Social prescribing for mental health: an integrated approach

"It’s nice to be told: 'We want you to do these activities because we know you can'... it’s a form of encouragement. Drugs are telling you, 'You are ill'... but activities are telling you 'You can do things'. You can get the right support."

Focus group participant

Project Report
October 2014
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Foreword

“The greatest future achievement in medicine will not be some new technological achievement, but if we can better support people to look after themselves.”

Ivan Illich

“You can’t just think medication, you have to think lifestyle, social interaction, activities, and the real things that you are treated for are the things in life”
"If you’ve got the right support you can manage your life"

Focus group participants

If you were to take a quick look at the way health and social care resources are currently arranged, you might be excused for concluding that physical health and mental health are two quite distinct entities. And yet increasingly we are faced with evidence that suggests this is not the case. Mental and physical health conditions often come hand in hand, and interact in ways which complicate and disable everyday life.

People with diabetes, hypertension and coronary artery disease are twice as likely to have mental health problems, and those problems are even more likely for people with chronic obstructive pulmonary disease and cerebro-vascular disease. If you have two or more of these long term conditions, you are seven times more likely to have depression. And these statistics work both ways: people with mental illness have an increased risk of developing diabetes, cardio vascular disease and other chronic conditions. If we are to change this, and also make sure that people with serious mental illness are able to live a long and healthy life, we need to take a different approach to wellbeing.

The increasing prevalence and complexity of long term health problems and the financial pressures facing the NHS in the coming years, pose a huge challenge to the way we traditionally think about providing help and support. Having a holistic, person centred approach must be central to services in the future if we are to tackle the challenges of long term ill health and ensure the best value for money.

In the West of Newcastle, colleagues in primary care are attempting to do just that. Together with partners from the voluntary and community sector, service user and carer groups, the NHS and social care, they have established an impressive track record of investment and testing in social prescribing. This extraordinary commitment to innovation has culminated in the Ways to Wellness project, a large scale social prescribing programme that is about to become operational. Furthermore, Ways to Wellness is one of a very small
number of pioneering initiatives funded by social investment; there is consequently huge interest, both nationally and locally, in what is happening in Newcastle West, and in the learning that will come from it.

This report describes a small but important programme of work that has acted as a kind of bridge between Ways to Wellness and the NESTA social prescribing project that preceded it. It focuses on the importance of adopting an integrated approach, and advocates that social prescriptions, and the systems and services that deliver what has been prescribed, should take into account both the mental and physical wellbeing of the person, irrespective of the problems they may be initially presenting with. This thinking informs a number of outputs from the project, including workforce design tools, and the development of peer support and peer champions to further promote social prescribing for mental health.

The report is refreshingly honest; it includes an account of an unsuccessful attempt to test out a methodology for understanding better some of the financial implications for service providers that can result from social prescribing. The learning from this work has been used to inform a useful set of recommendations, many of which have already been incorporated into the ongoing design of the Ways to Wellness project.

However, the recommendations emerging from this project have much wider application, and in each case a target audience has been identified. I would encourage all colleagues in leadership roles across the local health and social care system to consider them seriously.

As the recently appointed Chief Executive of an NHS Foundation Trust that provides specialist Mental Health and Disabilities Services in Newcastle, I can see many links and synergies between the greater recovery focus we are adopting in our services, social prescribing and personal health and care budgets. At the heart of all of these approaches is a firm belief in the importance of enabling people to live as full a life as possible, by gaining support to manage their needs and deliver their aspirations through identified life goals.

I am excited by the potential opportunity that has been created through this work. We must now seek to seize the opportunity and be open to the possibility of doing things differently to support people to live healthier and more fulfilling lives, whatever their physical or mental health needs.

John Lawlor, Chief Executive, Northumberland, Tyne and Wear NHS Foundation Trust, October 2014
Overview

*Social Prescribing for Mental Health* was a small, time limited initiative that ran for one year from February 2013. It came about as a result of findings that had emerged from the NESTA Social Prescribing Pilot in Newcastle West CCG. Specifically, we wanted to improve the effectiveness of social prescribing for people with mental health problems and increase their take up of ‘the social prescribing offer’. This includes people whose mental ill health is linked to physical illness or long term conditions. The project consisted of four main strands:

- Focus groups with actual and potential social prescription recipients;
- Consultation with mental health voluntary and community sector (MH VCS) service providers about their experiences of social prescribing;
- Development of the Link Worker role to include competencies, support and training. Link Workers are a key element of the model that has been developed locally;
- Increasing access to activities and available on social prescription, and costing them.

The findings and recommendations emerging from the project form the basis of this Executive Summary and are included below. A final workstream, to identify and test a model for developing peer support and peer champions, is now underway. This will help to further promote the social prescribing offer for those with mental health needs. All of the project’s work has been closely aligned with *Ways to Wellness,* a major programme of social prescribing for people in West Newcastle who have long term health conditions.

Key project findings and recommendations

**Recommendation 1 - Encourage system integration and service redesign:**

*Target audience - Wellbeing for Life Board, health and social care commissioners, service providers, Ways to Wellness Board.*

Improvements to the social prescribing offer for people with mental health needs will only be partly achieved by focusing on the roles of Link Workers and their competence and confidence. Some of the issues that need to be addressed are systemic, so there also needs to be a focus on collaboration, interagency working, and redesigning services:

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1. *Newcastle Social Prescribing Project, Final Report, ERS Research and Consultancy, August 2013*
1. Increase and maintain familiarity and contact between Link Worker host organisations; all service providers need to have greater knowledge of what each other does;
2. Enable Link Workers to have closer contact with GP practices e.g. be available at set times at the practice to see patients 'there and then';
3. The principle of 'any door is the right door' reduces energy spent debating whether a referral is 'appropriate' or not. This is especially important given the high degree of co-morbidity amongst those who make most use of primary care and who can potentially derive most benefit from a social prescription;
4. Commissioners should encourage shared pathways and collaboration via their contracts and service level agreements with providers;
5. Redesign services so that they are as accessible as possible whilst also emphasising individual and community assets.

Recommendation 2 - Promote access to psychological therapies and other specialist advice: Target audience - GPs and other referrers, service providers (especially Link Worker employers, and psychological therapies providers), Ways to Wellness Board.

'Stuckness' or inability to engage with a Link Worker or a social prescription often masks other problems that are a priority for the person. These need to be identified and attended to before there is energy available for other things:

6. All practitioners need better awareness of how to access psychological therapies - enabling patients to deal with emotional/psychological blocks to engaging with socially prescribed activity;
7. Psychological therapies staff should be trained and confident in working with the psychological impact of physical health problems and long term conditions;
8. Practical issues such as debt, housing, work or relationship problems can present major barriers to using a social prescription. Navigation to the right help and advice may need to happen before, or alongside trying out groups or activities.

Recommendation 3 - Develop the capacity and contribution of the Voluntary and Community Sector: Target audience - Voluntary and Community Sector service providers and infrastructure organisations, health and social care commissioners, service users and carers, Ways to Wellness Board.

As providers of services and activities, and as hosts of Link Workers, voluntary organisations, charities and community groups have a major part to play in making social prescribing work more effectively for people with mental health problems. Many already provide signposting and help to access other services as standard practice. Calling a referral 'a social prescription' makes little difference to the response that is offered:
9. Directories have a part to play - but there is no substitute for practitioners who have ready knowledge of what is available and how to support people to access it;
10. This needs to include up to date knowledge of mainstream resources. Some prefer to access support that is not identified as part of the mental health system;
11. VCS infrastructure networks have an important contribution to make;
12. The development of the Newcastle Voluntary Sector Consortium will also facilitate collaboration and cooperation within and across the sector.

**Recommendation 4 - Monitor and review funding flows and budgets:**

*Target audience - Health and social care commissioners, Ways to Wellness Board, VCS service providers.*

13. Currently when a voluntary sector organisation or group helps someone via a social prescription, this is undertaken as part of their existing commissioned or charitably funded activity. In contrast, a medical prescription comes with costs and funding attached. This needs monitoring and further attention over time, especially given the pressure on funding and budgets experienced by the VCS.

**Recommendation 5 - Be aware of tensions in the wider system:** *Target audience: Wellbeing for Life Board, Ways to Wellness Board, Mental Health Programme Board, Job Centre Plus, mental health service providers, Link Workers, voluntary and community groups.*

There are several aspects of the wider economic and socio-political environment that can impact on the success of social prescribing for people with mental health needs:

**Benefits and welfare**
14. People with mental health needs who receive Employment Support Allowance lose income if they are moved to Job Seekers' Allowance. This is a risk given the policies of the Government's Work Programme. One person had a social prescription for 'physical activity and lifestyle change' but they were in the Work Programme and did not feel able to make these changes - it was the GP's agenda but not the person's.
15. Such challenges can act as a disincentive. Link Workers need to be sensitive to the issues and may need to spend significant time with people who are ambivalent about change for these reasons, in order to work through the understandable barriers.

**Stigma**
16. Stigma about having a mental health problem can be an issue. This might be more acute for a person with a physical health condition who is being given a social prescription to
help their mood. It is important that all referrers and Link Workers are aware of and sensitive to the effects of stigma and how to address them.

**Capacity of mainstream groups and activities**

17. Link Workers are effective at helping people access mainstream community activities like walking groups or photography clubs. These are finite resources however; there are limits to any group's ability to absorb new members, especially those who might lack confidence or who are rediscovering their social skills following a period of ill health. This needs careful consideration, as the number of social prescriptions increases.

**Recommendation 6 - Increase awareness of the mental health Link Work offer with GPs and the primary care team:** *Target audience: Ways to Wellness Board, CCG, GPs.*

18. The degree to which different practices in the same CCG were involved varied massively. Two practices made over 50% of all the referrals; more than half made none.

19. Ways to Wellness is likely to have more success in this respect by dint of its scale and longevity. This could also increase demand for social prescribing for mental health. This should be monitored.

**Recommendation 7 - Potential contribution of public mental health initiatives:** *Target audience: CCG, Ways to Wellness Board, Public Health Commissioners.*

20. Further promotion and development of the mental health social prescribing offer could be brought about by exploring public health initiatives including social marketing;

**Recommendation 8 - Design and test a model for social prescribing champions and peer support, for people with mental health needs:** *Target audience: Social prescribing for mental health project steering group, mental health service users, Ways to Wellness Board, Public Health Commissioners*

21. A further piece of work should be commissioned to develop and test a model for identifying, training and supporting mental health social prescribing champions and peer support.

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Introduction

1. This report

This report is about the Social Prescribing for Mental Health project, a small scale, time limited initiative that ran for one year from February 2013. The project was set up in response to some of the learning that emerged from the NESTA People Powered Health social prescribing pilot in Newcastle West CCG. The report is published at a time when social prescribing, in the form of Ways to Wellness, is gaining considerable momentum within the CCG.

Social Prescribing for Mental Health focused on challenges involved in making social prescribing work more effectively for people who have mental health needs, either as a primary diagnosis, or as secondary problem associated with one or more long term conditions (LTCs).

In writing a retrospective account of the development of any project, it is all too easy to present a narrative that appears to describe a clear, coherent series of steps from problem definition, to project initiation, delivery and evaluation. Such an account rarely does justice to the multilayered deliberations that are frequently a feature of any attempt to make something 'work more effectively', and this is perhaps especially the case where the project's territory incorporates any of the following:

- improving wellbeing, especially emotional, psychological and mental;
- introducing innovative, non-traditional ways of helping patients and responding to their needs;
- enabling changes in the behaviour of health professionals and support workers, the organisations they work in, and of course in patients.

