

# **Social Prescribing (Health Referrals) - Learning from Ageing Better**

## **Introduction**

Ageing Better is a test and learn programme. It is collecting information and insights from across 14 partnerships to identify learning that will be useful for other programmes and organisations delivering activities aimed at reducing social isolation in people aged 50+.

We have grouped our national learning from Ageing Better into three themes:

- **CONTEXT** - We know from Ageing Better that the reasons for social isolation are many and varied and happen for a myriad of reasons including macro issues such as inequalities and deprivation as well as personal circumstances. These often occur in combination meaning people's situations are complex.
- **CONNECTIONS** - The people who are most socially isolated (where isolation is entrenched and embedded) will need some level of one-to-one support to help address their isolation.
- **ECOSYSTEM** - The Ecosystem is fundamental to addressing social isolation as it is the space where individuals connect with the community. It works preventatively to keep people socially connected and steps in when social isolation occurs. It includes interventions that people 'need'; activities and groups people 'want' to engage with; opportunities and provision for people to set up their own groups; and community development which includes age friendly activity.

This paper focuses on our learning around social prescribing involving a health referral. It links into our national learning in the following ways:

**Making connections** - Social prescribing is an approach to help identify, reach and connect with socially isolated people and through a person-centred approach, connect them to activities and support in their local area.

The focus of this report is on social prescribing linked to a health referral and it is based on the learning and insights from the Camden, Cheshire, Leeds, Leicester and Torbay Ageing Better areas who attended a workshop in Jan 2019. We have also aligned our work with the definition of Social Prescribing used by HM Government in ‘A Connected Society’.

At the end of this report we provide links to specific learning reports from Ageing Better areas on this topic.

## Context

Social prescribing enables organisations to refer people to a range of services which offer support for either social, emotional or practical needs. These could include feelings of loneliness, as well as for debt, employment or housing problems. Social prescribing connects people to community groups and services, often through the support of a Link Worker. These connector schemes employ individuals (Link Workers) who take referrals from local agencies (including GPs), and work with people to produce a tailored plan to meet their wellbeing needs. They help people to overcome social isolation and feelings of This can involve a range of activities from arts participation, befriending and sport or exercise, as well as debt, housing or employment advice.

We also align our insights and key messages to the model of Social Prescribing used by NHS England and shown below.



There is a significant ‘buzz’ around the term Social Prescribing. In some cases the terms Social Prescribing and active signposting are used interchangeably. In Ageing Better, however, we align to the NHS model where the Link Worker is employed to give “one-to-one” time to people to help and support them. This is a step beyond signposting people to sessions or activities.

We have themed our learning into some key messages mirroring this model. It covers:

- The link worker
- Workforce development
- Support for community groups
- Easy referral from all local agencies
- Personalised plan
- Common outcomes framework

However, we begin by describing what Social Prescribing looks like in Ageing Better areas and how the activities funded by this Programme align to any existing activities.

### **What is Social Prescribing in Ageing Better areas?**

In some areas Ageing Better funded services have complemented an existing Social Prescribing service whereas other areas have introduced Social Prescribing. Whatever the model, the support available through Ageing Better Social Prescribing services fell into two categories:

- Short term - often referred to as a Navigator role or Health and Wellbeing Coordinator. A short intervention for 6 to 8 weeks that concentrates on solving specific problems that are often health related. For example, they may work with someone who is missing appointments or is struggling to access a benefit or caring support. People who access this service are likely to be referred directly by their GP and so will be part of their system.
- Long term - often referred to as a Connector type role. This is a longer term intervention often over 3 months. This involves working with a person to access activities in their community and to overcome more entrenched habits and behaviours.

We found that where the short term offer was funded outside of Ageing Better, they would refer onto the longer term offer once an immediate problem or need was solved or identified

We also found that alongside the short term and long term support the Social Prescribing service also identified a need to access specialist mental health services. In some areas Ageing Better identified this as a significant gap and as a result went on to commission services to meet this need and we consider this further later in this report.

### **The Link Worker**

As set out earlier, Social Prescribing is more than just active signposting. The Link Worker role is designed to support someone to consider 'what matters to you' and to work on the barriers they face engaging with activities or services. Our learning is that there is a wide range of support which people need.

