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An Evaluation of Social Prescribing for Secondary Care in Norfolk and Waveney

COMMISSIONED BY SOUTH NORFOLK AND BROADLAND HEALTH AND WELLBEING PARTNERSHIPS (PART OF THE NORFOLK AND WAVENEY INTEGRATED CARE SYSTEM)

Part of the Health Innovation Network

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NHS

Contents

Executive Summary

This Health Innovation East report, commissioned by the South Norfolk and Broadland Health and Wellbeing Partnerships (part of the Norfolk and Waveney Integrated Care System (ICS)) , evaluates the Social Prescribing in secondary care pilot. The service was delivered across four local authorities and one Voluntary Community and Social Enterprise (VCSE) organisation.

The main purpose of the pilot was to explore the viability and value of a social prescribing offer to an acute hospital after the adoption of the service from primary care. It also offered an opportunity to experiment with working in a more integrated way across different organisations as part of the newly formed Norfolk and Waveney Integrated Care System.

In summary, the data illustrates that the service effectively reaches out to individuals who may face health inequalities due to social determinants such as housing challenges and unemployment. The service saw an average rate of referrals of 33 per month between March 2023 and December 2023, ranging from 6 to 51. 12% of those who were referred into the service did not engage. An accumulation of 171 onward referrals were made to a range of VCSE organisations, particularly for financial (28%), housing (18%) and mental health and wellbeing support (11%). A small number (n=9) of patients who were surveyed expressed satisfaction with the service (75%) and the majority felt the service met their expectations (53%).

Findings are based on a mixed-methods analysis of data collected from March 2023 – December 2023. The social prescribing teams collected quantitative data through monitoring of 330 patients who engaged in the service, as well as a patient survey. Qualitative data was obtained from semi-structured interviews involving healthcare and management staff from across secondary care sector organisations.

The qualitative findings underscore the critical importance of stakeholder engagement, streamlined referral processes, and enhanced communication strategies. The findings highlight the need for comprehensive education campaigns for healthcare professionals and patients to increase awareness of social prescribing benefits and referral pathways. Collaboration with multiple stakeholders is essential for efficient service delivery and effective referral mechanisms, while addressing information governance issues is crucial to minimise delays. Enhancing social prescribing visibility within hospitals and exploring expansion opportunities can improve service accessibility. Encouraging preoperative referrals and promoting holistic care approaches to support patients throughout their healthcare journey, is important, particularly in the context of increased support needs post-COVID-19. Implementation of these strategies will support improvements in patient referral and engagement rates. There are also opportunities for more consistent and detailed patient monitoring across stakeholders, which would allow for a greater understanding of patient demographics and needs as well as outcomes following social prescriber intervention.

By implementing these recommendations, social prescribing initiatives can enhance patient outcomes and pave the way for sustainable, patient-centred delivery models.

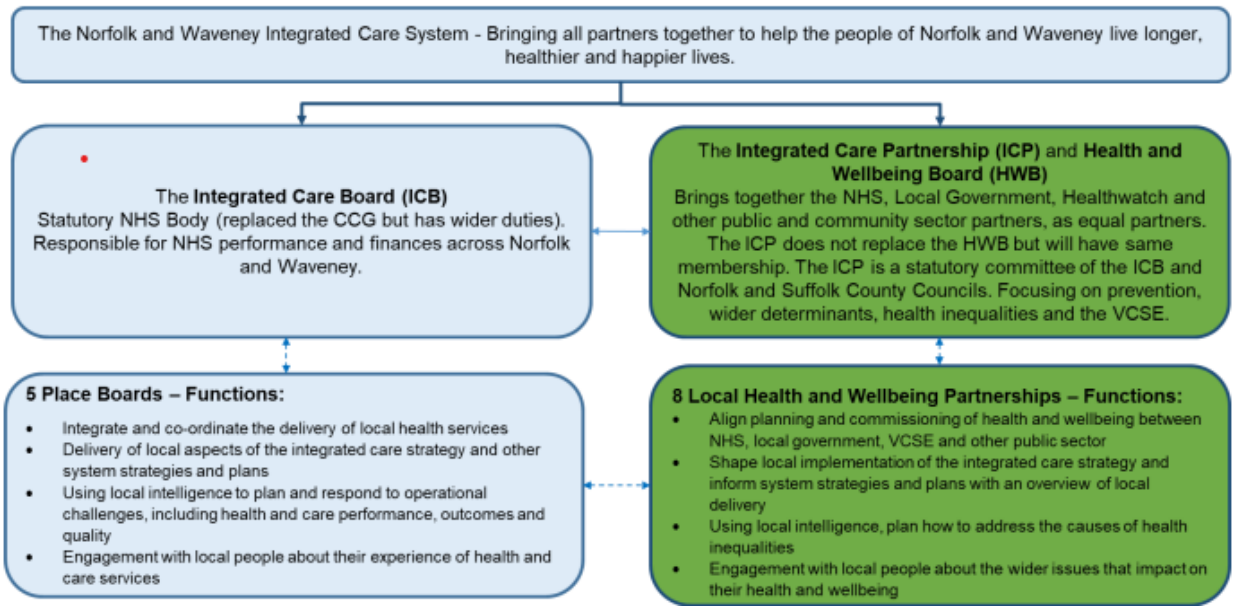
Introduction

Social prescribing service background

This report considers the Norfolk and Waveney ICS (Integrated Care System) secondary care Social Prescribing service, which was delivered across local authority and VCSE partners. Social Prescribing is an approach that connects people to activities, groups, and services in their community to meet the practical, social, and emotional needs that affect their health and well-being. It is a key component of universal personalised care, which works towards a more personalised approach to health and care so that people have choice and control over their mental and physical health (1).

The new landscape of Integrated care systems, and integrated care boards, epitomised the cross-sector approach that developed for the social prescribing service. Figure 1 provides a high-level overview of the Norfolk and Waveney ICS and describes how each component links and works together. Wider system partners have a vision and set of common goals for improving the health, wellbeing and care of people living locally, and has developed relationships between the different parts of the health and care system to enable the ambitions of the ICS to be realised (2).

