked or downplayed this aspect of the role and its potentially beneficial outcomes for patients. We argue here for its recognition and validation as part of the link worker role, provided that link workers receive adequate support and supervision.

Other studies have emphasised the importance of the continued relationship between link worker and patient, as an enabler of solution-focussed work [42, 43]. It has been

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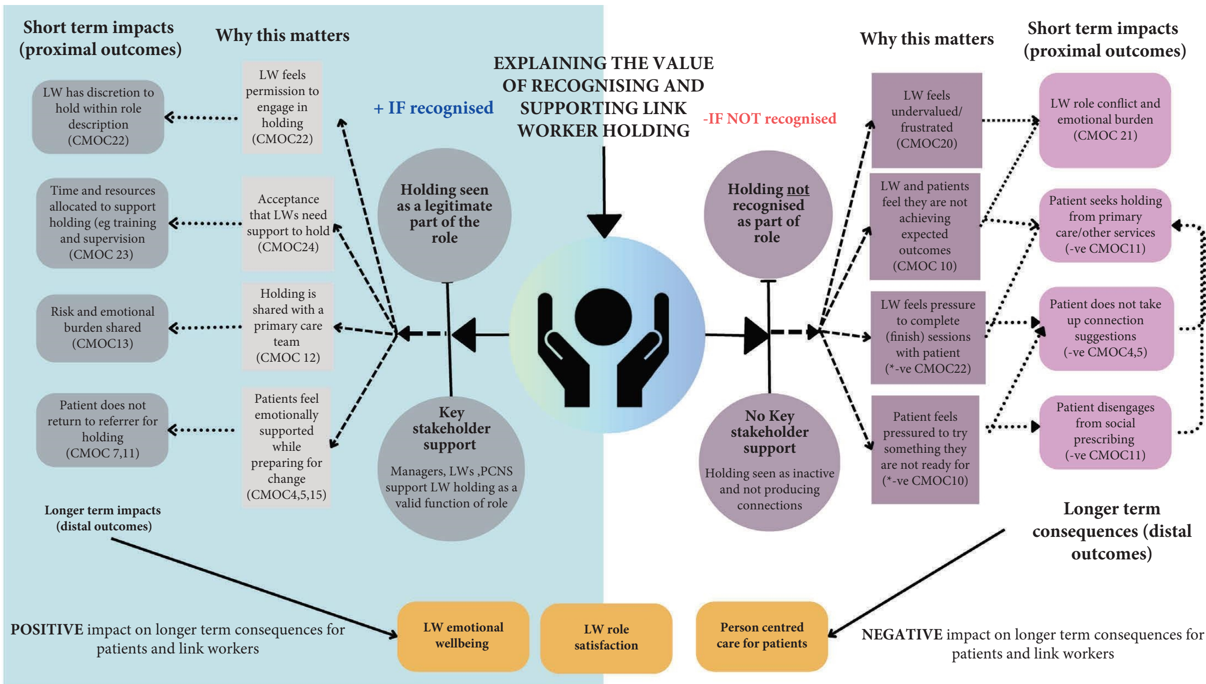

Figure 2: Programme theory of the value of recognising and support link worker holding. (*"–ve CMOCn" indicates that the numbered CMOC has not been activated—these are our theories).

Table 5: Summary of implications of legitimising and supporting link worker holding.

