Health & Social Care in the Community

WILEY

RESEARCH ARTICLE OPEN ACCESS

Using the Candidacy Model to Understand Service Users' Experiences of Access to Social Prescribing

Peter Unwin[1] | Coco Burnside[2] | Nick Evans[3] | Frances Howie[1]

[1]School of Health and Wellbeing, University of Worcester, Worcester, Worcestershire, UK | [2]Institute of Health, University of Cumbria, Carlisle, UK | [3]School of Science and the Environment, University of Worcester, Worcester, Worcestershire, UK

Correspondence: Peter Unwin (p.unwin@worc.ac.uk)

Received: 1 July 2025 | **Revised:** 18 January 2026 | **Accepted:** 4 February 2026

Academic Editor: Mohammad Niroumand Sarvandani

ABSTRACT

Social prescribing is an increasingly well-known international model of healthcare, yet there is little agreement about its role and efficacy. This paper comprises a secondary analysis of findings from service users in a small-scale (n.8) qualitative study in the English Midlands using the approach of candidacy, a comprehensive framework with the potential for achieving a deeper understanding of social prescribing. Participants were accessed through local social prescribing link workers, who were located within general practitioner services. A candidacy approach recognises that the ways in which individuals perceive their health needs are key to understanding how or why they assert a claim to be a candidate for services. The aim of the paper is to add to the voices of lived experience within social prescribing and to explore whether the application of a candidacy framework brings about new insights. The original study on which this paper is based employed a mixed-methods approach in one clinical commissioning group area with a significant rural population. The secondary analysis brought forth three new themes not originally illuminated—accessibility of the service (permeability), financial constraints (appearances) and relationships with social prescribing link workers (adjudications).

Recommendations are that communities, and especially rural ones, need to be made more aware of their local social prescribing offers, that social prescribing staff take fuller account of individuals' contexts and that healthcare staff need to be clear about how services are explained. Further larger-scale research is needed to demonstrate the ways in which candidacy theory can remain relevant within increasingly digitalised and complex health services where the opportunities for face-to-face negotiation are limited.

1 | Introduction

This paper explores research findings regarding service user engagement with social prescribing services through the lens of 'candidacy' [1]. Social prescribing is a model of healthcare support facilitated by social prescribing link workers, non-professional staff whose role is to connect individuals to a range of nonmedical services in the community [2]. This support can, for example, include gardening projects, debt or financial advice, adult education and healthy living programmes. Historically, social prescribing schemes in the United Kingdom have developed organically and been highly diverse in both definition and practice. Thus, they are analogous with a locally driven 'bottom-up' approach to healthcare [3]. Social prescribing became a formal system of the National Health Service (NHS) via its Long-Term Plan [4] and represents a 'top-down' approach, in principle enabling greater consistency and equality in access to and provision of social prescribing across the entire United Kingdom.

One of the main benefits claimed by proponents of social prescribing is that it has the ability to address health inequity [5, 6]

through its focus on the consequences of people's social, economic and physical environmental contexts [7, 8]. Dayson and Bennett [9] stated that additional outcomes of social prescribing include increased employment, improved physical health and long-term financial benefit. However, such initiatives must be physically and financially accessible if they are to engage marginalised populations [10]. For example, rural dwellers facing transport barriers may be unable to access service locations that might be readily accessible for urban dwellers. Thus, contrary to widely held assumptions, it can be argued that social prescribing might inadvertently increase health inequity.

Lorenc et al. [11], p.190, explained how the 'inverse prevention law' means that those most in need of preventative interventions can be the least likely to receive them, going on to claim that even when interventions successfully improve overall population health, they may also serve to increase health inequalities. This implies that because social prescribing is an individually targeted intervention which focuses on personal behaviour change, it may be ineffective at reducing overall health inequity. Similarly, Gibson et al. [12] asserted that social prescribing has the potential to exacerbate, rather than reduce, health inequalities. These perspectives correlate with the findings of Mackenzie et al. [13], p.1, who argued that social prescribing could be labelled as a 'fantasy paradigm' in that it deploys individual-level health interventions which will never be able to address the underlying political, social and cultural determinants of health. Given such general concerns about the efficacy of social prescribing, it is appropriate to further unpack the way in which it functions in order to better understand its scope and limitations. Dixon-Woods et al., [14], p.1), in a critical interpretative review of the literature on access to healthcare, stated that candidacy theory offered 'a useful means of understanding access' to healthcare. Similarly, Mercer et al. [6] identified candidacy as a helpful framework for explaining the differences in social prescribing outcomes noted above, especially amongst vulnerable groups. Westlake et al. [15], p.3, however, placed greater emphasis on social prescribing link workers performing a valued and consistent 'holding' role for vulnerable individuals in an NHS system which did not otherwise offer much emotional support.

The main aim of this paper is to explore whether the core constructs of the candidacy framework, such as perceived eligibility, suitability and deservingness, might apply to the different manifestations of social prescribing services. In so doing, it draws upon views elicited from eight service users across one English clinical commissioning group who were enrolled in a larger project researching the professional identities of social prescribing link workers [16]. The construct of candidacy is first explored below, followed by a discussion of methodology and project design. Findings from semistructured interviews are then presented and analysed against the candidacy framework assembled by Dixon-Woods et al. [1], leading to conclusions and recommendations regarding best practice and future research directions.