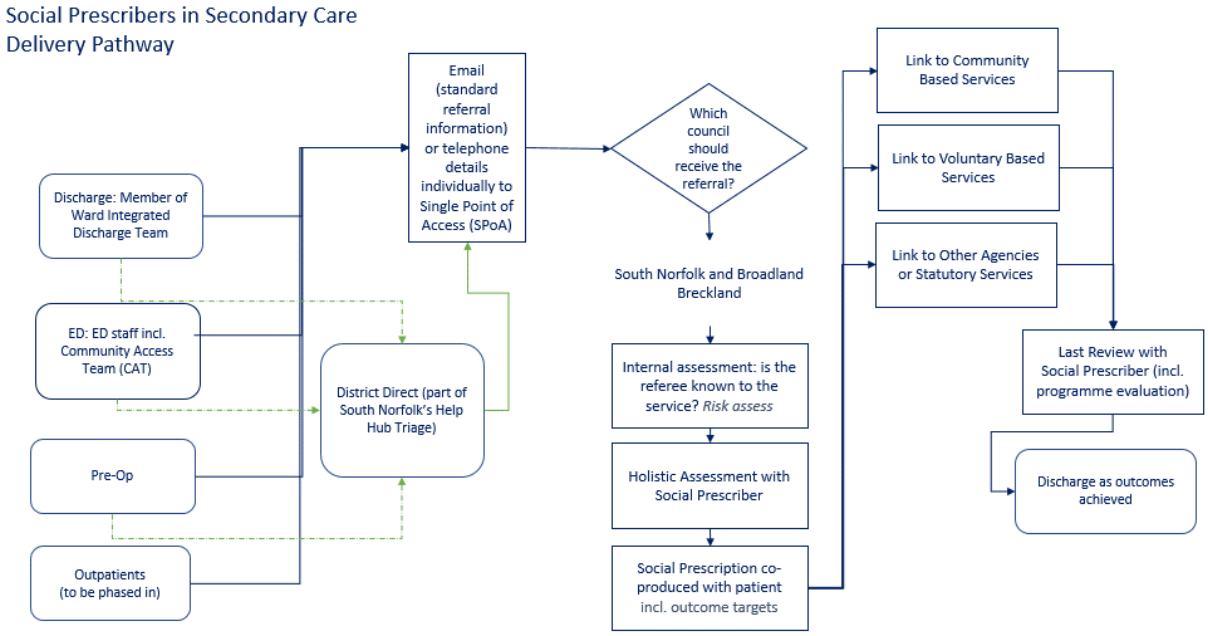
Figure 1: Norfolk and Waveney Integrated Care System and component parts



The Norfolk and Waveney service model provides a single point of access for referrals from secondary care services at Norfolk and Norwich University Hospital, including emergency department, discharge, and outpatient services in Respiratory and Diabetes, pre-operative assessment and Spire Norwich Hospital. Figure 2 showcases the delivery pathway of the social prescribing service. Nine Full Time Equivalent (FTE) Social Prescribers have been employed across the central locality in Norfolk and Waveney Integrated Care System (N&W ICS), linking

A&E, outpatients, discharge and Preoperative patients from the Norfolk and Norwich University Hospital (NNUH) with non-clinical, voluntary sector and community-based organisations. The social prescribing service is delivered by four local authorities and one VCSE organisation with Social Prescribers employed on FTE fixed one-year contracts: Norfolk Citizen Advice Bureau (1 FTE), North Norfolk District Council (2 FTE), South Norfolk District Council (2 FTE), Broadland District Council (2 FTE) and Breckland District Council (2 FTE). A further two FTE Social Prescribers have been placed within District Direct to take referrals from the Pre-Op Assessment teams within NNUH. Social Prescribers were available to support the primary care social prescribing service should they have capacity as there were no data of the expected demand. The referrals were managed across the five districts based on service user location. Once a referral is received Social Prescribers will establish contact with the individual by phone to discuss the support that the service user would like. Throughout this person-centred discussion, the Social Prescriber ascertains the needs of that individual and shares information about local services that may meet that need.

Figure 2: Social Prescribers in secondary care delivery pathway



Existing literature

Research has demonstrated the need for non-medical health services, as only 20% of health outcomes result from clinical interventions, while the remaining 80% are driven by wider determinants of health, such as lifestyle choices, social networks, and environmental factors (2). Moreover, the Marmot Review (3) recognises housing specifically as a social determinant of health and that good employment is a protective health factor, whereas unemployment contributes significantly to poor health. Social prescribing aims to address these determinants and meet the varying needs that influence health and wellbeing. Emerging evidence suggests that social prescribing can have a positive impact on a range of outcomes, such as reducing loneliness, improving mental health, social connections, and overall wellbeing (4). Similar

models with health and wellbeing community health workers have also found positive findings for deprived, traditionally hard to reach groups alternative support to the traditional public health approach (5). It can also reduce the demand for GP services, as one review of 14 studies found a 28% reduction in demand for GP services (6). Another review found that social prescribing can deliver a wide range of outcomes, such as work and volunteering, social wellbeing, education and skills, crime, housing, legal, income, and welfare, which are not routinely measured in service evaluations (7). Several reports have also identified numerous economic benefits of social prescribing, with Doncaster Social Prescribing Service finding that for every £1 of the £180,000 spent supporting vulnerable people, the social prescribing service produced more than £10 of benefits in terms of better health (8). Additional research valued the improvement to service user subjective wellbeing at £5425 per person, while the social return on investment was calculated as £3.42 per £1 invested (9). Notwithstanding this research focusing on social prescribing outcomes, there is still a knowledge gap regarding the process of implementation within social prescribing programs specifically.