Key positive outcomes of legitimising holding practice for link workers (*IF adequate link worker support is provided*)		
1	*Positive patient outcomes*	Patients may benefit from increased emotional support and a more patient-centred approach, leading to improved wellbeing and self-management
2	*Reduced healthcare appointments*	Patients may rely less on primary care professionals for emotional support, aligning with the goal of reducing inappropriate healthcare appointments
3	*Enhanced patient-link worker relationships*	Acknowledging holding as a valid role can strengthen the bond between patients and link workers, promoting trust and better communication
4	*Improved link worker job satisfaction*	Link workers may experience greater job satisfaction, reduced frustration, and decreased burnout due to having a more well-rounded role that includes emotional support
5	*Lower burnout rates*	Link workers may experience reduced burnout and frustration when their role includes holding work, as it provides a more holistic approach to patient care
Key negative outcomes of holding practice (*where support* for *link workers is NOT provided)*		
1	*Negative patient outcomes*	Patients feel emotionally overwhelmed and pressured to achieve goals they may not feel ready for, therefore not able to prepare for change at their own pace
2	*Longer healthcare appointments*	Patient is likely to return to the referrer for holding support, which is time consuming for practitioners
3	*Lack of job satisfaction and frustration for link workers*	Holding practice requires permission for link workers to invest adequate time in meeting with patients without pressure to meet unachievable connecting goals
4	*Link worker burn out*	Insufficient capacity and support for holding patients with multiple challenges and risks can lead to emotional burden, potentially causing link workers to leave their role

argued that, while holding is vital for supporting patients in primary care, it is difficult to define and measure impacts of such relational work [24]. Reduction in GP appointments is seen as an important outcome for social prescribing [3]. While link worker holding will not necessarily result in reduced attendances, and indeed our previous review suggested GP attendance may increase as health concerns are uncovered by link workers [7], holding allows healthcare professionals to focus on the clinical issues that are within their remit and can reduce the emotional labour for members of the primary care team.

The need for holding can be seen as a symptom of structural issues, including scarce public services and community support, underpinned by inequities that impact health

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Table 6: Recommendations for supporting link worker holding.

	Recommendation		Related CMOcs
1	*Holding work be written into job descriptions*	It may be called something like "emotional support while patients are waiting to access services or preparing for making change in their lives"	22
2	*Link workers need flexibility in case management*	Holding work is resource intensive. This must be considered when planning social prescribing services (e.g. number, location and length of appointment) to allow LWs to hold certain patients	19, 23
3	*Link workers need allocated time to spend in the community as well as working with individual patients*	Focus on holding may have an impact on other parts of the link worker role such as opportunities to make connections in the local community	19
4	*Link workers are given support to hold*	This would constitute sharing of risk (through multi-disciplinary team meetings or other case discussions with a social prescribing team leader or clinical lead), clinical supervision, peer support and training	13, 23
5	*Holding must be person-centred*	A review of who is the most appropriate person to hold a patient is essential-it may be the link worker but could be another healthcare professional or service (including the VCS) who could best perform this function for the patient	12

and well-being. Tackling the social determinants of health is an aspiration for social prescribing [44]. It is unclear whether social prescribing has the capacity to make impacts on wider structural factors [16], and it has been argued that it may widen health inequalities [17, 45]. This creates a tension in practice for link workers. One of the functions of holding is to allow link workers to support patients through containing and witnessing their distress, even when they are not able to "fix" these issues. However, it could also be argued that link workers in the study were papering over the cracks of a failing system, unable to deal with rising needs or to tackle the root causes of health inequalities, and making demand for services less visible. It is important to recognise this potential impact and to continue to monitor alternatives to link worker holding within other services. Link worker holding will not be sustainable where its goal is to replace services; this is not beneficial for patients needing professional expertise or for link workers tasked with work which is beyond their skill set. Policy changes are also needed to tackle inequities and the socio-economic root causes of the challenges presented by many patients in this study.

Holding work involves emotional labour. Our data, alongside other studies, reveal that self-care in primary care is not prioritised [46], potentially leading to burnout and attrition, exacerbated by COVID [47]. This emotional work is being shifted to additional roles within primary care [47, 48]. Strategies for provision of emotional support for practitioners in primary care, including link workers, are vital. Link workers should be informed of this aspect of the role when recruited and if they chose to accept the role, be provided with proper support.

4.1. Implications for Practice. We recommend validating holding as a management strategy for some patients supported by link workers. Our data suggest that in certain situations, holding may be the most beneficial approach. Link workers often feel pressured to measure their success by numbers of referrals seen and sessions allocated, above the relational aspect of their role. Recognizing the importance of holding would allow them to engage more effectively with complex cases. Viewing it as a legitimate part of their role gives them permission to hold when necessary, also reducing pressure to achieve connection goals when not appropriate. That said, we must also consider the impact of holding on link workers and their caseloads. Our recommendations for practice are set out in Table 6.