2 | Candidacy and Social Prescribing

A candidacy framework has previously been used to describe the ways in which potential service users' eligibility for healthcare and medical intervention is jointly negotiated between themselves and services [1]. Candidacy is a dynamic and contingent process which is continually defined and redefined through the interactions between healthcare professionals and individuals [14]. Social prescribing represents a structured approach through which link workers support patients in a negotiated and person-centred process that is bounded by structural and resource constraints. Referrals to social prescribing should function as offers rather than commands, and engagement depends on the patient's own motivation and capacity to act [17]. While negotiation and co-production are central to effective social prescribing, the boundaries of ethical practice and safeguarding considerations are inherently present in social prescribing systems. Measures of service utilisation are argued to be inefficacious in understanding access to healthcare because they do not acknowledge how individuals present to services, nor how their candidacy is judged by healthcare professionals, what offers of intervention are made, and whether individuals choose to accept these offers. The construct of candidacy is particularly useful for exploring access to social prescribing because it provides a comprehensive scaffolding to help understand how an individual's eligibility and suitability for healthcare interventions are negotiated and recognised. Candidacy goes beyond the clinical criteria for access and delves into the social, economic, cultural and organisational dynamics that influence whether and how individuals are identified as suitable candidates for healthcare interventions and then negotiate their access.

Dixon-Woods et al. [14] argued that the accomplishment of access to healthcare requires significant work on behalf of the service user, identifying seven aspects or factors which shape, impact or obstruct their continued journey of candidacy, namely: (i) identification of candidacy, (ii) navigation, (iii) permeability, (iv) appearances at health services, (v) adjudications, (vi) offers and resistance and (vii) operating conditions and the local production of candidacy.

2.1 | Identification of Candidacy

Identification of candidacy refers to how individuals recognise that their symptoms require medical attention [14] and that accomplishing access to health services requires considerable effort on their part. The amount, difficulty and complexity of this engagement, particularly given the growth of online access points for most health services, may all act as barriers. The level of challenge for marginalised populations to assert candidacy is therefore significant.

Dixon-Woods et al. [1] argued that the ways in which people recognise their health and symptoms as meritorious of medical care are fundamental to understanding how or why they assert a claim to candidacy. They found that people in more deprived situations were likely to recognise candidacy as a series of crises and to only seek intervention in response to specific events that are perceived as warranting candidacy.

2.2 | Navigation

According to Dixon-Woods et al. [1], navigating a route to enter or maintain engagement with health services requires the mobilisation of a range of resources. This includes knowledge and information, as well as practical resources. They argued that more marginalised populations have less access to these resources, which may obstruct their continued candidacy. As a first

step, potential service users must have knowledge of the services on offer. Dixon-Woods et al. [1] highlighted a concern that less affluent communities may lack awareness and knowledge of services such as social prescribing. More affluent people tend to know doctors and healthcare professionals socially and thus acquire shared knowledge which is unobtainable by marginalised populations [18, 19].

Navigating candidacy also requires the mobilisation of a range of practical resources (Dixon-Woods et al. [14]). A key resource is transport, which the lack of access to, or availability of, has a significant impact on socioeconomically disadvantaged populations, particularly in rural areas [20, 21]. The theory of candidacy enables further understanding in terms of when marginalised individuals access services despite financial barriers. Evidence from Goddard and Smith [22] demonstrated that more marginalised social groups perceive financial costs of attending health services to be a barrier, although this is not sufficient to deter them when they experience an acute issue.

2.3 | Permeability

The third pertinent aspect of candidacy is the permeability of services and how easy it is to find a way through them. Permeable services are those which require fewer qualifications of candidacy and the mobilisation of fewer resources to use. Alternatively, less permeable services require more qualifications such as meeting the conditions for referral, and increased cultural alignment between service users and healthcare professionals. Dixon-Woods et al. [1] provided the example of appointment systems decreasing permeability for disadvantaged populations due to requiring resources such as a stable address, literacy and the ability to attend appointments at specific times.

2.4 | Appearances at Health Services

Appearing at health services, whether in person or virtually, involves individuals asserting their claim to candidacy. In-person appearances provide more opportunity to explain health issues, particularly for those unsure of medical terms and lacking knowledge about systems and onwards referral. Liberati et al. [23] explored how the COVID-19 pandemic in particular had resulted in reduced permeability for many service users. Their participants reported that system-wide service changes caused increased challenges in accessing mental health services, which also remained challenging to navigate after acceptance, partly because of increased digitalisation.

2.5 | Adjudications

The fifth relevant factor regarding candidacy is that of 'adjudications' ([1], p.191), whereby the professional judgements of healthcare professionals regarding the presenting service users' candidacy significantly impact subsequent access to health services and interventions. Healthcare professionals were seen to make decisions based on moral beliefs regarding service users' 'deservedness', and service users who were judged potentially to benefit most from interventions were those deemed most likely to be 'worthy' of it. Annandale et al. [24] claimed that such judgements are strongly related to healthcare professionals' local operating environments and resource constraints. In this way, professionals could be argued to be acting as 'street-level bureaucrats' who interpret top-down policy and protocols at a face-to-face level [25]. The work of Liberati et al. [23], who described the way in which health professionals made individual decisions during the COVID-19 pandemic, has resonance with this street-level bureaucracy concept. They found that healthcare professionals were routinely confronted by complex decisions and ethical dilemmas about care provision and that the way they made judgements about access was likely to have had important implications for equity.