Health Innovation East previously conducted a review of social prescribing implementation models and outcomes (10). The review highlighted that social prescribing delivery models vary significantly across the UK, and there is a lack of comprehensive evidence to understand its impact. Recommendations from this review included a focus on training new staff, ensuring staff stability, involving physicians, and implementing information technology systems. It is also important to have quality strategic and ground-level leadership, flexibility of organisational culture, and the availability of resources. A critical systems approach reflected three key areas of consideration when implementing a new social prescribing service; barriers and facilitators; relational issues and "emotional buy in" (11). The World Health Organization (WHO) recognise that developing a social prescribing programme is a non-linear process and some iterations based upon feedback may be required before settling on the final model (12).

On the whole, literature suggests, social prescribing has a significant role to play in addressing wider determinants of health, improving health outcomes for patients and offering economic benefits to systems (13). However, more research is required to understand its implementation process fully. Moving forwards organisations need to adopt best practices in training, staff stability, physician involvement, and technology implementation to ensure successful implementation.

Aims of the report

This work aims to gain an understanding of the implementation and ongoing aspects of social prescribing delivery within secondary care in Norfolk and Waveney. Through this exploration, we aim to identify challenges, enablers, and opportunities to enhance future social prescribing implementation, delivery, and sustainability of social prescribing initiatives and services. The evaluation aims to address two evaluation questions:

1. What do the experiences and feedback of staff involved in delivering this model of Social Prescribing tell us about the model's acceptability and feasibility?
2. What do patient demographic measures tell us about the uptake of the model?

Objectives

1. To identify the population who are accessing the Social Prescribing service.
2. To describe the activity completed and support provided to service users.

3. To explore patient and stakeholder experiences of the service.

Methodology

Quantitative Data Collection

Quantitative data was collected by Norfolk and Waveney ICB and shared with Health Innovation East for analysis. Health Innovation East has not independently verified the data and did not design the data collection approach but has provided an analysis and synthesis of the key findings in this report.

To address objectives 1 and 2 services self-reported data at points of contact with service users. These include:

- Service user demographics; Age, Gender, nationality, housing status and employment status.
- Service engagement and outputs; origin and number of referrals received, reason for referral, top issues discussed with social prescriber, signposting / referrals made, date of first contact, support declined at first contact, cumulative contacts, case status, client disengaged during process.
- Patient experience; patient surveys

This report includes data collected between March 2023 – December 2023. Social prescribing services collated the data in Excel. One data sheet was amalgamated by Norfolk and Waveney ICB, which covered the origin of referrals and total referrals received across the five providers. This sheet accounts for 330 referrals. Additionally, four of the five providers kept a more detailed Excel spreadsheet that outlined the reason for referral, contact made, disengagement during the process, issues discussed, and signposts/referrals made. These were standardised with the support of Norfolk and Waveney ICB to provide one consistent data set for data analysis. These account for just 157 referrals and were collected from April 2023 – November 2023. The Norfolk and Waveney ICB provided information to Health Innovation East on the signposts they had made to community groups, which were then categorised to provide an explanation of the type of support these provide, such as financial or mental health and wellbeing.
A patient survey was developed by Health Innovation East, to be conducted by Social Prescribers with their service users. Subsequently several iterations of the final patient survey (see objective 3) were co-developed and conducted by Norfolk and Waveney ICB. Consequently, different surveys were used by the different departments and due to discrepancies in the questions asked across stakeholders, only two questions and 20 of the 29 available individual patient feedback could be analysed:

- Are you satisfied with the support you received?
- Did the service meet your expectations?

In total n=16 surveys were incomplete. Four of the five providers gathered survey data. The surveys were completed via telephone whereby each district called those who had engaged with their social prescribers. Answers were collated in an Excel spreadsheet before being shared with Health Innovation East for analysis.

Qualitative Data Collection

To develop a more detailed understanding Health Innovation East conducted 1:1 interviews with eight staff involved in delivery of the service, working in social prescribing or team lead roles. Staff were invited to participate and asked to contact the evaluation team to express an interest in taking part in the interviews. Participants were provided with participant information sheets and consent forms. Interviews were conducted via Microsoft teams, recorded, and transcribed. Interviews lasted up to one hour each.

Transcripts were imported into NVivo (qualitative data analysis software) where the data was coded and analysed for key themes. Initial codes were generated in relation to study objectives and the topic guide, emergent codes were also identified and incorporated into the analysis. Axial codes were reviewed and refined to inductively generate themes, based on their perceived relationships.

Social Prescribers across their respective organisations developed case studies to share patient stories. These can be explored in Appendix 2.

Findings

Quantitative Findings

Objective 1: Identify the population who are accessing the Social Prescribing service

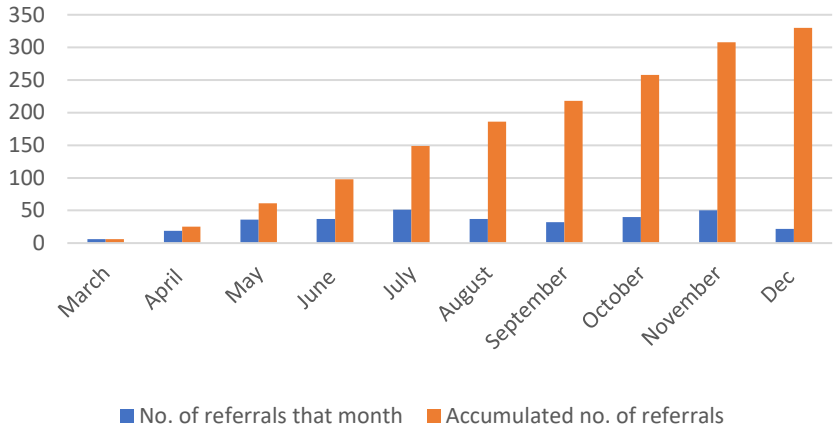
Table 1 provides summary data for social prescribing service user demographics. Service user referrals were evenly distributed across genders, whilst most service users were White British (92%) reflecting the population of the area as per the 2021 census (94.7% white) (13). Almost one-third (29%) of those referred were in social housing, whilst 25% (n=37) were homeowners. Additional housing status options included living with family (n=2, 1%), prefers not to say (n=2, 1%) and no fixed address (n=1, 1%). Housing (n=44, 29%) and employment status (n=31, 22%) were also often unknown.

