Social prescribing
A pathway to work?
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About us

Through its rigorous research programmes targeting organisations, cities, regions and economies, now and for future trends; The Work Foundation is a leading provider of analysis, evaluation, policy advice and know-how in the UK and beyond.

The Work Foundation addresses the fundamental question of what Good Work means: this is a complex and evolving concept. Good Work for all by necessity encapsulates the importance of productivity and skills needs, the consequences of technological innovation, and of good working practices. The impact of local economic development, of potential disrupters to work from wider-economic governmental and societal pressures, as well as the business-needs of different types of organisations can all influence our understanding of what makes work good. Central to the concept of Good Work is how these and other factors impact on the well-being of the individual whether in employment or seeking to enter the workforce.

For further details, please visit www.theworkfoundation.com.

Acknowledgements

The authors would like to thank colleagues at The Work Foundation for their work on this project, Cicely Dudley, Stephanie Scott-Davies and David Shoesmith. They would also like to thank representatives at our case study sites – Bromley by Bow Centre, Herts Help, Ways to Wellness Newcastle, and the Rotherham Mental Health Social Prescribing Service – for participating in their participation and their help and advice with this project. We would further like to thank Nicholas Herbert and members of the Social Prescribing network.

This project was supported by a grant from AbbVie, as part of the Fit for Work UK Coalition.

Glossary

There are several terms being used to describe different aspects of social prescribing. For clarity, definitions of the key terms mentioned in this report are set out below.

Social prescribing service

Refers to the service which employs the Link Worker(s) and the subsequent groups and services that a person accesses to support and empower them to manage their needs provided by the central service.

Link Worker

Link Workers have a variety of names e.g. health advisor, health trainer and community navigator. In this report it refers to a non-clinically trained person who works in a social prescribing service, and receives the person who has been referred to them. Briefly, the Link Worker is responsible for assessing a person’s needs and suggesting the appropriate resources for them to access.

Community services

Refers to services, support, interventions and activities which are accessible in the local area. They may include health services, but it is also much wider.
This report is an excellent and timely analysis of the current and potential role of social prescription in supporting work opportunities for those, who are either unable or do not have the confidence or motivation to work.

It is excellent because it reminds us that the ability to work is itself a social determinant of health and wellbeing and thus requires the support of any health system. It is also excellent as it is practical - examining four vanguard social prescribing organisations, warts and all, and showing how they are contributing towards work opportunities and how they might be able to do more with the right sort of support. The report’s call for “Good Practice Guidance” is welcome and something that will be very helpful both to commissioners and frontline link workers/social prescribers, who provide the connection between the prescriber and the appropriate services that might enable someone to get employment.

This report is also very timely as social prescription is now poised to “go viral” - there are over 600 members of our national Social Prescribing Network, which began only this January, 10 Clinical Commissioning Groups are now providing universal coverage of social prescription for patients and GPs and 49% of CCGs are now supporting social prescription in some way or another.

20% of patients presenting to a GP have a social problem and frequently this is either job or lack of job related and anything that supports GPs, GP practices and their link workers/social prescribers/community connectors to provide help and support is welcome. An employed person, as the report says, is less likely to need medical services and someone in a fulfilling occupation is less likely to fall ill. Helping people to get gainful employment is thus a social must but also a means of making the health service sustainable to something that was not previously within the ability of the individual GP.

Social Prescription has changed everything. General practice, through social prescription, now has the means of supporting a greater working population and it is now necessary for professionals, contracts, national targets and inspectors to extend their ambitions beyond purely process biomedical markers and start to grapple with things that may have more meaning and importance to their patients and which may be more significant in terms of overall health outcomes – such as having a job.

One of the founders of our great social prescribing movement was Dr James Fleming, a charismatic GP in Burnley, where mortality statistics are the worst in the country. He shook a system providing only biomedical solutions, which frustrated patients and GPs alike. He asked himself: “When a patient comes to see me and his main source of depression is not having a job – why do I give him an antidepressant? Shouldn’t I be helping to get him a job?” That lightbulb moment led to James creating “Green Dreams” in Burnley and the potential for patients to have occupational experience and develop the confidence and self-esteem to get a job rather than sitting passive, defeated and demoralised at home with only the “soma” of the medically prescribed antidepressant.

Foreword
This report builds upon James’ mission. It shows how four leading social prescribing organisations are trying to grapple with the problem. It raises the whole issue as both urgent and possible. Social prescription has fought on many fronts: to tackle obesity, loneliness, to help those with long term disease that use the health services most and those with social issues such as benefits and housing. This report is a timely reminder that those of us leading social prescription locally must also add to our list the imperative of helping people to get jobs. Not only jobs, but jobs that are fulfilling, enjoyable and disease preventing.

They say that “the darkest hours come before dawn”. These are dark hours. Rates of depression, diabetes and cancer are all rising. Increasing NHS demand and increasing hospital debts are threatening NHS sustainability. The answer, we hear, is about patients being cared for in communities rather than hospitals but social care budgets are slashed and primary care receives an every decreasing percentage of the NHS budget.

Only one solution remains. To go upstream and remove some of the causes of that increasing demand from an increasingly ill population requiring ever more hospital and primary care services. Part of that solution is contained within this report. A gainfully employed population will incur less health costs and social prescription can provide the means of achieving this. Congratulations to the Work Foundation and Fit for Work UK Coalition for providing this clarion call of wisdom combined with good plain common sense.

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Around one in three people of working age have a long-term health condition (LTC) or disability. In many cases this will affect their ability to work, as well as affecting a range of other everyday activities. As such poor health is a risk factor for unemployment and economic inactivity.

The most common health conditions among the working age population relate to the musculoskeletal system and to mental ill-health, both of which are associated with poorer work outcomes (see figure 1). Outcomes are even worse where someone has multiple conditions, and particularly when these include a mental health condition.

**Figure 1: Employment rates and health conditions (%)**

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Employment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>No health condition</td>
<td>80%</td>
</tr>
<tr>
<td>Overall employment rate</td>
<td>73.5%</td>
</tr>
<tr>
<td>Any health condition</td>
<td>61.1%</td>
</tr>
<tr>
<td>Musculoskeletal condition</td>
<td>59.7%</td>
</tr>
<tr>
<td>Long-term health condition</td>
<td>59.6%</td>
</tr>
<tr>
<td>Equality Act Disabled</td>
<td>46.1%</td>
</tr>
<tr>
<td>Mental health condition</td>
<td>42.7%</td>
</tr>
</tbody>
</table>


Addressing the ‘disability employment gap’ – the difference in the employment rate between those with and without disabilities, which currently sits at over 30% – is a target of the current government, and a challenge outlined in the recent Green Paper on Work, Health and Disability. There is a multitude of influences on the likelihood of someone with one or more LTCs or disabilities being in work. Influencers include the functional barriers that many people encounter when entering or trying to remain in work, but these in themselves are also driven by a variety of structural and social factors. Such factors limiting likelihood of being in work include poor access to timely appropriate healthcare and to vocational and employment-related support and advice, as well as facing stigma and discrimination. Stigma, and self-stigma, can also have an adverse effect on self-confidence and motivation to work, which are also important predictors of employment.

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Social prescribing is a model vaunted as having some potential to reduce the gap. Social prescribing provides a link between medical and social support – with General Practitioners (GPs) connecting patients with a range of non-medical community-based social support, through ‘prescribing’ or referring them to it. It aims to empower individuals to improve their health and wellbeing and social welfare, particularly where traditional clinical interventions have not resulted in significant improvements.

Employment, and particularly good quality work (see Box 1), is in many cases positive for health and wellbeing.⁶ Many studies have shown positive effects for mental health in particular.⁷ The benefits of good work have been specifically linked to health, and to ongoing health improvements⁸ even for those with severe health conditions like schizophrenia, where work is associated with improvements in a range of health outcomes, including reduced hospital admissions and likelihood of relapse.⁹,¹⁰

Given the potential health benefits of working, helping people to enter or remain in good quality, health-promoting work can be viewed as a sustainable health outcome.

In this paper we look at social prescribing through a ‘work’ lens – exploring the extent to which social prescribing might be contributing towards broader recovery goals such as a return to full functioning and to work, and how this might be happening in practice.

**Our approach**

The purpose of this research was to understand the current use, and the implications of use, of social prescribing as a mechanism for achieving work-related outcomes. We looked at the extent to which work is included in the social prescribing remit, and how this is addressed in practice. Additionally, we were interested in where there might be potential to increase effectiveness of social prescribing in this regard, and what the barriers and enablers to this might be.

An initial review of the grey and academic literature uncovered little reference to the role of work in this context. This has not been a key feature of previous large-scale studies on social prescribing, which is itself a relatively new area of research and practice.

We therefore took an exploratory approach. This was in two stages: first we ran a short survey with members of the UK Social Prescribing Network¹¹ to better understand their experience of social prescribing, and where work fits in their views.¹² Secondly, we undertook four case studies of social prescribing services. We explored how each service works, is delivered and experienced by clients in order to learn how social prescribing is, in practice, achieving a wide range of health and social outcomes, potentially including work. Full details of the case studies can be found in the appendix.

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⁷ Modini, M; Joyce, S; Mykletun, A; Christensen, H; Bryant, RA; Mitchell, PB & Harvey, SB (2016) The mental health benefits of employment: Results of a systematic meta-review. Australasian Psychiatry. Vol 24(4) 331–336
¹⁰ The Social Prescribing Network is made up health professionals, researchers, academics, social prescribing practitioners, representatives from the community and voluntary sector, commissioners and funders, patients and citizens working together to share knowledge and best practice, to support social prescribing at a local and national levels and to inform good quality research and evaluation. For more information: https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/social-prescribing-network
¹¹ The survey involved some free text questions to allow for further comment. Some of these have been used as quotes
The premise of social prescribing builds on the strong evidence that health outcomes are socially determined; the conditions in which people are born, grow, live, work and age influence health. Social prescribing services have existed for many years, though it is only recently that a concerted effort has been made to formalise, define (see Box 2), and expand the practice.