2.6 | Offers and Resistance

Candidacy theory recognises that some people will exercise agency by either taking up, resisting or refusing an offer of services. Resistance to taking up an offer may be due to apprehension, lack of understanding of what the offer might comprise, or an inability to afford or access a specific service. People may not agree with professional decisions, or a service offered may not be acceptable in sociocultural terms. For example, in many Romani and Traveller cultures, men may refuse to participate in a talking therapy offer because being open about mental ill-health is seen as a weakness. Similarly, some Romani and Traveller women may refuse a health service offered by a male professional [26].

2.7 | Operating Conditions and the Local Production of Candidacy

Dixon-Woods et al.'s [1] final aspect of candidacy refers to the perceived or actual appropriateness and availability of services, including the macrostructural factors impacting people's candidacy positioning. The rapid and far-reaching changes in health services brought about by the COVID-19 pandemic saw many face-to-face interchanges being replaced by remote and online services. These macrolevel changes were largely accepted without question given the health threat that the pandemic posed to health professionals and patients alike [27]. However, in order for service users to be able to exercise their candidacy, they need to be made aware of the ways in which their local health services are to be delivered, especially at times of large-scale system change.

In summary, given that social prescribing typically operates as an individually targeted intervention focused on behavioural change, its capacity to address structural determinants of health is limited. Mackenzie, Skivington and Fergie [13], p.1, characterise it as a 'fantasy paradigm', suggesting that individual-level interventions are insufficient to address the political, social and cultural foundations of health inequity. It is, however, important to pay attention to the individual-level lived experience of how social prescribing works in practice. Candidacy theory might be seen to offer a valuable framework for such analysis, Dixon-Woods et al. [14] emphasising the potential of such an approach as a helpful framework for understanding access to healthcare, emphasising the negotiated and dynamic processes through which individuals come to be seen as eligible for services. Previous research has suggested that candidacy may help explain variations in social prescribing outcomes, particularly among vulnerable populations [6]. However, the application of candidacy to social prescribing remains underdeveloped; hence, this paper's adoption of a candidacy approach to help illuminate service user perspectives on social prescribing services.

3 | Methods

The data presented in the following are derived from a larger research project, the details of which have appeared elsewhere in this journal [16, 28]. In this larger project, the focus was on the roles of social prescribing link workers and the fit of their work with the NHS model. Mixed methods using semistructured interviews and surveys with staff and service users were employed for this original research. All interviews were audio-recorded and transcribed, with the subsequent transcripts being sent to participants for ratification, as recommended by Cresswell (2013). The interviews took place during the summer and autumn of 2022 within one clinical commissioning group spanning two English Midland counties. These contained nine out of the ten geographical area types identified in Defra's Rural Urban Classification (2021) [29], thereby covering the full range of urban and rural environments outside of the 'Urban: Major Conurbation' category, although they were generally more rural and less ethnically or socioeconomically diverse than the national average. It must be emphasised that the following sections represent a secondary analysis of the original data gathered as part of the above research study, focussing on service users' personal experiences and perceptions of social prescribing. The original data were thoroughly reviewed and re-coded by the research team in the light of the discovered relevance of candidacy theory. The original study had received NHS ethical approval (IRAS ID: 249236).

3.1 | Design

A critical realist approach characterised the original research project, combining the beliefs that a real world exists independently of human perception and that our understanding of the world is inherently mediated by our own socialisation and social context [30]. Such an approach has been argued to be appropriate within primary care research, as it seeks to understand the complexity of services whilst incorporating perspectives of social reality [31]. Due to the exploratory nature of the research, qualitative semistructured interviews were viewed as appropriate because they allowed for the building of rapport with participants, an ability to qualify or explain questions, and opportunities to ask for elaboration of initial responses [32–34]. Interviews were then conducted with current or recently discharged service users of social prescribing services, exploring participants' health and social backgrounds; experiences of social prescribing referral processes; initial perceptions of social prescribing; preferences surrounding models of health and rapport with social prescribing link workers; impact of geographical location upon access to social prescribing; transport; costs of engaging with social prescribing and issues of access. Retrospectively, many of the responses obtained via such probing were found to have relevance to the candidacy factors discussed above—identification of candidacy; navigation; permeability; appearance at health services; adjudications, offers and resistance; operations conditions and the local production of candidacy as perceived by the participant.

3.2 | Recruitment and Interview Process

Participants were recruited for the original project through social prescribing link workers, most of whom were based within general practitioner services. All social prescribing link workers who had expressed an interest in assisting with recruitment were emailed with details of inclusion and exclusion criteria, participant information sheets and consent forms. Inclusion criteria defined participants as having a minimum age of 18 years old, not being known to be experiencing physical or mental crises, having sufficient English language abilities to participate, and not having concerns regarding mental capacity. Recruitment efforts resulted in responses from six social prescribing link workers who, in turn, provided contact details for a total of 11 service users. Three potential participants did not respond to attempts to reach them. It was deemed inappropriate to contact a person more than three times to avoid them feeling pressurised to participate, with one voicemail or email message left at the final attempt. Therefore, a total of eight interviews took place with participants whose ages ranged from 26 to 89 years old, the majority being aged over 60. All were White British, and none were in employment at the time of the interview.

Interviewees were offered the choice of location for their interview. Two participants chose to be interviewed in their homes, and six requested telephone interviews. Home visits were considered low risk, as all participants had been referred by social prescribing link workers with no concerns reported. Lone working policies were followed to provide safety for the researcher. Interviews commenced by introducing the research and the researcher, lasting on average approximately 50 min. The confidential nature of the research was stressed, and the chance to ask questions or withdraw without any need for concern was reiterated to participants. Participants' names have been anonymised in the following using pseudonyms that they chose.

