Embedding work and related outcomes into social prescribing

Overcoming challenges and maximising opportunities

The Work Foundation
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Executive summary

Purpose

In recent years, there has been increasing interest from high level national and regional policymakers in social prescribing as a means of improving public health and wellbeing. This has included growing recognition of its role in supporting individuals to find and/or retain work. This is significant given how important work – and in particular ‘good’ work – is for people’s self-esteem, personal fulfilment, and, in turn, their health and wellbeing. As such, work is increasingly being recognised as a ‘health outcome’ in and of itself.

This research has sought to investigate whether this changing policy emphasis has influenced social prescribing in practice, thus resulting in changes to social prescribing services’ work ‘offer’ and emphasis placed on work and related outcomes. We have explored the ‘value’ attached to work and the degree to which barriers to embedding work-related outcomes persist in current social prescribing services. Ultimately, we aimed to inform policymakers about the realities of social prescribing as a route to work and whether these ‘high level’ policy aspirations have come closer to being realised.

Background

Social prescribing services are gaining recognition as an innovative and effective means of improving the public’s health and wellbeing. Social prescribing enables (often primary) healthcare professionals to refer people to a range of non-clinical services, normally provided by the community and voluntary sector, where they can ‘co-create’ interventions designed to improve their health and wellbeing. It is based on the premise that health is determined by a range of factors, i.e. social, economic and environmental circumstances, and therefore improving health requires a holistic, whole-person approach. A growing evidence base suggests that social prescribing offers a number of benefits, including:

- behavioural change and lifestyle improvements;
- acquisition of learning, new interests and skills;
- better support, community integration and reduction in social isolation and loneliness;
- improvements to physical health.

Social prescribing has also been recognised for its role in supporting individuals to find and/or retain work, i.e. producing work and related outcomes. That social prescribing can produce work and related outcomes (e.g. finding work or volunteering), is significant given how important work is for people’s health and wellbeing. Work is a key determinant of self-worth, status and social participation and fulfilment. For most people, being in work – particularly ‘good’ work (where people have autonomy, control, support, etc.) – protects and improves their health, while being out of work has the opposite effect. As such, recent years have seen increasing emphasis, by policymakers and practitioners alike, placed on what can be done to integrate people with complex, long-term, chronic health and social problems into the workforce; thus recognising the value of ‘work as a health outcome’.

Through its holistic, whole-person approach, addressing and improving a wide range of health and wellbeing outcomes and their determinants, there is increasing interest in the potential of...
social prescribing services to succeed where ‘traditional’ clinical interventions have failed, potentially serving as a means of integrating people with complex, long-term, chronic health and social problems – a group with low rates of employment – into work. This was the premise of a previous (2016) Fit for Work Coalition/Work Foundation report7, which explored how widespread employment-focused services were within the social prescribing ‘sector’. It hypothesised two ‘pathways’ to work:

(i) **direct**: where an individual is referred to a work-focused service; and

(ii) **indirect**: where, by first addressing basic needs and building on people’s ‘assets’, (e.g. improving confidence and self-esteem, reducing symptoms of anxiety and depression, as well as providing education, training and volunteering experience, social prescribing can break down the barriers to work), this equips people with the skills they need to find – and stay in – employment.

It found that work and related outcomes were not a common feature of the social prescribing landscape at that time and therefore the true potential of a ‘work focus’ for health and wellbeing benefits was not being realised.

Since the publication of this report, the social prescribing policy landscape has changed significantly. There has been increasing attention from high level national and regional policymakers of its value in improving the public’s health and wellbeing, and specifically as a route to work for people with long-term health conditions. For instance, the Government Joint Work and Health Unit’s8 2017 *Improving Lives* command paper stated that it “will work with NHS England and the Social Prescribing Network to explore opportunities to increase, where appropriate, the focus on work as a route to improved health and wellbeing, and to embed employment outcomes into evaluation measures”9.