We have found there is a need for Link Workers to provide short term interventions that help tackle a specific need. In addition there is also a need for longer term interventions that help people overcome more ingrained habits and behaviours. However, this can in many cases only be effective if there is also access to specialist mental health support.

Time to Shine (Leeds) through their Supporting Wellbeing (Social Prescribing project)

found a large amount of mental health needs and alcohol abuse not previously recognised by GPs. They have needed to refer to external specialist agencies to provide this support.

Ageing Well Torbay also identified a need for specialist mental health services. They were able to use Ageing Better funds to commission a pilot mental health project to work with their other services. They had originally anticipated this would provide between one and three sessions of support but they found that this was often insufficient and so extended the capacity of the service.

**Key message:** The Link Worker role needs to provide short term interventions that help tackle immediate needs. They also need to provide a Connector role that offers longer term support and works with the community to ensure there are suitable places for people to go. In order to be effective, the Link Worker also needs access to specialist mental health services to complement their delivery.

Our learning from Ageing Better is that the length of time a Link Worker connects with someone should be flexible.

Brightlife (Cheshire) offer people a set number of appointments, usually between 6 and 12. They found this worked better than a fixed time period as it allowed for people experiencing health problems or disengaging for varying reasons to remain connected to the service. They found people might need a break from the service because of hospital stays or changes in their caring or family arrangements. Using a fixed number of appointments also means caseloads and workloads are easier to manage. Brightlife also undertake an initial assessment against Level 1, 2 or 3 with Level 3 receiving the highest level of support. This again helps with the management of workloads and different cases.

Ageing Better in Camden found that a combination of longer face-to-face sessions and shorter catch ups, for example over the phone, helped them provide both the appropriate level and mix of support. This helps ensure the relationship between the Link Worker and older person is focused on moving on and thinking about next steps.

Time to Shine (Leeds) works alongside an existing Social Prescribing service with a focus on frail and elderly people. This means their engagement is much more long term. This is learning echoed across Ageing Better and commissioners need to be aware of how realistic change is when considering some long term complex conditions in older people.

**Key message:** There is no one size fits all or one length of time that will suit. Link Workers should not be expected to fix all problems within a single time period. Complex cases need more time than more straight forward cases. People may also move from a straight forward case to a more complex case as the relationship between the Link Worker and older person develops and the older person is able to fully explain their situation. However, it is possible to group people into categories of complexity to help with management of workloads and cases.

Projects across Ageing Better have engaged volunteers to supplement the work of the Link Worker. However, this has been challenging. Ageing Better in Camden and Ageing Well Torbay both struggled to recruit and match volunteers as part of their Social Prescribing service. Relying on volunteers to provide part of the offer can result in older people getting 'stuck' as there is a shortage of people to support them on the next stage of the pathway. The power of the volunteer is their commitment

and that brings an extra element of value to the relationship ‘It takes time to do the matching but it is magic when it works.’

Using volunteers as part of a Social Prescribing service does not save time or resource. They will add considerable value but will need and deserve good levels of support and will require time to recruit and manage.

Our learning from Ageing Better is that people often shy away from being described or seen as “formal” volunteers. However many are happy to be the ‘Friendly Face’ that welcomes new people to a group.

**Key message:** Volunteers have a role to play but ideally later in the journey once the issues have been diagnosed and a plan is in progress. It would not be appropriate in the early stages of a Link Worker’s role where there is too much pressure on the volunteer. Volunteers are not a low cost solution. It takes time to match volunteers to older people and there is considerable time needed for supervision and support.

## Workforce development

Ageing Better learning around workforce development can be grouped into two sections. First, around the roles, responsibilities and personal qualities of the Link Worker. Second, how the wider health sector works with the Link Worker.

The Link Worker role requires a range of skills and experiences. They need to not only be able to build a relationship with the people they work with, but to also have their eye on the end stage and bridging the gap for the person they are working with between their current position and connecting with the wider community. Their role is not one of friendship, but of supporting people to make a transition.

In Ageing Better the areas have used Boundary Training to help Link Workers understand and manage this relationship. Good Boundary Training needs to consider how to identify unhealthy relationships including what to do if you are worrying about someone in your own time. Training and support needs to be nuanced, role specific and not just about managing professional relationships.