Three main challenges were encountered in the original interview process. First was the issue of memory. Three interviewees specifically disclosed having memory issues and others could not fully remember their social prescribing experience, including their route of referral or the services to which they had been referred. Second, some participants continually digressed from the topic of social prescribing, possibly because of their uncertainty about its essence. Third, there was some ambiguity regarding the nature of social prescribing. A majority of participants were unsure how they became involved or whether social prescribing was related to the NHS. One person did not know how they were referred to their social activity group, despite this having been arranged by a social prescribing link worker, and two referred to their social prescribing link workers by different titles, such as 'social worker' or 'social provider.' These challenges in themselves were revealing about the local operating conditions of social prescribing services, such a poor level of understanding clearly inhibiting any potential for the exercise of candidacy.

3.3 | Data Analysis

Data were transcribed verbatim using NVivo 12 software to assist in its organisation. This is a commonly used tool to help support thematic analysis and thus to identify, analyse and interpret commonly occurring patterns, or 'themes,' within a dataset [35–38]. Establishing codes associated with distinctive blocks of descriptive text within the transcribed interviews, such as that referring to the 'length of social prescribing session,' represented the initial data coding. The software was especially valuable for enabling codes to be recorded, moved into different orders,

recoded and reorganised as the analysis progressed. In this way, overarching themes could be built up; for example, 'engagement,' which captured the 'length of session' code alongside others including motivation and lifestyle. Revision of themes then occurred over subsequent weeks, rereading the data associated with codes and 'stepping away' to consolidate patterns and interpret data in different ways. As directed by Braun and Clarke [39], there was a focus upon reflection, rigour and deep engagement with the data, appropriate to qualitative analysis. For the purposes of this paper, the data codes associated with the interview transcripts were specifically extensively reworked to cross-reference them against the pre-established factors of candidacy.

4 | Findings

The original study [16, 28] had found that the day-to-day practice of social prescribing varied considerably across the clinical commissioning group area; that rates of referral to social prescribing services were low; and that service users were generally positive about their social prescribing experiences, although they were unsure about how they had become involved and about what agency they had within the social prescribing system. Secondary analysis of the original study, via re-evaluating the data under a candidacy framework, was subsequently discovered to offer the possibilities of new insights into social prescribing through the perspectives of service users. Three new themes were produced that can be seen to represent significant insights into the future effectiveness of social prescribing. These themes chime directly with some key principles of candidacy theory and illustrate its relevance—accessibility of the service (permeability), financial constraints (appearances) and relationships with social prescribing link workers (adjudications). These themes are considered in more detail in the following, alongside the other components of candidacy theory—identification of candidacy, navigation, offers and resistance and operating conditions.

4.1 | Accessing Social Prescribing

The service user participants in this research reported their sex as being six females and two males. Seven participants successfully accessed social prescribing through their general practitioner or primary care provider, with the exception of one person who was unsure how he had been referred. Participants disclosed experiences of a range of physical and mental conditions which could influence their ability to access social prescribing services if this required in-person attendance. For example, seven of the eight participants had one or more physical issues such as joint or mobility problems, diabetes, long COVID or fibromyalgia. Six participants reported some form of depression or low mood. One of these participants reported feeling actively suicidal around the time of their original referral, a concern which was being addressed elsewhere.

Six participants reported being able to drive and having access to a private vehicle. The two nondrivers were Billy and Bub. Billy's wife drove him to groups, whereas Bub had no access to transport and could only attend very local groups. Bub lived in an urban location with many amenities within walking distance. However, due to fibromyalgia and having a young baby, she could walk only short distances and struggled to access the steps to her flat with a pushchair. Participants often raised the availability of public transport, with Mary Louise and Roxy stating that rural provision was poor and expensive:

> Roxy - '*They only have about one bus a day here now, I think. They used to have a proper bus service. There's a bus stop up the road, but the government you know... no public transport!'*

4.2 | Financial Barriers

The financial cost of attending groups appeared to significantly influence appearances at services. Three participants reported that the expenses associated with the groups recommended by their social prescribing link workers were a barrier to their attendance. Three participants had attended (and been offered) groups which were free of charge, while two reported paying to attend at least one group. There was disagreement among participants regarding whether or not cost would prevent engagement. When asked if he was happy to pay the £5 per attendance fee for a horticultural therapy programme, Roxy replied: *'Oh yes! You can't expect something for nothing you know!.* Alternatively, Bub and Dianne would not have attended their recommended groups had there been a cost involved. Billy reported that the only activity he had been offered, a fitness class, cost £2 per session. He was happy and able to pay for this but felt he could not afford anything more expensive:

> Billy - *'Cost would be an issue obviously just because of our financial capabilities at the moment, Umm, both my wife and I are off work, both for physical and mental health reasons.'*

4.3 | Relationships With Social Prescribing Link Workers

Here, the data were reconsidered with respect to adjudication, another key principle to which candidacy draws our attention. Face-to-face contact has been argued to be an essential aspect of social prescribing and was included in Polley et al.'s [19] definition of the practice. This is because healthcare professionals can use such encounters to gain more complete knowledge about individuals in order to judge the level of need and the type of intervention that would be most beneficial. Nevertheless, this mode of contact was not found to be prevalent with the eight participants interviewed above, where it appeared that participants had no influence over the mode of contact with their social prescribing link workers. Two stated they had never met their social prescribing link workers face-to-face, and five mainly held phone consultations, with face-to-face meetings being the exception.