The description that follows mainly comprises a record of project aims, activities and lessons learned. Where it is especially important to do so however, this report also tries to capture the essence of the debates we had whilst designing, undertaking and reviewing the project’s workstreams.

The work undertaken in each of these project strands is set out in the relevant chapters below. Before this however, there is some additional background to this project, and around the concept of social prescribing.
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VOLSAG
VOLSAG is Newcastle upon Tyne's Voluntary Sector Mental Health Network

Terminology
Throughout this report, the terms 'service users', 'patients', 'clients' and 'people', are used interchangeably, in order to reflect the fact that the project incorporated various agencies and different organisational cultures.

Acknowledgements
This report, and the piece of work it describes, would not have been possible without the active involvement of people with experience of mental health problems, members of VOLSAG, the project steering group, and other colleagues from primary care and the voluntary sector in Newcastle.
2. About the Social Prescribing for Mental Health project

Social Prescribing for Mental Health came about as a result of findings that were, by autumn 2012, already emerging from the NESTA Social Prescribing Pilot. Specifically, we wanted to address a need to improve the effectiveness of social prescribing for people with mental health problems; various factors were perceived to be negatively impacting on take up of 'the social prescribing offer' by this group.

A group of interested parties from Newcastle West CCG and the local mental health voluntary sector was invited to an exploratory meeting. As a consequence, a bid was successfully made for £32.5k 'Mental Health Bundle Monies' from NHS North East (the Strategic Health Authority at that time). The objectives, outputs and outcomes that were defined in the original project bid can be seen in Appendix 1, along with membership of its Steering Group. The project formally began in February 2013.

From the outset, an overarching aim was to build on and be closely connected to the two other social prescribing initiatives invested in and developed by Newcastle West CCG:

- NESTA, People Powered Health pilot (2011 - 2013), and
- Ways to Wellness (2013 - ongoing)

These are both described in greater detail below.

The nature of this project, in common perhaps with any attempt to introduce and develop something called social prescribing, compelled us to consider (and reconsider) a number of philosophical puzzles and linguistic tensions that have significant impact on funding and service provision, as well as on our thinking about the nature of care and support.

For example, the concept of co-morbidity is very well established in medicine and health care, but thinking, funding and services are too often predicated on deciding if need is 'mental' or 'physical'. This is borne out in the latest dashboard developed to support the national mental health strategy, which has separate targets for 'long term physical health conditions among people with long term mental health

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3 See page 7 for further information on the NESTA Pilot

4 In medicine, **comorbidity** is the presence of one or more additional disorders (or diseases) *co-occurring with* a primary disease or disorder; or the effect of such additional disorders or diseases
problems' and 'long term mental health problems among people with long term physical health conditions'.

This issue is not just philosophical or theoretical; the tension and complexity it encapsulates has a very real, sometimes limiting effect, especially when the intention is to introduce new ways of working that stray across traditional boundaries and run counter to cultural expectations. Arguably this is precisely what is happening when a GP (a medical practitioner) makes a social prescription.

Furthermore, in order to make a social prescription work in practice, new kinds of support workers have been developed (for example Link Workers), and agencies and organisations providing activities and resources also need to consider different ways of working. Taking these different factors into consideration, four project workstreams were defined (see table 1. below):

Table 1 Project Workstreams

| 1. Focus groups with actual and potential social prescription recipients |
| 2. Consultation with MH VCS service providers about their experiences of social prescribing |
| 3. Development of the Link Worker role to include competencies, support and training model |
| 4. Increasing access to activities and groups available on social prescription, and costing them - a model for a time limited experiment |

These different strands are explored in turn below, after the following chapter which gives further context and background to the project.

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3. **Context and background**

**What is social prescribing?**

Social prescribing is the use of non-medical interventions to achieve sustained healthy behaviour change and improved self-care; it supplements the support a person gets from their health care professional, and it can in practice take many forms. A doctor or other health care professional can prescribe an intervention, as they would medicine/drugs. Typically, the interventions include physical activity, healthy eating/cooking, social interaction, welfare rights advice and support with positive social relationships. The interventions are usually run by charities or community groups, who have dedicated staff trained to use recognised models of behaviour change. The staff ensure that there is shared decision making, enabling patients be an equal partner in managing their health. Activities can also be peer led.

**What are long term conditions?**

Long term conditions (LTCs) are conditions that cannot be cured but can be managed through medication and/or therapy. There is no definitive list of long term conditions, but they include arthritis, lung disease, diabetes, asthma and coronary heart disease. Over 15 million people in England suffer from LTCs. More than 4 million of these also have mental health problems, and many of them experience significantly poorer health outcomes and reduced quality of life as a result. In terms of NHS spending, at least £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year.¹

People with LTCs and associated mental health problems experience poorer health outcomes and reduced quality of life as a result. They are proportionately higher users of health services (GP appointments, prescription drugs, outpatient services and in-patient hospital bed days). Around one in every two GP appointments are estimated to be for patients with one or more LTC, and compared with the general population, people with diabetes, hypertension and coronary artery disease have double the rate of depression, and those with chronic obstructive pulmonary disease, cerebro-vascular disease and other chronic condition have triple the rate.²

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¹ Long-term conditions and mental health: The cost of co-morbidities, The King’s Fund, February 2012
² See ‘No Health Without Mental Health, The economic case for improving quality and efficiency in mental health’ Department of Health 2011
NESTA - People Powered Health

In August 2011 NHS Newcastle West CCG was awarded £100,000 from NESTA (National Endowment for Science, Technology and the Arts) to plan and deliver a pilot project to 'embed a single, integrated process of social prescribing into healthcare pathways for people with LTCs'. The project was part of NESTA’s ‘People Powered Health’ programme, which aimed to support the design and delivery of innovative services for people living with LTCs.

The NESTA project explored new ways of meeting the needs of a significant group of primary care patients with complex problems including:

- those with long term conditions
- those with mental health needs greater than can be managed by organisations currently delivering link work* and who cannot access mental health services/IAPT as they do not meet diagnostic criteria and/or initial assessment identifies they will not benefit from CBT

*In the NESTA model, Link Workers act as a bridge between the GP/Primary Care Team and the community, supporting the person to access and engage with the prescribed activity. Link Workers were based in three different voluntary sector organisations - HealthWORKS, Age UK and the Carers’ Centre.

The NESTA social prescribing pilot ended in March 2013. Altogether 6 practices made 124 referrals, 51% for physical health reasons, 48% for mental health. Despite the cessation of the formal pilot, some strands of activity related to the project’s long term aim of scaling up social prescribing have been continued in order to enable further testing of the model.

From a mental health perspective two subsequent developments are key:

- Social Prescribing for Mental Health - the thinking around this project began in late 2012, with funding available from February 2013. This project is the focus of this report;
- Moving Forward was engaged as a fourth Link Worker provider organisation, in order to provide a pathway for patients with a range of mental health needs, including more complex problems (referrals began in February 2013).

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8 http://www.nesta.org.uk/project/people-powered-health
In August 2013 an external evaluation of the NESTA social prescribing pilot was published by ERS Research and Consultancy.\(^9\) Recommendations included:

- The need to include pathways and support for people with mental health needs;
- Access to adequate resources for Link Worker training and support;
- Better coordination between different organisations providing Link Workers;
- Clearer information and explanation for patients;
- Stronger engagement of GPs;
- Clearer systems for capturing patient outcomes.

These recommendations informed the subsequent work of the Social Prescribing for Mental Health Project and Ways to Wellness.

**Ways to Wellness\(^{10}\)**

This major initiative to support people with long term health conditions to have a better quality of life is initially being led by VONNE\(^{11}\). It is supported by Newcastle West Clinical Commissioning Group (CCG) and ACEVO\(^{12}\) with initial project costs funded from the Social Enterprise Investment Fund.

Ways to Wellness was established in December 2013 as a company limited by shares, and formally launched in April 2014. It is in the process of procuring suitably experienced VCS providers to deliver a Link Worker service (50 by the end of the first year of operation). Link Workers will receive referrals from GPs and practice nurses, assess people’s needs and develop personal goals, and provide buddying and signposting into local activities and networks and sources of information, advice and support.

The Company is raising further money from social investors in order to demonstrate an economically sustainable case for intensively scaling up social prescribing, as a viable solution to the growing financial burden of LTCs in health commissioning. It is estimated that some 30,000 – 40,000 people living in Newcastle West suffer with one or more LTCs. This project aims to reach about 5,000 patients per year.

The measurable impact will be threefold:

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\(^11\) VONNE is the regional infrastructure body for the Voluntary and Community Sector (VCS) in the North East of England - [http://www.vonne.org.uk/](http://www.vonne.org.uk/)

\(^12\) ACEVO is the Association of Chief Executives of Voluntary Organisations - [http://www.acevo.org.uk/](http://www.acevo.org.uk/)
• **for patients with LTCs** - that they will be better able to manage their daily lives, look forward to a healthier and longer life expectancy and will use their GP services, prescription drugs and hospital services less frequently;

• **for the CCG** - it will reduce their annual costs of treating patients with LTCs allowing them to achieve savings and/or re-allocate resources and innovate its patient services;

• **for the NHS** - it will provide evidence of alternative treatment options for people with LTCs operating at scale and delivering cashable savings. It will reduce the demand upon acute hospital trusts and offer a best practice

The west of Newcastle upon Tyne is an area that includes some of the most deprived wards in England. There is evidence that people in lower socio-economic groups tend to suffer proportionately more, and earlier in life, with LTCs, have poorer health outcomes and consume more health service resources. It is estimated that the treatment and care of patients with LTCs account for more than £100 million of the annual budget of Newcastle West CCG.

Based upon the services already in place it is estimated that social prescribing for 5,000 patients in Newcastle West would cost approx £1.3m - £1.5m per annum, and could result in annual cost savings to the CCG of more than £2m - £2.5m (prescription drugs, outpatients and hospital admissions) – i.e. a potential cost saving of more than £140 - £200 per patient per year. If these projected savings are realised, social investors would be repaid within 7-8 years. This project is of national importance as one of only a few Social Impact Bonds being developed in the health field, and one of only a few projects really scaling up the delivery of social prescribing.
Project Workstreams

1. Focus groups with service users:

   a. What we wanted to do

   We were keen to find a way to make sure that the experiences and concerns of service users were gathered and incorporated into the overall learning from the project. Service users in this context were defined as people who have some level of mental health need, for which they have received (or might in the future receive) a social prescription.

   We wanted to try and find out more about what service users thought about the term 'social prescription' and to understand better their thoughts about what it is like to receive one.

   a. What we did

   Involve North East\textsuperscript{13} was commissioned to carry out 4 focus groups in August and September 2013, in order to capture specific views and experiences to feed into the ongoing design of social prescribing in Newcastle West CCG. What would make social prescribing more attractive to patients? What issues and factors do we need to be aware of? One group was drawn from primary care and the others from mental health service users in three different voluntary sector mental health settings. A variety of discussion questions was put to the participants, who were made up of a mixture of people, some who’d had a social prescription, and some who had not. The focus groups also included people whose mental health needs were supported within primary care, those who had used specialist mental health services, and people who had both physical and mental health needs.