4.2. Strengths and Limitations. We generated comprehensive data from a broad range of participants at primary care sites across England that varied in geographical location and socio-economic characteristics. Observations of interactions between link workers and patients enriched our understanding of the role and in particular the nonverbal elements of holding practice which would not have been gleaned from interview data alone. Observational data were key to surfacing the largely hidden work of holding, which was not often recognised or valued by practitioners or link workers themselves.

The researchers were able to build rapport with link workers and the majority of primary healthcare professionals. Through the observational work, they were aware that a small number of professionals were seen as having sceptical or very negative views about social prescribing. Multiple attempts were made to secure interviews with these sceptical staff to ensure their voice was heard. Unfortunately, and for a number of reasons (including workloads and scheduling), these attempts were not successful. That said, not everyone interviewed had only positive things to say about social prescribing.

Where feasible, researchers offered a choice of in-person interviews to patients, but this was not always possible due to geographical distances and this may have impacted our sample. Patients who agreed to participate and were able to take part in a remote interview therefore may not have been

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representative of the wider link worker caseload. Multiple attempts were made to contact patients for follow-up interviews, but not all patients were able to take part in these follow-ups.

Alongside these practical challenges, researchers experienced challenges in hearing distressing stories recounted by patients and link workers. This was supported by reflexive note taking and debriefing sessions with the team. One researcher found poetry writing a useful reflexive tool when hearing these stories [49].

5. Conclusions

Data highlighted that holding is performed by link workers in primary care. It appeared to be a valid part of their role amidst rising needs and service pressures. Patients acknowledged its importance in social prescribing. Yet, link workers, employers, and primary care colleagues often overlooked or undervalued it. Recognizing and acknowledging holding as an aspect of link worker responsibilities is essential. Adequate resources and support for emotional labour should be provided to mediate potential impact on job satisfaction and link worker retention, but link worker holding is not a substitute for policy changes needed to address health inequalities and scarce resources. If holding as an activity is ignored, we risk losing an element of the service which is valued most by patients with complex social and mental health challenges.

Data Availability

Due to the consent process for data collection with participants and sites, no data can be shared except for quotations in reports, journal articles, and presentations.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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References

[1] S. Tierney, G. Wong, and K. R. Mahtani, "Current understanding and implementation of 'care navigation' across England: a cross-sectional study of NHS clinical commissioning groups," *British Journal of General Practice*, vol. 69, no. 687, pp. e675–e681, 2019.

[2] C. Frostick and M. Bertotti, "The frontline of social prescribing-How do we ensure Link Workers can work safely and effectively within primary care?" *Chronic Illness*, vol. 17, no. 4, pp. 404–415, 2021.

[3] Nhs England, "NHS long term plan 2019," https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/.

[4] Nhs England, "NHS long term workforce plan 2023," https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/.

[5] M. Marmot, "Fair society healthy lives," 2010, https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review.

[6] M. Whitehead and G. Dahlgren, *Policies and Strategies to Promote Social Equity in Health*, Institute for Future Studies, Stockholm, 1991.

[7] S. Tierney, G. Wong, N. Roberts et al., "Supporting social prescribing in primary care by linking people to local assets: a realist review," *BMC Medicine*, vol. 18, no. 1, p. 49, 2020.

[8] S. Eaton, S. Roberts, and B. Turner, "Delivering person centred care in long term conditions," *BMJ*, vol. 350, p. h181, 2015.

[9] M. Bertotti and K. Husk, "Social prescribing, evidence and progress; the view from England," *The European Journal of Public Health*, vol. 31, no. Supplement_3, 2021.

[10] K. Husk, J. Elston, F. Gradinger, L. Callaghan, and S. Asthana, "Social prescribing: where is the evidence?" *British Journal of General Practice*, vol. 69, no. 678, pp. 6-7, 2019.