Participants' views on their relationships with social prescribing link workers suggested that these were relational, affective and iterative rather than being a discrete series of adjudications. Service users reported that social prescribing link workers were seen as like themselves, rather than as clinical professionals:

> DP - *'...[is] not like seeing a doctor, and it's not like seeing the mental health people at the doctors.'*

> Billy - *'doesn't come across as sort of an NHS sort of worker. Erm, he comes across as erm, as like a friend... He didn't come*

across as like judgemental or... some GPs that I've seen in the past, what they say was quite stuffy and quite set in their ways.'

Billy explained how his social prescribing link worker: '*texts me about football, you know, he just texts us. Did you like that result? Or something like that.*' These quotes demonstrate how Billy did not originally expect cultural alignment between himself and NHS staff. Yet, from his social prescribing link worker being friendly, open and sharing interests such as football, it enabled him to feel as though he was on a shared journey and, hence, to continue his journey of candidacy. This would have been unlikely if the social prescribing link worker had been as he expected—"*stuffy*." The above narratives suggest that non-judgemental interactions encourage candidacy take-up, Billy's account showing that adjudication is not simply about eligibility but about whether individuals feel recognised, safe, and morally accepted within the service. The report of one form of social prescribing relationship having lasted over five years is perhaps unusual, but it does challenge any view that social prescribing is primarily about gatekeeping and resolution, supporting the argument that social prescribing can operate on a relational and iterative footing.

The logistical restrictions of the social prescribing link workers were noted by some participants, resonating with the 'offers and resistance' principle of candidacy theory. Billy explained that despite the holistic approach of their social prescribing link workers in her consideration of his wider family dynamics, they were unable to provide any formal assistance for his daughter, as she was under 18 years old. His social prescribing link workers were only able to point him 'in the right direction.' Dee was 'only allowed so many times,' referring to having a finite number of sessions with her social prescribing link worker. Sparrow discussed how time constraints on her social prescribing link workers had led to short sessions and the lack of a meaningful relationship, in which she felt she had no agency.

5 | Discussion

A core finding of the original study [16, 28] was that no service user participants had any prior knowledge about social prescribing, and although largely positive about their overall experience, most were unsure about how they came to be a recipient of their social prescribing service. Participants did not reflect in any great depth about experiences of negotiation, offers and appearances which is perhaps not surprising given their lack of engagement with the whole process from referral to appearance. However, had the research team been aware of the theoretical framework which candidacy offered to their exploration of social prescribing, then participants may have been encouraged to delve more deeply into the possibilities that negotiations did in fact take place between social prescribing link workers and themselves. The relative passivity of service users reported in the original study might thereby have been challenged had the research team adopted candidacy as an approach to explore issues of access, negotiation and outcomes in greater depth.

In the clinical commissioning group area studied, a lack of consistency was apparent in the practices of social prescribing link workers, relationships with service users having primarily been developed via telephone calls, rather than in-person. This led to variations in the ways individuals navigated the social prescribing system, although a general pattern of contact identified was one of initial telephone contact followed by monthly check-up calls until case closure. The two exceptions to this pattern were evidenced where in person contacts lasted some months. Despite the dominance of the telephone-based approach, five of the eight participants expressed positive views of their social prescribing link workers, the remaining three participants not feeling able to comment due to their minimal contact or lack of recall. However, even in the positive accounts of interactions, no views were directly expressed that might be taken as demonstrating meaningful in-depth involvement in candidacy negotiation between service users and professionals. This may partly be attributed to the perfunctory nature of many human interactions during the COVID-19 pandemic, when technicist modes of service delivery dominated, and it may also be that both service users and social prescribing link workers were unaccustomed to negotiating their healthcare needs in any setting. Service users may have been grateful to receive any kind of service in times of pandemic and hence may not have felt comfortable asserting their agency in any potential negotiating processes.

The above findings suggest that contextual factors, rather than organisational factors alone, influence the permeability of social prescribing services. Physical and mental illness, caring duties, and the logistics of rural transport all impact on the meaningful access to services. Dixon-Woods et al. [1] conceptualised permeability primarily in terms of organisational openness, the above narratives suggesting that while services might purport to be open to all, they remain functionally impermeable when individuals' contextual issues are taken into account. Bub's above narrative is illustrative here in that she is aware of services, but her candidacy for these services is constrained by her parenting responsibilities and her lack of appropriate transport. Bub's narrative suggests that permeability might be seen as more than service design and that it should embrace the alignment between service parameters and individual living contexts.

With respect to permeability, the NHS model of social prescribing includes referrals being made from local authorities and other agencies and also expects there should be a clear and easy process for self-referral [40]. There may indeed have been provision for self-referrals, but as participants were unaware of social prescribing prior to their involvement, they would have been unable to refer themselves and thereby unable to exercise candidacy from the position of having initiated such interaction.

Six participants had internet access, demonstrating that digital technologies may potentially enable rural people or those with mobility or travel difficulties to access social prescribing. For example, Fixsen et al. [41] argued that digital technology may enable people to engage in social prescribing from a distance, provided that they have sufficient digital literacy. During the COVID-19 pandemic, Fixsen, Barrett and Shimonovitch [27] found that the enforced move to online services and activities was beneficial for service users who were previously unable or unwilling to attend sessions in person. They claimed that, despite social prescribing originally being conceptualised around in-person relationships, the pandemic and recent technological developments have altered the landscape. Nevertheless, digital-only healthcare would have excluded the two participants in this

research who did not have internet access. These two participants, Roxy and Sparrow, both lived in villages and relied on ad hoc private transport to reach services due to a lack of public transport provision. It is clear that a permeability 'solution' for one individual (such as a move to online provision) can actively create obstacles for another, with candidacy theory here helping us to be mindful that barriers to access can take numerous forms and remain persistent. Thus, applications of candidacy theory should be far more sensitive to geographical contexts.