\textsuperscript{13} http://www.involvene.org.uk/
Table 2: Focus Group discussion questions

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<td>1.</td>
<td>What do you understand by the term Wellbeing and Health?</td>
<td>Characteristics of good Wellbeing and Health, and bad?</td>
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<td>2.</td>
<td>What are the factors that you think most affect your Wellbeing</td>
<td>and Health?</td>
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<td>3.</td>
<td>What sort of services (health or otherwise) most affect your</td>
<td>Wellbeing and Health?</td>
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<td>4.</td>
<td>What, for you, would show that some particular activity or</td>
<td>service was working – or not working – for you?</td>
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<td>5.</td>
<td>If your GP, or someone else in the practice, ‘prescribed’</td>
<td>something non-NHS to help improve your overall wellbeing, how</td>
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<td></td>
<td>something non-NHS to help improve your overall wellbeing, how</td>
<td>would you react?</td>
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<td>would you react?</td>
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<td>6.</td>
<td>Would it have to be something in your existing ‘comfort zone’,</td>
<td>or would you be prepared to try something new and potentially</td>
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<td></td>
<td>or would you be prepared to try something new and potentially</td>
<td>daunting?</td>
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<td>daunting?</td>
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<td>7.</td>
<td>If you were advised by your GP to go to a gym or join a</td>
<td>particular group, what would encourage you (or put you off)</td>
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<td>particular group, what would encourage you (or put you off)</td>
<td>about the person who was your first point of contact?</td>
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<td>about the person who was your first point of contact?</td>
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<td>8.</td>
<td>You would be given someone who would act as your Link Worker</td>
<td>to keep in touch and make sure things were going ok, and also</td>
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<td>to keep in touch and make sure things were going ok, and also</td>
<td>to work with you. What do you think would be important to</td>
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<td>to work with you. What do you think would be important to</td>
<td>make this stage work well?</td>
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<td>make this stage work well?</td>
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<td>9.</td>
<td>The success of social prescribing depends to a large extent</td>
<td>on whether you as a patient are happy with the idea. But you</td>
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<td></td>
<td>on whether you as a patient are happy with the idea. But you</td>
<td>could also take control and ask your GP to ‘prescribe’ a</td>
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<td>could also take control and ask your GP to ‘prescribe’ a</td>
<td>specific activity yourself. Is this something you’d be</td>
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<td>specific activity yourself. Is this something you’d be</td>
<td>comfortable doing?</td>
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<td>comfortable doing?</td>
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<td>10.</td>
<td>Where would you go to find ideas and information about non-NHS</td>
<td>services?</td>
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b. What happened - summary of key themes emerging from focus groups

1. Participants had a good understanding of terms like 'wellbeing' and 'health' in relation to their own lives, and in terms of connections between mind and body.
2. Internal and external factors affecting wellbeing were acknowledged, with a particular emphasis on finance, housing, the impact of welfare and benefit reforms, and the negative perceptions of disability and unemployment being portrayed in the media.
3. Professional systems of support are valued, but it was recognised that these can create dependency.
4. Social networks were seen as very important, but they can be difficult to establish.
5. Access to good information (e.g. about what groups and activities are available), and knowing that you can ask your GP for a social prescription is key.
6. Being signposted and linked into activity by organisations and support workers is seen as an effective way to get connected.
7. GP referral into activity (social prescription) is seen positively, and might be preferred over medication; but it depends on how well the GP knows the person, how sensitively the idea is introduced, and how tailored the activity is to the person.

8. Choice is important.

9. Link Workers need to be accepting, tolerant of difference, and able to establish trust.

10. Motivation can change from day to day and at different times of the day, and can be affected by mood and the effects of medication.

11. Stigma can be an issue - for example when it becomes known that access to a mainstream group has been facilitated via a social prescribing route.

12. Currently there are perverse policy incentives - most notably, taking up voluntary work, or indicating that you can cope with exercise or social activity could result in changes to, or withdrawal of, disability or out of work benefits. This makes some service users anxious or ambivalent about taking a social prescription.

d. Quotes from focus group participants

Factors that affect wellbeing and health
"If you've got the right support you can manage your life", “it's getting the support in the first place is the hard bit"
"being isolated is a bad sign, a sign of bad health",
"... if you've got a good doctor you're fine"
“You can't just think medication, you have to think lifestyle, social interaction, activities, and the real things that you are treated for are the things in life"
“I would prefer to be prescribed to take part in something accessed by the community, rather than be institutionalized”
"Practical courses... like learning to play the guitar...how to paint.. not necessarily all vocational"
"I think talking helps having someone to talk to, counselling sessions, groups, relating to each other so you don’t feel on your own. A lot of people do feel very alone and alienated, they don’t want to see anybody, and sometimes they’re frightened”
" More positive towards your day if you've got something to do and you know it's helping".
“And going to the gym on days you don’t want to go, you feel great when you’ve been"

Reactions to being offered a social prescription
“What I would want to know from the GP is why have you chosen this particular activity for me? What is about me? Have you chosen this because I look and appear
physically fit? Even though I’ve got mental health problems? Why do you think it’s suitable and how will it benefit me? Because I don’t know whether he is assessing me correctly to do such an activity that might be taxing or stressful or physically stressful, you know?”

“I would try as long as I was physically – I’ve got a touch of arthritis – as long as I was physically able to do it I would try it”

“It depends on how well you are and where you are in your recovery, doesn’t it?”

“…I was really nervous, I hadn’t been on a bike since I was young, they provide the bike and the water bottle and helmet, we went on the Quayside, the business place, that was the first time and I was hooked.”

“I think if a doctor is just going to give you medication you feel it’s not so caring, you’re just a number, but if he is going to prescribe something that is going to help you physically or social activities I think it would make you feel more valued, that they actually care to get you back well without just popping pills”

“It’s nice to be told, “We want you to do these activities because we know you can” so a form of encouragement. Drugs are telling you, “You’re ill” but activities are telling you, “You can do things”. You can get the right support.”

“It can make somebody better by them going to the gym, for example, depression, you’re not paying for the medication which costs thousands and you’re more likely to get that person back into work”

The importance of being ready and having a choice

"You don’t want to be forced into anything, you need to have a choice"

"What's good for one isn't necessarily good for another person"

"I think the GP would have to have quite a good rapport and understanding of the patient because it’s no good recommending fishing to someone if they're terrified of water"

“I mean I wouldn’t have said I was at rock bottom but I was quite low and she offered me the gym and I didn’t feel ready.”

“Some people need a push, if they’re forced to go and take part in exercise then they get to actually enjoy it, but it’s the initial push”

“…if they try and push you when you’re feeling low, it can make you worse and it makes you panicky, so it all depends on the way you’re feeling at the time really”

“… what I would expect them to do is say to go to Moving Forward and they will give you a whole range of options as to what you want to do and they will help you ease into it. So you’re not pushed”.

“But if it’s put like say ‘how do you think about this?’ then they give you other leaflets which I’ve had and you take home and have read them … then it might be a week or two after you look at it differently and you might think yes, this might be all right.”
Challenges, constraints, and stigma

“...night times are out because once you take your medication you are in no fit state to go out...”
“I feel very uncomfortable because I hate going to groups that are just full of normal people because I’m not one of them ... nobody invites you into their conversation”
“They get you to fill in questionnaires and I started crying once because the questions were quite emotional”, “I couldn't finish the class, I had to go home”
“The only thing with that is kind of everybody knew that I was getting the salsa free because you had to go up and say, “I’m with the Taking Part Workshop” and so people know you’ve gone through your doctor kind of thing, ..”

Factors that are helpful, qualities a Link Worker needs to display

“..trust is a massive, massive thing for people like us because most of our issues have been because we’ve tended to trust people in the past and been abused in lots of different ways”
“It’s hard opening up to somebody and letting that person in and seeing all the turmoil, you’ve got to have some kind of trust there”
“Warm, friendly, understanding, non-judgmental, encouraging”
“I think if they’re bubbly and enthusiastic it helps you a lot”
“But wouldn’t it be ideal if they actually had problems in the past themselves and they’ve used a gym and found it beneficial and then it would kind of inspire you wouldn’t it”
“..and not to push you, I think that’s important because if they push you I end up pushing back and saying, “No I don’t want to”
“I would also want them to come with me for the first few weeks to certain groups or certain sessions ... so that I have somebody to talk to and then I would want them to come with me ... until I’ve decided ...”.

Taking manageable steps - support that helps

“I think it’s important having somebody like Moving Forward because they tend to ask you what your interests are and work around you, ... you might not have any interests at that time but they’ll introduce you to things and they go along with you or make the phone calls for you because ... you think, 'Oh I'll do it tomorrow ... so they do all that for you and make the arrangements for you, then they go along with you for your first couple of times, so then once you get there you think, ‘Oh there’s nothing to it’, and you can go on your own”.
“Maybe a phone call to say “Oh we’ve missed you”, and them saying, “Just come in for ten minutes”, somebody just to give you that push, or just go in for a gossip and a natter, catch up on what’s happening”
Asking a GP for a social prescription
“Because it’s not advertised or anything, what’s available to people, you basically find out yourself or you find out by somebody else telling you”. “We were interested in the gardening one and I’m still waiting for a phone call, over a year!”

Access to information
“I’ve come to pick up leaflets at the doctors for specific things and there’s nothing, the odd few, but a long time ago there were leaflets on everything, what’s on, all the things you would have and they’re not there now, which I think is the best place to have them”. “All the different types of services and when they say ‘what your problem’, depression, ‘oh there’s this group, that group, the next group’. That’s a good idea, they’d just have a look, I mean they mightn’t know what the group does but if it’s on there then they can refer you to it and you can take it from there”.

The impact of welfare reform and tensions in the system
"I go to Moving Forward, and I know from my appointment at the Job Centre that I gave them the impression I was well, so that could go against me"
"It sounds a fantastic idea but then again how would it work for people on benefits? I mean if you are going for sickness benefit and you want to go and put in for DLA and then they say ‘Oh well my doctor sends me to the gym’ that’s basically a big X isn’t it?"
"I’m due to go for a medical now and I’ve been told off so many people, 'Please don’t mention that you’ve gone to salsa', because as far as they’re concerned if you can get yourself up on a morning and get dressed, you’re fit for work"
"I’m scared, I wanted to go in and say, 'I’ve been doing stuff to help me get back into work, mix back into the community' but I know the minute I say that they will stop my benefit there and then"
"If you ... do exercise because you’re prescribed it and then you’re going for a sick note how does that work? You’re at the gym and asking for a sick note?"
"To be classed as a scrounger ... taking people’s money"
"Feeling that you are less value as a human being to the rest of society"
2. Consultation with mental health voluntary sector organisations (MHVCS):

a. What we wanted to do

Over the life of the NESTA Pilot a number of presentations about the project had been made to voluntary sector organisations and community groups (VCS). It was clear from the questions and feedback at these events that VCS organisations have considerable curiosity and concern about social prescribing, especially in terms of:

- clarity about what is (and isn't) social prescribing;
- opportunities that may exist for them as potential providers of prescribed activity, or as employers of Link Workers;
- fears that the groups, activities, signposting, and support required to make social prescribing work well would create additional demands that are not funded.

