

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; and,
- improvements to physical health^{1,2,3,4}.

Social prescribing has also been recognised for its role in supporting individuals to find and/or retain work, i.e. producing work and related outcomes⁵. 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 fulfilment⁶. 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

¹ <https://www.tandfonline.com/doi/full/10.1080/17533015.2017.1334002>

² <https://bmjopen.bmj.com/content/7/7/e015203>

³ <https://www.ncbi.nlm.nih.gov/pubmed/29130869>

⁴ <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3437-7>

⁵ University of Westminster. (2018). What does successful social prescribing look like. Mapping meaningful outcomes. *Unpublished presentation*

⁶ Black Working for a Healthier tomorrow

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).

⁷ Steadman, K., Thomas, R., & Donnalaja, V. (2017). Social prescribing: a pathway to work? London: The Work Foundation.

⁸ Combining expertise from the Department of Health and Social Care the Department for Work and Pensions

⁹ Department for Work and Pensions and Department of Health. (2017). *Improving Lives*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

¹⁰ NHS England. (2018). Draft Common Outcomes Framework for Social Prescribing. Retrieved from: <https://www.somersetccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=6915>

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 services¹¹ 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

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 staff¹². 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 Sheffield¹³, 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

¹² HM Government. (2018). A connected society. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Loneliness_Strategy_web_Update.pdf

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

Contents

1. Introduction	1
1.1. The context	1
1.2. This paper	2
2. The social prescribing landscape: existing evidence	4
2.1. What is social prescribing?	4
2.2. Changing policy emphasis around social prescribing	8
2.3. The changing evidence base	10
2.4. Concluding comment	12
3. Social prescribing and work in 2018	13
3.1. Survey findings 2018	13
3.2. Findings from the qualitative research 2018	15
3.3. Concluding comment	21
4. Embedding work into social prescribing: challenges and opportunities	22
4.1. Challenges presented by further integrating work into social prescribing	22
4.2. Opportunities presented by further integrating work into social prescribing	26
4.3. Concluding comment	28
5. Conclusions and recommendations	29
5.1. Conclusions	29
5.2. Recommendations	31
Appendix	35

List of Figures

Figure 2.1 – Draft Common Outcomes Framework for Social Prescribing	10
Figure 4.1 – Herts Help service overview	16
Figure 4.2 – A ‘positive upward spiral’ – how social prescribing can lead to work	19

List of Boxes

Box A – Social prescribing model typology	4
Box B – Employment rate (%) by number of health conditions (age 16-64, April – June 2016)	6
Box C – Most common reasons for referral	13
Box D – Most common client goals	13
Box E – Service changes in Rotherham	18
Box F – Service changes in Hertfordshire	18
Box G – Service changes in Bromley	18
Box H – Client A journey towards work	20
Box I – Client B journey towards work	20

1. Introduction

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, and the role it can play helping people secure work. This study has sought to investigate whether this changing policy emphasis has influenced social prescribing in practice. A particular focus has been whether social prescribing services' work 'offer' has changed, with more emphasis placed on work and related outcomes, thus seeing work as an important health outcome. Ultimately, the study 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.

1.1. The context

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; and,
- 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. This is especially 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 report¹⁴, 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

¹⁴ Steadman, K., Thomas, R., & Donnalaja, V. (2017). Social prescribing: a pathway to work? London: The Work Foundation.

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’s¹⁵ 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”¹⁶.

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 qualifications¹⁷.

It is in this context that we carried out this new research, updating the findings from the 2016 study.

1.2. This paper

1.2.1. Aims and methods

We sought to investigate whether this changing policy emphasis has influenced social prescribing in practice (while recognising that some of the more recent changes in policy emphasis would not yet have filtered through), thus resulting in more emphasis on work and related outcomes and changes in the work ‘offer’. We explored the ‘value’ attached to work and the barriers to embedding work-related outcomes into social prescribing services. Ultimately, we aimed to inform policymakers about the feasibility of social prescribing as a route to work and whether these ‘high level’ policy aspirations can be realised.

To do this:

- *first*, we reviewed academic and grey literature published between 2016 and 2018, exploring whether any research had been conducted on work and related outcomes in social prescribing, what factors influence the work ‘offer’ and any lessons that can be learned from this;
- *second*, we distributed a short survey to members of the Social Prescribing Network, the aims being to (i) better understand how work and related outcomes are integrated into social prescribing in practice and services’ work ‘offer’, and (ii) determine get an

¹⁵ Combining expertise from the Department of Health and Social Care the Department for Work and Pensions

¹⁶ Department for Work and Pensions and Department of Health. (2017). *Improving Lives*. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

¹⁷ NHS England. (2018). *Draft Common Outcomes Framework for Social Prescribing*. Retrieved from: <https://www.somersetccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=6915>

indication of whether the emphasis placed on work and related outcomes has increased since 2016;

- *finally*, we conducted primary – qualitative – and secondary research with four, geographically spread, social prescribing services that featured in the 2016 report, as well as an interview with providers of an employment-focused service that used social prescribing principles (*Raising Aspirations* in Tower Hamlets), and interviews with four senior social prescribing stakeholders¹⁸.

1.2.2. Paper structure

Chapter 2 explores how the social prescribing ‘landscape’ has changed in the last two years and in doing so sets the ‘policy context’ to the study. It begins with a definition of social prescribing, its benefits and how it acts as a route to work. It then outlines the growing importance of social prescribing in policy – both generally and as a route to work – before discussing the findings from the literature review.

Chapter 3 outlines the findings from the primary research conducted for this study. First, the survey findings are presented, followed by the research involving the four services featured in the 2016 report with explicit emphasis on changes that have occurred since and the implications for their work ‘offer’.

Chapter 4 explores the challenges and opportunities to further integrating work outcomes into social prescribing identified by the research.

Chapter 5 offers our overall conclusions and recommendations on how the challenges to further integrating work and related outcomes into social prescribing can be overcome, and how the opportunities can be maximised, serving as advice to policymakers.

¹⁸ Including: two Social Prescribing Network Steering Group members; a member of the London Mayor’s office leading on the development of a social prescribing vision for London; and an academic involved in WorkingWin ‘Health-led Employment Trials’ in Sheffield.

2. The social prescribing landscape: existing evidence

This chapter explores how the social prescribing ‘landscape’ has changed in the last two years and in doing so sets the ‘policy context’ to the study. It begins with a definition of social prescribing, its benefits and how it acts as a route to work. It then outlines the growing importance of social prescribing in policy – both generally and as a route to work – before discussing the findings from the literature review.

2.1. What is social prescribing?

Though it is attracting increasing interest from policymakers, practitioners and academics, there is still a lack of consensus regarding what, exactly, constitutes social prescribing. That said, there is some agreement that, at its most basic, it is a process where “primary care patients are linked or referred to non-medical sources of support in the community and voluntary sector”¹⁹. Typically, people will be *referred to a ‘Link Worker’* for a face-to-face conversation during which they can *design their own personalised* (i.e. person-centred) *solutions*, (i.e. ‘co-produce’ their own prescription, thus empowering them to improve their health and wellbeing)²⁰. Most referrals come from the health and social care system, primarily from GPs but also from hospitals and specialised medical services.

By enabling healthcare professionals to refer people to a range of non-clinical services, social prescribing represents a departure from the ‘medical model’ of health. It recognises that illness and health status is caused and determined by a range of non-medical, social, economic and environmental factors, and that any ‘intervention’ or ‘prescription’ should address these, (i.e. embrace a holistic or ‘whole-person’ approach, thus acting on the social determinants of health)²¹. Whilst funding sources vary, the majority are from the health and social care system, for example via Clinical Commissioning Groups.

Box A – Social prescribing model typology

- **Signposting.** Signposting is an integral part of the social prescribing pathway in all models. Essentially, it involves referrers (mostly GPs) pointing patients towards appropriate support/projects in the community best placed to help them. Often, there will be no relationship between the referrer and the organisation they point to and minimal contact/follow-up with the patient.
- **Social prescribing light.** The most widespread model, comprising community or primary care-programmes referring people to a specific programme to achieve specific objectives. Feedback/monitoring mechanisms may not be in place.
- **Social prescribing medium.** Still addresses specific needs/behaviours but delivered through partnership with third sector/voluntary organisation with formal assessment from a ‘health facilitator’ or Link Worker. More likely to have feedback/monitoring mechanisms in place.
- **Holistic:** Involves direct primary care integration and referral, a comprehensive network of local provision, strong partnership working, and consideration of all aspects of support – including budgeting, nutrition, addiction, loneliness, access to employment, etc. Goes beyond addressing specific needs.

Source: Kimberlee et al. (2015)²²

¹⁹ Pilkington, K., Loeff, M., & Polley, M. (2017). Searching for real-world effectiveness of health care innovations: Scoping study of social prescribing for diabetes. *Journal of Medical Internet Research*, 19(2).

²⁰ See: <https://www.westminster.ac.uk/patient-outcomes-in-health-research-group/projects/clone-of-social-prescribing-network>

²¹ World Health Organisation. (2008). *Closing the gap in a generation*. Retrieved from <http://www.bvsde.paho.org/bvsacd/cd68/Marmot.pdf%5Cnpapers2://publication/uuid/E1779459-4655-4721-8531-CF82E8D47409>

²² <http://eprints.uwe.ac.uk/24818/1/808-2245-1-PB.pdf>

Social prescribing services generally fall into four broad categories (though some overlap between them is inevitable). Models range from basic *signposting* services to more *holistic* provision (see Box A above for an overview). While signposting is sufficient for some clients (e.g. those with less complex needs), *the more holistic the service, the better the outcomes*²³. More holistic services will have more and *better links with the local community*, ensuring a wider range of client needs can be met. Furthermore, in such services, *Link Workers* – widely considered integral to success of social prescribing services^{24,25} – spend more time with clients and are more likely to be *co-located* in GP surgeries – both important factors for producing optimal outcomes.

2.1.1.1. The benefits of social prescribing

Conceived as a health intervention, primarily in the clinical ‘space’, assessments of the effectiveness of social prescribing have often concentrated on clinical factors²⁶, e.g. reductions in: demand for general practice^{27,28}, accident and emergency (A&E) attendance^{29,30}, and other secondary care services like emergency hospital admissions³¹. That said, there is growing recognition of the broader benefits of social prescribing. For example, recent studies have shown that social prescribing can lead to: improved mental health, i.e. improved confidence, self-esteem, reduction in anxiety, depression, etc.³²; better health/lifestyle behaviours³³; acquisition of new skills³⁴, and reductions in loneliness/isolation³⁵.

Given the diverse range of outcomes associated with social prescribing, attempts are currently being made by researchers at University of Westminster to develop a comprehensive account of its positive effects and impacts. This includes outcomes related to *mental health*, e.g. anxiety, depression, self-esteem confidence; *social outcomes* like isolation, loneliness, self-worth, quality of life; *physical and lifestyle outcomes* like blood pressure and diet; and (what they refer to as) *‘circumstantial’ outcomes* like education, training, volunteering and employment³⁶.