Social prescribing as a route to work is also now included in the Joint Work and Health Unit’s programme of work. As part of this, it has worked with NHS England and the Social Prescribing Network (which has grown from 400 to almost 2,000 members in the last two years), informing the development of the ‘Draft Common Outcomes Framework for Social Prescribing’. Released in April 2018, it calls for a “consensus on what outcomes should be measured to show the impact of social prescribing”, aiming to ‘map’ social prescribing’s “main outcomes”, including “employability, including staying in work, finding new employment”, as well as wider work-related outcomes including volunteering, accessing training and gaining qualifications10.

It is in this context that we carried out this new research, exploring how the sector and social prescribing services have changed and hence whether the ‘high level’ policy aspirations to enhance the focus on work and related outcomes in social prescribing has come closer to being realised in practice.

**Key findings**

The 2016 FFW/WF paper found that whilst there was a “lack of recognition in the literature” of social prescribing as a route to work, in practice there was considerable “potential for social prescribing to progress closer to work via an ‘indirect pathway’, (i.e. as part of the larger goal of improving health and wellbeing).

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8 Combining expertise from the Department of Health and Social Care the Department for Work and Pensions
In contrast, the literature review for the present study found that, to degree, this had changed: a number of evaluations, with an explicit emphasis on social prescribing as a route to work, were published in the last two years. In addition, there were more references to work and related outcomes (e.g. whether clients found work, went into volunteering, training or education). That said, as with the 2016 study, the evidence suggested that, primarily, social prescribing services still provide an indirect route to work (rather than direct), first addressing more basic needs through non-work activities which can lead to education, training and volunteering, for example.

Building on the findings from the literature review, the findings from a survey of Social Prescribing Network members carried for this study also revealed widespread recognition of social prescribing serving as a route to work. There was also further confirmation that the ‘indirect route’ appears to be the most common focus. Volunteering, for example, was again frequently cited – as it was in the literature review.

The findings from primary and secondary research conducted with four social prescribing services found that these services are located more towards the holistic ‘end’ of the social prescribing spectrum: all had strong partnerships with third/voluntary sector organisations, dedicated Link Workers and feedback/monitoring mechanisms in place. Whilst getting people into work via a ‘direct route’ was not prioritised by these services, there was, arguably, more value attached to work. For instance, there was, comparatively, much greater recognition – and emphasis placed on – social prescribing as an indirect route to work (described as a ‘positive upward spiral’). Also, all services now collected some form of work/employment data (unlike in 2016).

In addition, some service changes indicated a move towards greater integration of work and related outcomes. For example, discussions had taken place with Jobcentre Plus and an education/training provider had been brought into one of the services. Though consistent with them, it was not clear whether these changes were linked with the changes in policy emphasis discussed earlier.

Overall, the findings suggest that social prescribing services still sit primarily in the health ‘space’ and thus there is a strong focus on health/clinical priorities. Indeed, other service changes had been driven primarily by clinical priorities/changes in client base, arguably representing moves away from integrating work and related outcomes. Also, referrals still came exclusively from the health and social care system. As such, there was some evidence of a potential ‘cultural issue’ around a lack of recognition of the role work plays in improving health and wellbeing. Furthermore, there were concerns over the length of time it takes social prescribing services to produce outcomes, and the need for any emphasis on work and related outcomes to account for this (hence the greater recognition of social prescribing services as an ‘indirect route’ to work). Furthermore, some felt that social prescribing – being distinct from employment services – should not, and does not have the capacity/expertise to, focus on work and related outcomes. That said, there was recognition that links with wider employment-focused services, e.g. JCP, could provide a solution to this.

This updated study suggests that further integrating work and related outcomes into social prescribing schemes still presents a number of challenges. That said, with growing awareness of the value of social prescribing amongst high level policymakers and its potential to integrate people with complex, long-term health conditions into the workforce – and recognition, within the sector, of how it (indirectly) does this – there are clearly a number of opportunities as well.