Additionally, the economic recession, and especially the cuts to social care funding resulting from the Government’s austerity programme, have had a very negative impact on the VCS, and have significantly reduced the availability of traditional income streams such as grants and small contracts. These factors have heightened both interest and concern about the implications of social prescribing for the sector.

We therefore wanted to provide an opportunity for the mental health voluntary and community sector (MH VCS) providers in Newcastle to share their knowledge and experience of social prescribing, especially the NESTA model, in order to capture any themes, comments, and other feedback from their perspective. This learning could then be fed into the CCG’s ongoing development of social prescribing via Ways to Wellness.

b. What we did

We organised a one off, half day event, targeted at MH VCS providers who work with people from GP practices in the Newcastle West CCG; and who preferably already had some experience of receiving referrals via a social prescription and using the Link Worker model.

This consultation event took place on 23rd July 2013. The aims of the session were:

- To provide an overview of social prescribing in Newcastle West CCG, including:
  - NESTA social prescribing project
  - Social prescribing for mental health
Ways to Wellness

- To facilitate collective feedback on social prescribing from a MH VCS provider’s perspective
- To encourage increased/shared understanding of social prescribing, especially developments in Newcastle West CCG

c. What happened - summary of key points

- There is a growing understanding of social prescribing practice generally, and in Newcastle specifically; but there is still a sense of uncertainty about what is and what is not defined as ‘social prescribing’. 

- Similarly, there is debate about how a social prescription differs from a more traditional referral, especially when the service offer/response may be very similar - or even identical in each case.

- Within the MH VCS sector (as in the sector generally) there is a longstanding level of experience of delivering:
  (i) Link work or activity which is ‘close to’ link work; and/or
  (ii) Activities that support mental wellbeing and health

- There is acknowledgement that progress has been made, but significant questions remain about commissioning and funding the various elements of any social prescribing model, in addition to issues relating to:
  a. Patient and professional awareness
  b. Need for clarity in defining the target population of any given model
  c. Agreement on the preferred model or models
  d. Skills and competencies of workforce (e.g. Link Workers), specifically in relation to support for behaviour change
  e. An effective, cohesive, and sustainable VCS offer
  f. Demonstrating impact of specific interventions

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14This may be especially true in the mental health field, where there is a longstanding discourse around the concept that engagement in activity and occupation can be inherently beneficial.
d. Discussion of specific issues and themes

Levels of knowledge and involvement
All the organisations represented had a good level of understanding of the wide scope of the term ‘social prescribing’ and the need for specific definition and agreement at any one time to avoid confusion about which aspects of social prescribing are involved.

All were aware they and others are already delivering activities which come under the umbrella of social prescribing, although these are currently not commissioned or funded as such, with the exception of one organisation which is funded by the CCG and the Local Authority to provide Link work for people with mental health needs.

Experience of the NESTA Pilot
There was a mix of representation from organisations that had and had not been directly involved in the NESTA project. Those involved felt that:

- NESTA referrals had been of a higher level of need, requiring a greater degree of support than anticipated;
- Presenting issues were not always the real priorities for the person, with underlying issues emerging as staff began to work with them;
- Referral profiles were reported as weighted to those in their 30s - 50s raising questions about the need to define target populations;
- Concerns about younger peoples' needs and their perceptions of activities currently available.

One organisation that was offering a different social prescribing model, had deliberately avoided the practices engaged in the project, focusing instead on Ouseburn in the east of the city.

Referral routes
Are varied and already include GP, health care professional and health trainer referral, although there is a high proportion of self-referrals. There is awareness that people with higher needs are likely to benefit from additional support e.g. Link Worker support to access mainstream activities. There was acknowledgement that GPs/HCPs (among others) are not able or expected to hold all relevant and up to date information on the what is available in order to refer patients directly.
**Types of social prescription**
Participants reported a range of responses depending on the needs of the individual including:

- Not always time limited
- 1-1 Link work model
- Specific programmes of support
- Self help groups
- Informal peer support (‘natural buddying’)
- Normalising – linking into ordinary activity
- Identifying barriers

**Link Workers**
Participants recognised the importance of having Link Workers with a ‘nurture’ skill set, a consistent approach to setting and measuring goals in order to provide support to effective behaviour change, and a comprehensive knowledge of the social prescription ‘offer’. One organisation was aware of, and referring or signposting on to, over 1000 activities; all of whom had been quality assured via a paper-based check.

**Outcomes**
WEMWBS\(^{15}\) was in use by more than one organisation to demonstrate ‘the distance travelled’, with others using alternative means e.g. a version of the Outcomes Star.\(^{16}\) The difficulties managing and monitoring an individualised approach were noted by the group.

**Commissioning**
The issue of funding flows in social prescribing was a major concern amongst attendees - including reference to the fact that unlike a traditional medical ‘prescription’ no funding is currently attached to a social prescription or referral. Significant questions were raised about commissioning and funding the various elements of any social prescribing model. There was uncertainty about what commissioners want to commission; how they will commission and whether social prescribing services will, if commissioned, be for the purposes of social inclusion or public health. There is a perception by some in the MH VCS that social prescribing might provide a source of income, and there is a need therefore for ongoing clarification if this is not the case.

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\(^{16}\) [http://www.outcomesstar.org.uk/](http://www.outcomesstar.org.uk/)
Funding
The question ‘Who will fund the social activity e.g. the zumba class?’ (especially in light of health and local authority funding cuts, closure of community and leisure facilities etc) was raised, given that in the NESTA Pilot funding was notionally attached to Link Workers but not to the services or activities people are linked into. Questions were also asked about similarities/differences between social prescribing personal budgets and personal health budgets.

Costs
The issue of potential incentives for GPs and other practitioners to ‘prescribe’ the offer was raised, together with a concern over any potential need to distinguish between 'social prescription referral' and ‘ordinary referral' as some providers are not set up to be able to offer different levels of input to individuals depending on their referral route. In the light of pressures on GPs’ prescribing budgets it was noted there may be a tendency to choose the economical option, and there are concerns about how this impacts on social prescribing. The costs of a social prescription (e.g. for 6 weeks, 6 months) and how this compares with pharmaceutical prescription costs were queried.

Patient and professional awareness
Concerns were raised about levels of patient and professional awareness, recognising the need for ongoing marketing to increase both of these. The importance of patient awareness and demand i.e. ‘patient pull’ to support scaling up of social prescribing was discussed, together with the issue of levels of internet usage by both existing clients and those not yet engaged. In relation to online information and service directories the question ‘Why replicate Google?’ was raised, together with the suggestion to consider developing search engine optimisation.

Target population
The need for clarity in defining the target population was stressed. There is concern (reflecting the Sure Start experience) over whether current provision and opportunities are being targeted at the most appropriate groups and the risk of incentives (such as payment by results) leading to ‘cherry picking’ was noted. The suggestion to target young people was put forward on the grounds that as their unhealthy behaviours are not yet as ingrained, it may prove effective to promote lifestyle change. To avoid the issue of stigma being attached to a referral from a GP, consideration could be given to providing reassurance that no-one need know.
Different social prescribing models

The need was expressed for caution when referring to ‘the’ model as there are potentially different kinds of approach. Issues raised about the Link work model included:

- ‘How does this model fit with new agendas?’
- ‘Why are we wedded to the Link Worker model? Has it been proven?’
- ‘Who employs the Link Worker?’

Repeated reference was made to the required skills and competencies of the workforce, specifically in relation to support for behaviour change.

Applicability in mental health

The sophistication of any model and the demands of delivering and managing it were stressed by participants, along with concerns that the ‘social prescribing model is being stretched’ to cover levels of need which require more intensive support and/or longer-term funding. The typical length of involvement (i.e. the 10 week model of 6 - 8 sessions) although a ‘neat offer for many other conditions’ was felt to be too short for those with complex and enduring mental health needs (or fluctuations in health). Concerns were expressed about the ability of such time limited interventions to support sustained behaviour change and continuation of activity beyond a ‘funded prescription’. The notion of a ‘repeat prescription’ was also raised.

The social prescribing offer

A key issue for attendees was about the knowledge of ‘what is out there’ and whose role and responsibility is it to hold and maintain this knowledge i.e. Link Worker rather than health or care professional. One key to success is Link Workers with the knowledge and understanding to refer or signpost on to those activities which are effective in supporting and embedding behaviour change. The group recognised the need for MH VCS providers, including Link Workers, to be ‘more aware’ of the contribution by the ‘wider sector e.g. arts, culture, heritage type activities, not just health and social care world’.

This aspect raised the issue of competitiveness between providers, resulting potentially in reluctance to ‘hand on’ people to other organisations. Another risk noted was ‘that there will still be a focus on the ‘usual suspects’ e.g. larger providers - even in the context of increased recognition of what the wider sector has to offer.’

Demonstrating impact

Issues arising from the need to demonstrate the impact and outcomes of specific interventions included:

- ‘How do we reliably and consistently measure outcomes’ while ‘making it workable’?
• ‘How to balance a centralised model (i.e. everyone monitoring on one sheet, ideal but unrealistic)’ with the needs of individual organisations and funders to avoid ‘fragmentation of monitoring forms’?

• An unexpected outcome was that social prescriptions can and do increase workload, emphasising the need to focus on long term benefits and change.

• The issue of ‘fruit falling in another garden’ i.e. ‘if benefits are realised elsewhere which are not health related e.g. lower re-offending rates, should they pay into the pot?’

What has gone well?
Positive aspects reported of progress with social prescribing to date included:

• Increased understanding by GPs/health care professionals of the voluntary sector offer;
• Collaboration between partners and stakeholders within the sector and on specific boards;
• The optimism and creativity engendered; and the recognition that social prescribing is ‘great for people’.

What could be better?
In order to add value to collaboration and creativity, the following needed to be in place:

• An outcomes model
• A commissioning framework
• Data and information systems

Further work was felt to be needed on being more business-like, from commissioners being ‘clear and specific about what outcomes they are buying’ to the sector being ‘very clear about what we are offering – even if it is very tiny first steps’ and developing search engine optimisation, so professionals can be better informed about what activities and groups are available.

The potential to learn from commissioning and delivery of employability and training models, and to consider how to engage with and meet the needs of younger people (e.g. online booking) were also suggested. Finally it was stressed again that Link Workers need to be ‘knowledgeable, skilled and confident in motivating and ‘linking people in’.”
3. Development of the Link Worker role

a. What we wanted to do

The external evaluation of the NESTA project\(^{17}\) suggested that there was a need to think further about different aspects of the Link Worker role, especially in relation to working with people with mental health needs. Initial discussions by the project steering group raised a number of potential challenges:

- Difficulties in making initial contact (for example when the client is so lacking in confidence that communication becomes a major issue);
- The time required to develop trust;
- Challenges of enabling behaviour change for people with certain needs e.g. inability/fear/reluctance to leave the house, or use public transport, or cope with social situations;
- Link Workers feeling/being out of their depth;
- Lack of suitable groups and activities to signpost people on to;
- Risk of creating dependency.

In this workstream we therefore wanted to consider the following questions:

- *Should the Link Worker role be generic or specialist?*
- *How can Link Workers be supported to work with more challenging clients, especially when there are psychological and emotional issues that act as a barrier to engaging with activity?*
- *What training and professional development opportunities exist for Link Workers?*

For example, a generic Link Worker might be less likely to think about a person in terms of their diagnosis. On the other hand, a Link Worker who has knowledge and confidence about mental health issues might feel more confident about talking to the person about their psychological or mental health needs and how they might get more specific help. Similarly a Link Worker who is familiar with a range of physical health conditions might feel more comfortable supporting people to manage needs associated with managing a long term health condition more effectively.