The growing recognition that social prescribing can produce work and related outcomes, either by directly supporting clients into jobs, or indirectly by improving their ‘employability’ (i.e. setting them on a ‘journey’ towards work through activities like volunteering, education and training), is significant given how important work is for people’s health and wellbeing. Indeed, it is a key determinant of self-worth, status and social participation and fulfilment³⁷. As such, social prescribing, by providing a route to work – particularly ‘good’ work (where people have autonomy, control, support, etc.) – can serve as an important means of improving and

²³ Salford CVS and the University of Salford. (2018). Social prescribing in Greater Manchester. *Forthcoming*

²⁴ <https://bmjopen.bmj.com/content/7/7/e015203>

²⁵ <https://bmjopen.bmj.com/content/7/4/e013384>

²⁶ <https://westminsterresearch.westminster.ac.uk/item/q1455/a-review-of-the-evidence-assessing-impact-of-social-prescribing-on-healthcare-demand-and-cost-implications>

²⁷ Kimberlee, R., Ward, R., Jones M. and Powell J. (2014) Proving Our Value: Measuring the economic impact of Wellspring Healthy Living Centre’s Social Prescribing Wellbeing Programme for low level mental health issues encountered by GP services. University of West England

²⁸ Longwill, A. (2014) Independent Evaluation of Hackney Well Family Service, Family Action.

²⁹ Bertotti, M., Frostick, C., Findlay, G. Harden, A., Netuveli, G., Renton, A., Carnes, D., Sohanpal, R. Hull, S and Hutt, P (2015) Shine 2014 final report Social Prescribing: integrating GP and Community Assets for Health, Health Foundation

³⁰ Farenden, C., Mitchell, C., Feast, S. and Verdenicci, S. (2015) Community Navigation in Brighton & Hove. Evaluation of a social prescribing pilot, carried out by Impetus

³¹ Palmer, D. Wheeler J, Hendrix, E., Sango, P N, Hatzidimitriadou E. (2017) Social Prescribing in Bexley: pilot evaluation report, Mind in Bexley

³² <https://www.tandfonline.com/doi/full/10.1080/17533015.2017.1334002>

³³ <https://bmjopen.bmj.com/content/7/7/e015203>

³⁴ <https://www.ncbi.nlm.nih.gov/pubmed/29130869>

³⁵ <https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3437-7>

³⁶ University of Westminster. (2018). What does successful social prescribing look like. Mapping meaningful outcomes. *Unpublished presentation*

³⁷ Black Working for a Healthier tomorrow

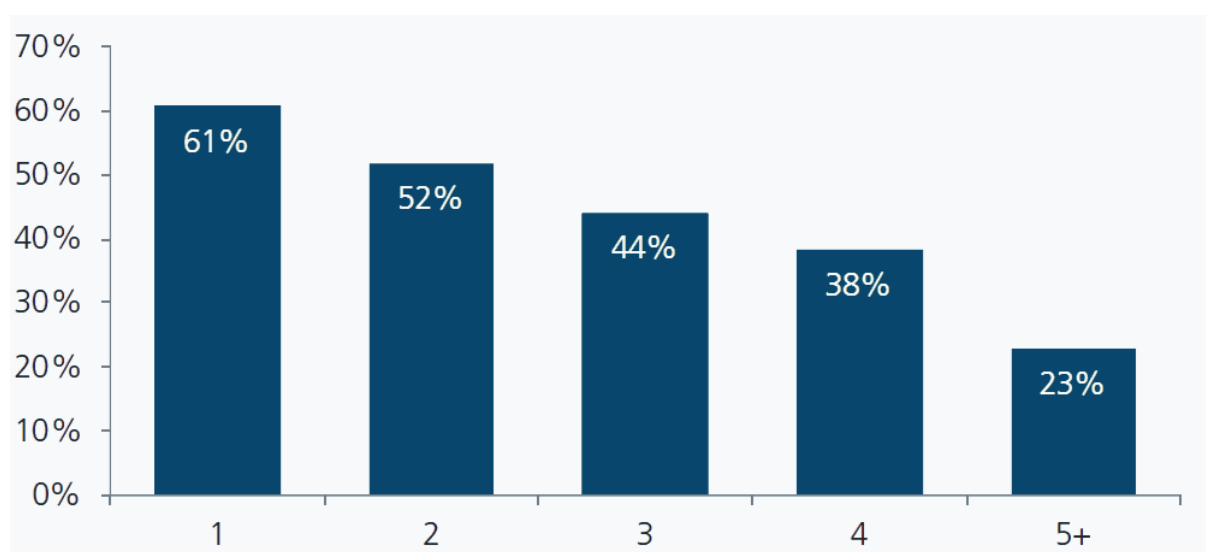
protecting people’s health. For – as we know – being out of work has damaging health effects^{38,39,40}.

Growing acknowledgement of the value of work to social prescribing has also been reflected more widely. The 2016 Government green paper on work, health and disability⁴¹ marked a period of increasing policy interest in finding ways of integrating more people with complex, long-term, chronic health and social problems into the workforce. As a result, this has led to a rise in interventions, (e.g. ‘Individual Placement and Support’) that aim to get people with health conditions into work (providing they want to), acknowledging the evidence that work is possible even for people with complex problems^{42,43}, providing not just an income but status, social networks, and a sense of purpose⁴⁴. Modern ways of working that support more flexible working arrangements, and therefore with the potential to offer more supportive, ‘digitally-enabled’ working environments, are a further example of the opportunities being explored⁴⁵.

2.1.2. Social prescribing and work

Effectively addressing complex, long-term, chronic health and social problems is difficult to do in routine primary care. GPs are increasingly presented with insoluble problems – social care services lack capacity – leaving some people are ‘trapped’ in a space where no support is available. Social prescribing, through its holistic, whole-person approach, impacting on a wide range of health and wellbeing outcomes, *may have the potential to succeed where more traditional – clinical – interventions have failed.*

Box B – Employment rate (%) by number of health conditions (age 16-64, April – June 2016)



Source: Work, health and disability green paper: data pack

It has therefore been suggested as a means of integrating people with complex, long-term, chronic health and social problems – a group with low rates of employment (see Box B above)

³⁸ Coats, D., & Max, C., (2005). Healthy work: productive workplaces. London: The Work Foundation

³⁹ McKee-Ryan FM, Song Z, Wanberg CR, Kinicki AJ. (2005) Psychological and physical well-being during unemployment: a meta-analytic study. J Appl Psychol. 90(1):53-76.

⁴⁰ Waddell & Burton, 2006

⁴¹ <https://www.gov.uk/government/consultations/work-health-and-disability-improving-lives/work-health-and-disability-green-paper-improving-lives>

⁴² Steadman, K., Sheldon, H., and Donnalaja. V. (2016).

⁴³ Bevan, S., et al. (2013).

⁴⁴ Waddell, G. and A. K. Burton (2006).

⁴⁵ Work Foundation (2018) Technology, Productivity and Working Anywhere.

– into the workforce⁴⁶. This was the premise of an earlier (2016) Fit for Work (FFW) Coalition/Work Foundation (WF) report⁴⁷. It hypothesised two ‘pathways’:

- (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*, equipping people with the skills they need to find – and stay in – employment.

Theoretically, any service ‘model’ (i.e. from basic signposting to holistic) can support people into work via the direct and indirect pathway. However, in practice, the 2016 report found more evidence of social prescribing serving as an *indirect route to work*, and that *more holistic services* with more and better links to the community facilitated by (ideally co-located) Link Workers who were *able to work with clients over the long-term* were most effective.

Consistent with this, the current review for this study found more evidence of social prescribing serving as an indirect route to work, specifically through *volunteering*. For example, a scheme in Blackburn with Darwen focuses on volunteering as a means of improving service users’ outcomes, the rationale being that it helps “develop their skills and confidence, which in turn increases their employability”⁴⁸. Data from 2017 show that 61 out of 92 clients who ended up volunteering felt it had improved their chances of finding work⁴⁹. Similar findings are reported in a 2017 evaluation of a Durham-based social prescribing service, which offers clients access to a ‘supported volunteering programme’. Over 50% of those participating went onto further volunteering, learning or work⁵⁰.

The present review also found wider evidence of what factors played a role in determining *how effectively a service might support someone into work* (mainly related to Link Workers; LW). For example:

- **LW knowledge**: whether employment is considered an option for a client may depend on a LW’s knowledge of suitable local employment and/or training/volunteering opportunities⁵¹, as well as their awareness of the role work can play in improving and protecting one’s health and wellbeing.
- **LW approach**: how ‘innovative’ LWs are prepared to be with clients, e.g. accompanying them to activity classes, getting involved in advocacy, liaising with family members, etc., is thought to impact on whether they will be directed to volunteering or employment opportunities⁵².
- **Co-location of LWs in GP surgeries**: considered an effective means of promoting employment-related outcomes by providing a ‘link’ between health services and employment or employment-related services^{53,54}.

⁴⁶ <https://www.shaw-trust.org.uk/ShawTrustMediaLibraries/ShawTrust/ShawTrust/Documents/Shaw-Trust-response-to-improving-lives-Green-Paper-Feb-2017.pdf>

⁴⁸ <https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--6c2.pdf>

⁴⁹ <https://www.local.gov.uk/sites/default/files/documents/just-what-doctor-ordered--6c2.pdf>

⁵⁰ Mawson, F. (2017). Overview of Year 3 of County Durham social prescribing service

⁵¹

<https://westminsterresearch.westminster.ac.uk/download/f3cf4b949511304f762bdec137844251031072697ae511a462eac9150d6ba8e0/1340196/Making-sense-of-social-prescribing%202017.pdf>

⁵² <http://eprints.uwe.ac.uk/30293/>

⁵³ https://www.learningandwork.org.uk/sites/niace_en/files/document-downloads/Addressing%20barriers%20to%20employment%20for%20disabled%20people.pdf

⁵⁴ Tower Hamlets

All these factors are in part determined by the social prescribing service model. As such the evidence leans towards more holistic services which give LWs more autonomy, time with the client and have deeper integration with GP practices and the wider community.

2.2. Changing policy emphasis around social prescribing

A key driver for this study, has been the changing policy emphasis. During the last two years social prescribing has received a lot of attention from high level national and regional policymakers, and the social prescribing policy landscape has changed significantly. Most recently, its value has been explicitly recognised at the highest level of government: October 2018 saw the Prime Minister launch the Government's 'loneliness strategy', citing it as one the "greatest public health challenges of our time" and identifying social prescribing as key to tackling it⁵⁵. Through it, the Department of Health and Social Care (DHSC) and NHS England have committed to improving and expanding social prescribing services: by 2023, government will support all local health and care systems to implement social prescribing schemes, supporting the aim to have a "universal national offer available in GP practices"⁵⁶.