Box 2: Defining social prescribing

‘A mechanism for linking patients with non-medical sources of support within the community’.


‘A means of enabling GPs and other frontline healthcare professionals to refer patients to a Link Worker - to provide them with a face to face conversation during which they can learn about the possibilities and design their own personalised solutions, i.e. ‘co-produce’ their ‘social prescription’ - so that people with social, emotional or practical needs are empowered to find solutions which will improve their health and wellbeing, often using services provided by the voluntary and community sector.’

Social Prescribing Network (January 2016)

Social prescribing services or activities are extremely varied (see Box 3), potentially including sports, leisure and art activities, as well as activities more focused on health, education or skill development.

Box 3: Types of Social prescribing interventions

- Community education groups
- Arts, creativity, learning and exercise on referral
- Self-help groups
- Computerised CBT
- Bibliotherapy/self-help reading
- Group activities on referral
- Volunteering
- Time Banks
- Signposting information and guidance
- Supported education and employment
- Adult learning
- Knit and natter clubs
- Fishing clubs
- Gym-based activities
- Guided/health walks
- Green Gym/gardening clubs
- Cycling
- Swimming and aqua-therapy
- Team sports
- Exercise and dance classes
- Physical activity
- Learning new skills
- Mutual aid
- Befriending

Source: The University of York Centre for Reviews and Dissemination ‘Evidence to inform the commissioning of social prescribing’ Available at: http://www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf

The concept of social prescribing appears to have support among many GPs; a recent survey by Nesta identified that four out of five think social prescriptions (alongside medical prescriptions) should be available from GP surgeries. Social prescribing is often recognised as a health intervention, and as such services are usually focussed on direct health outcomes; however, the growing evidence base suggests there are a wide range of benefits of social prescribing beyond those directly associated with health, including:

- Improvement of psychological and mental wellbeing.
- Behavioural change and lifestyle improvement.
- Acquisition of learning new interests and skills.
- Better support, community integration and reduction in social isolation and loneliness.
- Benefits to physical health.

**The health context**

As the pressure on the NHS continues to grow - with the combination of funding limitations, people living longer (and often not in good health), and increasing prevalence of LTCs – we must continue to focus on finding new ways to prevent, treat and sustainably manage ill-health.

This is core to the NHS *Five Year Forward View*, published in 2014. The report outlined a “shared vision for the future of the NHS based around the new models of care”, and signalled a new strategy for NHS service delivery in order to close widening gaps in health inequalities, quality of care and funding of services, with specific reference to the ‘emerging’ model of social prescribing.

Indeed, social prescribing is increasingly gaining traction as a new approach to sustainable, holistic patient care. The approach builds upon the 1986 Ottawa World Health Organisation charter which recognised that health improvements would not occur by only developing more health services or imposing centralised public health solutions. It is seen as part of a larger movement to address health inequalities by tackling the social determinants of poor health, while also increasing access to alternative pathways and interventions for patients, assisting under-pressure GPs who may struggle to find appropriate, effective treatment solutions for patients with complex needs.

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(15) Dayson, C. Bashir, N., Bennett, E., & Sanderson, E. (2016). The Rotherham Social Prescribing Service for People with Long-Term Conditions-annual evaluation, Sheffield Hallam University and CRESR.


(20) NESTA, (2013). More than medicine: new services for people powered health. Innovation Unit, PPL, NESTA.


How does work fit in?

Social prescribing services often explicitly focus on improving health outcomes and reducing direct NHS costs. Given the broader range of benefits recorded above, we argue that the benefits of social prescribing are likely to be far wider, and may even extend to work. This has been recognised in other social prescribing research; Kimberlee et al (2013) concluded that “Commissioners should be aware of the additional economic value provided through SP [social prescribing] projects which include: harnessing volunteers, beneficiaries returning to employment and training and child care responsibilities and community capacity enhanced.” This is not a new premise: back in 2003, the Scottish Development Centre for Mental Health found that in social prescribing services, and particularly as a means of to strengthening links between healthcare providers and community, voluntary and local authority services, “there are potential solutions to the wider determinants of mental health, for example, leisure, welfare, education, culture, employment and the environment.”

Figure 2: Social determinants of health

As concluded by the 2010 Marmot Review on reducing health inequalities, around 70% of health outcomes are determined by social factors, and just 30% by clinical interventions. Work, whether you are employed, and the conditions and nature of work, are social determinants of health. For many people being in work, and particularly being in work of good psychosocial quality (i.e. offering some autonomy, control, appropriate rewards, social support) has been found to have a sustained positive effect on health, while unemployment, and poor quality of work, have both been shown to be harmful for health. Improving access to good quality

Source: Dahlgren and Whitehead (1992)

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work is increasingly recognised as a public health priority\(^\text{35}\). Further this premise is reflected in the aforementioned NHS Five Year Forward View, wherein the health of the NHS workforce – the largest workforce in the UK – has been prioritised. The importance of work has also received attention in the reports of the Chief Medical Officer\(^\text{36}\), in regards to both mental illness, and the ‘baby boomer’ generation (i.e. 50-70 year olds)\(^\text{37}\). The importance of finding people sustainable work is also central to the welfare system, as well as a challenge for productivity and economic growth at a national and a local level\(^\text{38}\).

Consequently there has been considerable focus in recent years – culminating in the publication of a new Work, Health and Disability Green Paper – on the development of effective interventions to support people with LTCs and disabilities to find or remain in work. One example of an evidenced-based intervention is ‘Individual Placement and Support’ supported employment, which has been found to improve employment outcomes for people with severe mental health conditions; it is currently being trialled with other groups\(^\text{39}\) and recommended for testing with others\(^\text{40}\). This model is underlined by a number of principles, including co-locating of health and employment support, time-unlimited individualised support (for the client and employer), and seeking competitive work quickly (i.e. as soon as the client states an interest)\(^\text{41}\).

Despite the range of functional, social, and structural barriers to work many people with LTCs and disabilities experience, many would like to work and, with the right support would be able to work, and work well. This is true even among those with quite complex health difficulties\(^\text{42, 43}\). Work is more than just an income, and often comes with a range of social benefits – such as status, social networks, and a sense of purpose\(^\text{44, 45}\) (see Box 4).

### Box 4: Potential benefits of good work

‘Good work’...
- is therapeutic;
- helps to promote recovery and rehabilitation;
- leads to better health outcomes;
- minimises the deleterious physical, mental and social effects of long-term sickness absence and worklessness;
- reduces the chance of chronic disability, long-term incapacity for work and social exclusion;
- promotes full participation in society, independance and human rights;
- reduces poverty
- improves quality of life and wellbeing

**Source:** Waddell and Burton, 2006

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Volunteering may also be beneficial, depending on the individual, their needs and preferences. It may also be seen as part of the progression towards working. In this research, volunteering is viewed as a work outcome\(^{46}\).

In terms of social prescribing as a means of improving work outcomes, we hypothesise there are two potential pathways, depending on the individual, and their stage in the recovery journey.

1. **Direct** where an individual is referred to a focussed work support service, e.g. the Bridging the Gap programme (see Box 5)

2. **Indirect** where an individual is referred to non-work social prescribing activities which have a positive impact on them e.g. through improvements to health and wellbeing, social inclusion, confidence, or engagement in physical activity, which might put them in a better position to think about work and related goals in the medium to longer term

To illustrate the ‘indirect’ pathway, consider the hypothetical example of someone with musculoskeletal problems (e.g. arthritis) who has fallen out of work and become isolated, with a consequent reduction in the physical activity which might be beneficial in terms of pain management, as well as a loss of confidence. Referrals to activities such as a walking or gardening groups, might address social exclusion and physical inactivity. This might be the first step towards a range of other quality of life and functional outcomes, including work.

In the following section we report the findings from our questionnaire and case studies to understand how social prescribing works in practice when thinking about work.

**Box 5: Bridging the Gap - an employment focused social prescribing service**

Bridging the Gap (BTG) provides support to unemployed people with health conditions by assessing their needs and providing them with access to services to help them to both move towards employment and to better manage their health condition. The service takes an evidence-based approach by integrating health and employment services, whilst utilising the assets of the individuals themselves. Patients can either self-refer to the service, or be referred by their GP or JobCentre Plus Work Coach. In this sense it provides GPs with a holistic referral option that goes much wider than a medical consultation, covering medical (including physio and mental health) and non-medical issues as appropriate. This can operate alongside existing treatments to improve health and well-being. BTG case managers provide individualised support, and also act as a signposting or gateway service, providing service users with, and referring them to, an extensive range of interventions and activities. Clients are linked with sources of information and support within the community and voluntary sector such as volunteering, training, and financial, legal and housing advice. The service is distant and distinct from the Work Programme or other government mandated intervention.

The Bridging the Gap pilot programme is a Department of Health ‘Innovation, Excellence and Strategic Development’ funded initiative. It is delivered by two partner organisations – The Fit For Work Team Ltd and Pathways Community Interest Company.

(46) NB: For the purposes of this research work-related outcomes includes volunteering, work-related activity such as job search or CV writing, improved confidence about returning to work, or achieving work.
This section provides an overview of the main findings from the questionnaire and case study interviews.

**Questionnaire**

In order to better understand the position of work in social prescribing in practice, we developed a short questionnaire which was distributed to members of the Social Prescribing Network. We received 40 responses. Respondents were mainly Link Workers or managers of social prescribing service, though some led specific social prescribing activities. The majority of services responding provided both in-house support and signposted people to other services. The questionnaire asked specifically about working-age clients (i.e. 16-64 year olds); almost half responded that most or all of their clients were of working age and had at least one LTC.

The feedback confirmed that work is a feature of the social prescribing agenda – but not the main goal. Box 6 shows that work, and training and learning are rarely reasons for referral into the service. However when respondents were asked about ‘goal setting’ (Box 7), achieving or moving closer to work was more commonly identified.