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\(^{17}\) ERA Social Prescribing Evaluation Report August 2013
b. What we did

We focused on the following aims:

- Design a range of suitable job descriptions and specifications;
- Look at training and accreditation of Link Workers.
- Explore different ways of providing support and supervision.

The outputs and outcomes that resulted from exploring these three areas are summarised below.

**Job descriptions and specifications**

Workforce development meetings were held between Moving Forward\(^{18}\) and HealthWORKS\(^{19}\), with the aim of exploring and defining:

- The competencies the generic Link Worker role requires to work with different client groups;
- A 'higher level' Link Worker role with greater knowledge/confidence e.g. in mental health or in physical health conditions;
- Systems of ongoing support and development that could be put in place so that Link Workers can more confidently address the barriers that prevent people from making the most effective use of social prescribing.

These meetings produced a competency based suite of materials, building on the job descriptions and person specifications that already existed:

- Generic Link Worker Job Description (see Appendix 4)
- Generic Link Worker Person Specification (see Appendix 5)
- Link Worker Job Description (LTC) (see Appendix 6)
- Link Worker Job Description (MH) (see Appendix 7)

The National Competency Framework for Health Trainers\(^{20}\) was reviewed and we agreed that it defines the required Link Worker ‘curriculum’ comprehensively. This was produced by Skills for Health and The British Psychological Society.

**Accreditation opportunities for Link Workers**

The possibility of developing a bespoke local programme of accreditation was briefly considered, but the costs involved were felt to be prohibitive. Instead, the National

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\(^{18}\) [http://movingforwardnewcastle.co.uk/](http://movingforwardnewcastle.co.uk/)
\(^{19}\) [http://www.healthworksnewcastle.org.uk/](http://www.healthworksnewcastle.org.uk/)
\(^{20}\) [http://www.healthtrainersengland.com/competencies](http://www.healthtrainersengland.com/competencies)
Health Trainer Accreditation framework offered by City and Guilds \(^{21}\) was felt to provide a model for accreditation of the Link Worker role that could be adopted locally. We will test its applicability to the mental health Link Worker role.

**Training opportunities for Link Workers**

Some initial exploration of relevant short courses and training available locally was undertaken. It was agreed that this project did not have the scope to fully map what is available, or to consider quality assurance of external training provision. It was however established that certain options merited further investigation:

- **Mental Health First Aid** - this can be supplied by various local agencies (e.g. HealthWORKS)
- **Psychological Therapies modules** - also readily available locally (e.g. Newcastle Talking Therapies)
- **Online training and development sites** - there is a wide selection of opportunities for web based learning, some are free, some fee based. While these should not be ruled out, the project steering group felt strongly that such methods fail to provide the peer support and group dynamics that can be key elements of a shared learning and development process.\(^ {22}\)

**Link Worker supervision and support**

At the commencement of the project there was a strong perception that Link Workers in non-mental health host organisations were experiencing difficulties when providing link work to people with mental health needs. A supervision and support model was designed and put in place to include the following elements:

- **An Action Learning Set** - to include a senior member of staff and a Link Worker from each host organisation. The overall aims are to reflect on/improve process of working together to ensure best outcomes for service users.
- **Telephone/email support model for MH issues** - an additional resource for Link Workers to get support around helping people to manage their mental health conditions.
- **Telephone/email support model for LTC issues** - an additional resource for Link Workers to get support around helping people to manage their physical health conditions.
- **Evaluation and outcomes feedback form** - this was designed to capture the impact and effectiveness of the above initiatives from the Link Worker’s perspective.


\(^{22}\) A sample list of web based learning options is included as Appendix 8
c. Discussion and key learning points (what happened in practice)

Job descriptions and specifications
The project’s work in this area has been fed directly into the development of the Link Worker role in Ways to Wellness.

Accreditation opportunities for Link Workers - National
The National Health Trainer Accreditation framework offered by City and Guilds is going to be accessed by two Link Workers from the Moving Forward service. The cost (£800 per place) is funded by the project and this will provide useful information about how well this training is applicable to Link Workers in mental health settings.

Training opportunities for Link Workers - Local
This will be developed further by Ways to Wellness.

Model for Link Worker supervision and support
The model of supervision and support that was designed and put in place (i.e. the action learning set and helplines) was not in fact used. The offer was made but not taken up. At one level the lack of uptake of these systems of support reflected capacity and time issues - Link Worker host organisations found it difficult to free up the necessary worker and manager time. However, it also became apparent that we might have created a solution to the wrong problem. We began to think less about client suitability and worker skill, and more about organisational culture, ways of working, and interagency collaboration. A number of themes emerged and these are now discussed below.

Shifting the focus - system integration

Certain challenges and barriers to clients engaging with a social prescription had been to some extent conceptualised entirely in terms of Link Worker confidence or client suitability. What if there are other factors? Could our perceptions about appropriate referral and client readiness sometimes be as much a consequence of organisational culture and ways of working, as they are about the characteristics of the individuals involved? After considerable debate within the project steering group we identified a number of different systemic factors that can impact on a person’s ability to engage with a social prescription.
Suitable/appropriate referrals for social prescription

Health and social care agencies tend to hold ideas about what is (or is not) an 'appropriate referral'. These ideas may be reinforced by an increasing emphasis on contracts, service level agreements, payment by results, and the requirement to clearly demonstrate impact and outcomes, but it is recognised that they can in practice be exclusive and unilateral.

This tendency can be even more marked in mental health services, where there are multiple ways of understanding (or labelling) need (e.g. medical, social, psychological, biological), and where there is also a tendency to think about a person's needs in terms of service categories (e.g. primary, secondary, specialist). Fluctuation in the experience and presentation of symptoms also have an effect. These factors conspire to make the notion of 'appropriate referral' in mental health services more loaded and less straightforward than it might be for other types of need or diagnosis. In contrast, the quote below from the manager of an organisation that employs mental health Link Worker offers a different way of thinking about the issue:

'I don't think there is a wrong referral for people with mental health issues as there is no easy way to identify when the right time for a referral is. As long as it is into a service that has the flexibility and timescale factored in. Without that people can feel they have failed and and fuel their belief things won't change.'

Making initial contact

It was noted that the process of initially engaging with a Link Worker can be challenging and problematic, even when telephone contact or a home visit are offered as options. The person may have discussed a social prescription with their GP, and apparently agreed to it, only to find that they face significant barriers to speaking to or meeting with someone new. This is unhelpful for the individual who still does not get the help they need, and it is also time consuming for the GP and the Link Worker.

Organisational culture and model of practice

The culture of an organisation, especially its way of working, is a critical factor. Essentially, some people require support - perhaps even light touch support - over a longer period of time than some ways of working allow. This needs to be balanced against the risk of creating dependency, but it is nonetheless a valid option. We recognise that 'time limited interventions' may be a feature of the service level agreement or contract that the provider has with its commissioners. But experience shows that some people, particularly those struggling with certain emotional or psychological issues, require encouragement, trust and confidence building, and
problem solving help over a lengthy period of time before they feel able to benefit from a social prescription.

In the light of these reflections, our thinking shifted away from focusing on issues related to worker competence and client suitability, to a focus that was more about organisational and cultural factors.

**Towards greater integration - two simple initiatives**

When it became clear that Link Workers and their host employers were not using the model of support and supervision we designed and put in place, a different approach was taken. Two practical, interagency initiatives were piloted.

**Attending each other's case discussions**

Link Worker host organisations arranged a series of visits to each other's case allocation meetings. This proved to be a really effective way of increasing knowledge about ways of working that different agencies operate. It also facilitated greater confidence about when it was appropriate to signpost someone to a different agency.

**Link Workers sessions in GP surgeries**

This was piloted in order to reduce instances where a person agreed to a social prescription with their GP, but then failed to respond to contact from the Link Worker. In a small number of surgeries times were agreed when a Link Worker would be present on a weekly basis. This meant that the GP could facilitate initial contact very quickly, and in a setting where the person already felt safe.
4. Developing social prescription activity for mental health

a. What we wanted to do

From the outset we were interested in seeing if there was a way to encourage MH VCS organisations to think more about the principles and practical issues involved in social prescribing, how these might apply to the people they work with, and how their service offer might develop to reflect this. For example:

- Minimising dependency by providing ‘light touch’, ‘just enough’ support;
- Signposting and connecting people into mainstream community activities and resources whenever possible;
- Collaboration with and cross-referral to other organisations that may be better suited to work with the person and their needs;
- Offering recovery orientated interventions that encourage hope.

We also wanted to see if we could incorporate some of the thinking from the personalisation agenda, especially given the imminent implementation of personal health budgets. In particular we wanted to:

- Experiment with the idea of having access to a small individual budget (up to £100) to see if this would increase motivation, interest in and uptake of mainstream activities and groups;
- Begin to road test some of the practical issues involved with the implementation of personal health budgets.

b. How we tried to do it - the pilot

Between June and September 2013, with input from MH VCS members of VOLSAG, we developed a pilot with the aim of increasing the number and range of activities available via a social prescription to people with mental health needs. This included:

- A ‘hub and spoke’ model that would ensure referrals were signposted to the right place;

http://www.personalhealthbudgets.england.nhs.uk/About/
• Moving Forward (already established as an existing Link Work provider) would act as the hub, with eight different MH VCS service providers signing up to provide the spokes:
  o Age UK Newcastle
  o Crisis Skylight
  o Key Enterprises
  o Launchpad
  o Newcastle and Gateshead Art Studio
  o Ouseburn Farm
  o Tyneside Women’s Health
  o West End Youth Enquiry Service

• A system for accessing a small individual budget, up to £100, that would enable the patient/person to overcome any specific financial blocks to engaging with activity; for example, transport or equipment costs, group or course fees;
• A defined set of outcome data and information about the cost of interventions provided;
• An involvement fee for participating organisations who provided the required data set.

This diagram illustrates the essence of the model:

**SUMMARY OF DATA TO BE PROVIDED:**
- WEMWBS (before and after)
- Narrative testimony/personal stories
- Notional cost (for contracted activity) - what input was required
- Actual cost (of any individual recovery budget), what it was used for, and the difference it made
The initial design allowed for a cohort of 100 people to take part in the pilot, which was expected to run from September 2013 to January 2014.

In order to maximise the number of eligible referrals, it was agreed that all mental health referrals from general practices in West Newcastle CCG would be included, irrespective of whether they had been referred specifically for social prescribing.

