Health Innovation East

Improving lives together
Norfolk and Waveney Integrated Care System

AN EVALUATION OF SOCIAL PRESCRIBING AND ONE-OFF PERSONAL HEALTH BUDGETS IN NORFOLK AND WAVENEY

Part of the Health Innovation Network

Office for Life Sciences

NHS

Executive Summary

This Health Innovation East report, commissioned by Norfolk & Waveney ICB, evaluates the ICB's social prescribing in secondary care pilot.

In summary, the findings suggest that the introduction of the social prescribing service and the One-Off Personal Health Budgets (OOPHB) delivery had a positive impact on mental, social, and environmental wellbeing of patients. Staff reported that patients' needs were met for 98% of referrals made, supporting either admission avoidance or expedited discharge. System-wide outcomes were also positively influenced by the service with evidence of an average of 5.3 bed days saved per patient, as well as a 7% re-admission rate over 90 days which is less compared to other Norfolk & Waveney Emergency rates.

Findings are based on a mixed-methods analysis of data collected from November 2022 – November 2023. Quantitative data was collected by the social prescribing team through monitoring of 382 patients who engaged in the service and a staff survey. Qualitative data was obtained from semi-structured interviews involving eleven healthcare and management staff from across secondary care sector organisations.

Barriers to implementation of the service included robustness of data, information governance concerns, and delayed recruitment. Literature highlights that these challenges are shared nationally across social prescribing services and are not unique to the Norfolk & Waveney service.

The findings highlight the critical importance of improved integration of the service within the broader healthcare system, emphasising staff buy-in at all levels. For the future sustainability of the service, it is crucial to consider securing continuous funding, facilitating strategic conversations, and prioritising a standardised evaluation process, which should include recording of costs and savings associated with delivering the service. This evaluation concludes that the pilot has implemented a successful foundation, which along with identified opportunities, provides a strong platform to develop services to benefit patients and the wider system.

Introduction

This report considers the Norfolk and Waveney ICB Social Prescribing service based within secondary care. 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). This pilot is funded through NHS England (NHSE) to integrate Social Prescribing roles within secondary care and offer One Off Personal Health Budgets. The aim of the pilot was to support safe, effective, and expedited discharge as well as to aid admission avoidance. The service intended to address the Urgent and Emergency Care Recovery Action Plan (2) and the guidance document for One Off Personal Health Budgets within Hospital Discharge Pathway (3). Figure 1 displays the service model and referral pathway for the Norfolk and Waveney ICB Social Prescribing service.

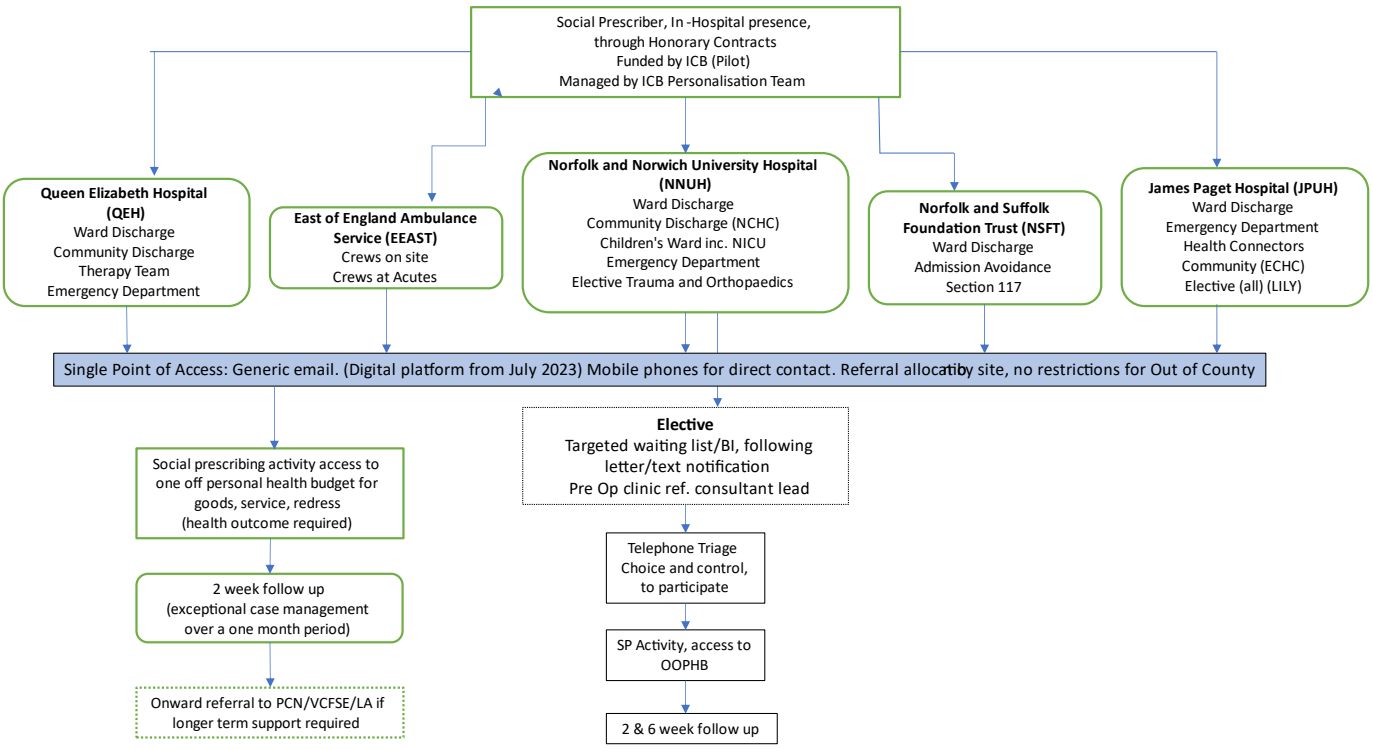


Figure 1: Service model and referral pathways for the Norfolk and Waveney ICB Social Prescribing service.