Table 1. Social Prescriber user demographics

Mean Age (N, Range, SD)		64 (156, 17-95, 19)
Gender N (%)	Female	82 (53%)
	Male	74 (47%)
Ethnicity N (%)	White British	117 (92%)
	Portuguese	3 (2%)
Housing Status	Social or housing association	44 (29%)
	Unknown	44 (29%)
	Homeowner	37 (25%)
	Private Rent	14 (9%)
	Other	5 (3%)
Employment Status	Unemployed (retired)	52 (38%)
	Unemployed (long-term sick or disabled)	32 (23%)

	Unknown	31 (22%)
	Unemployed (seeking employment)	10 (7%)
	Regular employment	10 (7%)

Figure 3: Number of referrals received each Mar-Dec 2023.



Data shows that the social prescribing service received 330 referrals between March and December 2023. Figure 1 shows the service received a similar amount of referrals month on month during the pilot period, with an average of 33 referrals (Standard Deviation = 14). The minimum number of referrals came in month one (March) with six and the most in July at 51.

Table 2. Number, and origin of referrals made by secondary care stakeholders.

*Discharge N (%)	132 (41%)
*Pre-Op (DD) N (%)	83 (26%)
*Unmet Needs - Ambulance Service N (%)	45 (14%)
*ED N (%)	38 (12%)
*Outpatient – SNH N (%)	19 (6%)
Outpatients – respiratory and diabetes	4 (1%)

**NNUH department*

Table 2 shows that a large proportion (n=132, 41%) of referrals to the service were made by the NNUH discharge team. Referrals tended to be made by email (n=206, 62%), as opposed to telephone (n=44, 13%), while the pre-op referral form was used for that service specifically (n=80, 24%).

Table 3. Number of referrals received by service providers.

Norwich N (%)	90 (27%)
North Norfolk N (%)	36 (11%)
Breckland N (%)	46 (14%)
South Norfolk N (%)	37 (11%)
Broadland N (%)	34(10%)
Pre-Op (DD) N (%)	83(25%)

The division of referrals across stakeholders delivering the service is varied. Over one quarter (n=90, 27%) of all referrals were handled by Norwich, closely followed by the Pre-op team who did 83 (25%) referrals between March and December (Table 3).

Table 4: Top 5 reasons for referral into social prescribing service

Referral Reason N (% of all referral reasons)	Not stated	42 (27%)
	Finances	33 (21%)
	Housing	23 (15%)
	Social Isolation	17 (11%)
	Mental Health & Wellbeing	15(10%)

The data shows that a large proportion (27%, n=42) of referrals being made to the service came with no reason for the referral. Of those with a listed reason for referral Finances (n=33, 21%), Social Isolation (n=17, 11%), Housing (n=23, 15%), and Mental Health and Wellbeing (n=15, 10%) were the most common.

Objective 2: Describe the activity completed and support provided to service users

Table 5: Service user interactions with the service

Mean accumulative contacts made (N, Range, SD)		4 (135, 1-25, 4)
Issues discussed	1	104
	2	60
	3	36
Number of signposts/referrals made per patient	1	87
	2	52
	3	36
Additional information provided		32

Data (Table 5) shows that service users tended to discuss one issue with social prescribers, however, 60 individuals discussed two, and 36 individuals received support for three separate issues. An average of four contact points per patient, and a range of 1-25 suggests a personalised approach to support depending on patient needs. This is also reflected in the range of issues discussed with Social Prescribers. A cumulative total of 171 referrals were made to other organisations. There were 17 (8.5%) issues discussed where social prescribers were able to provide support directly because of their expertise and advice, ranging from 7% to 25% dependent on provider. 11 of these instances, spanning two of the providers, required no further signposting or support from another organisation and were dealt with wholly in house.

Table 6: Top five service types referred to by social prescribers.

Type of service referred to N (%)	Finances	45 (28%)
	Housing	28 (18%)
	Mental health services	17 (11%)

	Community centres & activity groups	14 (9%)
	Befriending (Age UK)	13 (8%)

Table 6 presents the range of services referred to by their overarching theme. Over 65 individual services were referred to by the social prescribers, a full list of which can be found in Appendix 1. The data shows Finances (n=45, 28%), Housing (n=28, 18%), Mental health services (n=17, 11%), Community groups (n=14, 9%) and Befriending (n=13, 8%) as the top five service types to be referred into. Additional service types referred into covered adult social services (n=10, 6%), other practical support such as transport (n=10, 6%), education, training, and employment (n=9, 6%), caring support (n=7, 4%) and physical health charities (n=6, 4%) such as MS society or stroke survivors.

Table 7: Top 5 reasons for disengaging from the social prescribing service.

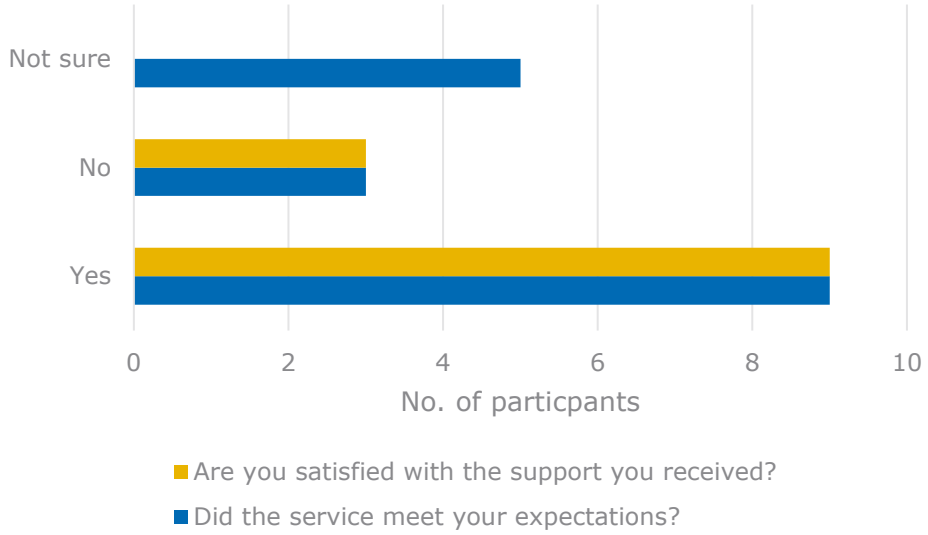
Reason for disengagement	Never engaged	15 (38%)
	DNA first appointment	6 (15%)
	No support required	6 (15%)
	Unknown	5 (13%)
	Support elsewhere	3 (8%)
	Circumstances changed	2 (5%)
	Hospital re-admission	1 (3%)
	Location	1(3%)