Many respondents recognised the value of work, and the benefits in terms of service provision. The majority (70 per cent) agreed that employability and work-related outcomes should be included in the specifications of social prescribing services, with reasons given including that work has a role in reducing *social isolation*, improving *self-confidence*, and *self-esteem*, as well as having a more direct impact on someone’s health and wellbeing.

“I see employment as one of the key tenets in a person’s well-being. For that reason I think it should feature in social prescribing programmes’ specifications. I would caveat that by saying that it is important to recognise that a social prescriber might not necessarily be able to take someone all the way to employment, so it is important to consider what other advances a client might have made”

Questionnaire response

“It’s an important part of someone’s wellbeing, yet it’s not the only thing to consider”

Questionnaire response

Others were more tentative in their support for the inclusion of work-related outcomes. Some simply felt that this required more specialist knowledge than they could provide, while felt clients were often not ready for work.

“I think it is a great outcome, but not everyone will be able to even think about employment or volunteering. In reality, not everyone is ‘fit to work’”

Questionnaire response
“Social prescribing needs to focus on building the individual’s confidence and stabilising their social landscape; employment is, and always will be, secondary to that, especially in cases where the individual’s life is chaotic or intergenerational.”

Questionnaire response

“The individuals referred can have such varying circumstances that it would be complex to focus on so many specific things. Just focus on helping the individual resolve problems and improve their overall wellbeing. The rest will follow.”

Questionnaire response

Some displayed concern that broaching work too soon, when the client does not feel ready, would impinge upon the person-centred, client-led approach which underpins social prescribing. Further, some mentioned that discussions about work were made more complex in some cases due to patient concerns about mandated government employment programmes, such as the Work Programme; described by one respondent as ‘bullying’ their patients.

Some respondents provided services which might support work outcomes. When asked what kind of work-related services they offered clients (multiple choice), the most frequent activities were indirect supports such as increasing people’s social networks, volunteering, health and wellbeing programmes, and confidence building programmes. A number also suggested that supporting clients with welfare benefits, work and housing related, was part of their role.

Others did not feel work support was in their remit, and instead referred clients on to appropriate services.

“The majority of our clients have mental and physical health difficulties which restrict their ability to work. Where clients are able and willing to work we can signpost them on.”

Questionnaire response

The questionnaire also asked whether service commissioners or funders ask for data on employment-related outcomes of the service. Almost half responded that they did, with the information captured including i) how many people moved into work from benefits, ii) numbers of clients who gained work, training, education or volunteering, and iii) the number of clients learning new skills or gaining qualifications. Reasons respondents gave for not collecting outcomes on employment or employability included again that they did not have the specialist skills to do this and instead signposted people on. A few were uncomfortable with work outcomes entirely, concerned that introducing this dimension might detract from the health and wellbeing focus.

“That would change the nature of social prescribing. If the intention is to improve health outcomes and reduce costs to the NHS then the measures need to be around wellbeing.”

Questionnaire response

**Box 7: What are the most common type of goals**

From most frequently suggested to least?

1. Improve mental wellbeing
2. Improve physical health
3. Enhance social networks
4. Make lifestyle changes e.g. reducing alcohol consumption or eating healthily
5. Achieve or move closer to work
6. Improve financial situation
7. Improve housing situation
8. Develop new skills

**Work in practice**
Case study findings

Building on the questionnaire findings, we conducted four case studies to provide a more in-depth exploration of social prescribing and work. Data was collected using semi-structured interviews and a review of documentation provided by the organisations to find out: i) who uses their service, ii) how they operate and, iii) the extent to which work is in their remit including how, if appropriate, their clients achieve work-related outcomes. Participants included GPs, Link Workers, commissioners, service managers and clients.

The four services used as case study organisations are described briefly below; full details of the case studies can be found in the appendix. The services we chose were geographically dispersed in England, and varied in structure and the level of support provided. See Box 8 for further information on different categories of social prescribing services.

- **Herts Help** (Stevenage, Hertfordshire) - a telephone-based social prescribing service providing free, independent support and advice to all adults over the age of 18 living in Hertfordshire. Community Navigators (expert voluntary sector and community services) also offer face-to-face support in the West of the county. It is collaboration between Hertfordshire County Council and the NHS. *Light/Medium*

- **Rotherham Mental Health Social Prescribing Service** (Rotherham, South Yorkshire) – a pilot scheme co-ordinated by Voluntary Action Rotherham and funded by Rotherham Clinical Commissioning Group (CCG). It provides support to people in secondary mental health services. Clients are referred to an adviser who sign-posts them to appropriate support. *Medium*

- **Bromley by Bow Centre - Social Prescribing Service** (London) – open to anyone over the age of 18 who is registered at one of the six linked GP surgeries. The Centre provides a holistic, integrated service, including a range of in-house support and activities including a GP practice, and an employment service. Funding for the social prescribing service comes from the GP practices and the local CCG. *Holistic*

**Box 8: Categorisation of Social Prescribing models** (summarised from Kimberlee et al 2013)

**Social Prescribing as signposting:** Signposting is an integral part of the SP pathway in all models. In some this is the limit to the intervention, i.e. referrers (mostly GPs) signpost patients to appropriate support or projects within the community who are best placed to help them with their needs. There will not necessarily be any links with the GP practice, deliverers of projects nor any means of feedback. The interventions offered will be what is known about by the GP or referrer.

**Social prescribing light:** This is the most widespread model of SP where referrals are made to a specific project designed to address a patient’s specific need or to achieve a specific goal e.g. healthy eating course for someone at risk of developing Type II diabetes. Feedback or monitoring processes may not necessarily be in place and only one need is being sought to be addressed.

**Social prescribing medium:** Like SP light, this model still addresses specific needs or behaviours however it is delivered through partnership with third sector or voluntary organisations and involves formal assessment of need by a health facilitator or Link Worker. Due to its partnership working it is more likely to have formal feedback mechanisms to the GP or referrer.

**Social Prescribing holistic:** Perhaps the most comprehensive form of delivery, this model (the Bromley by Bow model) is co-designed with primary care practitioners or CCGs, often emerging due to specific local or geographical socioeconomic need. The model becomes an integral part of what the GP surgery offers, acknowledging that SP interventions can offer something beyond conventional clinical interventions. This model goes beyond addressing specific needs and assesses and supports holistically all clients’ needs.
Ways to Wellness (Newcastle-upon-Tyne, Tyne and Wear) - an umbrella organisation that delivers social prescribing in the west of Newcastle-upon-Tyne for people with long-term conditions. Initial funding to develop the service model and build capacity was given by Department of Health Social Enterprise Investment Fund (SEIF), ACEVO and the Big Lottery Fund. Ways to Wellness provides the link between the CCG and four service provider organisations, one of which we focused on for the case study: Changing Lives.  

Who uses social prescribing? 

Primary users of social prescribing services have been identified in previous studies as i) frequent attenders of GP clinics; ii) people with a history of mental health problems; iii) people with two or more long term conditions; iv) people who are social isolated; v) people with untreatable or poorly understood conditions (e.g. irritable bowel syndrome and chronic fatigue syndrome); or, vi) people who do not appear to be benefiting from clinical medicine and drug treatment. This was to some extent reflected in our case studies.

Case study organisations had formal service eligibility criteria; this was decided locally, and reflected the challenges and commissioner priorities. Herts Help and Bromley by Bow have the broadest criteria, accepting referrals from anyone over 18 within geographical parameters, whereas Rotherham Social Prescribing Service and Ways to Wellness only accepted referrals with very specific criteria i.e. specific mental health conditions or long-term conditions respectively. Discussions with Link Workers suggested that the most prevalent conditions faced by service users are heart disease, diabetes, chronic breathing difficulties (including Chronic Pulmonary Obstructive Disorder and asthma) and mental health conditions.

Beyond health, for all four services, the majority of clients referred were unemployed and on work-related or sickness benefits. In the case of Herts Help, a large number of referrals were for the elderly. The main issues for which people were referred are summarised below:

- **Financial issues, in particular advice on welfare benefits** were amongst the most common reasons for referral. In one of the services, it was suggested that the number of requests relating to welfare advice is so great that they need to make clear that this is not their role and are not qualified to provide people with appropriate information and advice. Other financial issues are related to debt and general money struggles, including difficulty providing the household with enough food;
- **Housing** was also a major source of concern for clients. Issues ranged from poor living conditions, overcrowding, and lack of facilities including the right adaptations for physical disabilities;
- **Anxiety and low mood** was a common reason for referrals. Many clients presented with moderate mental health issues that were not being sufficiently managed by traditional clinical services. Clients were often described feeling they lacked a sense of purpose and meaning in life, and did not have much to do in their daily routines;
- **Social isolation** is a related issue which was frequently seen in clients. Some clients have not left the house in years and had difficulty getting outside or talking to people. For this reason some of the social prescribing services offer face-to-face home visits.
- **Unhealthy lifestyle behaviours** were less frequently cited, but support for changing lifestyles and developing healthier behaviours was still seen as a common need. This includes reducing smoking, improving diet or increasing exercise.

In some of the case study organisations, there was a high likelihood that people would be presenting at the service when they were in a crisis, for example, due to an immediate financial or housing concern, while for others it might be more of a response to a longer term situation which had seen no improvement.

(47) NESTA (2013). More than medicine: new services for people powered health. Innovation Unit, PPL, NESTA.
What are the key elements of the social prescribing services?

Despite the variability in the four case studies, there are a number of elements common to all:

- **Entry via the health system:** For all four services, referrals are predominantly from health services, in particular GPs and other primary care health professionals. In the case of Voluntary Action Rotherham, referrals are specifically from secondary mental health services.