Participants differed considerably in whether payment for attending socially prescribed services was perceived as acceptable, expected, or exclusionary. Roxy's assertion that one "can't expect something for nothing" contrasts sharply with Bub and Dianne's inability or unwillingness to engage with paid activities. Such service user perspectives resonate with the candidacy construct of 'appearances' but also reveal a moral dimension which is governed not only by material considerations but also by moral evaluations of deservingness, value and legitimacy. Dixon-Woods et al. [1] recognised that appearances involve negotiation, but the above narratives demonstrate that internalised moral discourses shape whether individuals feel entitled to participate at all.

These above remarks highlight how, particularly in times of austerity, there is a lack of choice open for onwards referral by social prescribing link workers. Participants reported that their mental health struggles, combined with financial and housing worries, sometimes prevented them from taking up new opportunities. The evidence demonstrates how candidacy is a socioeconomic product, with the ability of individuals to present themselves at this stage of the process serving to support the claims of Gibson, Pollard et al. [42] that social prescribing has the potential to exacerbate existing inequalities rather than to reduce them.

One social prescribing link worker in Moore et al. [16] stated that individuals must be willing to engage and open to help for them to be appropriate for referral to social prescribing services. This type of adjudication conflicts with any notion of negotiation or offer and suggests that any person seen as 'unwilling' was not deserving of referral to social prescribing, all power here clearly resting with the professional. Such a stance is clearly opposed to providing encouragement and helping people mitigate the barriers to candidacy. The concept of recursively [23] has relevance here. This is because service users who had previously experienced barriers in attempting to access healthcare may come across as less 'willing and open,' resulting in healthcare professionals making adjudications regarding their deservedness of referral. Liberati et al. [23] argued that renewed attention is required regarding the importance of familiar healthcare professionals reaching out to those less likely to assert their own candidacy, an argument supported by the evidence presented in this paper.

The NHS summary guide to social prescribing ([40], p.13) states that social prescribing link workers are 'employed to give time' for negotiations and offers to take place, but such interactions did not appear commonplace. Dee reported that she "wasn't sure who I was seeing about what'" and Sparrow was unsure whether she was still involved with the social prescribing service or had been discharged from it. These reported experiences suggest a lack of clarity within services and that confusion can arise from service users interacting with different teams and organisations at the same time, while offers and resistance appear to be primarily shaped by system constraints rather than by individuals' accepting or resisting offers. The narratives in the present study partly support Westlake et al.'s [15], p.3, identification of social prescribing link workers performing a valued and consistent 'holding' role for vulnerable individuals within NHS systems.

It is appreciated that this was a small-scale study in one clinical commissioning group, and only individuals who had successfully navigated their way into social prescribing services were interviewed. Furthermore, the above research participants were recommended to take part in the original research by their social prescribing link workers which may have led to some bias in responses, although the responses received did not appear to be guarded or contingent but were open and frank, highlighting both positive and negative aspects of social prescribing experiences. The limited duration of interviews, particularly when participants had only a vague understanding of social prescribing, further constrained the depth of data collected. Three participants reported having memory problems, and it may be that this prevented fuller articulation about their candidacy journeys. It could also have been the case that the complexity of navigating systems meant that they had become passive recipients of healthcare rather than actively asserting their candidacy, particularly in a time of pandemic, when individuals may have been grateful to receive any service offered. Additionally, the exclusion of potential participants who did not have a good command of English language also placed limitations on the study data.

6 | Conclusions

The framework of candidacy can be seen to offer a way of providing a highly appropriate way to conceptualise the numerous sets of obstacles that individuals face when attempting to engage effectively with social prescribing. It adds understanding to the ways in which access to social prescribing is impacted, obstructed and negotiated between individuals and the services potentially available to them. This paper suggests that future research might helpfully embrace candidacy theory to illuminate the voices of service users, with a view to provide greater insight and analysis into the factors which prevent potential service users from accessing social prescribing, as well as constituting a helpful approach to understanding how individuals navigate its systems. The candidacy approach also inherently profiles the voices of social prescribing participants, which have seldom been heard to date in the literature.

Despite the above caveats, the findings of this research have practical implications for the future delivery of social prescribing. For policy development, embracing candidacy theory can inform the creation of policies which address the barriers revealed by service users, thus better ensuring that social prescribing opportunities reach a broader and more diverse population. In terms of design, the findings suggest that programmes should be structured to better support and guide service users throughout the process of becoming candidates for social prescribing provision. Training for social prescribing link workers should incorporate modules that emphasise the importance of recognising and addressing the broader factors influencing candidacy, thereby improving the effectiveness and reach of social prescribing initiatives. Such training might also emphasise the need

to clearly explain new initiatives such as social prescribing to local populations, including techniques for clarifying whether details and arrangements had really been understood and emphasising that such services were negotiable.