[11] Nhs England, "Workforce development framework: social prescribing link workers," 2023, https://www.england.nhs.uk/long-read/workforce-development-framework-social-prescribing-link-workers/.

[12] S. Sandhu, T. Lian, C. Drake, S. Moffatt, J. Wildman, and J. Wildman, "Intervention components of link worker social prescribing programmes: a scoping review," *Health and Social Care in the Community*, vol. 30, no. 6, pp. e3761–e3774, 2022.

[13] R. Kimberlee, "What is social prescribing?" *Advances in Social Sciences Research Journal*, vol. 2, no. 1, 2015.

[14] S. Calderón-Larrañaga, Y. Milner, M. Clinch, T. Greenhalgh, and S. Finer, "Tensions and opportunities in social prescribing. Developing a framework to facilitate its implementation and evaluation in primary care: a realist review," *BJGP Open*, vol. 5, no. 3, 2021.

[15] A. Beardmore, "Working in social prescribing services: a qualitative study," *Journal of Health, Organisation and Management*, vol. 34, no. 1, pp. 40–52, 2019.

[16] K. Gibson, T. M. Pollard, and S. Moffatt, "Social prescribing and classed inequality: a journey of upward health mobility?" *Social Science and Medicine*, vol. 280, 2021.

[17] A. Moscrop, "Social prescribing is no remedy for health inequalities," *BMJ*, vol. 381, p. p715, 2023.

[18] S. Cocksedge, R. Greenfield, G. K. Nugent, and C. Chew-Graham, "Holding relationships in primary care: a qualitative exploration of doctors' and patients'