Furthermore, the newly-appointed DHSC Secretary of State, in setting out his "priorities for the health and social system", suggested that social prescribing should be preferred to "over-prescription of unsophisticated drugs" to improve individuals' health and wellbeing⁵⁷. Building on this, Government has made a number of policy commitments:

- Creating a *National Academy for Social Prescribing*, providing a resource that GPs and other health professionals can draw on for guidance, expertise, and knowledge of what works and what is available in their communities⁵⁸. Though no date for delivery has been stated, this would help GPs refer patients to appropriate services, and ensure that Link Workers are not solely dependent on their own knowledge of what is available in local areas.
- Announcing plans to launch (in 2019) an '*online social prescribing platform*' for commissioners and healthcare staff, as well as regional steering groups
- A '*training/accreditation scheme*' for Link Workers⁵⁹ Currently, there is no formal training for Link Workers and their capacity and capability will likely vary greatly from service to service.
- A '*national database*' of local social prescribing schemes, including contact details of charities and other organisations running schemes.
- In July 2018, 23 social prescribing schemes in England were awarded a share of £4.5 million from the 'Health and Wellbeing Fund'.

At a regional level, the Mayor of London recently prioritised making social prescribing a "routine part of community support across London"⁶⁰ as 'Key Commitment' within the Health Inequalities Strategy⁶¹. This was followed, in October 2018, by a 'call for evidence' from the London Assembly's Health Committee. It aims to explore the current provision of social prescribing in London as well as what can be done to boost access to and uptake of it across the capital⁶².

⁵⁵ <https://www.gov.uk/government/news/pm-launches-governments-first-loneliness-strategy>

⁵⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Loneliness_Strategy_web_Update.pdf

⁵⁷ <https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system>

⁵⁸ <https://www.gov.uk/government/speeches/the-power-of-the-arts-and-social-activities-to-improve-the-nations-health>

⁵⁹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Loneliness_Strategy_web_Update.pdf

⁶⁰ <https://www.london.gov.uk/what-we-do/health/social-prescribing#>

⁶¹ <https://www.london.gov.uk/what-we-do/health/health-inequalities-strategy#>

⁶² https://www.london.gov.uk/sites/default/files/social-prescribing-call_for_evidence.pdf

These recent Government commitments follow calls made earlier in the year by the Royal College of General Practitioners (RCGP) for every GP surgery to be “funded to have access to a dedicated social prescriber”⁶³. This is particularly important given how integral GPs are to social prescribing – often being the first point of contact for people receiving social prescriptions. This would represent a significant change as social prescribing services’ integration into GP practices is, at the moment, dependent on local factors and whether the funder (e.g. a local Clinical Commissioning Group) funds it – thus it varies between services. This call from the RCGP comes after the mid-2016 publication of the ‘General Practice Forward View’ from NHS England, which identifies social prescribing as one of the ‘10 High Impact Actions’ to release GP time to provide care⁶⁴.

Enabling GPs to provide social prescriptions has also been backed by the National Institute for Health and Care Excellence (NICE)⁶⁵. Furthermore, in 2017, NICE endorsed a social prescribing assessment tool⁶⁶.

2.2.1. Social prescribing as a route to work

In addition to the attention social prescribing has been given as a means of improving health generally, it has also gained increasing recognition – in high level policy circles – as a way of integrating people with complex, long-term health conditions into the workforce.

For instance, four of the 23 social prescribing schemes in England, awarded funding from the ‘Health and Wellbeing Fund’, are explicitly focusing on improving service users’ employment-related outcomes⁶⁷. This represents a change in how social prescribing services are normally funded (e.g. at a more local level by Clinical Commissioning Groups).

This announcement of funding follows an explicit commitment outlined in the 2017 *Improving Lives* command paper 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”⁶⁸. This paper, from the Government’s Joint Work and Health Unit (working across DHSC and the Department for Work and Pensions), sets out a range of measures to improve employment prospects for people with disabilities and long-term health conditions. It is therefore significant that social prescribing has been identified as a way of doing this.

As a result, social prescribing as a route to work is also included in the Joint Work and Health Unit’s work programme. As part of this, the Joint Unit has worked with NHS England and the Social Prescribing Network, informing the development of the ‘Draft Common Outcomes Framework for Social Prescribing’ (released in April 2018 and due for full publication in early 2019). Because social prescribing is still a relatively new innovation, there is no standard framework for measuring impacts. Thus, 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”. Its initial focus is “impact on the person” (see Figure 2.1 below), which includes – importantly – an assessment of the extent to which social prescribing services report on “employability, including staying in work, finding new employment”, as well as wider

⁶³ <http://www.rcgp.org.uk/about-us/news/2018/may/rcgp-calls-on-government-to-facilitate-social-prescribing-for-all-practices.aspx>

⁶⁴ <https://www.networks.nhs.uk/nhs-networks/releasing-capacity-in-general-practice/messageboard/general/611331738>

⁶⁵ <https://www.nice.org.uk/>

⁶⁶ <https://www.southwestyorkshire.nhs.uk/2017/08/30/social-prescribing-tool-endorsed-by-nice/>

⁶⁷ <https://www.gov.uk/government/publications/social-prescribing-schemes-to-be-funded-by-the-health-and-wellbeing-fund-2018/social-prescribing-schemes-to-receive-funding-from-the-health-and-wellbeing-fund-2018>

⁶⁸ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/663399/improving-lives-the-future-of-work-health-and-disability.PDF

work-related outcomes including volunteering, accessing training and gaining qualifications⁶⁹. Thus recognising social prescribing as both a direct and indirect route to work.

Figure 2.1 – Draft Common Outcomes Framework for Social Prescribing



Source: NHS England (2018) Draft Common Outcomes Framework for Social Prescribing

Alongside the efforts from Government and NHS England, stakeholders in the social prescribing ‘sector’ are carrying out work to better understand the range of outcomes associated with social prescribing. In the last two years alone, the Social Prescribing Network has grown significantly: from around 400 to almost 2,000 members⁷⁰. With this, there has been a ‘broadening’ of referrers into social prescribing schemes; while previously referrals were mainly from primary care, they increasingly come from adult social care, the welfare and statutory sector, and secondary and tertiary care⁷¹. Researchers at the University of Westminster therefore argue that the range of outcomes measured must reflect the increasing diversity of referrers and growing involvement of these sectors. This is in part to ensure that the impact of social prescribing on the social determinants of health – work being a significant one – is fully recognised⁷².

Thus, recent years have seen increasing recognition of the general health and wellbeing benefits associated with social prescribing. It is in this context that we carried out this new research, updating the findings from 2016.

2.3. The changing evidence base

The literature review for the present study explored, using a systematic approach, academic and grey literature published between 2016 and 2018. In contrast to the findings of the 2016 FFW/WF report, which found few references to work and related outcomes in the literature, this review found four evaluations assessing social prescribing services’ impact on work and

⁶⁹ <https://www.somersetccg.nhs.uk/EasySiteWeb/GatewayLink.aspx?allId=6915>

⁷⁰ Correspondence with Social Prescribing Network leading members

⁷¹ University of Westminster. (2018). Outcomes in social prescribing: brief. *Unpublished*

⁷² *Ibid.*

related outcomes. Although the developments in evidence are modest, they provide interesting insights into changing practices.

All four explicitly recognise *the important role social prescribing can play in returning people to work*. For example, a 2016 report on a service in Gloucestershire recognised it as one of the “potential opportunities provided by social prescribing”⁷³, while a 2018 evaluation of services in Tower Hamlets (London) described social prescribing as a “key facilitator for supporting people into employment”⁷⁴.

Employment-related goals/needs, e.g. clients seeking ‘employment advice’⁷⁵, describing themselves as ‘looking for work’⁷⁶ or seeking ‘learning/training/employment’⁷⁷ were given as reasons for referral/considered priorities by some clients of all the services. These goals/needs were not that common, however. For example, only 13% (285) of clients referred to the Tower Hamlets service presented with employment-related needs⁷⁸.

In terms of *reporting on employment and related outcomes*, all services (except one) provided some form of quantitative data. The Gloucestershire service included analysis of data from over 2,000 clients. Outcomes recorded after 6 months include number of patients referred onto some form of training, e.g. IT, returning to college, apprenticeships, etc. (40), patients going onto volunteering (31) and those returning to employment (10). Data provided by the Bristol evaluation, which assessed 128 clients over 12 months, found that 17% of clients (9 out of 53) who were either looking for work, long-term sick, in education or training, or on bail, had found work following their interaction with the service⁷⁹. The authors suggest these results are comparable to the Government’s flagship ‘Work Programme’⁸⁰, which is significant given that the Government programme is explicitly aimed at getting people into work, while this social prescribing service was not.

The Rotherham evaluation collected data on ‘work, volunteering and other activities’, which comprised 1 of 8 ‘wellbeing measures’ recorded. Based on outcomes for 298 clients, results show that, between 2015/16 and 2016/17, 10 (3%) of clients had found employment, 48 (16%) had engaged in training or education, and 38 (13%) had volunteered⁸¹. Furthermore, data indicate that, across all the outcomes studied, between baseline and follow-up the “greatest progress” was made against the ‘work, volunteering and social groups’ outcome, suggesting the service was effective in moving clients closer to work.

Finally, the Tower Hamlets service evaluation, despite identifying volunteering/employment outcomes as a key indicator of the service’s success, did not collect ‘hard’ data on employment or volunteering outcomes. The rationale being that return to work is a long-term process and thus may not have been captured by the 8-month evaluation period. That said, the evaluation reported qualitative evidence of the positive role the social prescribing intervention played in securing work outcomes. As such, the authors suggested that, as a result of the service, a number of clients had in fact gone onto training, volunteering or employment⁸².

Thus, in contrast to the 2016 review, these four studies indicate social prescribing services – and evaluations of them – may be placing more emphasis on work and related outcomes. All

⁷³ <http://eprints.uwe.ac.uk/30293/3/Report%25406.pdf>

⁷⁴ <https://towerhamletstogether.com/resource-library/2/download>

⁷⁵ Gloucester

⁷⁶ Bristol

⁷⁷ Tower Hamlets

⁷⁸ Tower Hamlets

⁷⁹ Bristol

⁸⁰ Provided by a range of employment support specialists from the private, voluntary and public sectors

⁸¹ Rotherham

⁸² Tower Hamlets

four services recognise that social prescriptions can lead to work and collect data on employment, i.e. finding work, and related outcomes, i.e. education, training or volunteering.

That said, proportions of clients finding work/going onto education, training or volunteering are relatively low. Indeed, none of the services were primarily focused on work. This is therefore further evidence of social prescribing acting as an *indirect pathway towards work*. Furthermore, the services studied were more towards the holistic 'end' of the social prescribing spectrum with integration into GP practices and clients typically having several sessions with Link Workers over a period of months. As stated earlier (in Section 2.1.2), such services may be better equipped to support clients into work.

2.4. Concluding comment

Social prescribing services fall into four broad categories from basic signposting to holistic. More holistic services tend to produce better outcomes, in part by embedding Link Workers in GP practices, giving them more autonomy and time with clients. Social prescribing offers clients many benefits including work and related outcomes, both crucial for sustaining improvements in health and wellbeing. Evidence seems to suggest that, primarily, services provide an *indirect route* to work, first addressing more basic needs through non-work activities eventually leading to education, training and volunteering, for example. The same factors determining service effectiveness seem to affect how well a service can support clients into work, with more holistic services being better equipped.