The Link Worker also needs to be seen as an “honest broker” by all partners. They need to be able to communicate at a range of different levels and use the appropriate language for each audience. They need to be able to liaise with others and be assertive. Where needed they need to work closely with other partners to get the job done. The Link Worker also needs to recognise the value of providing feedback to partners and to initiate and maintain this communication flow. In Ageing Better we acknowledge there can sometimes be tensions between health and social care and the Link Worker has an important role here in asking the right person for the right support.

The people the Link Worker connects with will often have a degree of complexity to their issues including suicidal feelings or complex and difficult lives. It is essential there is a support network around the Link Worker. This includes a good manager who can provide supervision and support. We are still exploring how formal this support should be, however, link workers should have access to professional support if needed and sufficient management time needs to be allocated to allow this. The client group Ageing Better works with means there will inevitably be issues of bereavement and this too requires support for staff teams.

Brightlife (Cheshire) has a management structure that includes individual and team meetings. But the manager will also take the whole team for tea and cake at a local coffee shop if they are having a difficult or challenging week. This flexible support can help Link Workers to have the resilience and skills to manage and navigate

complex cases.

Ageing Better Camden provide sessions twice a year around bereavement. Initially the plan was that this training would be a one-off but the practical reality means bereavement is now recognised to be a part of the Link Workers role.

**Key message:** The Link worker needs to be part of a peer support network, working with people who understand the unique stresses and strains of the role and can provide appropriate support. They also need good management support and access to clinical supervision if required to help them manage the emotional challenges of the role.

In Ageing Better the Link Workers have been based in the voluntary sector. This has many advantages. The sector provides flexibility and has more of a history of taking a person centred and strength based approach in supporting older people. However, one of the challenges this presents is in accessing and recording information about participants in a health context and connecting to the multi-disciplinary teams.

In Ageing Better we had a range of models. In Time to Shine (Leeds) the Link Workers are based in third sector organisations. They do not have access to health or social care systems and this creates real issues at times in delivering their offer. In Ageing Better Camden they have agreements with health whereby the Link Workers have access to the systems and can easily share information about the people they are working with. Ageing Well Torbay do not have access to systems but do attend the Multi-Disciplinary Team (MDT) meetings, allowing them to share information about the people they are working with.

**Key message:** Link Workers need access to health and social care systems and if this isn't possible should attend Multi-Disciplinary team meetings.

## Easy referral from all local agencies

Our learning is there is no such thing as an easy referral mechanism. There are complexities in secondary care and the relationships they have (or don't have) with primary care. There are many different strands to secondary care, all of whom may want to refer into a Link Worker or Social Prescribing service.

Ageing Better is finding that often if people have nowhere else to go they are sent to Social Prescribing. This means some people arrive with complexities. They are referred on when the health and social care teams have reached the end of their service or patience and it is more in hope than expectation that Social Prescribing will be able to help. As referenced earlier there will often also be a need for access to good mental health services. We found that training such as Mental Health First Aid and Assist are useful and have a role but they are not a replacement for being able to refer to specific mental health support services. Specialist mental health support is beyond the expertise and role of the Link Worker.

In Leicester Ageing Together (LAT) they found they were getting a lot of inappropriate referrals. This was due to a lack of understanding about the services and activities LAT could offer. To address this they spent time with the Adult Social Care access teams, raising awareness about their work and offer. This helped increase the flow of appropriate referrals. Brightlife (Cheshire) also hold regular sharing sessions with their local health and social care teams. A point stressed was the need to keep talking and attending team meetings and sessions as a result of the level of staff turnover in health and social care.

We also think Link Workers and the Social Prescribing teams should form part of the feedback loop to Commissioners in both health and social care. They are well

positioned to help local commissioners understand what the real gaps in the local offer are.

**Key message:** The referral network is never ‘done’. It requires constant review and updating and relationships need constant input and work. There is a churn of staff and CCGs are going through restructures and changes - so the wider workforce connections are changing and this is time consuming. There is a need to continually visit team meetings to keep communication routes open and and to raise awareness of the types of referral suitable for a Social Prescribing service.

## Support for Community Groups

As well as the Link Worker there needs to be support for community development. This is a key element of the transition discussed above as it is vital that there are the “spaces” or groups for someone to be able to move into and belong to. Investment in time and resources is needed in the community to make sure the community offer is accessible. If people are being referred back into their community, there has to be somewhere for people to go.