- **Links to community services:** The social prescribing services provide a link between clients and the wide range of services, activities, and institutions which exist in the community around them. They offer a singular pathway through which people are enabled to access a wide range of opportunities (e.g. befriending services, meditation, art classes, or indeed work support services) that they otherwise would not be aware of or engage with. In our four case studies, most only linked clients to existing community services, though Voluntary Action Rotherham was able to commission additional services to support clients’ needs where gaps were identified.

- **Dedicated ‘Link Workers’:** All four services had dedicated experts with knowledge of local voluntary and community activities to act as the link between them and clients. The title of ‘Link Workers’ was commonly used, but locally they were also known as VCS Advisers and Community Navigators. The Link Worker undertakes an initial assessment of client’s needs, and then links them into appropriate services in the community. In our examples, all take an active listening or coaching approach to need identification and goal development. The time spent with Link Workers varied considerably between services; from open-ended support, to a single assessment session.

- **Person-centred approach:** A key factor of both the Link Workers approach and the way services are framed is that it is person-centred, i.e. the Link Worker is not the expert in the interaction, but will be guided by the patient and focus on their personal goals. The Link Worker and the individual co-produce a plan. Where clients are presenting in crisis, or with longer standing concerns, it is the individual that should dictate their most pressing needs, with the role of the Link Worker being to help them identify this.

- **Focus on client health and wellbeing:** Though the services respond to a broad range of client’s needs, the overriding focus of all services was to improve client health and wellbeing. All the case study organisations monitored wellbeing improvements, although they varied in how strictly this is monitored.

Does social prescribing lead to work outcomes?

Case study organisations were asked what elements of their service were relevant in regards to work and work-related outcomes, both directly and in-directly. Though most of their clients were not in work, as noted above, moving towards work was rarely identified as an immediate priority. Clients are asked about a range of goals as part of an initial holistic assessment, and Link Workers indicated that they often ask their clients if they have any work goals they would like to pursue or if they are experiencing difficulties at work as part of the assessment process; noting that ‘Work, volunteering and other activities’ is a ‘point’ on the Wellbeing Star.

It was suggested that in general, despite some clients being interested in going back to work in the long term, work was rarely identified as a priority goal at the assessment stage. The majority of Link Workers also suggested that referrals to specific work services (i.e. services that offer support with CVs, interview practice and job search etc.) are rare compared to referral to other types of activities and services.

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In a few cases, Link Workers did not seem to be aware of any community employment support services. Where community employment support had been identified and accessed via the social prescribing service, the feedback from Link Workers was not positive. Often the only employment support Link Workers were aware of was that provided through the Department for Work and Pensions via JobCentre Plus (JCP), which was also not viewed positively.

“JCP isn’t very supportive – the right employment support doesn’t really exist locally. In JCP can’t even use the phones without money – sometimes feels like it’s actually pushing them into not finding work.”

Link worker

Bromley by Bow was an exception in that it offers in-house employment services. The referral rate for skills and employability is currently 1 in 6 (17.5%) indicating that links do exist, but rates could still be improved.

More common was the in-direct approach, wherein work is seen as a broader wellbeing goal. This reflects the purpose of the social prescribing service being to help someone to improve their health and wellbeing, and/or achieve sufficient stability in their lives (particularly where they have presented in crisis), with recognition that after this has been achieved, work might become a possibility that they feel able to and wish to pursue.

“I believe that if someone has significant social problems they won’t find their health important. We need to unpick issues and then get to their health. This is the ultimate aim, to improve people’s health...If you improve their wellbeing first, resolve issues and then you can talk about health. Sort this out first”

Link worker

Although we found that work is not usually a priority for clients, as was the case with the questionnaire, overwhelmingly those we interviewed thought that the relationship between social prescribing and work outcomes is worth exploring, and that employment is a positive input in terms of wellbeing. This was true across the range of participants – from service managers, Link Workers and GPs, as well as clients (see examples below).

GP participants reflected on the fact that work can have a substantial positive impact on the health and wellbeing of their patients.

“Work is a clinical health outcome…. work is a priority for society”

GP

She further suggested that many of her patients were unemployed, and that their poor health and the reason they needed further support can be partially explained by the negative consequences for people’s health and wellbeing of unemployment.

“work gives you a structure. People who work need less social prescribing because their health tends to be better…. .... People tend to get in a sickness mind-set when they are unemployed... The less you do the less you want to do…. Patients then become isolated and this has a negative impact”

GP

This concept was repeated by another interviewee, who suggested that employment may prevent people with health conditions from worsening health and developing co-morbid mental health distress.
Client examples

We asked case study originations to identify clients who would be happy to discuss work with our researcher. Each client had identified work as a specific goal, and were being supported by the social prescribing service to achieve it. Their journeys are described in the following boxes.

Each client example demonstrates how the social prescribing model involves working with people to identify a range of individual (and often non-clinical) challenges, and although this may not at first seem significant for work, addressing them can be the key to achieving it.

A stand out feature of all client interviews was the gain in confidence resulting from their involvement with social prescribed activities. For several clients the lack of confidence and self-belief was so deep as to stop them from doing anything, sometimes even leaving their homes.

“Confidence and believing in myself were the biggest barrier [to leaving house].”

Client

For others the lack of confidence is related to their health condition, for example, people who have fluctuating conditions, are sometimes afraid of participating in activities because they fear they will face a relapse, as illustrated in Wendy’s case:

Client A: Fighting fears and building self-confidence

Wendy was referred to Voluntary Action Rotherham (VAR) by secondary mental health services. She had been unemployed for less than a year, and despite the fact she was volunteering once a week she spent a lot of time on her own at home.

“I was at home and I wasn’t really doing much. My confidence hit rock bottom”

With the help of her Link Worker she began an art therapy course and some counselling.

“I was looking to get my confidence back, try something new, get out of the house really... I just wanted a bit of a social life”

These activities helped her gain the confidence to look for new work opportunities. She found counselling particularly useful to rebuild her self-esteem and to reduce her fear of relapse. She soon started looking at job adverts and applied for a position. She thought that going back to work would take some time, but it all happened rather quickly.

“I didn’t think I would get back to work as quickly as this”

She is now working full-time but still keeps in contact with her VCS Adviser, meeting up every couple of months. Wendy has stopped attending the activities she was signposted to through VAR as work filled her time, however she felt that they were vital for giving her the impetus she needed to return to work.

“It basically gave me the kick that I needed”

(50) All names have been changed to protect clients’ anonymity.
Both the ‘active listening’ process clients undertake with their Link Worker, and the activities they subsequently engage in, are identified as having a positive influence on self-confidence and self-esteem. The ongoing, trusting relationship with her Link Worker and the connection she provided to activities in the community were crucial for Zoe to make progress:

**Client B: Instilling hope**

Zoe was referred to Changing Lives (a Ways to Wellness provider) in Newcastle by her GP. A lively woman, very engaged in her community, whose job involved providing support to others, she suffered a setback after experiencing a stroke. Her health condition left her unable to go back to work and she felt that she had lost both work and community relationships.

“I wanted to do the things I was doing before”

At the time of referral she was feeling lonely and a loss of purpose. At first, meetings with the Changing Lives Link Worker were in her home. She described her Link Worker as “the link to my beginning of changing”.

They talked about her past life as well as the future and where she saw herself in the following five to ten years. It was crucial to her that she was able to return to being helpful to the community around her; the way she was before the stroke. She missed her job terribly and was overwhelmed by a feeling of uselessness. Zoe had felt that she was wasting away and that worried her.

Thanks to her Link Worker she joined a painting club and started volunteering with the elderly at Age UK and in a care home. She says these activities gave her a reason to wake up in the morning and get out of the house. Working with older people also means that she doesn’t feel too conscious of the speech impediments caused by the stroke.

“It’s been challenging, but I can now see a light at the end of the tunnel”.

She says her Link Worker was the “lightbulb” that allowed for the change to happen. The one-to-one attention and support was what she feels has made the biggest difference “she understands me and where I’m going”.

“The service revived me and gave me hope…the service is more than a doctor”.

Many Link Workers said that their clients often have the motivation to make changes in their lives, but need someone to tell them they can and to give them encouragement. This is what happened in Margery’s case:
The improved social networks that stem from engaging with activities were frequently mentioned. Service providers spoke about clients engaging and making friends with their peers at the activity itself or simply getting used to speaking and engaging with people again as in Yaz’s case:

**Client D: Building social network**

Yaz contacted Herts Help a year ago. He is in regular weekly contact with his Community Navigator (Link Worker) with whom he has built a solid friendly relationship. He was referred by the IAPT team due to low mood and depression. His mental health difficulties were as a result of the challenges he faced living with a physical health condition and forced him to leave his job. As a result he had become socially isolated. Herts Help arranged volunteering opportunities for Yaz.

One of the first experiences he had was volunteering at the local library; however, this was not very positive due to an inappropriate manager. The Community Navigator supported him in this situation and forced him to leave his job. He eventually left his role.

The Community Navigator suggested that he begin a computer course to help him give his days a purpose and to build a social life. Although challenging, Yaz says he enjoyed it very much, in particular because of the people he met at the course. Having reached the end of the course he chose to stay on as a volunteer. Again, he enjoys both the work and the social contact he has with his colleagues.

“Everybody talks and gets on…it’s great…I enjoy work and the conversations I have with my colleagues”

He is now considering returning to work, although he is concerned that his physical disability would make it hard for him to work in many offices.

The Community Navigator continues to provide him with support which they both believe is crucial to help him.
Which outcomes are captured and measured?

All the case study organisations collected some form of outcome data, e.g. for reporting to funders and commissioners. This differed across organisations, with the nature of the data reflecting local priorities, e.g. where funding was short term this was reflected in the nature of outcomes measurement captured.

Interviews with service commissioners identified different views on the extent to which outcomes of social prescribing services should be measured. For example, some stated that measurement of outcomes was a requirement of their regular reporting; highlighting that given the competition for funds there is a need to justify why social prescribing should be invested in rather than other services) and ensure commissioners are shown the benefits of their investment.