This is in keeping with the fact that Moving Forward, like many MH VCS providers, offer the same basic service to everyone irrespective of the referral route.

c. What happened in practice

For a number of reasons, the model that was designed was not fully tested. This was due to a number of factors:

- Fewer primary care referrals than expected were received;
- Those who were referred during the timescale were able to be signposted and supported to attend mainstream community resources, or in some cases psychological therapies. It was therefore not necessary for Moving Forward (as the hub) to refer any one on to the other MH VCS organisations who were part of the model (the spokes);
- A summary breakdown of the referrals received is set out in the table below

<table>
<thead>
<tr>
<th>Referrals to the Moving Forward Hub September 13 - November 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total referrals from primary care in West CCG in the period: 21</td>
</tr>
<tr>
<td>- Number received using social prescribing referral form 10</td>
</tr>
<tr>
<td>- Number received conventionally 11</td>
</tr>
<tr>
<td>Of these:</td>
</tr>
<tr>
<td>- in the application/activity planning process (number also been referred to psychological therapies for additional help) 11 (3)</td>
</tr>
<tr>
<td>- taking part in community activities 6</td>
</tr>
<tr>
<td>- signposted to housing and debt advice 1</td>
</tr>
<tr>
<td>- on hold whilst undertaking more intensive therapy 1</td>
</tr>
<tr>
<td>- declined help 1</td>
</tr>
<tr>
<td>- not responding to calls 1</td>
</tr>
<tr>
<td>People requiring individual budgets to help them engage with activities (one person did identify finance as a barrier, and was offered travel expenses, but was then unable to continue due to physical health problems) 0</td>
</tr>
</tbody>
</table>
d. Discussion and key learning points

We developed a carefully constructed pilot to increase the range of activities available. We also planned to gather information about the costs of interventions from different providers. In practice this did not happen. With the benefit of hindsight there are a number of factors that contributed to this outcome:

• There were fewer primary care referrals than expected - 21 between September 2013 and November 2013 (inclusive), and only 10 as a social prescription;
• Those who were referred to the 'hub' (Moving Forward) during the project timescale did not require support from more specialist voluntary sector mental health resources, i.e. the 'spokes'. Their needs were able to be met by mainstream community services, activities and groups.
• Some clients did require additional support before they were able to access and enjoy community resources. This included unresolved personal or emotional problems, including housing, debt, relationships or psychological issues. Where this was the case clients were signposted to the relevant agencies and if necessary supported to access them.

These results could indicate that those who are typically referred for mental health interventions via a primary care social prescription do not tend to require the more intensive support designed for those with more severe needs. However, caution is recommended before drawing any such conclusions from this experiment:

• Pathways into help and support are many and varied. Individuals have different preferences, and the accessibility of voluntary sector service providers means that most agencies work with a wide spectrum of need.
• A person may be referred to or choose to access several mental health services simultaneously, circumventing the hub and spoke model.

Individual budgets
The option to increase uptake of socially prescribed activity by using a small individual budget (e.g. up to £100 to pay for course fees, equipment, bus fares) was built into the model’s design but was also not taken up. There could be a number of reasons for this. These include

• Concerns that any problems solved by such financial support only reoccur when it runs out;
• Concerns that the time limited nature of this project would create anomalies, with some individuals getting an individual budget but not others;
• Personalisation (especially direct payments) are not yet an established part of the mental health system in the local area.
Stories from the front line

a. What we wanted to do

Our intention was to gather information about the treatment pathway, key experiences and outcomes of a cohort of 50 - 100 people receiving a social prescription for mental health reasons. We expected this to include examples of people using a wide variety of different kinds of support, including services provided by different parts of the mental health voluntary and community sector. We felt that this would provide us with a rich source of useful information about how social prescribing works in practice for people with mental health needs, and what issues and areas might need to be considered for improvement.

The data to be captured included:

- Patient details (age, gender, ethnicity etc);
- Presenting problems and brief history;
- Intervention information e.g. inputs, outcomes, timescale;
- Financial information - the cost of the support provided, whether this was 'contracted activity' or over and above the usual service offer; whether an individual budget had been used and if so for what;
- Pre- and post- intervention WMWEBS scores.\(^{24}\)

b. What happened in practice

As set out above (see page 36), fewer referrals were received than was expected. In addition, the needs of those who were referred consistently meant that there was not a need to signpost on to the wider mental health voluntary sector. This meant that we were not able to assemble as wide a set of information as we originally had hoped.

We were however able to generate a reasonably rich data set from the people referred to the hub, i.e. Moving Forward. These comprise the 19 referrals that were received between September and November 2013. It also includes one referral that was received in May 13, by way of comparison. One further person chose not to engage at all. Below we explore some of the collective features of this cohort.

Characteristics of 19 clients from West Newcastle receiving a service between September and November 2013, and one referred in May 2013 (as an example of a longer term intervention). Only 10 were referred as a social prescription, but all received the same response from the service provider.

**Gender**
- Men
- Women

**Ethnicity**
- White British
- Other

**Age**
- 18 - 35
- 36 - 50
- 51 and over

**Referring Practice**
- Betts Avenue
- Fenham Hall
- Prospect
- Throckley
- Parkway
- Saville
- Westerhope

**Cost**
- £100 or less*
- £101 - £250 **
- <£250 (£1325)

**WMWBS**
- Completed pre
- Waiting for post
- Declined
- Not started #

* Includes clients who are only at the initial stage of engagement and also 3 who for different reasons declined support after initial contact
** Includes clients who continue to receive 'light touch' support (e.g. occasional phone call)
# Clients are not asked to complete the initial WMWBS assessment until they have begun to participate in their activity plan
c. Stories from the front line - discussion and key learning points

From this initial cohort it is possible to discern a number of characteristics, the help that was identified as being needed, the interventions received and the progress made.

Referral source
While 7 practices made referrals, over 50% were received from 2 practices. There are 18 practices in Newcastle West CCG altogether. This suggests very different referral behaviour from one practice to the next.

Reasons for referral
The following reasons were given for the social prescription (some individuals were felt to need help in more than one area) by the GP/other referrer:

<table>
<thead>
<tr>
<th>Reason</th>
<th>How often given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety, depression, low mood</td>
<td>13</td>
</tr>
<tr>
<td>Social isolation</td>
<td>10</td>
</tr>
<tr>
<td>Physical health condition</td>
<td>8</td>
</tr>
<tr>
<td>Help with confidence and low self esteem</td>
<td>4</td>
</tr>
<tr>
<td>Suicidal feelings and/or self harm</td>
<td>3</td>
</tr>
<tr>
<td>No reason given for referral</td>
<td>1</td>
</tr>
</tbody>
</table>

Initial engagement

At Moving Forward Link Workers try to make contact with new clients by phone on the day they receive the referral and offer an appointment as soon as one can be arranged, usually within one week of the referral. This consists of an initial interview, assessment and goal setting session. However it is not uncommon for there to be significant challenges and barriers to be addressed before the person feels able to agree to a face to face meeting, or to experiment with any activities or groups. This sometimes reflects the fact that the person has personal priorities that may outweigh the stated reason for referral.

For example, 6 of the 20 referrals needed help and advice with debt and financial issues, and this often took precedence. Two needed psychological help and therapy was the priority.

Timescales
These vary considerably. Whereas 3 people were supported to set goals and supported to engage with activities and groups within one month of first contact, 6 required sensitive and patient encouragement over a period of 3 - 6 months before they felt able to try out and stick with activities or groups. Difficulties commonly included social anxiety and low confidence, but practical issues such as hospital appointments and financial problems also had an effect. In other cases, positive
progress was interrupted by factors such as physical illness or personal life events such as bereavement.

**Reasons for declining involvement**

After initial contact, three people declined to become involved with the service at any level. Reasons included work commitments and pregnancy. A fourth person wanted to wait until they knew the outcome of being referred to the Work Programme.

**Cost of the interventions**

The costings given are best understood as work in progress, mainly because the majority of the people involved is still receiving a reducing degree of input.

<table>
<thead>
<tr>
<th>Cost*</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>£75</td>
<td>Initial assessment and goal planning; telephone encouragement until the person is ready to engage with activities (approximately 3 hours).</td>
</tr>
<tr>
<td>£25 - £200</td>
<td>Cost of declining involvement, depending on when the person decides to opt out and the degree of support already provided.</td>
</tr>
<tr>
<td>£75 - £200</td>
<td>Typical cost of providing assessment, goal setting, and initial support to access and engage with activities, depending on the degree of support and encouragement provided. This can reflect 'light touch' but ongoing involvement over a six month period.</td>
</tr>
<tr>
<td>£1000+</td>
<td>On occasion a much greater level of support and help is required. For example if required the Link Worker can support the person to use public transport. In one example, 13 sessions were provided in addition to the initial goal setting process (4 meetings), and the total cost was £1325. This included help to use public transport, and initial support to attend a college course.</td>
</tr>
</tbody>
</table>

*These figures represent full cost recovery (based on unit costs) and they are covered within the contract Moving Forward has with its commissioners.

**Activities accessed**

Despite the small number of referrals analysed, a wide range of activities and groups were accessed. These are in addition to the psychological therapies and debt counselling referred to above.

- College or other educational courses - 4
- Mindfulness - 3
- Art groups - 3
- Women's groups (e.g. walking, confidence building, reading) - 3
- Volunteering - 3
- Work/training - 2
- Other - anxiety management, hearing voices group, photography, diabetes awareness
Link Workers signpost clients to a range of service providers and community resources including Newcastle City Learning, local Colleges of Further Education, courses held by Tyne and Wear Museums, established community groups, and social/leisure groups originally enabled by Moving Forward.

**WMWEBS**

The Warwick Edinburgh Wellbeing Scale is a validated, well established measure that reflects current concepts of mental wellbeing. Individuals indicate how often each of a set of 14 positive statements applies to them e.g. 'I've been feeling useful' and 'I've been feeling close to other people'.

We had hoped to be able to compare scores taken when people first engaged with activities, with scores taken at the end of their involvement with Link Worker support. However this proved to be difficult as no complete sets of 'before and after' data were collected within the timescale of the project. Getting clients to fill a second questionnaire on exit from the service or at follow up is consistently a challenge. It is also the case that some individuals decline the opportunity to complete the scale at any point.

d. Case studies

Pages 45 and 46 feature two more detailed examples of the way that people have been helped by the link worker approach.

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### Case Study 1: Angela, 35yrs, White British

**Team:** Moving Forward Newcastle

#### Goals set
- Participate in activities for enjoyment to regain sense of own needs
- Find strategies to manage anxiety and pain relief
- Plan for a return to education

#### Brief History
- Single mother of young children recently separated from partner
- Anxiety and Depression
- Physical illness
- Had to stop degree course due to health issues

#### Inputs: How we have contributed to change
- Engage with client at a date and time suitable to them.
- Activity planning to identify steps needed to achieve the end goal of a return to education
- Building positive relationship
- Regular contact
- Phone calls / text / emails
- Research to find activities that met specified interests and goals
- Support to attend initial sessions of activities and short courses and follow-up to ensure that attendance was maintained

#### Activities: What actions the client actually took
- Completed a short course in Photography
- Attended an eight-week course to gain strategies for better management of depression, anxiety and pain
- Enrolled on an art course

#### Outputs: What the client achieved
- Uses specific techniques to assist pain management and to improve wellbeing and has independently accessed further training to develop these skills
- Organised a peer support group for other people who are faced with similar issues to herself
- Rethought her career plan and independently enrolled at college to gain qualifications for this new career path.