The social prescribing policy landscape has seen significant changes since 2016, some developments. Whilst those occurring in late 2018, are still likely to be filtering through, increasing emphasis placed on social prescribing as a route to work from the Joint Work and Health Unit and the *Improving Lives* strategy in 2017 may have had some impact. This is potentially demonstrated by the findings of the literature review for the present study which, in contrast to 2016, found evaluation evidence of work and related outcomes being collected and social prescribing serving as an indirect route to work. Caution, however, is needed because the number of studies (four) showing this is still low.

3. Social prescribing and work in 2018

This chapter outlines the findings from the primary research conducted for this study. First, the survey findings are presented, followed by the qualitative research involving the four services featured in the 2016 report with explicit emphasis on changes that have occurred since and the implications for their work ‘offer’.

3.1. Survey findings 2018

We distributed a short survey to members of the Social Prescribing Network (SPN). The aims were:

- (i) to better understand how work and related outcomes are integrated into social prescribing in practice and the services’ work ‘offer’, and
- (ii) to get an indication of whether the emphasis placed on work and related outcomes has increased since the last study in 2016.

To meet the second aim, the findings from the FFW/WF 2016 survey (also distributed to SPN members) served as an indicative ‘baseline’ (albeit with different respondents), to allow for comparisons to be made over the last two years.⁸³

The questionnaire was aimed at services with working age (i.e. 16-64) clients with at least one long-term condition (LTC)⁸⁴. Almost half of respondents identified as Link Workers and over 20% were managers of social prescribing services – a similar proportion to 2016. When asked whether clients are offered support ‘in house’ or signposted elsewhere, the majority of respondents (75%) said that their organisation does ‘both’ (compared to 60% in 2016), with fewer than one fifth only signposting (compared to one quarter last time). Compared to 2016, fewer services (20%) reported that over 75% of clients were working age with at least one LTC.

Regarding the *most common reasons for referral*, employment/work and work-related factors like training and learning were rare (see Box C for a full list). This is comparable to 2016. Furthermore, the most common reason (physical and mental health) remains unchanged). This is, in some respects, to be expected given that social prescribing users typically have complex/long-term health issues and employment, training, etc., though potentially long-term goals, are unlikely to be amongst clients’ top priorities/needs.

Box C – Most common reasons for referral

1. Physical and mental health
2. Lifestyle change
3. Social welfare advice
4. Financial advice
5. Social isolation
6. Wellbeing
7. Self-care/management of an LTC
8. Employment/work
9. Training and learning

Box D – Most common client goals

1. Improve financial situation
2. Make lifestyle changes
3. Improve mental wellbeing
4. Enhance social networks
5. Improve physical health
6. Achieve/move closer to employment
7. Develop new skills
8. Improve housing situation

With that in mind, we might expect to see employment and related outcomes more prominent amongst *clients’ most common goals*. This – to some extent – is the case. As Box D shows, ‘achieve/move closer to employment’ ranked slightly higher amongst clients’ goals than it did for reasons for referral – though it was by no means a common goal. As above, this finding is comparable to 2016, suggesting no significant change.

⁸³ 48 responses for the present study compared to 40 in 2016 can only be indicative rather than representative of the social prescribing sector

⁸⁴ The survey was distributed to all members of the Social Prescribing Network via its Newsletter, which has a circulation of about 2,000. It is impossible to know what proportion of this population was eligible for the survey, i.e. involved in a social prescribing service that works with working age clients with at least one long-term condition.

Regarding the *type of employment/employability support* offered by the services, more than half of respondents cited their 'health and wellbeing programme', implying an understanding that, by first focusing on clients' health and wellbeing needs they can 'break down barriers' to work, i.e. the 'indirect pathway'. Furthermore, over half of respondents (a greater proportion compared to 2016) offered *volunteering*, which is again more evidence of recognition of social prescribing serving as an indirect route to work, giving clients experience that may move them closer to the labour market. There was widespread recognition amongst respondents of the value of work. The majority (67%) agreed that *employment and related outcomes should be included in social prescribing programmes* (a slight increase from 64% last time). Those that agreed acknowledged the role of work as powerful social determinant of health, for example:

“Employment is a key to securing finances, housing, reducing social isolation ... this is key to good wellbeing and health.”

Questionnaire response

Others, despite agreeing, gave more qualified support. While they recognised the importance of aiming for and including work-related outcomes, they warned that social prescribing services should not be held accountable for these outcomes. This was reflected in other responses. Work and related outcomes should be included but more as long-term goals as outcomes that are unattainable in short term “puts undue pressure on Link Workers and, in turn, patients” (questionnaire response). Again, this is recognition of social prescribing serving as an indirect route to work and the need for work and related outcomes to account for this.

Though they were in the minority, some rejected the idea of including work-related outcomes. In some cases, this was because their clients were simply not ready/able to work (e.g. clients receiving cancer treatment or of pension age). However, there was also a sense of trepidation that if social prescribing services focused on return to work, they could be seen as pushing a “political agenda” (questionnaire response) or increasing pressure already put on them by Department for Work and Pensions to find work. Others suggested that short timescales, e.g. six months, meant finding work was unrealistic.

Fewer than a third of respondents (31%) stated that *commissioners/funders ask for data on employment and related outcomes*. This is significantly lower than the share recorded in 2016 (48%). This could be indicative of commissioners placing less emphasis on such data. However, it could also be indicative of differences between the respondents to the 2016 and the present survey. The former featured more services with a higher proportion of working-age clients, it is therefore logical that commissioners of these services might put more emphasis on work-outcomes.

Regarding the *type of employment-related data commissioners asked for*, there were no obvious differences between surveys. Requested data included either the number of clients finding work, going into volunteering, receiving education or training, or a combination of all of them.

Finally, the survey for the present study asked whether, in the last two years, respondents felt their service had placed *more or less emphasis on employment and related outcomes*. While the majority reported 'no change', four respondents said they had noticed a positive change. Two attributed this to the introduction of Universal Credit⁸⁵, prompting more clients to raise work-related issues/goals. Another commented that since introducing a 'volunteer programme' there had been greater emphasis on work-related outcomes:

⁸⁵ <https://www.gov.uk/universal-credit>

“We have had a natural increase of employment by volunteering – it raises people’s self-esteem, increases confidence and communication skills”.

Questionnaire response

This represents further recognition that social prescribing – through volunteering – can serve as an indirect pathway to work.

Several respondents that reported no change in emphasis highlighted the person-centred nature of social prescribing and thus any ‘push’ or ‘drive’ to include any particular outcome – whether related to work or not – would be inconsistent with the principles behind the approach.

Finally, while most respondents recognised the value of work, there was some evidence of a potential lack of awareness regarding the role that work can play in improving people’s health and wellbeing – and the drive to increase work and health integration. For example, one respondent commented that, by focusing on employment goals, social prescribing would be duplicating other services’ efforts, thus blurring boundaries between health- and employment-focused support. This lack of awareness was referenced by another respondent, who argued that social prescribing research “is from mostly a medical model and does not sit that comfortably with employment research norms”.

3.2. Findings from the qualitative research 2018

This section reports on the qualitative research conducted for the present study with the *same* social prescribing services featured in the 2016 FFW/WF report⁸⁶. First, we give an overview of the services and outline their similarities and differences. We then explore what emphasis they place on work and related outcomes, how this has changed since 2016, as well as the general changes to the services that have implications for their work ‘offer’.

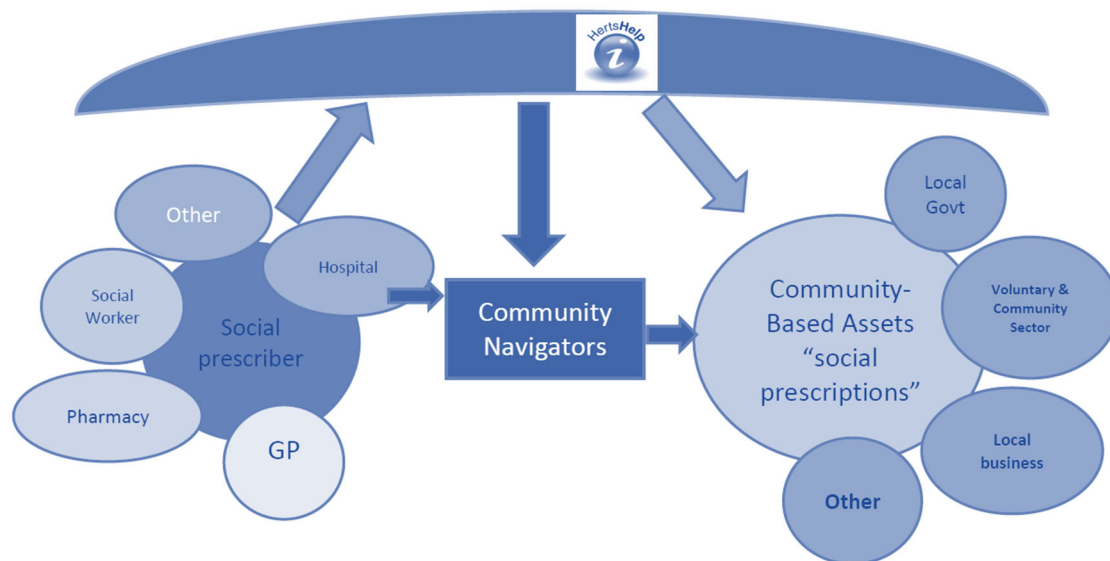
3.2.1. Introduction to the services

The four services featured in 2016 and now are geographically dispersed across England. Thinking back to the ‘typology’ of social prescribing services outlined earlier in Box A (p. 24), all four services are towards the holistic ‘end’ of the spectrum, i.e. have partnerships with third/voluntary sector organisations, dedicated Link Workers and feedback/monitoring mechanisms in place. A brief description of each is provided below.

Clients are referred to **Herts Help** (Hertfordshire) by (mainly clinical) referral agencies. Appropriate cases are sent to Community Navigators (CN) who meet and set goals with the client (see Figure 3.1 below). Anybody aged over 18 and living in Hertfordshire is eligible for the service, providing they do not need long-term care or a ‘crisis intervention’. The service is primarily focused on reducing social isolation and improving wellbeing and clients are typically 65 or over. CNs have strong links with community services and clients’ progress is tracked/monitored with tools, e.g. the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS).

⁸⁶ Qualitative findings are reported for 3 of 4 schemes involved in the 2016 research; evidence for Bromley by Bow Centre was sourced from a recently published service evaluation

Figure 3.1 – Herts Help service overview



Source: Herts Help (2018)

Voluntary Action Rotherham (VAR), South Yorkshire, was established in 2012. As coordinator of voluntary and community sector (VCS) activities, VAR can commission new services, based on clients' needs, that do not already exist in the community. The main aim is reducing clients' health service costs (e.g. reduced medication costs/time spent with GP). Dedicated Link Workers work with clients to improve *all* non-clinical aspects of life that impact on health and wellbeing, drawing on strong links with community services (with the ability to commission new ones as appropriate). Two schemes run side by side: (i) a *long-term conditions scheme* designed to reduce demand on acute hospital care which receives 1,500 referrals a year from all GPs in Rotherham (most clients are above pension age); and (ii) a *mental health scheme* which supports people with non-psychotic disorders/have been stable for two years or more. Referrals – around 200 a year – come from Rotherham, Doncaster and South Humber Community Mental Health Services (RDaSH). Most clients are of working age.