None of the organisations collected data on work outcomes, and this data was not required by funders or commissioners. The main focus of each service was on health and wellbeing-related outcomes, often viewed as a proxy for NHS expenditure. The most common outcome measures were:

- **Health service usage outcomes:** This usually takes the form of reduction in hospital and GP visits. However, not everyone we interviewed agreed that this should be the primary measure of success of social prescribing services. It was suggested that as many clients have long-term conditions that require ongoing treatment, they are still likely to visit their GP even if their wellbeing and self-management is improved.

- **Health and wellbeing measures:** All services monitored wellbeing improvements and some, such as Ways to Wellness in Newcastle, have fairly strict targets and ways of measuring them. Interviewees agreed that it is important to keep track of such outcomes, although opinions differed on how strictly these outcomes should be measured. For example, should there be a target of wellbeing improvement that clients should achieve in a given timeframe? A few Link Workers voiced concerns that targets within rigid timescales might push some of them to discharge clients inappropriately or to disregard issues that are more difficult to address and require more time.

Summary

Though services differed in structure and resource, a few core principles united them; including to some extent the attitude towards work. Whilst work-related outcomes are seen as valuable, the emphasis for social prescribing services is primarily to improve the health and wellbeing of clients, and in practice the interpretation of this was quite limited. Clients rarely have work as their primary goal; dealing with immediate concerns or crises such as financial worries or social isolation takes precedence. Work is often seen as a longer term goal to be achieved once crises have been solved, self-confidence and social networks have improved or clients can manage their health better, but there was no clear pathway for work support, either in terms of community support or in-house specialist skills. Despite this, there are some examples of clients being successfully supported to achieve work outcomes. The potential to build on this will be discussed in the next chapter.
The aim of social prescribing is to help individuals find non-clinical solutions which will improve their health and wellbeing. Though it is unlikely that people will access or be referred to social prescribing services for the primary purpose of achieving work (and it is important to make clear that this is not, and should not be the purpose of these services), we believe that there would be benefits in making work a more central part of the services, given that work is an important determinant of health and wellbeing.

The client stories, highlighted in the previous section, demonstrate that people who seem far from employment can, upon accessing social prescribing, gain it with the support of the service; and often do so sooner than anticipated. We therefore see an opportunity within social prescribing to better support clients for whom work is important and may contribute to improving their health and wellbeing to achieve this outcome and to achieve it sooner than they would otherwise do.

In the following section we discuss how social prescribing might be better used as a means of providing support to achieve work-related outcomes. First we will outline ‘what works’ and what can be built on, before reflecting on the challenges, and identifying potential solutions to allow us to move this agenda forward.

Social Prescribing as a first step towards work-related outcomes

As suggested above, in terms of work outcomes, social prescribing provides a means of helping people to identify possibilities and goals, and work towards them through linking people in with community-based employment support services. Through social prescribing people are placed on a pathway, on which they can move towards broader recovery, wellbeing, and quality of life goals, which might include work. It has a clear role in building confidence, hope and self-efficacy, and enhancing social networks, and in that sense helps enable and empower them to reach towards their goals.

It is clear from our findings that the relationship between social prescribing and work is quite complex as there are a range of factors which have an impact on clients’ ability to return to work. These include personal barriers such as lack of self-confidence, lack of work ethic, lack of appropriate skills, difficulty in managing one or multiple health conditions. Although the purpose of social prescribing is to benefit an individual’s health and wellbeing by addressing a variety of issues which prevent them from living their life to the full, in doing this social prescribing also offers a first step towards work-related outcomes.

The main factors that stand out from our analysis in terms of how social prescribing links to work outcomes are confidence and social networks. Both clients and social prescribing professionals interviewed stated that improved confidence often represents a crucial stepping stone towards work-related outcomes, as a lack of confidence was identified in interviews as one of the main barriers faced in returning to work. The first contact with the Link Worker and the engagement with activities that follow are pivotal to building clients’ self-esteem and confidence.
“Quite a few are ready to go back to work. Volunteering has been a really good stepping stone to return to work. [It’s] pivotal to employment”

Confidence, self-esteem and self-efficacy also can enable people to self-manage their health condition, and encourage belief in their recovery and in the feasibility of doing things that they may have felt were not possible for them due to their health barriers i.e. working.

A second important factor that lies behind work-related outcomes is the enhancement of social networks and what the literature refers to as social capital. Social capital can be defined as “networks [friends, family, colleagues, etc.] together with shared norms, values and understandings that facilitate co-operation within or among groups”\(^{(51)}\). It focusses on social relations that have productive benefits\(^{(52)}\). A robust social network can prevent people from falling into isolation which can be especially harmful to people with mental health problems, or indeed contribute to the development of both physical and mental health conditions\(^{(53)}\). If social capital is a positive input to people’s health, evidence suggests that social isolation is instead associated with depression, hypertension, dementia, disability, alcohol consumption, weight gain and smoking\(^{(54)}\). All the clients we spoke to experienced depression before using their social prescribing service and they all associated their poor mental state with loneliness. To them, developing relationships, firstly with their Link Worker, and then with their peers at the activities they joined, was the gateway to better mental wellbeing and, as a result, to having the confidence to engage in more activities and expand their social network. This in turn led to some of them feeling confident enough to apply for jobs or consider returning to work.

“What works in social prescribing for work-related outcomes?”

As a result of this research, we identified a number of elements that we believe are important if social prescribing is to positively contribute to improving work-related outcomes for clients. These are: an engaged Link Worker; a patient-centred approach; strong links with a wide range of good quality community support; the ability to fill gaps in existing community support; and, strong links (preferably co-location) with GPs.

Dedicated, engaged Link-workers

Building on previous research, we found that the Link Worker role was fundamental to helping clients achieve their goals and improve their wellbeing. All clients we interviewed maintained that meeting their Link Worker was the catalyst for change and represented the starting point of their recovery. This was particularly true where clients had been socially isolated, as this engagement with the Link Worker was seen as a crucial first step towards social reintegration. One of the main benefits of the Link Workers was that they were able to offer time to listen that a GP could not; a supportive, encouraging relationship to people who felt alone.

In terms of the interaction itself, both clients and services spoke about the value of the one-to-one support, and of a coaching approach. Coaching was identified as making a real difference to the clients we interviewed. This was understood as helping clients identify their goals by listening

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\(^{(54)}\) http://www.campaigntoendloneliness.org/threat-to-health/
(and particularly via ‘active listening’), being a positive and practical voice, and working with them to both identify their goals, and provide support to achieve them. This approach reflects the evidence around goal setting as a predictor of behavioural change in social prescribing\(^{55}\). The value was still recognised even where clients only received a single one-hour session (as was the case with one organisation). The skills of Link Workers in establishing client’s needs and signposting to appropriate support, even in such a short timeframe, were commended, being seen as hugely valuable in terms of motivation and moving clients forward.

“My role is about…trying to encourage people to think about what changes they would like to make if they could.”

Link worker

“People are not always ready for change, and the role of the Link Worker is to probe them and find different ways to look at things.”

Link worker

The person-centred approach

The person-centred approach is central to the service, and along with the approach of the Link Worker, enables the identification of the goals and outcomes that are really important to the individual, in both the shorter and longer term. The use of the Wellbeing Star\(^{56}\), mentioned by several participants, encourages discussion of work and volunteering as one of the areas of wellbeing, and therefore introduces the concept early on, even if the individual does not feel that it is an option for them at this time. It is important that people realise that work or volunteering is achievable for them, and they can access support to help them to do so. The flexibility of Link Workers was valued by participants, as it means they can be responsive to the changing and progressing priorities and needs of their clients. Again, this is particularly relevant to work outcomes, as feelings towards work may change as the individual becomes more confident over time.

Awareness of and links with a range of good quality community support

In order to link clients into services that reflect their personal objectives, the social prescribing service, and the Link Worker in particular, need a good knowledge of a wide-range of services and activities available in their local community. The reach of social prescribing services to access appropriate, good quality, community support and activities is a key feature, as they offer opportunities which in many cases clients would or could not access by themselves; in the words of one participant, they are “a lubricant between cogs”. They provide a link between health services and community services, and between individuals and the community. What’s more, they represent a single gateway to a range of options; a “one-stop shop”. In terms of work outcomes, having access to a wide range of support to address individually identified concerns and barriers instead of focussing exclusively on work appeared to be a positive.

In all the case studies we visited, Link Workers said that part of their job is to foster relationships with community organisations to understand what they offer and make sure they are kept updated on what’s available. To facilitate this, some case studies organisations used or developed a system which pooled information together on the available organisations in the community. Quality control was a concern noted by some, though the ability to assess this was limited, and often they were reliant on feedback from clients.

It was also important that Link Workers were afforded the space and autonomy to be responsive to clients’ needs and use their initiative to proactively source opportunities where there were no obvious answers among traditional community services. For example, one Link Worker described a client having interest in training to become a plumber, and so took the initiative to contact local training providers and plumbing companies to identify an appropriate opportunity.

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Capacity to fill gaps in existing community support

As suggested above, services that reflect the individual’s goals were not always available, something particularly true of work-related support. Building on this, the ability for the social prescribing service to commission local services where there is a gap (i.e. they do not exist locally or are of insufficient quality) was seen as highly valuable by interviewees from organisations that both did and did not have such capacity. The ability to fill such gaps resonated greatly in terms of employment support, as appropriate services were not thought to be available in case study organisation areas. Among our case studies only Bromley by Bow (a rather unique model) and Voluntary Action Rotherham were able to fund services to fill the gaps. Social prescribing services certainly appeared well-placed to understand what services were important for their clients, and would appear a useful voice when making local commissioning decisions.

Though in our case studies no good quality employment services were identified, services such as those provided by the Fit For Work Team (see Box 5) do exist in some areas and may provide an option in social prescribing commissioning.