#### Outcomes contributed to
- Increased self-esteem & motivation
- Better pain management and improved wellbeing
- Return to education with a new plan for future employment
### Case Study 2: Josie, 20yrs, White British

**Team:** Moving Forward Newcastle

**Goals set**
- Travel on public transport
- Participate in leisure and educational activities to socialise with people
- Enrol at college

**Brief History**
- Bullied at school
- Anxiety and Depression
- Socially isolated
- Unable to leave the house without support
- Engaging with CBT was not successful

**Inputs**
- How we have contributed to change
  - Engage with client at a date and time suitable to them.
  - 9 sessions of support to overcome issues with using public transport
  - Activity planning to identify steps needed to achieve the main goal of starting college
  - Building positive relationship
  - Regular contact
  - Phone calls / text / emails
  - Support to attend initial sessions of activities
  - 3 sessions of support to attend initial stages of college course
  - On-going contact to ensure that other activities are accessed during college breaks to ensure that social contact is maintained.

**Activities**
- What actions the client actually took
  - Took part in a Women’s Walking Group going out once a week
  - Joined a Reading Group meeting weekly
  - Completed a course in Anxiety Management
  - Completed a Women’s Confidence Course
  - Enrolled at college, completing Foundation and Level One in Beauty Therapy and due to start Level Two in September.
  - Short courses during college breaks

**Outputs**
- What the client achieved
  - Travels independently on public transport
  - Attends a range of educational and social activities
  - Is able to speak to people in unfamiliar situations and no longer requires support to attend activities
  - Has plans for a future career.

**Outcomes contributed to**
- Increased self esteem & motivation
- Increased social contact
- Return to education and planning for future employment
- Getting a puppy as now enjoys being out and about
6. Learning outcomes and project recommendations

This project focused on trying to increase the effectiveness of social prescribing for people with mental health needs - including people whose mental health needs are related to their physical health conditions. Our work did not always go as or intended or planned. Despite this, we have learned some important lessons, and these are now set out below as a set of recommendations. Each case recommendation contains a cluster of specific actions, and these are addressed to colleagues who we think are in the best position to consider them and act on them.

**Recommendation 1 - Encourage system integration and service redesign:**

*Target audience – Wellbeing for Life Board, health and social care commissioners, service providers, Ways to Wellness Board.*

Our experience suggests that improvements to the social prescribing offer for people with mental health needs will only be partly achieved by focusing on the roles of Link Workers and their competence and confidence. Some of the issues that need to be addressed are systemic, so there also needs to be a focus on collaboration, interagency working, and redesigning services:

1. Increase and maintain familiarity and contact between Link Worker host organisations e.g. regular attendance at each other’s team or allocation meetings. Service providers (and especially Link Worker host organisations) need to have greater knowledge of what each other does.
2. Enable Link Workers to have closer contact with GP practices e.g. be available at set times at the practice to see patients *there and then*, instead of having to arrange separate, subsequent appointments that the client may struggle to make;
3. The principle of ‘*any door is the right door*’ obviates the need for getting bogged down with whether a referral is ‘appropriate’ or not. This is especially important given the high degree of co-morbidity amongst those who make most use of primary care and who can potentially derive most benefit from a social prescription. Link Workers and their host organisations need to be able to quickly enable someone to get the right help.
4. Commissioners should explore ways of encouraging shared pathways and organisational cross fertilisation via their contracts and service level agreements with providers.

5. Redesign services so that they are as accessible as possible whilst also emphasising individual and community assets.

**Recommendation 2 - Promote access to psychological therapies and other specialist advice:**

*Target audience - GPs and other referrers, service providers (especially Link Worker employers, and psychological therapies providers), Ways to Wellness Board.*

We found that a person's 'stuckness' or apparent inability to engage with a Link Worker or a social prescription often masked other problems that were a priority for the person and needed to be identified and attended to before they had energy and attention available for other things:

6. Link Workers (and other practitioners in contact with the person) need better awareness of how to access psychological therapies - enabling patients to deal with emotional/psychological blocks to engaging with socially prescribed activity;

7. Agencies providing psychological therapies need to ensure that staff are trained and confident in being able to discuss and work with the psychological impact of physical health problems and long term conditions;

8. Practical issues such as debt, housing, work or relationship problems can present major barriers to using a social prescription. Navigation to the right help and advice may need to happen alongside trying out groups or activities - and in some cases any kind of occupation is out of the question until such personal circumstances have been addressed.

**Recommendation 3 - Develop the capacity and contribution of the Voluntary and Community Sector:**

*Target audience - Voluntary and Community Sector service providers and infrastructure organisations, health and social care commissioners, service users and carers, Ways to Wellness Board, Newcastle Voluntary Sector Consortium Board.*

As providers of services and activities, and as hosts of Link Workers, voluntary organisations, charities and community groups have a major part to play in making social prescribing work more effectively for people with mental health problems. Many voluntary sector organisations in Newcastle already provide signposting and help to access other services and resources as standard practice. For such
organisations, calling a referral 'a social prescription' makes little if any difference to the response that is offered to the individual:

9. Directories and service mapping do have a part to play but there is no substitute for practitioners who have ready knowledge of what is available and how to support people to access it.

10. This needs to include up to date knowledge of wider community and mainstream resources. Some who are referred for their mental health needs prefer to access support that is not identified as part of the mental health system.

11. Networks such as NCVS and VOLSAG have an important contribution to make in facilitating ever improved awareness and shared knowledge across the VCS.

12. The development of the Newcastle Voluntary Sector Consortium will also act as a positive influence as it can support and facilitate collaboration and cooperation within and across the sector.

**Recommendation 4 - Monitor and review funding flows and budgets:**
*Target audience - Health and social care commissioners, Ways to Wellness Board, VCS service providers.*

13. Ongoing analysis and thinking is required around funding flows and budgets. Currently when a voluntary sector mental health organisation or group contributes to supporting someone via a social prescription, this is undertaken as part of their existing commissioned or charitably funded activity. But numerous services are under threat as a consequence of reduced public sector budgets and pressure on charitable funds. There is a real risk that there will over time be fewer and fewer activities and resources for someone to be 'socially prescribed to'. A medical prescription comes with costs and funding attached but this is not part of the current model for social prescribing in Newcastle. This needs monitoring and further attention over time.

**Recommendation 5 - Be aware of tensions in the wider system:**
*Target audience: Wellbeing for Life Board, Ways to Wellness Board, Mental Health Programme Board, mental health service providers, Link Workers, voluntary and community groups, Job Centre Plus.*

There are several aspects of the wider economic and socio-political environment that can impact on the success of social prescribing for people with mental health needs:

**Benefits and welfare**

14. People with mental health needs who receive Employment Support Allowance will lose income if they are reassessed and awarded Job Seekers' Allowance
instead. This is a very real risk given the policies of the Work Programme led by
the Department of Work and Pensions, and managed by agencies such as Job
Centre Plus and ATOS. One person was given a social prescription for ‘physical
activity and lifestyle change’ but they were in the Work Programme and did not
feel able to make these changes - it was the GP’s agenda but not the person’s.

15. These are very real challenges that can act as a disincentive. Link Workers need to
be aware of and sensitive to the issues and may need to spend significant time
with people who are ambivalent about change for these reasons. Working
through the understandable barriers can be a lengthy business.

Stigma

16. Stigma is an issue for those with mental health problems. This might also apply to
a person with a physical health condition who is being given a social prescription
to help their mood. It is important that all referrers and Link Workers are aware of
and sensitive to the effects of stigma and how to address them.

Capacity of mainstream groups and activities

17. Link Workers can be very effective at helping people access mainstream
community groups, for example walking groups or photography clubs. These are
finite resources however; there are limits to any group's ability to absorb new
members, especially those who might lack confidence or who are rediscovering
their social skills following a period of ill health. This has already been an issue
and needs careful consideration, especially as the numbers of people receiving a
social prescription increases.

Recommendation 6 - Increase awareness of the mental health Link
Work offer with GPs and the primary care team:
Target audience: Ways to Wellness Board, CCG, GPs.

18. This project was only a small, time limited pilot but the degree to which different
practices in the same CCG were involved varied massively. Two practices made
over 50% of all the referrals; more than half made none.

19. Ways to Wellness, by dint of its scale and longevity, should have more success in
engaging GPs than previous initiatives. However, given that the emphasis is on
long term conditions and physical illness, it remains to be seen whether the
demand for social prescribing for mental health will increase as a consequence.
This should be monitored.

Recommendation 7 - Potential contribution of public mental health
initiatives:
Target audience: CCG, Ways to Wellness Board, Public Health Commissioners.

20. Further promotion and development of the mental health social prescribing offer could be brought about by exploring public health initiatives including social marketing i.e. ways that information and other resources can be used to influence behaviour change in a sustainable and cost effective way.

Recommendation 8 - Design and test a model for social prescribing champions and peer support, for people with mental health needs: Target audience: Social prescribing for mental health project steering group, mental health service users, Ways to Wellness Board, Public Health and health and social care commissioners.

21. A further piece of work should be commissioned with the aim of working with stakeholders (especially people who have used a social prescription to improve their mental health or emotional wellbeing) to develop and road test a model for identifying, training and supporting mental health social prescribing champions. These individuals can act as awareness raising agents with their peers and with professionals.
Appendices

Appendix 1: Project Objectives, Outputs and Outcomes

Project objectives

- To align existing provider services (Mental Health VCS Agencies) to test how individuals can be supported by mental health workers, acting as 'links' to enable better access to community resources and opportunities.
- To develop a pathway enabling GPs to refer this cohort to a mix of activities and psychological support, from staff with the appropriate competence/skill level and with the time needed to work with individuals to enable them to engage them in activities.
- To provide the required workforce development
- To explore potential for access to and use of personal budgets for activities
- To provide capacity for coordination by VOLSAG+
- To evaluate the effectiveness of approach in terms of client reported wellbeing

Project outputs

- Skills and competency development/training in working with people with mental health needs for Link Workers receiving GP referrals for social prescribing
- Development/training for those in specialist mental health Link work roles
- Referral pathway
- Cohort of 100 individuals referred by GPs for mental health Link work support
- 50 individuals enabled to access community activities or services
- Clear data about levels of eligibility for social care personal budgets within this cohort

Project outcomes

- Effective referral experience from GPs/HCPs to mental health Link work services
- Skilled, knowledgeable and confident Link Workers (in relation to supporting people with mental health needs) in those organisations delivering Link work e.g. to older people, carers, those with physical or lifestyle change needs.
- Skilled, knowledgeable and confident mental health Link Workers in those organisations delivering more specialist mental health support e.g. mental health buddies
- Increased uptake of personal budgets and improved alignment of social prescribing and the personalisation agenda in health and social care
- People living with a long term condition, with complex social, emotional or practical needs together with significant mental health needs have more choice and control and experience better health and wellbeing.
Appendix 2:

**Project Steering Group Members**

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brigid Joughin</td>
<td>GP MH Lead Newcastle West CCG</td>
</tr>
<tr>
<td>Steve Nash</td>
<td>Chair and Coordinator of VOLSAG</td>
</tr>
<tr>
<td>Chris Drinkwater</td>
<td>Chair of Ways to Wellness, Chair of Newcastle West CCG Partnership Forum</td>
</tr>
<tr>
<td>Sarah Jameson</td>
<td>Project Lead, NESTA</td>
</tr>
<tr>
<td>Sandra King</td>
<td>Project Director, Ways to Wellness</td>
</tr>
<tr>
<td>Scott Vigurs</td>
<td>Senior Manager, Mental Health Concern</td>
</tr>
<tr>
<td>Alisdair Cameron</td>
<td>Coordinator, Launchpad</td>
</tr>
<tr>
<td>Julia Perry</td>
<td>Coordinator, Moving Forward Newcastle</td>
</tr>
<tr>
<td>Rob Errington</td>
<td>Manager, HealthWORKS</td>
</tr>
<tr>
<td>Lynda Seery</td>
<td>Mental Health Lead, Public Health, Newcastle City Council</td>
</tr>
</tbody>
</table>