Ways to Wellness (Newcastle) serves clients aged 40-74 with certain medical conditions (e.g. chronic breathing problems, diabetes), where there is scope to improve outcomes through better self-management. Clients must be registered on the Quality Outcomes Framework list to enable comparisons with other patients not in receipt of the service (i.e. assessment of a 'counterfactual'). Outcomes are measured by comparing hospital costs of clients to those with the same conditions in another part of Newcastle. On average, engagement lasts 18 months. Link Workers are assigned to GP surgeries, working with them to obtain referrals. Funding is available to commission new services to meet clients' needs.

The **Bromley by Bow Centre** in London admits anyone aged over 18 registered at one of six linked GP surgeries. It is focused on supporting 'hard to reach' groups including young people, the long-term unemployed and older people. Clients can benefit from a range of services designed to increase skills, improve health and wellbeing and confidence, as well as employment-related advice/support, e.g. volunteering, work experience, job searching, etc. Employment advisors are on site and welfare and money management advice is provided. The model is holistic, with a range of activities and support provided in-house.

3.2.2. Commonalities between services

As stated at the outset, all services are towards the holistic end of the spectrum (with Bromley being the 'most' holistic). Despite variation in terminology, all services had *dedicated Link*

Workers supporting clients to set their own goals and determine how to reach them, as well as linking them with opportunities in the VCS and empowering them to be more independent in taking them up. This was made possible by strong existing *links and partnerships with community services*. Furthermore, all services had *feedback/monitoring mechanisms* in place, tracking clients' progress over time with a range of tools.

A characteristic common across all services is that the clients' needs must fit with what the service provides. Support is provided on a one-to-one basis over a finite period of time, with the aim of enabling/empowering the client to improve their ability to manage their own care within the community and – ultimately – to reduce hospital costs. Social prescribing is not a replacement for long-term care, but complementary to it; it should only be provided when it is *appropriate to the needs of the client*.

All services had *defined eligibility criteria* based on health or demographic characteristics – though some were more specific than others. *Referrals* came exclusively from the health and care system – primarily GPs but also hospitals and mental health services. In all cases, the *person-centred approach* directed and informed how Link Workers interact with clients. Furthermore, all services prioritised clients' *health and wellbeing*; with funding mainly coming from health services, objectives reflected that, i.e. were focused on reducing hospital admissions and associated costs. Finally, *employment outcomes, i.e. getting people into work*, were not a primary focus of any of the services. However, it was acknowledged that social prescribing, by breaking down 'barriers' to work, can serve as an indirect route to it (see Section X below).

3.2.3. Variation between services

Differences between the services were evident in the *specification of the client group*. While Bromley by Bow and Herts Help admit anybody aged over 18 (providing they do not need long-term care/a 'crisis intervention' in the latter case), VAR and Ways to Wellness only admit clients with specific health conditions/are of a certain age. This was reflected in the different *diagnostic tools* used by different services. The *organisation of the services* also varied. For example, VAR is contracted by the local Clinical Commissioning Group to co-ordinate the overall service and can commission new services – similar to Bromley. Ways to Wellness, in contrast, acts as a Special Purpose Vehicle funded through a social impact bond model⁸⁷. Finally, while *time spent with clients* did vary, interaction with the service would typically last at least several months, reflecting the often complex nature of clients' condition and the time it takes to produce outcomes, and the holistic nature of the services (i.e. basic signposting/light services typically have less contact time with clients).

3.2.4. Emphasis on work and related outcomes

As stated above, getting people into work was not the current main focus of any of the services studied – a position largely unchanged since 2016. This in part reflects the fact that social prescribing services continue to sit primarily in the health 'space', with their funding and referrals largely coming from the health and social care system. This was reflected in some of the service changes that had occurred since 2016 (see Boxes E, F and G below).

⁸⁷ <https://waystowellness.org.uk/shared-learning/questions-and-answers/>

Box E – Service changes in Rotherham

The mental health service offered in *Rotherham* has seen a significant change to its client base. Referrals now also come from the local hospital's Drug and Alcohol Unit. This change, requested by the funder (Rotherham Clinical Commissioning Group; CCG), reflects the fact that the CCG's – and, in turn, the service's – priorities are driven by health policy (as opposed to employment, for example). As a result, the complexity of the cases dealt with has increased. Clients are increasingly seen 'mid-way' through their clinical therapies (provided by the hospital) rather than when they have completed them (as was previously more often the case). This could have implications for the employment 'offer', as these clients may be considered 'further away' from the labour market. Although the exact numbers involved are unclear, data for 2018 indicate the proportion of clients going into work, volunteering or training may be falling, which could – potentially – be a reflection of the changing client base.

Box F – Service changes in Hertfordshire

Another service to see significant change is *Herts Help*. Five services⁸⁸ have been merged. Though not providing identical functions, the County Council Commissioner felt there was sufficient overlap to bring them together to benefit service users and health and social care services. All services retain existing contracts and funding. The main driver for this change was the need to support the hospital discharge service and ensure a more seamless transition from hospital to services to community services – and reduce likelihood of readmission. Thus, the rationale for the change reflects the services health/clinical policy priorities and as such potentially represents a move away from further integration of work and related outcomes.

Box G – Service changes in Bromley

In *Bromley*, the Centre was included in a recent borough-wide, social prescribing pilot where each GP practice in Tower Hamlets was assigned a named 'social prescriber'. An evaluation of the pilot – conducted six months into the 18-month programme – deemed the programme successful in improving clients' health and wellbeing, though work and related outcomes were not assessed⁸⁹. Furthermore, the evaluation identified the 'core elements of an ideal social prescribing model' for Tower Hamlets – work and related outcomes were not included.

That these services are not primarily focused on work also reflects their *person-centred approach* (clients rarely state 'work' as a goal), *funders' priorities* and *eligibility criteria*. Because social prescribing is, first and foremost, person-centred, Link Workers will not direct clients towards any particular outcome. Furthermore, because funders do not 'incentivise' these services to get people into work, the services, in turn, do not prioritise it. Finally, because clients typically present with complex health and/or social issues, they – and the Link Workers – may think they are 'too far' from the labour market, i.e. that work is unattainable⁹⁰. In two of the four services, Link Workers had discouraged some clients from 'overly ambitious' goals related to finding work. This could reflect a cultural view (also noted in the survey findings) that work is not rehabilitative and people are not ready for it until they are healthy, possibly attributable to the fact these services are primarily focused on clinical outcomes. It may also be partly because Link Workers do not necessarily have expertise in this area.

That said, since 2016 there is evidence of an increasing focus on work and related outcomes. All services now collect some data on work/employment, which was previously not the case (though there was no indication this was linked to increasing policy emphasis on social

⁸⁸ West Herts Community Navigator; Age UK (hospital discharge); Red Cross (out of county hospital discharge); PoHWER (hospital discharge at Watford Gen. Hospital); Herts Help at Home (county wide, help with paperwork, form filling etc.).

⁸⁹ <https://towerhamletstogether.com/resource-library/2/download>

⁹⁰ For some clients, e.g. the majority referred to Herts Help who are aged 75+, work is not – and never will be – a goal

prescribing as a route to work). Data for *Rotherham* show that 10 out of 316 clients (3%) in the mental health scheme had found work (increasing from 3/156 clients in 2015/16 to 7/160 in 2016/17). *Ways to Wellness* does not collect outcome data but reported that, of 17,258 client goals⁹¹, 75 pertained to ‘employment’, ‘job’ or ‘work’ (0.5% of the total). Furthermore, between July and September 2018, of 3,310 ‘issues’ opened at *Herts Help*, 6 were related to finding/staying in work (0.2%). Finally, data for *Bromley by Bow*⁹² show that 34 of 254 ‘direct’ referrals were for ‘employment’ (13%). These numbers reflect that work is not a priority for most clients, and thus there is little evidence of these services acting as a *direct route* to work.

In comparison, there was more evidence of these services providing an *indirect pathway* to work, i.e. producing work-related outcomes. For example, data for *Ways to Wellness* indicate that more than three times as many client goals are related to ‘volunteering’ compared to finding work. Also, its assessment tool – the ‘Wellbeing Star’⁹³ – measures clients’ progress across several ‘domains’ including ‘work, volunteering and other activities’. Of the eight domains measured, this domain consistently shows the second highest rate of improvement. Similar findings are reported by VAR: over four times as many clients had accessed ‘training and education’ or ‘volunteering’ than employment – and the numbers doing so were greater in 2016/17 compared to the previous year (though more recent data suggest this trend may be reversing). In addition, service users’ baseline data show that while their interest in ‘work, volunteering and social groups’ is initially very low, after 4-6 months support it increases markedly – more so than interest in any of the other ‘areas’ measured⁹⁴. Thus, while finding work may not initially be a focus, it is clear that the services are producing outcomes that break down barriers to employment, thus serving as an indirect route to work.

Figure 3.2 – A ‘positive upward spiral’ – how social prescribing can lead to work



Source: Service provider

⁹¹ Individual clients can have more than one goal

⁹² Between April 2017 and March 2018

⁹³ <http://www.outcomesstar.org.uk/using-the-star/see-the-stars/well-being-star/>

⁹⁴ These include: ‘where you live’; ‘money’; ‘managing symptoms’; ‘looking after yourself’; ‘lifestyle’; ‘feeling positive’; ‘family and friends’

All services recognised this indirect route. By prescribing non-work activities, 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*, equipping people with the skills they need to find – and stay in – employment. One participant described this as a '*positive upward spiral*' (see Figure 3.2 above).

Some service changes since 2016 reflected this. For example, in Rotherham, a new provider – the 'Learning Community' – had been integrated into the service. It delivers training on 'functional' maths, English and digital skills, as well as employability, self-confidence and motivation (the integration of this provider was not explicitly linked to changes in policy emphasis, however, but rather to address issues around digital inclusion). Though these outcomes can be described as work-related, as a 'first step' provider clients come into contact with them at the beginning of their 'journey'. Training is therefore more focused on 'basic' skills. Also, only around 1 in 10 clients identify getting into work/moving closer to work as a goal. That said, it represents clear evidence of the indirect pathway, as service users often went into volunteering following interaction with this provider.

Box H – Client A journey towards work

A man with a history of substance misuse who had recently moved to the area was referred to his local social prescribing service by his GP whom he was visiting because he had nowhere else to go. He was not in touch with family and estranged from his children; a sister is his only source of support. He wouldn't leave the house because he has many tattoos and fears how people will react to them.

In discussion with him, the Link Worker discovered that he loves animals, so he was encouraged to get a dog. This enabled him to meet people in the park while dog walking. He was reluctant to visit a mental health services team because he had to get a bus to do so and was worried about how people might view him. So, the Link Worker accompanied him.

He is now volunteering in local community. His wellbeing has improved significantly and he no longer visits his GP. This has occurred over a period of five months.