Close working and shared objectives with health services

An important element that appears relevant to achieving outcomes such as work is co-location of services, in particular the ability to integrate clinical and non-clinical support. This is an important part of the evidenced-based Individual Placement and Support model, and means that health can continue to be monitored and managed alongside and responding to employment support, within a clear feedback loop. Of our case studies, the Bromley by Bow Centre is the best example of a place where clients can easily move from their GP, to the Link Worker and to the required service, all within a few square metres. This gives a level of familiarity and perhaps ‘hand-holding’ that can be particularly useful for people who are very isolated and have very low confidence. Nonetheless, we recognise that the Bromley by Bow Centre represents a unique model that may not easily be replicated on a large scale or in other communities.

On a practical level, sharing objectives and outcome measures with the health system comes with benefits in terms of supporting health outcomes and reducing health costs. Though as discussed below, a potential concern with this is where the health outcomes sought are too limited, and may reduce the capacity of social prescribing service to achieve the broader range of patient goals. Concerns around work outcomes in the health and social prescribing system, given their relationship to the welfare system, may also be a concern.

The health system as a gateway to support

In terms of work outcomes, as well as other outcomes, there were recognised advantages of clients being referred to the service through the health system (in these cases via GPs or secondary mental health services), as opposed to via other pathways (such as the JobCentre).

One reason is simply that this avenue allows us to reach people who are likely to be experiencing considerable barriers to working, may not see work as a possibility, or who may be concerned about the effect work will have on their health, and therefore are unlikely to engage in work support on their own. This is also true of other activities, not only those relating to work.

“It’s important to get GPs on board because you’re trying to get clients to take them [the activities] on board….If I’m going swimming, I’m not prescribing myself going swimming.”

Service coordinator
Having healthcare professionals (often GPs), who are generally well trusted by patients, as the entry point to the service was also really important in engaging clients, as well as increasing recognition that such non-clinical support and activities are relevant to achieving improved health and wellbeing, rather than being seen as “softer” options.

“You need the medical endorsement to make this work. Most effective way to keep engagement.”
Link Worker

This builds on evidence around people with psychosis and other mental health conditions, in that negative perceptions of a healthcare professional about the ability to work or readiness to work of their patients (as opposed to others with the same condition) can influence the patient, and may reduce their motivation to seek work.

There are some inherent risks in linking health and employment support, in particular where there is any association with mandatory activities related to welfare payments. This issue was discussed in interviews; keeping social prescribing support distinct from the welfare system of the JobCentre was keenly emphasised as important, not least because engagement with the welfare system was one of the causes of stress for many clients accessing the service. The discussion here is limited to health and wellbeing services with no such attachment, and similarly to community employment support organisations with no such attachment.

What are the challenges for improving work outcomes through social prescribing?

As we have seen there is considerable potential in social prescribing to support people towards a range of wellbeing and quality of life goals, including work. This remains, however, a low priority area within social prescribing services. We have identified a number of challenges to raising the importance of work and improving work outcomes through social prescribing, which are: i) limited focus on health and wellbeing and health service use; ii) lack of expertise around work and related challenges (e.g. welfare system); iii) short-termism in service provision; iv) low availability and quality of local service provision; and, v) poor awareness of work as a health outcome.

Limited focus on health and wellbeing outcomes

The purpose of social prescribing services is to improve the health and wellbeing of clients. This was the focus of outcome data collection. Whilst some of the case study services did capture some data on work-related outcomes, this was not amongst the primary outcome measures and more often was not captured at all. There is therefore a gap in our knowledge of the wide range of benefits achieved through social prescribing, including the extent to which interventions (activities and support) lead to other socially and economically beneficial outcomes, such as work, and the effect that that might have on people’s health and wellbeing moving forward. Capturing work-related outcomes would be one way of measuring sustainable improvements in health and wellbeing, as well as serving as a proxy for functional and quality of life outcomes. Challenges related to this would be educating GPs and health professionals/referrers on the potential of social prescribing to improve work outcomes (and indeed, that this is even something they should be considering), better recognition of the potential value of work in terms of health and wellbeing, and finding a way to capture these benefits.
outcomes where services work with clients for a finite length of time, possibly ending before clients achieve work or are even ready to start thinking about it. Though the focus of this report is work, we would also suggest that capturing outcome measurements relating to a broad range of health determinants in addition to employment (e.g. acquisition of skills and qualifications, debt reduction, reduction in social isolation) would be valuable.

Further, having some continuity in data collection across services would improve our capacity to evaluate which models or approaches are more effective in different contexts; therefore allowing us to better make the case for the development of social prescribing services, and support the sharing of good practice more widely.

**Poor awareness of work as a health outcome**

Another challenge that we identified was the low recognition among services that work is a potential means by which health and wellbeing can be improved, rather than something which can only be contemplated once health and wellbeing has been improved. As such, work is often seen as a longer term goal – one which may or may not be achievable in the time period that a social prescribing service has to work with a client (see below), with shorter term goals prioritised. Indeed, though it is true that not all clients will be ready or able to consider work as a first step, others may benefit from a speedier focus on work, as has been seen to benefit some people with severe and common mental health conditions using the Individual Placement and Support model.

This is not to say that health care professionals do not recognise the importance of social determinants of health, including work. As suggested by one expert, it is fair to say that health care professionals fall into three groups: i) those who recognise and understand the importance of social determinants of health and seek to progress this more generally and through the social prescribing agenda, ii) those who recognise and understand the importance of social determinants of health, but do not see helping people with work, or debt, social isolation etc. as part of their remit, and; iii) those that haven’t moved beyond the bio-medical model of health, and don’t really acknowledge in any meaningful way the social model of health.

**Short-termism in services**

The way a service is funded may be a barrier to their effectively working towards work-related outcomes. Given that work may not be recognised as an immediate goal to work towards, but is more often viewed as a longer-term outcome of the service, if social prescribing services are not funded and provided on a longer-term basis, then such goals will not be achieved in a reporting cycle and therefore may not be seen as important, or even feasible. A longer-term approach would allow services to move beyond ‘fire-fighting’ and crisis management, and place more emphasis on longer term outcomes such as work.

> “I see employment as one of the key tenets in a person's well-being. For that reason I think it should feature in social prescribing programmes' specifications. I would caveat that by saying that it is important to recognise that a social prescriber might not necessarily be able to take someone all the way to employment, so it is important to consider what other advances a client might have.”

Questionnaire response

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Lack of expertise around work and related challenges (e.g. welfare system)

A number of the Link Workers we spoke to did not feel confident in addressing work issues. This was a particular challenge given the reported lack of appropriate employment support services in the community. This was further reflected in conversations about the welfare system and the Work Capability Assessment (WCA), where Link Workers were on occasion asked to provide support and advice that they did not feel they were qualified to.

As noted above, there was apprehension among Link Workers about encouraging people towards work before they were ready. One of the principles of Individual Placement and Support is everyone is eligible, and all that is required for access to employment support is an expressed motivation to ‘give it a try’; reflecting the evidence that wanting a job is overwhelmingly the most important factor for successful placement in paid employment.\(^{(60, 61)}\)

A further challenge here is keeping any work conversation and support distinct from the welfare system, with difficulties relating to work capability assessments and transitions to universal credit being noted as sources of concern for many clients. Providing welfare advice also requires expertise that Link Workers need to possess or have access to.

Availability and quality of local service provision

Having appropriate expertise is also important given Link Workers are expected to make judgements on the quality of any local employment support services, particularly on whether their approach is evidence-based. More generally, the apparent scarcity of good quality work support services in the areas where our case study organisations are based means that Link Workers have few options available to refer clients to. Whilst social prescribing can provide a range of general benefits, there is also evidence on employment-support services which improve employment outcomes for people with severe health and social barriers to work. Improving the evidence base on what types of services are effective, and improving access to them is a key challenge to be addressed.

It must also be recognised that community services are limited in their capacity by their funding. In order for social prescribing to be effective, resources need to be put into the community as well to support the development and sustained existence of good quality support services.

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Conclusions and Implications

In this paper we consider the social prescribing model through an employment lens. We found considerable potential for social prescribing to help clients to gain work, as part of the larger goal of improving health and wellbeing. We also found, however, that this aspect was not optimised, and employment was seen as relatively low priority within the model, with limited formal recognition or dedicated support available, and no outcomes measured.

We argue that work, and good quality work in particular, should be afforded more attention in this context. Good work is not only often beneficial for health and wellbeing; if someone is engaged in work then it is likely the according health and wellbeing benefits will be sustained. Indeed, this is particularly relevant where the social prescribing service or the community activities are time-limited, as it offers a longer term opportunity.

In order to optimise the contribution of social prescribing to sustained health and wellbeing outcomes, there needs to be greater recognition amongst commissioners, health professionals, social prescribing services, Link Workers and clients that with the right support work is something which is achievable, even in the short-term, and in the face of apparently considerable barriers.

If we are to take social prescribing to the next level, in terms of better integrating a work focus into social prescribing, employment needs to become a more considered part of it. This can be achieved by changes at several stages within the social prescribing 'journey'.

First, we would argue that positive conversations about work can begin early, as part of the initial assessment, building on the use of tools such as the Wellbeing Star. At this stage, if clients feel that work is something that they want and would be valuable for them, then it is important that Link Workers are positive about this possibility, and begin to explore this with the client and with community service providers. It must be better recognised that work can be approached early in the journey, and that someone does not have to be completely well to engage with work. This was a finding of the evaluation of IPS in IAPT, which found that some people wanted the employment support over the treatment\(^\text{62}\). In order to do this, Link Workers may need to be provided with guidance and training on the role that good work can have in terms of achieving broader recovery outcomes, and what evidence-based employment support looks like. This is also relevant in ensuring that Link Workers are equipped to manage, or can refer people to appropriate support to help with, enquiries relating to welfare and related processes (such as the Work Capability Assessment). As seen above, this is a major cause of stress for many clients, and the services need to be equipped to manage this as part of the health and wellbeing remit.