Of the total referrals made to the service, 39 (12%) of these did not engage with social prescribing services. This lack of engagement most commonly occurred because social prescribers were unable to effectively engage with these individuals. Once initially engaged service users predominantly didn't attend the scheduled appointment (n=6, 15%) or didn't feel they needed the support (n=6, 15%), see Table 7 for more detail.

Objective 3: Explore patient and stakeholder experiences of the service

Social Prescribers gathered information from patients about their experience of the service. Three providers tracked the engagement rates of their calls: number of clients attempted to have been called n=74, number of answered calls n=38, number of rejections to participate in survey by people answering n=13. In total 29 surveys were conducted, of these 16 were incomplete and 20 answered the two questions used in the analysis.

Figure 4: Patient satisfaction



Survey responses (Figure 2) show that of patients who responded (n=12) to the question 'Are you satisfied with the support you received', 75% (n= 9) responded 'yes'. Furthermore, 53% (n=9) of the patients who responded (n=12) to the question felt the service matched their expectations, however, 29% (n=5) were not sure. Within the free text columns, some of the service users explained why they weren't sure their expectations were met as, *"Didn't really understand who they were or why they were calling"* or *"I didn't really know what to expect."*.

Summary of quantitative findings

- 68% of referrals were unemployed and 29% in social housing, which are recognised social determinants of health.
- Over 65 people were referred to a range of VCSE organisations, providing support in a range of areas including financial, housing, mental health and wellbeing.
- The rate of referrals to the service remained much the same over the course of the pilot.
- 88% of all referrals made into the service engaged with social prescribers.
- Many referrals came with no demographic information and no reason for referral.
- A cumulative total of 171 referrals were made to local partner and community organisations for service users to get the support they need.
- Personalised support needs were demonstrated, with an average of 4 contacts per patient.
- Whilst there was limited service user feedback, 75% indicated that they were satisfied with the service.

Qualitative Findings

Findings from the staff interviews are presented in the order in which they were explored within the topic guide. These are grouped within the following subthemes identified from the data: (i) goals and objectives; (ii) stakeholder involvement; (iii) challenges; (iv) successes; (v) lessons learnt; and (vi) sustainability and future plans.

Main themes	Sub themes	Summary	Quotes
Goals and objectives	Hospital admission and discharge	Focus was placed on utilising social prescribing (SP) to avoid patients being unnecessarily admitted to hospital, as well as making sure that the discharge process was smooth and simple to expedite discharge and save bed days.	*'We would be alleviating potential for readmission from a discharge perspective and we could potentially be reducing unnecessary ED attendance.'* (P17)
	Holistic approach	Service delivery needed to be holistic, focussing on the service user as a whole person and not just the clinical issues.	*'We want to support people to move towards improving their health and wellbeing holistically, looking at their practical issues that are presenting to them in the here and now.' (P13)*
	Providing support	The need for support around multiple issues has increased, particularly since COVID.	*'A lot more people need support. We're seeing a lot more people who need support, specifically around finances, wellbeing and social isolation…The people that we've dealt with recently, COVID is a thing, what they're saying, when they were confined, they couldn't cope, they were isolated and they just couldn't manage.' (P15)*
	Building pathways	Participants felt there was a need to build pathways and links with other services to ensure they get referrals into SP and maintain good relationships.	*'Secondary care social prescribing is very much about building a pathway to ensure that we have really good links in all parts of secondary care, to enable us to give a really well-rounded view, to reduce waiting times, to make sure that people have really good health literacy. And very much aligned with the primary care goals, but in secondary care.'* (P11)
Stakeholder involvement	Collaboration hub	The importance of collaboration with multiple stakeholders and reaching out to them was	*'We run the collaboration hub meetings every Wednesday. So we work with various different organisations, voluntary as well. Starting from Age*

		discussed, highlighting that the service could not run efficiently without them.	*Concern, the Library Service, anything right up to NFST, Adult Social Care, we all work together, and you have to work together. It's not one thing, we couldn't just manage just us, we've got to use the services around us.'* (P15)
	Educational engagement	Educating others on what SP is and how it can help was frequently cited as crucial in increasing referrals and stakeholder engagement with the service.	*'It was a lot about trying to educate people very quickly about the wider detriments of health and how holistic support can work alongside clinical intervention, but also be more powerful for the long term.'* (P13)
Challenges	Information governance	Most frequently discussed in challenges faced was difficulties with information governance (IG) and the delays this caused in getting the project up and running.	*'We got stuck on a lot of like GDPR and data protection with regards to the hospital…I think there could have been more mitigation and due diligence completed in order to make sure that we didn't have those long pauses where we weren't able to deliver service.'* (P13)
	Lack of referrals	A lack of referrals was attributed to IG issues delaying them and HCPs not understanding or knowing about SP.	*'The main challenge is that we didn't have the referrals for a long time…I think the problem is the information flow and knowing that we were there in the first place, and professionals understanding what exactly, what work we do.'* (P14)
	Single point of access and referral process	Referral into SP via the 'single point of access' was felt to cause delays in SP picking up the referral, as well as unnecessary sending of data to multiple places.	*'But actually the referrals, if they'd come straight through to us direct, we could have actually probably dealt with the patient the same day.'* (P12)
	Lack of clarity around service	A lack of clarity around SP was highlighted not just in relation to other HCPs not knowing what it is but also patients not understanding what it is or why they were being referred,	*'There's no knowledge around what social prescribing is really. And if you mention NNDC, a lot of people put the phone down on you. The people are petrified, they think we're after some council tax or something.. and I*