**Attendees MH VCS Consultation 23rd July 2013**

- Alisdair Cameron (Launchpad)
- Yvonne Collins (Young Minds)
- Katie Dodds (Carers Centre)
- Ruth Evans (Taking Part Workshops)
- Mike Halsey (Key Enterprises)
- Matt Henderson (Taking Part Workshops)
- Simon Luddington (Mental Health Matters)
- Lisa MacDonald (Tyneside MIND)
- Kevin Meikle (NAGAS)
- Bob Malpiedi (NAGAS)
- Elaine Slater (Tyneside Women's Health)
- Julia Perry (Moving Forward)
- Steven Redpath (ISOS)
- Scott Vigurs (Mental Health Concern)
- Steve Nash (VOLSAG (FACILITATOR))
- Sarah Richard (MH Link work project (FACILITATOR))
- Sandra King (Ways to Wellness (PRESENTER))
## Appendix 3: Participant Profile, Service User Focus Groups

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26-35</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>36-45</td>
<td>7</td>
<td>28</td>
</tr>
<tr>
<td>46-55</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>56+</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>Not answered</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>23</td>
<td>92</td>
</tr>
<tr>
<td>White and Black African</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other ethnic group</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Appendix 4: Exemplar Link Worker Job Description and Specification

Job Description (exemplar)

Job Title (grade):  Generic Link Worker (Social Prescribing)

Location:

Responsible to:

Job Purpose

- To empower and improve the health and wellbeing of people living with long term conditions; facilitating self-management of their long term conditions; and building social capital, connections and resilience.
- To work in partnership with the community in the West of the City; and with relevant statutory, voluntary or community agencies to improve the quality of life for individuals identified as having high health and social needs.
- To encourage and support the development of lasting behaviour changes that underpin improved mental and physical wellbeing.
- To participate in record keeping to identify individual achievement and monitor the effectiveness of the service.

Principal duties and responsibilities

1. To assist in maintaining a source of information on resources, activities and contacts appropriate to people with long-term conditions.
2. To assist in taking referrals for the service, risk assessment and review.
3. To engage in personalised, action planning with people who have long-term conditions.
4. To motivate, encourage and support individuals to achieve the goals identified in their action plan.
5. To ensure effective and appropriate written, verbal and electronic communication within the team, with service users and external agencies.
6. To participate in the collection of data to monitor and evaluate individual progress and service performance.
7. To recognise the limits of your own knowledge and experience and to appropriately refer or signpost individuals on to specialists.
8. To engage in supervision and training with an active commitment to personal development.
9. To contribute to the implementation and monitoring of all policies, procedures and systems as they relate to service delivery.
10. To undertake any reasonable duties/responsibilities required to meet the needs of the service.

This job description is not intended as an exhaustive list of duties and responsibilities of the post, but reflects the key areas involved. It will be subject to review and amendments in line with developing service needs.
Appendix 5: Generic Link Worker (Social Prescribing) Person Specification (Exemplar)

<table>
<thead>
<tr>
<th>Specification</th>
<th>Essential</th>
<th>Desirable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience and knowledge</td>
<td>• Experience of working with people from disadvantaged communities</td>
<td>• Experience of working in the third sector</td>
</tr>
<tr>
<td></td>
<td>• Understanding of referral and assessment processes</td>
<td>• Relevant/recent validated courses</td>
</tr>
<tr>
<td></td>
<td>• Experience of agreeing personalised action plans</td>
<td>• Previous experience in a Link Worker/service navigator role</td>
</tr>
<tr>
<td></td>
<td>• Knowledge and application of professional standards and codes of conduct</td>
<td>• Experience of demonstrating impact and user outcomes</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of a broad range of relevant health issues including public health and health inequalities</td>
<td>• Knowledge of a broad range of local resources</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of relevant national policies and procedures across Health and Adult Social Care including equality and diversity and anti-discriminatory practice.</td>
<td>• Experience of networking</td>
</tr>
<tr>
<td></td>
<td>• Knowledge of the barriers people face in overcoming patterns of behaviour and inactivity that impact upon achieving health related goals</td>
<td>• Training/qualifications in psychological approaches (e.g. motivational interviewing, CBT, DBT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Experience of risk management</td>
</tr>
<tr>
<td>Skills and abilities</td>
<td>• Excellent communication and interpersonal skills in formal and informal settings</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Good written and record keeping skills</td>
<td>• Training /coaching skills</td>
</tr>
<tr>
<td></td>
<td>• Good analytical and assessment skills</td>
<td>• Presentation skills</td>
</tr>
<tr>
<td></td>
<td>• Able to demonstrate reflective practice</td>
<td>• Ability to identify gaps in service provision</td>
</tr>
<tr>
<td></td>
<td>• Excellent organisation and time management skills with ability to prioritise effectively</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Negotiation and problem solving skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Competent Microsoft Office user</td>
<td></td>
</tr>
<tr>
<td>Personal attributes</td>
<td>• Clear vision of the role</td>
<td>• Evidence of previous innovative practice</td>
</tr>
<tr>
<td></td>
<td>• Committed to ongoing personal development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tactful and diplomatic</td>
<td>• Advocate for the needs/rights of client group</td>
</tr>
<tr>
<td></td>
<td>• Assertive when required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Confident, motivated, outgoing and enthusiastic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Flexible and adaptable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Positive thinker – solution focussed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Commitment to co-production principles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Personal resilience</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: Exemplar Link Worker (LTC) Job Description  

NB It is expected that someone appointed to this role will have previous experience as a Generic Link Worker and have developed knowledge, skills and experience in this specialist area.

Job Title (grade): LTC Link Worker (Social Prescribing)  
Location: Responsible to:

Job Purpose

- To empower and improve the health and wellbeing of people living with long term conditions; facilitating self-management of their long term condition, building social capital, connections and resilience.
- To work in partnership with communities in the West of the City; and with relevant statutory, voluntary or community agencies to improve the quality of life for individuals identified as having high health and social needs.
- To work with other social prescription Link work organisations to ensure seamless referrals between the services.
- To encourage and support the development of lasting behaviour changes that underpin improved mental and physical wellbeing.
- To participate in record keeping to identify individual achievement and monitor the effectiveness of the service.

Principal duties and responsibilities

1. To maintain a source of information on resources, activities and contacts appropriate to people with long-term conditions.
2. To assist in taking referrals for the service, risk assessment and review.
3. To engage in personalised action planning with people with long-term conditions.
4. To liaise with and refer on to other social prescription Link work organisations when an individual’s needs are more appropriately met by another service or joint working would be beneficial.
5. To motivate, encourage and support individuals to achieve the goals identified in their action plan.
6. If and where appropriate to discuss and agree how any support or health related information would be disclosed to e.g. leaders of community groups or course tutors, to increase the likelihood of a successful outcome.
7. To ensure effective and appropriate written, verbal and electronic communication within the team, with service users and external agencies.
8. To participate in the collection of data to monitor and evaluate individual progress and service performance.
9. To recognise the limits of own knowledge and experience and to appropriately refer or signpost individuals on to specialist services where appropriate.
10. To engage in supervision and training with an active commitment to personal development.
11. To contribute to the implementation and monitoring of all policies, procedures and systems as they relate to service delivery.
12. To undertake any reasonable duties/responsibilities required to meet the needs of the service.

This job description is not intended as an exhaustive list of duties and responsibilities of the post, but reflects the key areas involved. It will be subject to review and amendments in line with developing service needs.
Appendix 7: Exemplar Link Worker (MH) Job Description

NB It is expected that someone appointed to this role will have previous experience as a Generic Link Worker and have developed knowledge, skills and experience in this specialist area.

Job Title (grade): Mental Health Link Worker (Social Prescribing)

Location: Responsible to:

Job Purpose

- To empower and improve the health and wellbeing of people living with severe and enduring mental health issues and other long term conditions; facilitating self-management of their long term condition, building social capital, connections and resilience.
- To work in partnership with communities in the West of the City; and with relevant statutory, voluntary or community agencies to improve the quality of life for individuals identified as having high health and social needs.
- To work with other social prescription Link work organisations to ensure seamless referrals between the services.
- To encourage and support the development of lasting behaviour changes that underpin improved mental and physical wellbeing.
- To participate in record keeping to identify individual achievement and monitor the effectiveness of the service.

Principal duties and responsibilities

1. To maintain a source of information on resources, activities and contacts appropriate to people with mental health issues and other long-term conditions.
2. To assist in taking referrals to the service and risk assessment.
3. To engage in personalised action planning with people, including assessment of personal circumstances and barriers to engagement. This may involve using a variety of psychological approaches to enable the individual to identify their own objectives.
4. To liaise with and refer on to other social prescription Link work organisations when an individual’s needs are more appropriately met by another service or joint working would be beneficial.
5. To motivate, encourage and support individuals to achieve the goals identified in their action plan. To monitor and review progress with the individual and update action plans as needed.
6. If and where appropriate to discuss and agree how any support or health related information would be disclosed to e.g. leaders of community groups or course tutors, to increase the likelihood of a successful outcome.
7. To monitor and review progress of the action plans.
8. When needed, to facilitate referrals to other mental health services. To work in partnership with those agencies where interventions can run concurrently or to liaise with all parties to determine when review and progression of the initial action plan is appropriate.
9. To ensure effective and appropriate written, verbal and electronic communication within the team, with service users and external agencies.
10. To participate in the collection of data to monitor and evaluate individual progress and service performance.
11. To recognise the limits of own knowledge and experience and to appropriately refer or signpost individuals on to specialist services where appropriate.
12. To engage in supervision and training with an active commitment to personal development.
13. To contribute to the implementation and monitoring of all policies, procedures and systems as they relate to service delivery.
14. To undertake any reasonable duties/responsibilities required to meet the needs of the service.

This job description is not intended as an exhaustive list of duties and responsibilities of the post, but reflects the key areas involved. It will be subject to review and amendments in line with developing service needs.
Appendix 8: Examples of web based learning opportunities for Link Workers

End of Life Care


http://www.network-publishing.co.uk/index.php?option=com_content&task=view&id=450&Itemid=828#coursecontent

Equality

http://vision2learn.net/channels/courses/equality-and-diversity.aspx

Dementia Care

http://www.scils.co.uk/

http://www.network-publishing.co.uk/index.php?option=com_content&task=view&id=347&Itemid=753#coursecontent

Deprivation of Liberty Safeguards

http://www.scils.co.uk

Mental Capacity Act

http://www.scie.org.uk/publications/elearning/mentalcapacityact

Mental Health Awareness

http://www.network-publishing.co.uk/index.php?option=com_content&task=view&id=372&Itemid=778

http://www.scils.co.uk/

Nutrition

http://www.scils.co.uk/

https://corelearning.skillsforhealth.org.uk

Safeguarding Adults – L1 refresher training - Gateshead

www.learningpool.com/gateshead

Safeguarding Adults - L1 top up training – Newcastle

http://www2.newcastle.gov.uk/contact.nsf/asiregformnew?readForm&form=safeadregn