One important element of community development is knowing what is happening locally and how to link into those groups etc., Our learning is that “asset mapping” takes a lot of work, much is informal, and it is constantly changing. Link Workers and their counterparts in the community just know (from experience) about the groups that exist and which are “open” as well as how suitable they are for people with more complex needs. Across Ageing Better we have trialled different tools to help make this information more accessible but have not yet found a magic bullet.

Community groups are dynamic - often opening and closing all the time so information can quickly come out of date. Link Workers and Community Workers hold lots of information in their heads but struggle to prioritise getting the information onto a system. Camden Ageing Better funded a website to promote community activities but found that the website is hardly used. Across Ageing Better we have found that “Word of Mouth” is what is trusted most when someone is deciding whether or not to join a group.

Camden Ageing Better have done a substantial amount of work with their local community centres to help make groups more accessible. The first Social Prescribing project they commissioned did not work. Following a review they found a lot of groups were doing good work. But there were also groups that were ‘cliquey’ although fulfilling a role for those members. They also found groups that were not appropriate for people with more complex needs. As a result of this review they are now encouraging community centres to advertise groups as being either ‘open’ or ‘invitation only’. This means a Link Worker will not support someone to access a group that is not equipped or confident to welcome someone with more complex needs. Some community groups are run by a small number of people and work very well for the group of people that attend but the group is not interested in growing or welcoming new members and the reality of new membership is a shifting group nobody feels comfortable with. As a result of the work they do with community centres Camden Ageing Better are able to better direct people to activities that will meet their needs.

Ageing Well Torbay have a Community Builder model. This provides a warm welcome service for people to access community groups. They have found to run a community group effectively you need a couple of people to take on the organisation role. With too few people it becomes ‘my’ group and becomes very personal. Spreading the workload around ensures the group isn’t relying on one person and people are not

overwhelmed by it.

**Key Message:** A Social Prescribing model needs to invest in the community offer as well as the Link Worker role. Where the Link Worker is working with people who have complex needs, the community groups should only be expected to work with smaller numbers. It is unrealistic to expect community centres and community groups to provide the transition routes identified by Link Workers without money and resources.

## Personalised plan

Our experience of the personalised planning in Social Prescribing is that it needs to work with the person holistically. It takes time to build a relationship between the Link Worker and older person and for trust to be built. Our experience is this relationship building phase is a key part of achieving good outcomes. It is important to have a good first visit that sets the relationship off in a positive way and then to tailor the frequency, type and content of support to meet their identified needs.

In Ageing Better we have found it helpful to offer the first visit as a home visit. The older person is more relaxed and it can help to give the Link Worker a 360 degree view of the person and their issues. Our experience is that Link Workers are capable deliverers with common sense who can manage the dynamic risk assessments of home visit requirements.

Brightlife (Cheshire) were finding the people they were working with in their Social Prescribing project had lots of different agencies they had to engage with. To help them remember who their Social Prescribing link person was and what they had agreed they would be working on they would leave a leaflet with a photo of the Link Worker on it together with a summary of goals and what they are working on together. Feedback was that other agencies and particularly family members found this very helpful. A Social Prescribing project will also do lots of work around the family and how their support can be more effectively deployed.

**Key message:** A personalised plan needs to be person-centred and built on what that individual wants to achieve. Offering a first home visit can be very beneficial to help build a relationship.

## Common Outcomes Framework

Within Ageing Better we have adopted an evaluation tool across the programme. It has allowed us to collect information across a range of dimensions including social isolation, wellbeing and loneliness. It has also allowed us to evidence that our services are reaching the most lonely and isolated.

Our experience with data collection within Social Prescribing projects is that to be effective they need a relationship building phase built in. The cultural appropriateness of the questions also needs to be considered. We have also found use of NHS numbers in collecting and analysing the impact of work within the health sector can be helpful but that there are a number of issues involved not least of which is the issue of consent for all parties.

## Further information

More detail on our wider insights from across the Programme to date together with an overview summary of our learning to date are available at [Ageing Better](#)



- Bristol Ageing Better - [Community Navigators](#)
- Cheshire (Brightlife) Learning on [Social Prescribing](#)
- Ageing Well Torbay - Social Prescribing Ecosystems
- Ageless Thanet - Social Prescribing Pilot [Social Prescribing Pilot](#)
- Social Prescribing [Insight Report](#)