An example of how the indirect route works in practice is provided in Box H above. By first addressing a client's more basic needs, they ended up volunteering, much 'closer' to the labour market than before they interacted with the service. Another example is given in Box I below. Evidence of this particular pathway to work was not found in 2016. In this case, a client was only able to take advantage and benefit from a more employment-focused service (and in turn find work) once they had addressed more basic needs through interaction with a social prescribing service.

Box I – Client B journey towards work

A woman with autism was referred to the social prescribing service and, after a number of months, was successfully 'discharged' from it. Later, she returned to the same service provider but through a different route: 'Building Better Opportunities' – a Big Lottery funded programme that aims to move people closer to work. Through this second, differently funded programme, she managed to obtain employment.

Thus, in this case, interaction with the social prescribing service indirectly led to employment, by first addressing the client's more basic needs, and, in turn, moving her 'closer' to the labour market. She was then in a position to benefit from a more employment-specific programme which might otherwise have been 'too much, too soon' had she not initially interacted with the social prescribing service.

Alongside acknowledgement of how social prescriptions can lead to work, there was evidence that two of the four services (VAR and Herts Help) have explored some form of integration

with Jobcentre Plus (JCP), the Government's employment service, since 2016. Specifically, Herts Help is discussing the possibility of holding a fortnightly 'clinic' at the local Jobcentre, exploring whether JCP clients' needs will fit with the service provided. VAR have also been in discussions with JCP, but they wanted to refer people to the service that, currently, are not eligible for the existing schemes. It was unclear whether this could be attributable to changes in policy emphasis on social prescribing as a route to work. One driver could have been the introduction of Universal Credit, which (it was believed) had prompted more clients to raise issues related to work. This represents a change from 2016, where JCP was not viewed positively.

3.3. Concluding comment

The survey findings found widespread recognition of social prescribing serving as a route to work. There was more evidence of the 'indirect route', where social prescribing breaks down barriers to work and produces work-related outcomes, which may lead to work. Volunteering, for example, was commonly cited – as it was in the literature review.

The qualitative findings found that the four services featured are 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. Getting people into work via a 'direct route' was not prioritised by these services. There was, comparatively much greater recognition – and emphasis placed on – social prescribing as an indirect route to work (i.e. the 'positive upward spiral'). Also, all services now collected some form of work/employment data (unlike in 2016).

Some service changes indicated a move towards integration of work and related outcomes. For example, discussions had taken place with JCP 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. Furthermore, other service changes had been driven primarily by clinical priorities/changes in client base, arguably representing moves away from integrating work and related outcomes.

Overall, the findings suggest that social prescribing services sit primarily in the health 'space'. Referrals come exclusively from the health and social care system. There was evidence of a potential 'cultural issue' around a lack of recognition of the role work plays in improving health and wellbeing. Also, 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. 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 as an indirect route to work).

Thus, further integrating work and related outcomes into social prescribing schemes presents a number of *challenges*, but 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. We explore these in the following chapter.

4. Embedding work into social prescribing: challenges and opportunities

As outlined in Chapter 2, the last two years have seen social prescribing gain recognition – in high level policy circles – as a potential route into work for people with complex, long-term health conditions, and means of reducing the ‘disability employment gap’ (DEG). This potential was explicitly recognised in the Government’s 2017 *Improving Lives* command paper and now forms a key part of the Joint Work and Health Unit’s current programme of work. This has informed the development of the Draft Common Outcomes Framework for Social Prescribing (from NHS England and the Social Prescribing Network), which places specific emphasis on outcomes including staying in work and finding new employment, as well as employability outcomes like volunteering, accessing training and gaining qualifications. Whilst some of the most recent changes in policy occurring in late 2018 are unlikely to have filtered through into current social prescribing practice, the increasing emphasis placed on social prescribing in recent years as a route to work, primarily from the Joint Work and Health Unit (e.g. the *Improving Lives* strategy in 2017) and the wider health community (e.g. GPs), does seem to have had some impact. Indeed, there is more evidence of data on work and related outcomes being collected, JCP involvement in services, and recognition of social prescribing serving as an ‘indirect route’ to work (through volunteering, for example).

However, the findings also show that there are still barriers to further integrating work and related outcomes into social prescribing services, and that services’ capacity to serve as a (direct/indirect) route to work is influenced by several factors including the service ‘model’ (i.e. how holistic it is), the role played by Link Workers, and the client base. Given growing Government interest in social prescribing as a route to work/tackling the DEG and the likely additional resource being put into social prescribing by the NHS through the Outcomes Framework, it is essential that these barriers are successfully navigated, thus *reducing the ‘gap’ between policy aspiration and practice*.

Thus, in the following sections we explore the challenges – and opportunities – associated with further integrating work outcomes into social prescribing. In doing so we draw on the findings from (i) the four social prescribing services featured in the research, (ii) an interview with providers of an employment-focused service (the *Raising Aspirations* pilot) which used social prescribing principles to get people with health conditions into work (with success – see Appendix), and (iii) four interviews with senior social prescribing stakeholders⁹⁵.

4.1. Challenges presented by further integrating work into social prescribing

In this section we consider the challenges to further integrating work and related outcomes into social prescribing identified by the research.

4.1.1. Funders’/commissioners’ priorities

The survey findings suggested that the proportion of funders/commissioners asking for work and related outcomes data had fallen since 2016. Furthermore, research conducted with the four social prescribing services showed that funders’ and commissioners’ priorities remain primarily dictated by clinical issues, such as reducing hospital admissions costs. Funders/commissioners, e.g. Clinical Commissioning Groups (CCG) comprising GPs, may lack awareness of the role that work can play in improving one’s health, i.e. ‘work as a health

⁹⁵ Including: two Social Prescribing Network Steering Group members; a member of the London Mayor’s office leading on the development of a social prescribing vision for London; and an academic involved in WorkingWin ‘Health-led Employment Trials’ in Sheffield.

outcome'. For example, a Rotherham CCG commissioner stated that work was "*not something we could look at from a health perspective*".

A recent survey showed that, while the majority of GPs recognise that work is generally good for health, a significant minority (around 1 in 5) believe that (i) staying in/returning to work is not an indicator of clinical success and (ii) a patient is not ready for work until fully recovered⁹⁶. Furthermore, there was a view that some healthcare professionals (e.g. GPs), are wary of social prescribing generally due to the lack of reliable evidence of its effectiveness in improving health and wellbeing outcomes – let alone those related to work. These views may also affect referrals given that the majority come from GPs.

Thus, diversifying funding streams beyond the health system to include the Joint Work and Health Unit (JWHU) or Department for Work and Pensions (DWP) could facilitate increased emphasis on work and related outcomes. Broadening referral pathways to include people from JCP could complement this. Though the JWHU and DWP have not yet funded social prescribing schemes, two of the services studied in this research had explored the possibility of referrals from JCP. The risk with this approach is that it becomes too work-focused, losing sight of clients' health and wellbeing. One way of mitigating this risk is putting emphasis on social prescribing serving as an indirect (rather than direct) route to work, with broader indicators (e.g. basic improvements in confidence, etc.) and volunteering being recognised as part of the 'journey' to work.

4.1.2. Measuring work as an outcome

Related to the above are the difficulties involved in measuring work as an outcome and evidencing how interaction with a social prescribing service might lead to it. There was some concern amongst survey respondents and interviewees that greater government involvement (e.g. from DWP or JWHU) and emphasis on work from the Outcomes Framework could compromise the person-centred nature of social prescribing. Work programmes tend to be evaluated in a different way to social prescribing schemes. For example, an Outcomes Framework Steering Group member argued that "*by definition, randomised control trials (RCTs), do not work with social prescribing because interventions are highly personalised*". RCTs focus on specific interventions to measure attribution, yet social prescribing interventions are typically diverse and clients' needs may be greater than originally anticipated at the point of referral. They therefore do not lend themselves to the type of measurement typically required by more work-focused programmes. It was also felt that the time it can take for social prescribing interventions to 'bear fruit' makes rigorous evaluation difficult. Any increasing emphasis on work from government and the Outcomes Framework must take these issues into account, bearing in mind that social prescribing can serve as an indirect route to work that may be long and unpredictable.

Furthermore, survey respondents and interviewees felt that an overt focus on finding work (through a direct or indirect route) could put undue pressure on Link Workers who do not necessarily have the training, skills or expertise that might be needed to support into/on a journey towards work. Rewarding only work outcomes (e.g. finding work) could also influence Link Worker behaviour to more actively support those perceived as 'closer' to the labour market. There was also concern over engaging with JCP and how that might affect relationships with clients. It was therefore felt that any work outcome must at least be measured over the long term and not just finding work but breaking down barriers to it, i.e. recognising the indirect pathway. The *Raising Aspirations* pilot (which ran in Tower Hamlets from 2013-15 – see Appendix) which used a social prescribing approach to get people into

⁹⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/214507/rrep733.pdf

work with positive results dealt with this in an innovative way. As the intention was to support people with multiple health and social problems into work, it moved away from explicit job outcome ‘targets’, therefore keeping Link Workers focused on holistically addressing clients’ complex needs with the use of a bespoke diagnostic tool that focused on removing barriers to work.

4.1.3. Expertise/capacity to deliver on work and related outcomes

Unlike in 2016, the services we spoke to did not report a lack of capacity in the voluntary and community sector (VCS) to facilitate work and related outcomes, i.e. providing education, training, volunteering or work opportunities. That said, there was evidence that the introduction of Universal Credit had prompted more clients to cite work-related issues/goals. This, in turn, prompted the services to reflect on whether they and the VCS would have capacity to meet clients’ work-related needs if they became more common – as they likely would with further integration of work and related outcomes. This was therefore considered a risk.

Related to this is the lack of experience in the social prescribing ‘sector’ of supporting clients into work. Though services are now measuring these outcomes the numbers are typically low. Link Workers, for example, are not – and cannot be expected to be – labour market ‘experts’. That said, they – like commissioners and healthcare professionals – may lack awareness of the role that work can play in improving people’s health and wellbeing (the research findings provide some support for this). Indeed, it was noted in two of the four services that Link Workers had, in some cases, discouraged clients from ‘overly ambitious’ goals related to finding work. This may be indicative of a cultural view that work is not rehabilitative and that people are not ready for it until they are healthy. This may be attributable to the health-/clinical-focused culture social prescribing operates in.

Of course, we are not advocating that *anyone*, regardless of their particular circumstances is able to and should work, but other interventions have shown that people with multiple health and social issues are able to work. Examples include the *Raising Aspirations* pilot and the Individual Placement and Support (IPS) model. The latter contends that anybody is capable of work providing that they want to and can be supported as such⁹⁷. The challenge here is that (i) social prescribing services and Link Workers may not be equipped to do so and (ii) they may not consider work a viable option even for those that want to. *Raising Aspirations* in Tower Hamlets addressed this by providing training to Link Workers, ensuring they had minimum qualifications in Advice and Guidance.

4.1.4. Variation in social prescribing service ‘models’

Thinking back to the ‘typology’ of social prescribing services outlined earlier in Box A (p.4), some service models are better equipped to support clients on a journey towards work than others. More holistic services, which have dedicated Link Workers integrated with health services (e.g. directly in primary care) who can work with work with clients over a long period of time, drawing on strong partnerships with the local VCS while tracking clients’ progress with tools, will be better able to support clients on a journey towards work.