Overall, the evidence presented in this paper demonstrates that candidacy theory provides a robust and logical framework for exploring the complex multifaceted nature of access to social prescribing services. The voices of service users have added moral and contextual dimensions of understanding to the realities of social prescribing, and have drawn attention to the need for moral and contextual components to be fully considered alongside systems and organisational arrangements. However, although candidacy theory places great emphasis on negotiation and interaction, it does not always recognise that offers and resistance are perhaps less enacted by service users but are governed more by institutional arrangements, which limit negotiations despite the positive types of relationships evidenced as part of the above study.

Further larger-scale research, designed around the framework of candidacy, could prove most valuable in helping establish an evidence base regarding the efficacy of social prescribing as viewed from the perspectives of its service users.

Funding

No funding was received for this manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data are not publicly available due to privacy or ethical restrictions.

References

1. M. Dixon-Woods, D. Kirk, S. Agarwal, et al., "Vulnerable Groups and Access to Health Care: A Critical Interpretive Review," *Report for the National Coordinating Centre for NHS Service Delivery and Organisation R&D(NCCSDO)* (2005): http://www.netscc.ac.uk/netscc/hsdr/files/project/SDO_FR_08-1210-025_V01.pdf.

2. S. Tierney, G. Wong, and K. Mahtani, "Current Understanding and Implementation of 'Care Navigation' Across England: A Cross-Sectional Study of NHS Clinical Commissioning Groups," *British Journal of General Practice* 69, no. 687 (2019): e675–e681, https://doi.org/10.3399/bjgp19x705569.

3. C. Dayson, "Social Prescribing 'Plus': A Model of Asset-Based Collaborative Innovation?" *People, Place and Policy* 11, no. 2 (2017): 90–104, https://doi.org/10.3351/ppp.2017.4839587343.

4. NHS England, *The NHS Long Term Plan* (2019), https://doi.org/10.38192/12.1.4.

5. Health Education England, "Social Prescribing at a Glance," no. March (2016), 1–56, https://www.hee.nhs.uk/sites/default/files/documents/SocialPrescribingataglance.pdf.

6. S. W. Mercer, B. Fitzpatrick, L. Grant, et al., "Effectiveness of Community-Links Practitioners in Areas of High Socioeconomic Deprivation," *Annals of Family Medicine* 17, no. 6 (2019): 518–525, https://doi.org/10.1370/afm.2429.

7. L. Morton, M. Ferguson, and F. Baty, "Improving Wellbeing and Self-Efficacy by Social Prescription," *Public Health* 129, no. 3 (2015): 286–289, https://doi.org/10.1016/j.puhe.2014.12.011.

8. K. Wahlbeck, J. Cresswell-Smith, P. Haaramo, and J. Parkkonen, "Interventions to Mitigate the Effects of Poverty and Inequality on Mental Health," *Social Psychiatry and Psychiatric Epidemiology* 52, no. 5 (2017): 505–514, https://doi.org/10.1007/s00127-017-1370-4.

9. C. Dayson and E. Bennett, in *Evaluation of the Rotherham Mental Health Social Prescribing Pilot* (Centre for Regional Economic and Social Research, 2016).

10. J. Pescheny, Y. Pappas, and G. Randhawa, "Patient Uptake and Adherence to Social Prescribing: A Qualitative Study," *BJGP Open* 2, no. 3 (2018): bjgpopen18X101598, https://doi.org/10.3399/bjgpopen18X101598.

11. T. Lorenc, M. Petticrew, V. Welch, and P. Tugwell, "What Types of Interventions Generate Inequalities? Evidence From Systematic Reviews," *Journal of Epidemiology and Community Health* 67, no. 2 (2013): 190–193, https://doi.org/10.1136/jech-2012-201257.

12. K. Gibson, T. M. Pollard, and S. Moffatt, "Social Prescribing and Classed Inequity: A Journey of Upward Health Mobility?" *Social Science and Medicine* 280 (2021): 114037, https://doi.org/10.1016/j.socscimed.2021.114037.

13. M. Mackenzie, K. Skivington, and G. Fergie, "The State They'Re in': Unpicking Fantasy Paradigms of Health Improvement Interventions as Tools for Addressing Health Inequalities," *Social Science and Medicine* 256, no. April (2020): 113047, https://doi.org/10.1016/j.socscimed.2020.113047.

14. M. Dixon-Woods, D. Cavers, S. Agarwal, et al., "Conducting a Critical Interpretive Synthesis of the Literature on Access to Healthcare by Vulnerable Groups," *BMC Medical Research Methodology* 6 (2006): 1–13, https://doi.org/10.1186/1471-2288-6-35.

15. D. Westlake, G. Wong, A. Turk, et al., "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," *Health and Social Care in the Community* 2024 (2024): 1–16, https://doi.org/10.1155/2024/2479543.

16. C. Moore, P. Unwin, N. Evans, and F. Howie, "'Winging It': An Exploration of the Self-Perceived Professional Identity of Social Prescribing Link Workers," *Health and Social Care in the Community* 2023 (2023): 1–8, https://doi.org/10.1155/2023/8488615.

17. S. Tierney, G. Wong, D. Westlake, et al., *Patient Buy-in to Social Prescribing Through Link Workers as Part of Person-Centred Care: A Realist Evaluation* (National Institute for Health and Care Research, 2025), https://www.ncbi.nlm.nih.gov/books/NBK616839/?utm_source=chatgpt.com, https://doi.org/10.3310/ETND8254.

18. H. Richards, M. Reid, and C. Watt, "Socioeconomic Variations in Responses to Chest Pain: Qualitative Study," *British Medical Journal* 324, no. 7349 (2002): 1308–1310, https://doi.org/10.1136/bmj.324.7349.1308.