		also not wanting to speak to the SP as they believed it was the Council calling. Confusion around the difference between SP and District direct was also discussed, which also made referring in difficult.	*think that's been proven with the project, definitely with the referrals that come in. There's just not enough known social prescribing wise.'* (P15)
Successes	United providers	The SP project was described as bringing providers together to discuss best practice, adapt and change.	*'We were actually all able to come together and share ideas of what best practice look like, and what do I do versus what does someone else do.'* (P13)
	Pre-op service	Participants felt referrals into SP prior to elective surgery were pivotal in ensuring a smooth discharge for patients. Benefiting both patients and the pre-op team.	*'The pre-op team are really happy with that… They reckon it probably saves them four to five bed days per problematic admission.'* (P17)
	Single point of access	Conversely some participants felt that the Single Point of Access referral process was a success of the project, due to its ease of use.	*'The referral pathway is one single telephone number, irrespective of where somebody lives…I don't see how we could have got it any more simple.'* (P17)
Lessons learnt	Information governance process	In line with information governance being spoken of as the largest challenge, this was also the most frequent lesson learnt. With participants feeling it should have been started much earlier.	*'When you're looking at a project like this, all that background work around, can we share data? Who's sharing the data? Why we can't share the data? All of that needed to have been done before even anybody signed up to it.'* (P12)
	Service promotion and relationships	Participants acknowledged the need for promoting the service more widely and building relationship with other hospitals to perhaps put a SP in place there or to share population health management data.	*'I think we could have just done a lot more foundation work, and I think that could have been done more collaboratively.'* (P11)
	Stronger business case at the start		

		A more cohesive plan and business case from the start was needed.	*'Not having a shared understanding of the expectations, not having a standard operating procedure in place, not having a firm business case available, led people on different paths.'* (P13)
Sustainability and future plans	Talk to patients and service users	To sustain SP services, it was felt that more discussions should be had with stakeholders to ensure that the services being offered are the ones that are needed.	*'Open and honest conversations with all our partners, you know, listen to them, what they find good, what they don't find good and really ensuring that you understand what your community needs because it's no good giving them something what they don't need.'* (P18)
	Ensure understanding	There needs to be a greater understanding of SP and what services it can offer.	*'If people who are on the front line in the hospital don't know we are there or understand what we do, then the link is just not there. The key is that link.'* (P14)
	Hospital presence	A greater and more consistent presence within the hospital is needed to ensure other HCPs know SP is available and to build relationships.	*'They need to be more visible, certainly on the wards and certainly around in the hospital, not tucked away in a little office on the phone.'* (P12)

Summary of qualitative findings

The findings from the interviews with social prescribing services highlighted several key themes and subthemes. Firstly, participants emphasised the importance of utilising social prescribing to prevent unnecessary hospital admissions and to ensure smooth discharge processes, thereby likely saving bed days and improving overall patient outcomes. They stressed the need for a holistic approach in service delivery, addressing the multifaceted needs of individuals, particularly heightened by challenges posed by the COVID-19 pandemic. Building pathways and fostering collaborations with other services were deemed essential for effective referrals and maintaining strong relationships. Another crucial aspect discussed was the involvement of stakeholders, emphasising the significance of collaboration hubs and educational engagement to increase awareness and understanding of social prescribing among healthcare professionals and the wider community. However, challenges such as information governance issues, lack of referrals, and confusion surrounding the referral process were frequently mentioned, underscoring the need for clarity and streamlining of procedures. These challenges should be considered in the context of the newly developing ICS, with projects across multiple providers, external to the NHS an emergent way of working. While a single point of access was deemed necessary, participants suggested that lessons could be learned to improve it, perhaps that an automated system might be more effective.

Despite these challenges, there were notable successes, including the unity among providers and the effectiveness of social prescribing referrals before elective surgeries. Lessons learned encompassed the importance of addressing information governance early on and promoting the service more effectively. Additionally, participants recognised that social prescribing services are still in a nascent stage, and providers are actively learning and raising awareness of how to collaborate effectively. Therefore, this project has provided a wealth of useful lessons for the future development and implementation of social prescribing services.

Patient stories

Throughout the programme social prescribers across providers gathered patient stories to depict the difference the service has made to patients and their individual health journeys. Four stories from across the providers are detailed below and further detail of these stories can be found in appendix 2.

Patient Story 1:

Social prescribing played a crucial role in supporting a patient (aged 55-60) facing significant financial strain and deteriorating health conditions. Through collaborative efforts with partner organisations such as Norfolk Citizens Advice and Equal Lives, the patient received tailored support to address their complex needs. This included assistance in claiming benefits, accessing care assessments, organising paperwork, and coordinating with healthcare professionals to accommodate vision impairment. As a result, the patient experienced improvements in mental health and reduction in stress, alleviating symptoms of their health condition and promoting independence and safety in their own home.

Patient Story 2:

Social prescribing proved invaluable in supporting Mrs. X, a 63-year-old double leg amputee, to access essential resources and services. Collaborating with partner organisations such as

Breckland Council and Victory Housing Association, social prescribers facilitated adaptations to Mrs. X's home, financial support inquiries, and access to community resources such as Age UK Norfolk and Citizens Advice. These interventions empowered Mrs. X to remain living independently, access specific support for her amputation, and feel more confident in reaching out to relevant agencies regarding her health and finances.