Second, is ensuring that there are good quality employment services (including welfare support) in the community. This may be particularly relevant where the social prescribing service interaction is time-limited, as it will be important to make sure that the client has access to all relevant services during their time with the Link Worker, and that they are engaged with appropriate support at discharge. Including work aspiration and support in the discharge process might be a way of enabling this. Link Workers should be encouraged to explore the options for employment support in the local community as part of wellbeing agenda. We recognise that many local areas may not have services of appropriate quality; therefore, there may be value in developing guidance for Link Workers to improve their confidence in this area; to enable and empower them to identify appropriate services, or to commission appropriate services (where the service has capacity).

Third, is in terms of outcome development and measurement. Currently we are unable to rigorously assess the extent to which social prescribing is achieving work outcomes, nor which model is most effective (and cost-effective) in doing so. Though we are able to draw out some of the key features as regards work, without specific data collection on work outcomes we cannot identify what services are finding particular success in this regard, and why. Encouraging the collection of data on work and related outcomes – as a standalone measure or as a proxy for functional recovery or self-efficacy – will not only allow us to evaluate, compare and improve services, but will also improve recognition of the importance of work as a key determinant of health and wellbeing.

We would not recommend a particular approach to social prescribing based on this research. Not only do we not have the data, but we also recognise the considerable variation in the models we looked at and some variation in who their clients are. For example, in Rotherham clients were referred from secondary mental health services and were relatively stable at the time of referral, while in other sites people were more likely to be referred at a time of crisis. The person-centred approach of social prescribing prohibits any approach that is too structured. We do however think that there are some key features of what a good social prescribing service might look like, which could be developed to encourage good practice, and can be built on as we continue to learn about social prescribing.

In summary, we believe the role of social prescribing in improving access to work, as a means of achieving client objectives and sustainable health and wellbeing goals, could be improved through the following recommendations, which are easily achievable and can offer tangible benefits to clients:

1. Include work, as a social determinant of health and wellbeing, as an outcome measure. This would have multiple benefits. It would reflect the broader agenda of improving the integration of work outcomes in the health system. This is driven by the increasing recognition of the benefits that good work can have for people in terms of managing and preventing poor health and improving wellbeing, as well as other social benefits, and by the recognition that GPs in particular can be an important influence on the extent to which people perceive themselves as being able to work. Collecting employment related data may also help engage a wider range of funders, as well as longer-term funding, given that these will in many cases be longer-term objectives. Further, in collecting consistent data on work-outcomes across social prescribing we will be enabled to compare, contrast, and learn how to achieve these goals better.

   As well as basic employment outcomes, i.e. work entry and sustainment, measures such as the Work Ability Index\textsuperscript{64} or the Job Seeker Self Efficacy scale\textsuperscript{65,66} might be useful tools.

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to assess where people’s barriers to work might be and the progress being made to address them. It will also help social prescribing services to measure the work-related impact that they have had, even if their remit does not stretch as far as returning someone to employment. Further, referral to employment support might be an outcome for those services who only work with clients on a short-term basis.

2. Develop good practice guidance on what social prescribing services should look like to achieve sustainable health and wellbeing outcomes. Previous research has stated that there is little good quality evidence to inform the development of social prescribing programmes.(67) These guidelines should be sufficiently flexible to reflect the person-centred approach of the service, and the commissioning arrangements, as well as the fact that some services have taken a bottom-up approach, such as Bromley by Bow, that is unlikely to be replicable. Further, these guidelines should be a work in progress, with space to evolve as we learn more about effective practice.

This should include guidance for Link Workers on the value of work and what effective work and welfare support might look like. We need to be sure that Link Workers are appropriately skilled and confident in supporting clients who would like to work to begin progressing towards this goal as soon as possible, and to ensure they are linked into support at discharge. It is recognised that in many cases Link Workers will not have a quality local service to refer or discharge clients into to assist with this goal. Ideally therefore, social prescribing services should have the capacity to commission services which fill gaps in community service provision, based on client demand.

Models such as the Bridging the Gap(68), and the lessons from other health and employment integration pilots, such as IPS in IAPT, and other evidence-based models(69) will provide valuable insights into what support is most appropriate and effective for achieving employment outcomes for people with LTCs and other barriers to work.

We believe that social prescribing offers an opportunity to improve health and wellbeing for a wide range of people, and would like to see its expansion to enable more people to benefit from its holistic, person-centred approach, and engage with valuable community services. Furthermore, we call for social prescribing to be taken to the ‘next step’ and action be taken to optimise the role of the service in supporting work opportunities for those clients for whom this is a desirable outcome, and as a means to improving health and wellbeing.

In the context of the new Green paper on Work, Disability and Health(70), social prescribing has been suggested as something to explore. The purpose of this project was not to investigate the feasibility of the use of social prescribing within the welfare system, but we feel it might be useful to provide comment based on the experience of conducting the research.

As discussed above, we believe that social prescribing has considerable potential to support some of the people farthest from work, with multiple and complex health and social barriers, to achieve their work-related goals. A key word here is their; social prescribing is both voluntary and person-centred, which requires activities to be led by the individual. This is unlikely to be compatible with conditionality and the mandatory aspects of the UK welfare to work programme. Indeed, the evidence of social prescribing as it is, hinges (much like Individual Placement and

(67) The University of York Centre for Reviews and Dissemination ‘Evidence to inform the commissioning of social prescribing’ Accessed at: http://www.york.ac.uk/media/crd/Ev%20briefing_social_prescribing.pdf [October 2016]
(68) Evaluation to be published.
Support) on the individual’s motivation and interest. The purpose is to empower individuals, build their efficacy and capacity, to be given sufficient time to do so, and to progress at their own pace. For this approach to fit into the welfare to work system it is our impression that there would have to be considerable changes to the way in which welfare to work operates. Pressuring clients towards outcomes sought by the government would not appear reconcilable with the social prescribing model.

Additionally, we must recognise that currently the WCA and related aspects of the welfare system have been identified as stressors by social prescribing services. This presents considerable challenges, and there might consequently be reluctance among services, and GP referrers, to work with the JobCentre in this way.

It is our view therefore that the ability of the social prescribing model to achieve a range of outcomes, including work, is dependent on several factors which clash with the welfare system as it stands. This is something to be borne in mind during the current period of health and work policy and practice reform.
Case study A: Herts Help, Stevenage, Hertfordshire

Herts Help is a telephone-based social prescribing service providing free, independent support and advice to all adults over the age of 18 living in Hertfordshire. Herts Help is a partnership between Hertfordshire County Council and the NHS. It was set up in 2010 when POhWER\(^71\) won the tender to deliver a single point of access to voluntary and community services and to improve links and networking between organisations for the benefit of vulnerable people, those in crisis and people with disabilities and health conditions.

The aim of the service is to ensure that people can access a range of social support via a single point of contact; whether it is urgent support with claiming benefits, support with domestic tasks or getting out and about to meet people.

All calls go to the Herts Help contact centre. In West Hertfordshire there is also the opportunity for call handlers to triage individuals with more complex needs to a Community Navigator (experts on local voluntary and community services).

Anyone can make a referral to Herts Help with social workers, GPs, friends and family using the service. People can also self-refer. Only about 8 per cent of referrals to Herts Help are from GPs. West Hertfordshire has more referrals from GPs than East Hertfordshire due to the Community Navigator Scheme which is funded by the CCG. In practice, clients are more often women than men, most of whom are of retirement age with a large number over 75. About half have at least one long term condition. The majority of service users are in receipt of welfare payments including out of work and sickness benefits.

On receiving a referral Community Navigators will call the individual and arrange to see them either at home or at their local GP surgery. They will identify the needs of the client and will make referrals to different services or agencies to support those needs. They may remain in touch with the client over the phone or face to face to ensure that all needs are met. In contrast, for the rest of Hertfordshire, Herts Help call handlers will try to find a solution to a caller’s need there and then, sign-posting them directly to the most appropriate service or agency. Calls can be a short as 5 minutes or longer depending on the caller’s need.

The main reason for referral is to access financial support especially in a crisis. People are often referred onto Age UK and Citizen’s Advice Bureau. A high volume of referrals to the Community Navigators are for support with transportation to hospital appointments and to social activities.

In terms of measuring outcomes, Community Navigators follow up twenty per cent of cases to find out what has been achieved. They also use SF12 outcome questionnaire\(^72\) (used to measure functional health and well-being) at the 3 or 6 month point and an outcome measure similar to the Wellbeing Star Outcome model is used by Herts Help and PohWER.

\(^71\) http://www.pohwer.net/
\(^72\) https://campaign.optum.com/optum-outcomes/what-we-do/health-surveys/sf-12v2-health-survey.html
Despite the majority of participants being unemployed or economically inactive, referrals to specific employment support activity are rare especially via the telephone and online services. Community Navigators are more likely than the call centre to make referrals for specific employment-related support but this is also rare. Community Navigators were more likely to view employment as a longer term goal, while their role was more often focussed on addressing immediate crises and shorter-term goals.

Case Study B: Rotherham Mental Health Social Prescribing Service

Rotherham Mental Health Social Prescribing Service was set up in April 2015 and is co-ordinated by Voluntary Action Rotherham (VAR). It is a pilot scheme, funded by Rotherham Clinical Commissioning Group, that is due to end in March 2017.

The service receives referrals from Rotherham, Doncaster and South Humber Community Mental Health Services (RDaSH) and focuses on two groups of people: those who suffer from long-term anxiety or depression or other non-psychotic disorders and those who have experienced at least one episode of psychosis but have been stable for a minimum of two years.

The main aim of the pilot is create opportunities for service users to sustain their mental health and wellbeing outside of secondary mental health services, thus improving discharge rates and increasing capacity within services.

Rotherham Mental Health Social Prescribing Service employs two link workers known as Voluntary and Community Sector (VCS) Advisers.