Evidence indicates the majority of social prescribing services are ‘light’ and those that only provide basic signposting are unlikely to be able to support clients on a journey towards work. This therefore represents an important barrier.

4.1.5. Scaling-up social prescribing

In addition to the above, a key challenge to further integrating work and related outcomes as part of a government drive or increased emphasis from the Outcomes Framework inevitably

⁹⁷ <https://www.centreformentalhealth.org.uk/briefing-37-doing>

raises questions about the feasibility of scaling-up social prescribing and the challenges involved in this. Excitement among some participants that social prescribing is rising up the policy agenda came with concerns that its 'identity' might be compromised or lost.

The research suggests that at least part of what makes social prescribing effective is that it is *delivered at a local scale and thrives on strong personal relationships* between the stakeholders involved (e.g. between referrers and Link Workers and the VCS). There was concern amongst interviewees that the principles of social prescribing, e.g. its highly personalised, person-centred approach, could be lost at scale – especially as part of a system prioritising particular outcomes. For example, interviewees felt that the success of the *Raising Aspirations* pilot in Tower Hamlets was compromised when it was scaled-up:

“When it goes mainstream politicians and senior managers get involved. Local delivery gets lost and it becomes part of the government system”

Raising Aspirations service manager

The close geographical proximity of the referrers, Link Workers the VCS facilitated the development of strong personal relationships which were considered vital to the success of the service. For example, Link Workers had a good understanding of what the VCS could offer and what would be appropriate for a given client. Greater government involvement and the scaling-up of the service brought closer scrutiny from policymakers, managers and systems which do not necessarily see or realise the value of these relationships.

Another challenge to scaling-up identified by interviewees is *Link Workers' unique skill set*, i.e. their ability to creatively produce a package of support tailored for each client, their knowledge (of local services) and ability to empathise and engage with people with multiple health and social problems. Described as the 'magic' of social prescribing, the importance of their role was frequently emphasised, for example:

“With all the changes in funding and different people coming and going, they [social prescribing schemes] succeed or fail on the basis of the individuals doing it. You can have all the systems in the world ... but if the right people aren't involved, it's not going to work”.

Social prescribing service manager

There was a sense amongst some interviewees, e.g. one of the members of the wider stakeholder group informing the Outcomes Framework, that Link Workers' skillset is so unique that it cannot be trained, and thus any attempt at providing it at systemic level would not work.

However, as mentioned above, *Raising Aspirations* successfully provided training to Link Workers and ensured all of them were accredited. Furthermore, an interviewee leading on the development of the Mayor's social prescribing vision for London highlighted the Greater London Authority's 'workforce development strand', which seeks to ensure that Link Workers, volunteers and NHS staff have sufficient training/expertise to successfully implement social prescribing schemes. Thus, with the right recruitment and training this is not an insurmountable challenge but there is evident anxiety over any potential expansion of the 'pool' of Link Workers.

Finally, an additional challenge relates to the 'management information systems' used by services which are often bespoke, tailored to local needs. Thus, *IT solutions may support scale-up but are likely to be complex*. Such systems are necessary to track clients' progress and ensure they do not have to repeat their 'story' to each person they meet through interaction with the service. This, however, represents a significant challenge given the diversity of social prescriptions and how closely tied they are to what is provided by the local VCS.

4.1.6. Summary

There are a number of challenges to further integrating work and related outcomes into social prescribing services. Some of them arguably represent *cultural barriers* which can, in part, be attributed to the fact that social prescribing sits primarily in a health/clinical 'space'. 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' behaviours. IPS shows 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 the *Raising Awareness* pilot that successfully got people with multiple health and social problems into work via a primarily indirect route.

That said, there are *practical barriers*, too, relating to the lack of experience and capacity to support clients on a journey towards 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 produce these outcomes, as well as the highly diverse nature of social prescribing interventions, recognising social prescribing can often 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.

4.2. Opportunities presented by further integrating work into social prescribing

Having explored the challenges presented by further integrating work and related outcomes into social prescribing we now explore the opportunities.

4.2.1. The person-centred approach

Social prescribing is extraordinarily good at linking vulnerable people with complex health and social needs to appropriate sources of support in the community. In doing so, it is an effective means of reintegrating the 'hardest to reach' groups, improving their health and wellbeing, and, by first prioritising their basic needs, empowering them to take steps towards employment (via confidence building, skill development, training, volunteering experience, and so on). The holistic, person-centred approach is instrumental in this process, allowing clients to meet their goals at their own pace.

Building the evidence base on what makes social prescribing an effective route to work should openly embrace the challenges outlined in the previous section. There is therefore a need for an evaluation methodology/tool that accounts for the diverse nature of social prescribing interventions and the principle of co-production, that can convince funders, health and employment policymakers and practitioners, the VCS, and – crucially – the individual client of its value as a (often indirect) route to work. While this may require a shift in current approaches to policy evaluation, it is essential in an innovative and dynamic environment. Methodologies embracing real-time evaluation, co-design, action research and 'innovation lab' principles are therefore more suited to demonstrating social prescribing's impact in this regard than conventional measures used to assess work programmes that draw on more established, e.g. RCT, methods.

4.2.2. Partnership building and working

The success of social prescribing is in part based on its ability to build trust and partnerships between local health services and wider services in the VCS. Thus, it has enabled stakeholders in different disciplines to unite around a common goal. For example, through co-location, Link Workers are integrated in GP practices where both can learn from each other; similarly, Link Workers have attended clients' case conferences. Could this partnership approach be extended to employment bodies/services too? It could be a vehicle for integrating health and work services.

One of the wider stakeholders we interviewed suggest an example of how this can work in practice is WorkingWin's 'Health-led Employment Trial' in Sheffield⁹⁸. It aims to provide support for people with health conditions that want to find/stay in work. Through co-design it unites several stakeholders – the local Combined Authority, JCP, and health services – around a common goal. This has been facilitated by recognition of the importance of tackling wider determinants of health, e.g. work, in Sheffield Sustainability and Transformation Plan⁹⁹. Another important enabler is the willingness of strategic and operational staff to be open to working with partners, putting aside sectoral interests to unite around the 'common good'. Attempts to integrate work into social prescribing practice can draw on this approach.

Similar approaches have been tried and tested in the social prescribing sector with some success – but not at scale. Examples include the *Raising Aspirations* pilot and the Bromley by Bow service featured in this report. 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.

4.2.3. Pooled funding

Pooled funding from diverse funding streams (e.g. beyond but still including health and social care), such as that provided by 'community investment funds', can support cross-sectoral and partnership working, prioritising clients' needs regarding of what 'space' they fall into (e.g. health, employment or otherwise). In itself, pooled funding would not necessarily tackle the cultural barriers that to different partners uniting around a common goal. However, it would signal the value of partnership working and, in turn, incentivise providers to offer joined-up services that put clients' needs first. This would help 'normalise' work and related outcomes as part of the social prescribing offer.

4.2.4. Summary

Further integration of work into social prescribing presents a number of opportunities. The development of a tool/methodology that can successfully articulate how social prescribing can lead to work that satisfies both funders and policymakers is needed. This can help 'make the case' for expanding social prescribing's already 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 may provide an effective mechanism for doing this. Diverse funding streams, away from the health and social care space, could lead to wider adoption of work outcomes given the clearly established benefits of finding work for all stakeholders involved (above all the client).

⁹⁸ <https://www.workingwin.com/articles/the-health-led-employment-trial>

⁹⁹ <https://www.sheffieldccg.nhs.uk/Downloads/Get%20informed/SheffieldPlaceBasedPlanFinalVersion.pdf>

4.3. Concluding comment

Clearly there are both challenges and opportunities to further integrating work and related outcomes. Challenges broadly revolve around cultural and practical barriers, e.g. lack of awareness of work as a means of improving health and a lack of experience and expertise in the sector to support a return to work journey. There are also specific challenges to scaling-up social prescribing and its work 'offer' and the implications and limitations of different service models. Opportunities relate to social prescribing's ability to reintegrate people with complex problems back into the community – the need to evidence this – and its proven track record in facilitating effective partnership working across different stakeholder groups that, ultimately, share a common goal. Pooled funding may be one way of facilitating this and thus help unite cross-sectoral partners around the goal of employment which brings clear benefits to all stakeholders.

In the following, and final, chapter we explore how policymakers and social prescribing stakeholders can overcome the challenges outlined above, as well as how to maximise the opportunities and, in turn, optimise work and related outcomes in social prescribing.

5. Conclusions and recommendations

5.1. Conclusions

This paper has shown that, since 2016, *the social prescribing policy landscape has changed significantly*. The sector has grown rapidly during this time and it has attracted attention from policymakers at the highest levels of government as an effective and innovative means of improving people's health and wellbeing. Furthermore, it has gained recognition as a potential route into work for people with complex, long-term health conditions and therefore a way of tackling the 'disability employment gap'. This potential is stated explicitly in the Government's 2017 *Improving Lives* command paper and it now forms a key part of the Joint Work and Health Unit's programme of work. This has informed the development of the Draft Common Outcomes Framework for Social Prescribing (from NHS England and the Social Prescribing Network), which places specific emphasis on outcomes including staying in work and finding new employment, as well as employability outcomes like volunteering, accessing training and gaining qualifications.

It is in this context that we carried out this research, building on the findings of a 2016 FFW/WF paper. Specifically, we *sought to investigate* whether this changing policy emphasis has influenced social prescribing in practice, thus resulting in more emphasis on work and related outcomes and changes in the work 'offer'. We explored the 'value' attached to work and the barriers to embedding work-related outcomes into social prescribing services. Ultimately, we aimed to inform policymakers about the feasibility of social prescribing as a route to work and whether these 'high level' policy aspirations can be realised.

The 2016 FFW/WF paper found *considerable potential for social prescribing to help clients to gain work via an 'indirect pathway'*, i.e. as part of the larger goal of improving health and wellbeing. However, it also revealed a "lack of recognition in the literature" of social prescribing as a route to work. More specifically, it uncovered few references to the role of work in social prescribing generally as well as it not being a "key feature" of evaluations or large-scale studies on social prescribing¹⁰⁰.

In contrast to the 2016 paper, *the literature review for the present study* found a number of evaluations all published in the last two years, with an explicit emphasis on social prescribing as a route to work. Most report on employment and related outcomes (e.g. whether clients found work, went into volunteering, training or education). Thus, the evidence suggested that, primarily, social prescribing services provide an indirect route to work (rather than direct), first addressing more basic needs through non-work activities eventually leading to education, training and volunteering, for example. It was also found that more holistic services are better placed to support clients on a journey towards work (i.e. those with dedicated Link Workers with strong links with the local community and sufficient contact time with clients, etc.)

The *findings from a survey of Social Prescribing Network members* revealed widespread recognition of social prescribing serving as a route to work. There was more evidence of the 'indirect route', where social prescribing breaks down barriers to work and produces work-related outcomes, which may lead to work. Volunteering, for example, was commonly cited – as it was in the literature review.