Patient Story 3:

Mr. X, an 88-year-old facing significant self-neglect and financial difficulties, benefited greatly from social prescribing interventions. Through collaborations with organisations like Voluntary Norfolk and Watton Medical Practice, social prescribers facilitated essential support such as weekly shopping assistance, utility bill payments, and safeguarding measures. By coordinating with healthcare professionals and social service agencies, Mr. X received improved nutritional intake, healthcare support, and a diagnosis of dementia with ongoing assessments for lack of capacity, ultimately reducing the risk of self-neglect and enhancing his overall well-being.

Patient Story 4:

Social prescribing played a critical role in supporting a retired 67-year-old man facing homelessness, financial instability, and health challenges. Through collaborative efforts with organizations such as Victory Housing and Financial Inclusion at NNDC, social prescribers facilitated essential support such as securing housing, financial assistance, and access to healthcare services. Additionally, interventions such as opening a bank account, addressing tax concerns, and accessing community resources like Men's Sheds and food banks helped improve the patient's overall well-being and provided relief from housing and financial concerns.

Recommendations

- Focus should be placed on having information governance procedures in place as early as possible, to avoid delays in referrals and service delivery.
- A consistent approach to data collection across stakeholders should be considered, perhaps in the form of a data management system, which should include measures for patient health and wider system-level outcomes.
- Enhance stakeholder engagement and education: Provide comprehensive education and awareness campaigns to HCPs and patients about social prescribing benefits and processes. Foster collaboration with multiple stakeholders, including healthcare providers, community organisations, and patients, to ensure efficient service delivery and referral pathways.
- Improve clarity and communication: Clarify the distinction between social prescribing and other healthcare services like District Direct to avoid confusion among both HCPs and patients. Enhance communication strategies to ensure patients understand the purpose of social prescribing referrals and feel comfortable engaging with the service.
- Expand service visibility and accessibility: Increase the presence of social prescribing within hospitals to raise awareness among HCPs and facilitate easier access for patients. Explore opportunities for establishing social prescribing services in other healthcare facilities or collaborating with neighbouring hospitals to broaden service reach and impact.
- Facilitate preoperative referrals and holistic care: Encourage preoperative referrals into social prescribing to support patients throughout their healthcare journey, including

facilitating smooth discharges and reducing unnecessary hospital admissions. Emphasize holistic care approaches within SP services to address the multifaceted needs of patients, particularly in the context of increased support required post-COVID-19.

Implementing these recommendations could help the effectiveness and sustainability of social prescribing initiatives, leading to improved patient outcomes and healthcare system efficiencies.

Strengths & Limitations

This evaluation is limited by the quantitative data available, which lacked rigour and consistency across providers. This was evidenced by the differences between the referral number data provided to Health Innovation East from the partner organisations and the master spreadsheet tracking referral numbers by the ICB. This is only partially accounted for by the pre-operative service and another provider organisation not able to provide more detailed referral information used within this report such as demographics, needs and deliverables, case studies, or survey responses. It is recognised that the pre-operative service data may not have been available as it is channelled through district direct. Another limitation is the use of different patient surveys across departments. Initially, a patient survey was designed by Health Innovation East for implementation by Social Prescribers with their service users. However, multiple iterations of the final survey were collaboratively developed and administered by Norfolk and Waveney ICB. Ultimately different surveys were adopted by the various providers, introducing inconsistency into the evaluation process. A strength of this evaluation is the mixed-methods approach which allows for a description of the service outputs as well as a more in-depth understanding of the implementation of the pilot service.

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Appendices

Appendix 1: Quantitative data sources

The following data sources are provided as shown on the Excel spreadsheets provided:

A list of VCSE partners who patients were referred to; Community centre, Park group, CAB, Befriending, Age UK (befriending), Early Help Hub, Shelter, Social Services, Mind, Employment services, Vision Norfolk, Library / books on wheels, Bereavement Café, The Swift Response, Transport plus, Art for Wellbeing, The REST hub, Childrens activities, Knit, stitch & natter, Get Me Out These Four Walls, Alopecia UK, Carers Matter, Recovery college, Homestead, Care co, N&W wellbeing service, Sheltered housing, Assisted living, Foodbank, Samaritans, Amputation society, stroke survivors, Menscraft, Safe at home team, local community groups, Stroke Association, local housing team, IHAT, Welfare Rights Team (Council), Referred Council Handyperson service

Appendix 2: Case Studies

Patient Story 1:

The patient (55-60yrs) unable to work (self-employed) due to deteriorating health condition. Unable to pay bills plus increase in living costs. At risk of losing home as mortgage payments in arrears and in need of adaptations to accommodate vision impairment.

What we did/facilitated:

- Helped client to claim UC/new style ESA
- Progressed care needs/OT assessment and **Adult Social Services** – identified possible safeguarding concern concerning financial abuse
- Progressed involvement of **NCC Sensory Support Team** and adaptations/assistive technology
- Organisation of client's paperwork including HMRC tax assessment request – notified **HMRC** of change in circumstances.
- Onward referral to **Equal Lives** for further discussion around reassessment of PIP award.
- Contacted **Vision Norfolk** (Community Worker) on client's behalf
- Onward internal **Norfolk Citizens Advice** referral for specialist debt advice with **Money and Pensions Service**.

Patient's personalised health outcomes:
Patient has been diagnosed with macular degeneration, has a spinal injury and asthma. Patient was supported to remain independent and safe in their own home

Partner organisations and teams who worked with us:

- Norfolk Citizens Advices Debt Team (Money and Pensions Service)
- Norfolk Citizens Advices Help to Claim
- Equal Lives

- Registered GP
- CFICS (Community Fully Integrated Care and Support Team)
- NCC Adult Social Services

Impact on patient:
Improvement in mental health and reduction in the stress of dealing with situation helped to alleviate symptoms of health condition.
Better communication between statutory services and patient, identifying the support needed for a vulnerable patient.