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perceptions," *British Journal of General Practice*, vol. 61, no. 589, pp. e484–e491, 2011.
[19] M. Balint, "The doctor, his patient, and the illness," *The Lancet*, vol. 265, no. 6866, pp. 683–688, 1955.
[20] J. Popay, U. Kowarzik, S. Mallinson, S. Mackian, and J. Barker, "Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part II: lay perspectives," *Journal of Epidemiology and Community Health*, vol. 61, no. 11, pp. 972–977, 2007.
[21] C. A. Chew-Graham, C. R. May, and M. O. Roland, "The harmful consequences of elevating the doctor–patient relationship to be a primary goal of the general practice consultation," *Family Practice*, vol. 21, no. 3, pp. 229–231, 2004.
[22] P. Stewart and T. O'Dowd, "Clinically inexplicable frequent attenders in general practice," *British Journal of General Practice: The Journal of the Royal College of General Practitioners*, vol. 52, no. 485, pp. 1000-1001, 2002.
[23] D. Mangin and L. Toop, "The Quality and Outcomes Framework: what have you done to yourselves?" *British Journal of General Practice*, vol. 57, no. 539, pp. 435–437, 2007.
[24] S. Cocksedge and C. May, "Pastoral relationships and holding work in primary care: affect, subjectivity and chronicity," *Chronic Illness*, vol. 1, no. 2, pp. 157–163, 2005.
[25] G. K. Freeman, "Holding relationships in general practice: what are they? How do they work? Are they worth having?" *British Journal of General Practice*, vol. 61, no. 589, pp. 487-488, 2011.
[26] G. Wong, G. Westhorp, J. Greenhalgh, A. Manzano, J. Jagosh, and T. Greenhalgh, "Quality and reporting standards, resources, training materials and information for realist evaluation: the RAMESES II project," *Health Services and Delivery Research*, vol. 5, no. 28, pp. 1–108, 2017.
[27] R. Pawson, *The Science of Evaluation: A Realist Manifesto*, SAGE Publications Ltd, London, UK, 2013.
[28] R. Pawson and N. Tilley, *Realistic Evaluation*, Sage, London, UK, 1997.
[29] E. De Weger, N. J. E. Van Vooren, G. Wong et al., "What's in a realist configuration? Deciding which causal configurations to use, how, and why," *International Journal of Qualitative Methods*, vol. 19, p. 160940692093857, 2020.
[30] H. Knoblauch, "Focused ethnography," *Forum Qualitative Sozialforschung/Forum for Qualitative Social Research*, vol. 6, no. 3, 2005.
[31] C. Trundle and T. Phillips, "Defining focused ethnography: disciplinary boundary-work and the imagined divisions between 'focused' and 'traditional' ethnography in health research – a critical review," *Social Science and Medicine*, vol. 332, 2023.
[32] A. R. Hochschild, "The managed heart," *Working in America*, pp. 40–48, Routledge, London, UK, 2022.
[33] A. Williams, "Hochschild (2003)-the managed heart: the recognition of emotional labour in public service work," *Nurse Education Today*, vol. 33, no. 1, pp. 5–7, 2013.
[34] M. W. Böhmer and C. Krüger, "Therapeutic relationships and the problem of containment: experiences of patients at a psychiatric training hospital," *South African Journal of Psychiatry: SAJP: the journal of the Society of Psychiatrists of South Africa*, vol. 25, no. 0, p. 1246, 2019.
[35] R. Glasgow, "Holding and containing a couple through periods of high intensity: what holds the therapist? Australian and New Zealand," *Australian and New Zealand Journal of Family Therapy*, vol. 38, no. 2, pp. 194–210, 2017.
[36] T. H. Ogden, "On holding and containing, being and dreaming," *The International Journal of Psychoanalysis*, vol. 85, no. 6, pp. 1349–1364, 2004.
[37] J. Bowlby, "A secure base," *Parent-Child Attachment and Healthy Human Development*, Basic Books, New York, NY, USA, 1988.
[38] P. Gilbert, "Compassion: from its evolution to a psychotherapy," *Frontiers in Psychology*, vol. 11, 2020.
[39] S. Cote, "A social interaction model of the effects of emotion regulation on work strain," *Academy of Management Review*, vol. 30, no. 3, pp. 509–530, 2005.
[40] D. Holman, D. Martinez-Iñigo, and P. Totterdell, "Emotional labor, well-being, and performance," in *The Oxford Handbook of Organizational Well Being*, Oxford University Press, London, UK, 2008.
[41] D. Martínez-Iñigo, P. Totterdell, C. M. Alcover, and D. Holman, "Emotional labour and emotional exhaustion: interpersonal and intrapersonal mechanisms," *Work and Stress*, vol. 21, no. 1, pp. 30–47, 2007.
[42] K. Walker, C. Griffiths, and H. Jiang, "Understanding the underlying mechanisms of action for successful implementation of social prescribing," *Open Journal of Preventive Medicine*, vol. 13, no. 02, pp. 41–56, 2023.
[43] J. Thompson, E. Holding, A. Haywood, and A. Foster, "Service users' perspectives of a national social prescribing programme to address loneliness and social isolation: a qualitative study," *Health and Social Care in the Community*, vol. 2023, pp. 1–8, Article ID 5319480, 2023.
[44] Ohid, "Social prescribing: applying all our health," https://www.gov.uk/government/publications/social-prescribing-applying-all-our-health/social-prescribing-applying-all-our-health.
[45] B. Kiely, A. Croke, M. O'Shea et al., "Effect of social prescribing link workers on health outcomes and costs for adults in primary care and community settings: a systematic review," *BMJ Open*, vol. 12, no. 10, p. e062951, 2022.
[46] R. Riley, J. Spiers, M. Buszewicz, A. K. Taylor, G. Thornton, and C. A. Chew-Graham, "What are the sources of stress and distress for general practitioners working in England? A qualitative study," *BMJ Open*, vol. 8, no. 1, p. e017361, 2018.
[47] J. Sheather and D. Slattery, "The great resignation—how do we support and retain staff already stretched to their limit?" *BMJ*, vol. 375, p. n2533, 2021.
[48] B. Baird, L. Lamming, B. Ree'Thee, B. Jake, and V. Dale, *Integrating Additional Roles into Primary Care Networks*, The King's Fund, UK, 2022.
[49] D. Westlake, "Creative enquiry-the interview," *Society for Academic Primary Care*, vol. 248.

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