With additional resource being put into social prescribing by the NHS through the Outcomes

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11 The same services featured in the 2016 FFW/WF report
Framework, it is important these challenges are overcome and opportunities maximised, thus reducing the ‘gap’ between policy aspiration and practice.

Key challenges identified by the research can be broadly categorised as cultural and practical barriers. The cultural barriers relate to social prescribing sitting in the health/clinical ‘space’. Due to this, funders/commissioners, referrers and Link Workers may not widely view work as a means of improving people’s health. This shapes targets and outcomes and, in turn, services’ behaviour. Other models, e.g. Individual Placement and Support, show that, with the right support, potentially anybody is able to work providing they want to. Thus, greater awareness of ‘work as a health outcome’ amongst social prescribing stakeholders could break down these barriers. Lessons can also be learned from employment-focused services using social prescribing principles, e.g. the Raising Aspirations pilot in Tower Hamlets, while bearing in mind the importance of putting emphasis on the ‘indirect pathway’ to work.

Practical barriers may, in addition, relate to the lack of experience and capacity to support clients on a journey to work. The input of new funding that incentivises work and related outcomes, (e.g. from government), could help fill this gap in capacity alongside training for Link Workers to ensure they have the required expertise. Indicators would, however, have to account for the likely long length time it would take to produce these outcomes, as well as the highly diverse nature of social prescribing interventions, recognising social prescribing appears to work best as an indirect route to work. Thus, outcomes may not be directly comparable to those produced by more conventional, shorter-term, work-focused programmes that lend themselves to more rigorous evaluation. There are also specific challenges to scaling-up social prescribing and its work ‘offer’, given how important local connections and relationships are to services’ effectiveness. Finally, another barrier relates to the variation in social prescribing models, with more basic signposting/‘light’ services being ill-equipped to support clients on a long journey into work.

Key opportunities presented by further integrating work and related outcomes relate to the need for a work-related social prescribing tool/methodology that can successfully articulate how social prescribing, (most likely) via an indirect pathway, can lead to work that satisfies both funders and policymakers. This can help ‘make the case’ for expanding social prescribing’s proven track record in and strong reputation for partnership working into the employment ‘space’, further breaking down the barriers separating health practitioners and work-focused providers. This would benefit from greater awareness of ‘work as a health outcome’ amongst healthcare professionals generally (specifically GPs) as well as stakeholders (e.g. Link Workers) involved in the social prescribing process. Pooled funding could be an effective mechanism for doing this.

Recommendations

These recommendations serve as advice to policymakers regarding how to overcome the challenges – identified by the research – associated with integrating work and related outcomes and how the opportunities outlined above can be maximised.

Recommendation 1: Improve awareness of ‘work as a health outcome’ among social prescribing stakeholders

Greater awareness of the health protecting and improving role work can play amongst funders/commissioners, referrers and Link Workers will naturally increase the emphasis social prescribing services place on work and related outcomes.
The Department of Health and Social Care (DHSC) have committed to creating an ‘online social prescribing platform’ in 2019 for commissioners and healthcare staff\(^\text{12}\). This platform should provide information on the role work plays in improving health and wellbeing and how social prescribing can serve as a route to work, thus potentially informing funders/commissioners’ priorities.

Furthermore, the proposed ‘National Academy for Social Prescribing’, also committed to by DHSC to provide GPs and other health professionals with guidance, expertise and knowledge of what works/is available in local communities, should promote work as a health outcome and how social prescribing contributes to it, thus potentially influencing referrals. By acting as a repository for knowledge on ‘what works’, it can serve as a platform for ‘best practice sharing’ in supporting clients into/towards work (e.g. Bromley by Bow Centre).

The DHSC have also committed to providing a national training scheme for Link Workers. This could serve to improve Link Workers’ awareness around how work can improve health and wellbeing and make an informed decision over whether a client can work (if they want to). It should draw on successful examples provided by Individual Placement and Support, which helps people with health conditions that want to into work, and the *Raising Aspirations* pilot – a work service using social prescribing methods to support people with complex health and social issues into work.