RDaSH practitioners identify suitable patients to refer. One of the VCS Advisers then meets with the client and RDASH practitioner to outline the service offer and to determine if the client wishes to partake in the scheme.

The VCS Adviser meets with the client at a place of their choice (most often at the client’s home) for a full social assessment lasting an hour. The assessment is client-centred and conducted via a guided conversation using an eight point tool adapted and devised by Voluntary Action Rotherham to identify which areas of the client’s life they would like support with. They devise an action plan together and the VCS Adviser makes referrals on behalf of the client to appropriate activities and support services to help them achieve their goals e.g. debt advice, accommodation, advocacy, as well as referral or support with attending classes through befriending schemes.

As part of the funding arrangements, Voluntary Action Rotherham commissioned voluntary sector organisations and groups to deliver specific support designed to help clients overcome some of the barriers to discharge. These include 1-to-1 support to help with motivation and confidence and groups to build up resilience, personal responsibility and to create opportunities for social contact and friendships to form.

VAR work on a client-centred basis and therefore work with the goals that the client has set. These may be employment-related although most clients set goals which may be antecedents to employment such as improving confidence, accessing activities independently and voluntary work.

VAR does not have in-house services specific to employability nor does it refer to a specific employment support service. VCS Advisers do make referrals to education and training however such as the Workers Educational Association and the Learning Community. The latter, for example, offers support with computers, functional skills in English and Maths, applying for jobs and interview practice.
There is a review with the RDaSH practitioner after ten weeks and another after sixteen weeks when they do another score of wellbeing. At the ten week review, the possibility of discharge from Community Mental Health Services may be discussed with the client where appropriate. After 16 weeks the client may choose to continue any of the social prescribing activities if they are available to them but they are discharged from the social prescribing service.

VAR measure a number of different outcomes. These include measures from the NHS Outcomes Framework such as “Enhancing quality of life for people with long-term conditions” and locally defined outcomes such as “Improvements in confidence and independence,” “reduction in the use of secondary mental health services,” and “increased access to employment, training and volunteering.”

More specific outcome measures concentrate on numbers of referrals, numbers of discharges from secondary mental health, and numbers of clients who complete programmes.

A number of outcome measures record clients’ progress towards employment, training and education as well as take up of voluntary work both during and following the programme. However, these are not the primary outcomes examined by the CCG.

Some clients have gone on to gain employment following volunteering and at times this has been sustained.

Case Study C: Bromley by Bow Centre

The Bromley by Bow Centre is a community organisation based in East London, working with some of the Capital’s most deprived communities. It focuses on providing support to people who are difficult to reach through conventional channels, including young people, long-term unemployed adults, and older people. Many of the people that Bromley by Bow offers support to have health conditions that may present a barrier to work, especially in the younger and older worker groups.

The Centre offers a range of services to its users, including support in moving into work. This can include developing skills, improving health and wellbeing, enhancing ‘soft’ skills and self-confidence, and specific employment-related advice and support such as help with volunteering, work experience, job searches, setting actions plans and goals, CV-writing assistance, and interview skills. The Centre’s model – which includes dedicated employment advisors, welfare and money management advice, health programmes to help adults to remain independent and active and to achieve their priorities, and an on-site GP surgery integrated within community programmes – allows it to provide bespoke, holistic support packages, tailored to the needs of the individual. It also forges links with local employers, allowing it to provide access to both employment opportunities and to shorter term volunteer and work experience placements.

The Centre delivers “Active Futures” a programme which specialises in supporting young people aged 14-35 years with learning difficulties and mental health needs to overcome barriers to employment and wellbeing. Building on the Motivate East Paralympic legacy programme in the area, inclusive sport is used to engage young people in the services, with the aim of tackling both the low level of disability employment and engagement in sport (as only 17.8% of disabled people are participating in sport weekly). The programme is delivered by Bromley by Bow and funded by Barclays, who also provide volunteers and offer opportunities for work experience for participants.

Whilst the Bromley by Bow Centre is not part of the Work Programme, it did strongly consider this, it nonetheless supports many who are on the Programme and works closely with JobCentre to support their clients. All of its users refer themselves to the services on an entirely voluntary
basis. The Centre attributes this to its ability to maintain a good relationship with its services users, particularly in integrating the care provided through the GP and health services, and the employment advisors.

Active Futures seeks to improve wellbeing and increase employability skills, while supporting progression into work and training via three key features:

- Inspiring – building on the 2012 Legacy “Inspire a Generation”, opening up a range of opportunities within the sports and fitness sector
- Engaging – utilising the attraction of participating in inclusive sport to support young people with learning disabilities and mental health needs into further training and employment
- Accessible – providing accessible and supportive learning programmes designed specifically around the needs and capabilities of individuals, with the aim of improving employability skills alongside wellbeing.

Active Futures works with a wide range of strategic partners, including the Disability Employment Advisors in local JobCentres, the local authorities, youth, disability and mental health organisations and charities, to support referral into the programme and to enable participants to access further support and skills and employment progression pathways. Of 95 young adults engaged in the programme through 2015, 41 entered further education or training, including Sports Leadership Level 2 training and 18 secured employment or long-term apprenticeships.

Case Study D: Ways to Wellness - West Newcastle

Ways to Wellness is an umbrella organisation that delivers social prescribing in the west of Newcastle-upon-Tyne. It provides the link between the Clinical Commissioning Group and four service provider organisations. Ways to Wellness subcontracts all the delivery work, manages the finance and provides quality assurance and monitoring for the provider organisations.

Set up in April 2015, the service was developed by the Voluntary Organisations’ Network North East, in collaboration with community providers and GPs practising in West Newcastle who were passionate about social prescribing and believed it would provide an answer to the needs of their patients that could not be addressed with medication and traditional referral routes. Although the providers collaborate closely with each other, each one takes referrals from clusters of 4 or 5 GP practices located in different areas of West Newcastle.

Referrals can come from any healthcare professional - from GP practices, hospital services or community services. Patients are eligible if they have one of the following long-term health conditions: chronic breathing difficulties (COPD), asthma, diabetes (Type 1 or Type 2), heart disease, epilepsy, thinning of the bones (osteoporosis) and are aged between 40-74. The three most common reported health conditions are diabetes (Type 2), asthma, and coronary heart disease. In the first year and a half just under 2,000 patients have been referred to the service, and 1,400 are still engaged with the service.

The main goals that patients set are related to increasing their activity levels. Other people need support understanding their health condition and how to manage it and with managing depression and anxiety. Social isolation is also a frequent barrier to clients' wellbeing. A number of clients seek advice with housing and benefits.

(73) Changing Lives, Mental Health Concerns, HealthWORKS Newcastle and First Contact Clinical. This case study is based on interviews with Ways to Wellness, the CCG and two service providers- Changing Lives and Mental Health Concerns.
Some GP practices use the Year of Care approach to guide long-term condition (LTC) reviews and support self-management for people with LTCs. Ways to Wellness Link Workers link in with Year of Care approaches, where relevant. Each provider has between 5 and 7 link workers who each manage a case load of between 40 and 70 clients. Link workers make contact with the client and complete a Wellbeing Star assessment, a version of the Wellbeing Star. This is an eight-point tool used to assess people’s health and wellbeing. Link workers use this to help clients identify areas on the different dimensions where they would like to see improvements and set achievable goals for these. The link workers’ objective is to help the clients to improve their score on the chosen dimensions, which is re-assessed approximately every six months.

Link workers have no restrictions on the number of times they meet with a client, although they work on a defined budget per client, which depends upon the length of time the patients are on the programme (payments are provided approximately every six months). The criteria for discharge includes the achievement of goals or loss of contact.

Link workers identify activities and services that will help clients achieve their desired goals. They work with voluntary organisations in the area, as well as social services. Some of the Ways to Wellness service providers offer in-house activities e.g. walking groups, mindfulness groups and psychotherapy sessions provided by volunteers. They often cross-refer between providers to take advantage of this. Some clients prefer these in-house activities as they are often led by link workers they already know. HealthWORKS also runs a community network database with information on all the activities that are going on in Newcastle. If no voluntary service or known activity is appropriate for the client in question, link workers search for the desired activity or service. If the link worker believes that to accompany the client to the first session (or more) will help address communication and confidence issues, they will do so.

At Changing Lives, one of the Ways to Wellness providers, 95 per cent of clients that use the service are not working although this does include some who are retired. Not many clients are deemed ready to work or to even volunteer. Some clients would like to work but believe that no one will hire them due to their health condition which they believe prevents them from working. Others are concerned that they will lose their benefits if they work. Link Workers have referred clients to employment support services for help with CVs and work experience leading to volunteering opportunities and some clients do health-related volunteering in hospitals such as peer support. There are a few clients who are in work but often it requires long hours and is stressful. Link workers encourage clients to try to put time aside for other activities and engage in something different.

The funding model for Ways to Wellness is unique. Initial funding to develop the service model and build capacity was given by Department of Health Social Enterprise Investment Fund (SEIF) and the Big Lottery Fund. Complementary to this, the early years of delivery of the service is financed through a Social Impact Bond (SIB). The Newcastle West Clinical Commissioning Group (CCG) is committed to paying back the invested money if Ways to Wellness can demonstrate improvement on agreed outcome measures. 60-70% of the outcome payments will be based on reduced hospital visits and 30-40% of the outcome payments are linked to improvements on the Wellbeing Star outcomes. The Big Lottery Fund Commissioning Better Outcomes Fund and the Cabinet Office Social Outcomes Fund are also committed to paying up to £2 million and £1 million respectively based on achievement. These resources will allow the service to run for seven years.

(74) Managed on behalf of the Department of Heath by The Social Investment Business between 2009 and 2013, see: http://www.sibgroup.org.uk/previous-funds
(75) See: https://www.acevo.org.uk/
(76) See: https://www.biglotteryfund.org.uk/
(77) SIB funding is made at risk and investors are repaid conditional on achieving results. Investors pay for the project at the start, and then receive payments based on the results achieved by the project.