Patient Story 2:

- Mrs X is a 63 yr. old white British woman who lives alone in social housing. She is a double leg amputee. Referred to Social Prescribing for support with a benefit enquiry.
- Gets support from her son with shopping and help around the house.
- Has support from a local church and neighbours, goes out once a week.
- Son getting pendant alarm and assistive technology referral made.
- Mrs X has been waiting 3 years for improvement to her home due to her disability.
- Mrs X is on high rate PIP and ESA and receives Housing Benefit however believes she should not be paying the bedroom tax.

What we did/facilitated:

- Contacted her housing association on her behalf to enquire about the adaptations to her home.
- Grants Adaptations Team at Breckland Council were contacted, I spoke with the team who advised they were visiting Mrs X to discuss starting adaptations.
- I contacted Adult Social Services on her behalf and was informed she was on the list for respite assessment due to adaptations to home.
- Signposted Mrs X to Age UK Norfolk/Citizens Advice for enquiries into the bedroom tax as Mrs X was confident enough to enquire herself about this.
- Information provided on the Swift service, an Independent Age Living with a long-term condition booklet, local Library events and the Amputation Foundation.

Patient's personalised health outcomes:

- Mrs X able to remain living independently in her home.
- Not requiring a care package.
- Able to access specific support around being an amputee.

Partner organisations and teams who worked with us:

- Breckland Council
- NCC Adult Social Services
- Victory Housing Association

Impact on patient:

- Mrs X stated she felt relieved that she knew what was happening now as she had struggled herself to gather any information.
- Mrs X feels that she will be more independent in her home.
- Empowered to reach out to relevant agencies re her health and finances.

Patient Story 3:

- Mr X is an 88 yr. old white British man who lives alone in a privately owned home.
- Safeguarding completed by ambulance crew due to the uncleanliness of the house, reports of incontinence, lack of food and apparent self-neglect.
- Undiagnosed heart condition.
- Unpaid utility bills and phone line cut off.
- No GP contact or attendance to vaccination reminders in recent years.
- Mr X was referred to the Social Prescribing for finance/debt support.
- No family/friends only concerned neighbours.

What we did/facilitated:

- I made enquiries to Adult Social Services asking if any referrals were in place for this gentleman or any support he had received in the past. Neighbour had raised concerns, I also raised concerns. ASSD assessed and NFS POC put in place.
- With consent I contacted his GP surgery for any relevant information and was told he had not attended the GP surgery in a long time, so they had little information. GP surgery discussed Mr X at MDT and plan to support him put in place.
- I contacted Voluntary Norfolk Community Response Team and arranged for a volunteer to do shopping once a week until Social Services had assisted to arrange a longer-term solution for this.
- Supported Mr X with immediate action to ensure utility bills paid and phone line reconnected with consent.
- Liaised regularly with Social Worker ensuring Mr X received the support required and raised concerns about ability to manage finances himself/vulnerability.
- I enquired to the Safe at Home Team for support with cleaning his home prior to discharge and a referral had been received. Also requested support with fitting plug socket locks due to unsafe use of microwave flagged by Social Worker.

Patient's personalised health outcomes:

- Improved nutritional intake as well as support around personal hygiene.

- GP support with cancer diagnosis and memory assessments.
- A diagnosis of dementia had been confirmed and an application to support with finances has been made with ongoing assessments around lack of capacity.

Partner organisations and teams who worked with us:

- District Direct Safe at Home Team
- Breckland Council
- Adult Social Services
- Voluntary Norfolk
- Watton Medical Practice

Impact on patient:

- Health and wellbeing needs are being managed, he is eating and drinking better, his home environment is clean and he is engaging well with the carers.
- Landline phone back up and running so able to then have a community pendant alarm- reduced risk of hospital admission.
- Reduced risk of self-neglect.
- Increased input from health professionals- a more collaborative approach.
- Advocacy support from Social Worker to assist Mr X choice of remaining safe in his home and having his needs and wishes met.
- Daily visits with people and regular interactions.
- Better relations with neighbours.

Patient Story 4:

- Patient is white male, 67 and is retired, living in a Victory Housing property.
- Patient was admitted to hospital after a fall.
- Whilst in hospital, his civil partner fell at home and passed away. Has no other family or friends.
- Medical history; ETOH Multiple Falls Chronic Macrocytic (Bone marrow produces abnormally large red blood cells) Depression COPD Marfans Syndrome (disorder of the body's connective tissues) - Being thin tall LBBB (Left bundle branch block).
- Property is in need of internal window repair due to police having to force entry when partner died. Also oven was removed due to damage from partner having a fall.
- Client is not on tenancy, Council tax records or electoral roll. Client has no automatic rights to succeed tenancy.
- Client has no Bank account or ID; pension is being paid into late partner's personal bank account. No passport, driving licence.
- Client claims no benefits, only state pension.

Action Taken & Outcomes:

- 2 x home visits with no-one home; eventually discovered client has been readmitted to hospital after a fall. Multiple subsequent visits & phone calls.
- MDT meetings with Victory Housing, ASSD &internal teams at NNDC
- Contacted GP to get proof of address as evidence for succession
- Opened Bank account for client; accompanied him to branch
- Paid tax rebate cheque into client's bank account
- Contacted DWP to freeze pension payment; then again to give new bank details.
- Co-ordinated with in-house Financial Inclusion (FI) team to get Council Tax Support awarded to patient.
- FI on-going involvement to assist with Pension Credit claim.
- Applied to NAS scheme for new Oven

- Encouraged client to visit GP for help with reducing alcohol consumption
- Signposted client to CGL & AA
- Referral to age UK – Money Matters Service
- Attempted to facilitate involvement with Men's shed but client was too unwell
- Issued food bank voucher
- Referral to North Walsham Good Neighbour scheme for help with food shopping

Future plans / management:

- Measures taken have provided client with relief from housing & financial concerns.
- Future plans to address loneliness/isolation when client is well enough
- Client still open to service

Partner organisations and teams who worked with us:

- Victory Housing
- Financial Inclusion (FI) ~ NNDC
- DWP
- ASSD at NCC
- EH at NNDC – funeral arrangements
- GP