19. M. Polley, J. Fleming, T. Anfilogoff, and A. Carpenter, "Making Sense of Social Prescribing," (2017), https://westminsterresearch.westminster.ac.uk/item/q1v77/making-sense-of-social-prescribing.

20. K. Field and D. Briggs, "Socio-Economic and Locational Determinants of Accessibility and Utilization of Primary Healthcare," *Health and Social Care in the Community* 9, no. 5 (2001): 294–308, https://doi.org/10.1046/j.0966-0410.2001.00303.x.

21. A. Tod, C. Read, A. Lacey, and J. Abbott, "Barriers to Uptake of Services for Coronary Heart Disease: Qualitative Study," *British Medical Journal* 323, no. 7306 (2001): 214–217, https://doi.org/10.1136/bmj.323.7306.214.

22. M. Goddard and P. Smith, *Equity of Access to Healthcare* (University of York, 1998).

23. E. Liberati, N. Richards, J. Parker, et al., "Qualitative Study of Candidacy and Access to Secondary Mental Health Services During the COVID-19 Pandemic," *Social Science and Medicine* 296, no. 114711 (2022): 1–9, https://doi.org/10.1016/j.socscimed.2022.114711.

24. E. Annandale, J. Harvey, D. Cavers, and M. Dixon-Woods, "Gender and Access to Healthcare in the UK: A Critical Interpretive Synthesis of the Literature," *Evidence and Policy* 3, no. 4 (2007): 463–486, https://doi.org/10.1332/174426407782516538.

25. M. Lipsky, *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services* (Russell Sage Foundation, 1980).

26. P. Unwin, J. O'Driscoll, C. Rice, et al., "Inequalities in Mental Health Care for Gypsy, Roma, and Traveller Communities: Identifying Best Practice," *NHS Race and Health Observatory. Inequalities-in-Mental-Health-Care-for-Gypsy-Roma-and-Traveller-Communities.pdf* (2023).

27. A. Fixsen, S. Barrett, and M. Shimonovich, "Weathering the Storm: A Qualitative Study of Social Prescribing in Urban and Rural Scotland During the COVID-19 Pandemic," *SAGE Open Medicine* 9 (2021): 205031212110291, https://doi.org/10.1177/20503121211029187.

28. C. Moore, P. Unwin, N. Evans, and F. Howie, "Social Prescribing: Exploring General Practitioners' and Healthcare Professionals' Perceptions of, and Engagement With, the NHS Model," *Health and Social Care in the Community* 30, no. 6 (2022): 1–10, https://doi.org/10.1111/hsc.13935.

29. Defra, "Rural Urban Classification," (2021), https://www.gov.uk/government/collections/rural-urban-classification.

30. R. Bhaskar, *A Realist Theory of Science* (Routledge, 2008).

31. E. A. Sturgiss and A. M. Clark, "Using Critical Realism in Primary Care Research: An Overview of Methods," *Family Practice* 37, no. 1 (2020): 143–145, https://doi.org/10.1093/fampra/cmz084.

32. A. Bolderston, "Conducting a Research Interview," *Journal of Medical Imaging and Radiation Sciences* 43, no. 1 (2012): 66–76, https://doi.org/10.1016/j.jmir.2011.12.002.

33. S. Jamshed, "Qualitative Research Method-Interviewing and Observation," *Journal of Basic and Clinical Pharmacy* 5, no. 4 (2014): 87–88, https://doi.org/10.4103/0976-0105.141942.

34. R. Dowling, K. Lloyd, and S. Suchet-Pearson, "Qualitative Methods 1: Enriching the Interview," *Progress in Human Geography* 40, no. 5 (2016): 679–686, https://doi.org/10.1177/0309132515596880.

35. R. E. Boyatzis, *Transforming Qualitative Information: Thematic Analysis and Code Development* (SAGE Publications, 1998).

36. J. Thomas and A. Harden, "Methods for the Thematic Synthesis of Qualitative Research in Systematic Reviews," *BMC Medical Research Methodology* 8, no. 45 (2008): 1–10, https://doi.org/10.1186/1471-2288-8-45.

37. G. Guest, K. M. MacQueen, and A. A. Namey, *Applied Thematic Analysis* (SAGE Publications, 2012).

38. V. Clarke and V. Braun, "Thematic Analysis," *Journal of Positive Psychology* 12, no. 3 (2017): 297–298, https://doi.org/10.1080/17439760.2016.1262613.

39. V. Braun and V. Clarke, "Conceptual and Design Thinking for Thematic Analysis," *Qualitative Psychology* 9, no. 1 (2022): 3–26, https://doi.org/10.1037/qup0000196.

40. NHS England and NHS Improvement, "Social Prescribing and Community-Based Support: Summary Guide," (2020), https://www.england.nhs.uk/wp-content/uploads/2020/06/social-prescribing-summary-guide-updated-june-20.pdf.

41. A. Fixsen, H. Seers, M. Polley, and J. Robins, "Applying Critical Systems Thinking to Social Prescribing: A Relational Model of Stakeholder 'Buy-in'," *BMC Health Services Research* 20, no. 1 (2020): 580, https://doi.org/10.1186/s12913-020-05443-8.

42. T. Pollard, K. Gibson, B. Griffith, J. Jeffries, and S. Moffatt, "Implementation and Impact of a Social Prescribing Intervention: An Ethnographic Exploration," *British Journal of General Practice* 73, no. 735 (2023): https://doi.org/10.3399/BJGP.2022.0638.