** Recommendation 2: Facilitate partnership working to include employment-focused services**

Social prescribing is extraordinarily good at building trust and partnerships between local health services and wider services in the VCS. This partnership approach could be extended to include employment bodies/services operating in the local community. Clients who have had/do not need more ‘basic’ needs met could be linked with these services towards the end of their ‘journey’ towards work.

Examples of how this works in the social prescribing space are provided by the *Raising Aspirations* pilot and the *Bromley by Bow Centre*. Both highlight the importance of co-locating staff from different agencies in a single place, removing the separation between the ‘clinical’ and ‘social’ (including employment) space. In the case of the former, Jobcentre Plus were directly involved.

Social prescribing services should, where appropriate, consider the possibility of taking referrals from Jobcentre Plus (JCP; providing clients’ needs are suited to what the service offers). Two services featured in this research have already spoke with JCP about this and the *Raising Aspirations* pilot provides a ‘template’ for how this might work in practice. The Joint Work and Health Unit (i.e. DHSC and Department for Work and Pensions; DWP) and NHS England could facilitate these conversations. JCP involvement should be considered carefully, however – social prescribing clients should not be put at risk of thinking that work might in any way be considered mandatory.

Existing examples of how this might work in practice are provided by WorkingWin’s ‘Health-led Employment Trial’ in Sheffield\(^\text{13}\), which supports people with health conditions that want to find/stay in work. Through co-design (a social prescribing principle), it unites different stakeholders (local Combined Authority, JCP and health

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13 See: https://www.workingwin.com/articles/the-health-led-employment-trial
service) around a common goal, recognising that role work plays in improving and sustaining people’s health and wellbeing.

**Recommendation 3: Diversify/pool social prescribing services’ funding streams beyond the health and social care system**

Currently, funding for social prescribing schemes comes primarily if not exclusively through the health and social care system, which inevitably influences what targets are set and which outcomes are measured.

- Given that social prescribing currently forms part of the Joint Work and Health Unit’s programme of work, it should explore ways of funding social prescribing services or pilots incentivising targets and outcomes that do not sit entirely in the health/clinical ‘space’, but still prioritise clients’ health and wellbeing through more work-focused measures.
- With emphasis placed on work and related outcomes by NHS England’s Draft Common Outcomes Framework and the anticipated release of new funding attached to this, this could provide social prescribing services with access to pots of funding tied to improving clients’ health and wellbeing through work and related targets.

**Recommendation 4: Carefully develop work and related outcomes for social prescribing services**

The integration of work and related outcomes into social prescribing must be carefully managed. In short, they must account for what is most likely to be an ‘indirect’ route to work.

- The Joint Work and Health Unit and NHS England through the Draft Outcomes Framework should focus on work and related outcomes that account for the complexity of clients’ needs and thus include a long-term time component. Furthermore, they should assess clients’ ‘journeys’ towards work using bespoke tools tracking progress against ‘stepping stones’ to work like volunteering, education and training and explicitly record them as such.
- Examples of diagnostic tools used in similar services, e.g. the *Raising Aspirations* pilot can provide a ‘template’ for what work and related outcomes should look like/how they could be measured.
- Given the likely long timescales involved, interest in social prescribing as route to work from Government departments like DWP must not be predicated on the expectation of an immediate/expedient return to work and similarly not impose any form of PBR.

**Recommendation 5: Commission new research to develop bespoke tools/methodologies**

Social prescribing is a powerful means of reintegrating the ‘hardest to reach’ groups into the community, improving their health and wellbeing, and, by first prioritising their basic needs, empowering them to take steps towards employment. There is a distinct lack of evidence demonstrating the value of social prescribing in this regard.

- To evidence social prescribing’s effectiveness as a route to work and, in turn, make a ‘business case’ to ministers in government departments, e.g. DWP, there is a need to develop a bespoke tool/methodology that accounts for the diversity in social prescriptions and the ways in which they break down clients’ barriers to work