The *findings from primary and secondary research* conducted with four social prescribing services¹⁰¹ 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,

¹⁰⁰ http://www.theworkfoundation.com/wp-content/uploads/2017/02/412_Social_prescribing.pdf

¹⁰¹ The same services featured in the 2016 FFW/WF report

dedicated Link Workers and feedback/monitoring mechanisms in place. Getting people into work via a 'direct route' was not prioritised by these services. There was, comparatively much greater recognition – and emphasis placed on – social prescribing as an indirect route to work (i.e. the 'positive upward spiral'). Also, all services now collected some form of work/employment data (unlike in 2016).

Some service changes indicated a move towards integration of work and related outcomes. For example, discussions had taken place with JCP 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. Furthermore, other service changes had been driven primarily by clinical priorities/changes in client base, arguably representing moves away from integrating work and related outcomes.

Overall, the findings suggest that social prescribing services sit primarily in the health 'space'. Referrals come exclusively from the health and social care system. There was evidence of a potential 'cultural issue' around a lack of recognition of the role work plays in improving health and wellbeing. Also, 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. 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 service as an indirect route to work).

Thus, further integrating work and related outcomes into social prescribing schemes presents a number of *challenges*, but 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 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, 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' behaviours. 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 principals, e.g. *Raising Aspirations*, while bearing in mind the importance of putting emphasis on the 'indirect pathway' to work.

Practical barriers 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 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 already 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.

5.2. Recommendations

It should be made clear that we are not suggesting that social prescribing should be thought of – primarily – as a 'return to work' service, or as a 'direct route' to work. Rather, we recognise that social prescribing services, by empowering clients to improve their health and wellbeing through a person-centred approach, *break down barriers to employment*, building confidence, developing skills, providing experience and, in doing so, set people on an 'indirect' journey or route towards work, i.e. a 'positive upward spiral'. Work is the most common means through which people achieve and maintain independence and a primary source of wellbeing and health, helping people into it is therefore entirely consistent with social prescribing principles.

That said, we recognise that different social prescribing services use different models (as outlined by the typology in Chapter 2) and services on the more holistic 'end' of the spectrum will be better placed to integrate work, owing to their integration with primary care, strong links with the local VCS, etc. Furthermore, differences in client base will dictate the extent to which work is a feasible outcome. For example, the service we reviewed in Hertfordshire mainly works with clients above pension age who are not – of course – in a position to work.

With these points in mind, we make a number of recommendations below that seek to build on the momentum created by government (specifically the Joint Work and Health Unit) and NHS England and the Social Prescribing Network (through the Outcomes Framework) around social prescribing as a (primarily indirect) route to work. 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.

5.2.1. 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 and commissioners of social prescribing services will naturally increase the emphasis social prescribing services place on work and related outcomes. The evidence suggests that, currently, funders/commissioners prioritise targets incentivising the reduction of health service costs without recognising the role that work – as a clinical outcome – can play in helping meet these targets.

Furthermore, research suggests a significant minority of GPs (around 1 in 5) do not believe staying in/returning to work is an indicator of clinical success nor that a patient is ready for work until fully recovered. In addition, this research found evidence of a view that some healthcare professionals (e.g. GPs) are wary of social prescribing due to the lack of evidence

underpinning its effectiveness generally let alone in relation to work. Given that GPs are the main referrers into social prescribing schemes it is vital they recognise the role work can play in improving clients' health and how social prescribing in particular provides a route to work.

Link Workers already have a diverse set of skills and cannot be expected to be labour market 'experts'. That said, they may also – like funders/commissioners and healthcare professionals – lack awareness of the role work can play in improving people's health and wellbeing. Integrating work outcomes into social prescribing services requires greater awareness of work as a health outcome amongst Link Workers given their role in co-creating goals with clients.

- The [Department of Health and Social Care \(DHSC\)](#) have committed to creating an 'online social prescribing platform' in 2019 for commissioners and healthcare staff¹⁰². 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.

5.2.2. [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. It has enabled stakeholders in different disciplines to unite around a common goal – improving the health and wellbeing of the client. This is demonstrated by, for example, co-location, where Link Workers are integrated in GP surgeries, where both parties can learn from each other. 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

¹⁰²https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750909/6.4882_DCMS_Lo neliness_Strategy_web_Update.pdf

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 Sheffield¹⁰³, 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 service) around a common goal, recognising that role work plays in improving and sustaining people’s health and wellbeing.

5.2.3. **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. Diversifying funding away from health and social care to include other funders that may place less priority on health/clinical outcomes and more employment and related outcomes could serve to increase work integration. In addition, pooled funding, e.g. ‘community investment funds’ can support cross-sectoral and partnership working, prioritising clients’ needs regarding of what ‘space’ they fall into (e.g. health, employment or otherwise).

- 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.

5.2.4. **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. At the very least, outcomes related to simply ‘finding work’ must be measured over the long-term, e.g. 12 months or more, depending on the severity of clients’ needs and how ‘far’ they are considered to be from the labour market. In addition, outcomes considered to contribute to ‘breaking down barriers to work’, e.g. volunteering, education, training, confidence building, etc. should be explicitly recognised as such. Through this, it would be possible to track how ‘far’ a client has progressed on a journey towards work. However, we strongly advise against any inclusion of ‘payment by results’ (PBR) in relation to clients finding work or taking up training, education, etc. Indeed, overt focus on work outcomes and return to work may adversely influence Link Workers’ behaviour, for example, who may prioritise clients who are ‘closer’ to work compared to those who are not.

¹⁰³ <https://www.workingwin.com/articles/the-health-led-employment-trial>

- 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

5.2.5. **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 (via confidence building, skill development, training, volunteering experience, and so on). The holistic, person-centred approach is instrumental in this process, allowing clients to meet their goals at their own pace.

There is a distinct lack of evidence demonstrating the value of social prescribing in this regard. Existing methodologies/metrics cannot account for the diverse nature of social prescriptions and their effectiveness in helping people into/towards work. Conventional methods commonly used in employment-focused programmes, e.g. RCTs, do not lend themselves to social prescribing's highly individualised approach. As a result, it is difficult to evidence and therefore convince stakeholders that social prescribing is a reliable route to work. The evidence is almost exclusively qualitative and anecdotal, largely based on case studies.

- 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

Appendix

The Tower Hamlets *Raising Aspirations* pilot programme ran from 2013-15 and was provided by three partners including: Jobcentre Plus (JCP); the local authority (London Borough of Tower Hamlets); and Poplar HARCA (a Housing Association). It was successful in delivering employment outcomes (e.g. finding work) using a social prescribing 'approach'. Elements considered integral to its success included the willingness of partners across the three organisations to adopt a different way of working and unite around a common goal (getting people into work), putting individuals' needs first. This, in turn, enabled integration between the three different partners, i.e. co-location, engendering close, personal relationships between stakeholders and dynamic case conferencing. Furthermore, it provided training/accreditation for its Link Workers, ensuring they were Level 4 in Advice and Guidance (IAG).

Key *similarities* to the social prescribing services featured in this study include:

- a Link Worker/caseworker who worked with the individual client and identified goals and the appropriate package of support;
- a holistic, person-centred approach;
- referral onto relevant services provided in the voluntary and community sector (VCS);
- working with people with complex health and social needs;
- people referred in (i.e. the client base) were considered 'far away' from the labour market; those considered 'closer' to it were dealt with by another Tower Hamlets programme (*Skillsmatch*);
- there was integration with health services (i.e. Poplar and Limehouse Health Network) and some referrals came from GPs and Employment and Support Allowance (ESA); and
- it was focused on a specific geography – in this case, a specific Ward.

Some key *differences* were:

- employment was a specific goal of the service;
- Jobcentre Plus was a delivery partner and referral agency alongside a Housing Association and Local Authority;
- primary health services were not a significant partner, funder or referrer;
- they were more focussed on addressing the barriers which prevented clients getting into work or being able to stay in work – the same 'whole life' approach, but from a different 'angle'; and
- as such, most clients could be described as closer to the labour market.

Looking at the social prescribing service model in Hertfordshire (Figure 4.2 on, p. 19), the differences between it and *Raising Aspirations* lie in the 'inputs' into the model (i.e. the 'social prescribers' or referrers on the left-hand side of diagram), while the 'outputs' (i.e. the prescriptions on the right-hand side) bear many similarities.

The service used a *bespoke diagnostic tool* – the 'Multiple Barriers Assessment Tool' (MBAT) developed by the project and used by staff to identify potential barriers to employment, ranging from basic skills like literacy and numeracy, to health-related issues like mental health and drug addiction, as well as lack of aspiration, motivation, education and training. This tool identified clients' needs at baseline and tracked their progress over time to quantify 'distance travelled' (and thus proximity to the labour market). It ensured that Link Workers were focused on holistically addressing clients' complex needs, rather than explicit job outcome 'targets'

(which, it was thought, might adversely affect Link Worker behaviour). Thus, the service, by focusing on these barriers, provided clients with an *indirect route* towards work.

Due to the success of the pilot in securing job outcomes for clients and the political desire – at local and national level – to help people considered ‘further’ from the labour market, as well as growing recognition of the need to move beyond a ‘siloed’ approach to solve persistent social problems (e.g. long-term unemployment), the service attracted attention from national-level policymakers and integrated (i.e. ‘mainstreamed’) into the London Borough of Tower Hamlets’s employment services, being merged with existing services (e.g. *Skillsmatch*) which were more focused on those considered ‘closer’ to the labour market. This brought with it a number of challenges, which are useful to consider in the context of social prescribing receiving more attention, the expectation of more funding and, in turn, more scrutiny and involvement from policymakers. The challenges included:

- the service no longer being located in a single place but rather operating from multiple locations (and thus losing the close, personal relationships between stakeholders);
- decreasing involvement of Jobcentre Plus, who still made referrals into the service, but less frequently;
- less emphasis on clients’ health, and more on employment/job ‘targets’;
- funders’ priorities towards ‘harder’, e.g. job-based, outcomes; and
- the need for a sophisticated Customer Relationship Management (CRM) system that works at scale.

As social prescribing receives more attention from policymakers as a means of addressing public health issues, services may face similar challenges to these. It is important that these challenges are dealt with effectively.

In sum, the key differences between *Raising Aspirations* and the social prescribing services explored in this research, are that both funding and referrals did *not* come from the health and social care system; health organisations were *not* key partners (although they were involved); and specific objectives did *not* have a health/clinical focus (e.g. reduction in hospital admissions). The primary aim was helping people into employment and referrals were largely from JCP (a key partner). Thus, finding work informed both the service’s goals and its referral route. So, it differs in that respect. But, when a client met a Link Worker, the same social prescribing *principles* were put into practice: a holistic, whole-person approach first addressing more basic needs and building on clients’ ‘assets’ to *break down barriers to work*, thus putting them on an *indirect pathway* to work.

Therefore, the key features of this model (i.e. effective partnership working across different ‘system actors’, training/accreditation for Link Workers, and the use of a bespoke diagnostic tool designed to break down barriers to work) can inform and direct how social prescribing can further integrate work and related outcomes into service provision.