The service model developed (Figure 1) provides a single point of access for referrals from secondary care services, including emergency department, community discharge and elective care. The model covers multiple hospital sites and an ambulance service, employing seven social prescribers, working collaboratively across sites. Employing an innovative approach, the service offers One-Off Personal Health Budgets (OOPHB) to provide people with the support they need to leave the hospital safely, this could be in the form of goods, a service or redress. They enable people to access personalised care and support when their needs cannot be met through existing commissioned services or unpaid care. Some example uses of this budget include the purchase of goods to allow them to safely return home, services to ensure their home is habitable and

comfortable, such as heating or specialist cleaning for hoarders, or to pay for intermediary accommodation, whilst a more permanent solution is sought. This is considered a more cost-efficient approach than an alternative setting and removes the implications of a patient residing in an acute setting, which they have no right to. NHS England(1) have developed a standard model showing key elements required for successful Social Prescribing, these include easy referral routes, collaborative commissioning and partnership working and creation of personalised plans (Appendix 2). It should be recognised that this standard model was developed with a focus on primary care models, which are the more commonly implemented models across the NHS. The National Academy of Social Prescribers review of funding models found that there is currently no available evidence for an Integrated Care System (ICS) funding model but recognised this model as a potential solution to voluntary sector capacity concerns seen in other models (4).

Relevant literature

Health Innovation East have previously completed a desk top review on delivering effective, networked social prescribing services, specifically relating to non-medical roles and their impact (5). This concluded that models of social prescribing delivery differ significantly across the UK in relation to the actual activities offered (health, social and economic), and in the level of support given to patients following referral. The same review concluded that there is not currently a comprehensive evidence base to understand the impact of these services, which this report seeks to support.

The need for non-medical health services is well evidenced with only 20% of health outcomes resulting from clinical interventions and the remaining 80% driven by wider determinants of health, such as lifestyle choices, social networks, and environmental factors(6). The wider determinants of health model (7) has long underpinned the discussion around health inequalities, reasoning that social, economic, and environmental factors are integral to population health outcomes. These principles are at the heart of social prescribing, which aims to meet the varying needs that influence health and wellbeing. There is an emerging field of evidence that explores social prescribing implementation methods and outcomes. Research examining pilots in the UK highlighted several common facilitators and barriers to social prescribing delivery (8,9). Factors that appeared to be particularly relevant for Integrated Care Boards (ICBs) include the existence of training for new staff, staff stability, clinical involvement, and information technology systems (8). More broadly a systematic review found facilitators and barriers were related to: the implementation approach, legal agreements, leadership, management and organisation, staff turnover, staff engagement, relationships and communication between partners and stakeholders, and the local infrastructure (10). In addition, many of the barriers and facilitators to the implementation of integrated care pilots were found to be those of any large-scale organisational change; for example, quality of strategic and ground-level leadership, flexibility of organisational culture, and the availability of resources. A report into the digital landscape of social prescribing in London details some key areas of consideration for social prescribing in a digital context, namely finances, interoperability, privacy, maturity, and evidence(11). Stakeholders listed some challenges as information sharing and IT governance, particularly within the NHS, culture was cited as a large challenge, and it was felt there was an opportunity to raise awareness and educate professionals around social prescribing(11). Despite this research base, there is a significant knowledge gap regarding the process of implementation within social prescribing programmes specifically (12–14).

Various evidence reviews of Social Prescribing models have been undertaken. One review of 14 studies found a 28% reduction in demand for GP services and concluded that the evidence

available supports a potential for reduction in demand for both secondary and primary care (15). The evidence suggests that Social Prescribing can have a positive impact on a range of outcomes, including a reduction in loneliness, improvements in mental health, social connections, and overall wellbeing (16). Another review found that more than half of the outcomes Social Prescribing can deliver are not being routinely measured in service evaluations, examples of these outcomes include work and volunteering; social wellbeing; education and skills; crime; housing; legal; income and welfare (17) More specifically, only 50% of outcomes relating to health and 22% relating to wider determinants of health are routinely measured.

Several reports have identified economic benefits of Social Prescribing, although these vary according to the target population and specific outcomes (18). Doncaster Social Prescribing service found that for every £1 of the £180,000 funding spent supporting vulnerable people, the Social Prescribing service produced more than £10 of benefits in terms of better health (19). 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 (20). Evidence also suggests demographic differences in those accessing services, for example a gender divide with nearly twice as many women than men accessing Social Prescribing being reported in one study (21).

Aim

The aim of this evaluation is to gain an understanding of the implementation of social prescribing within secondary care in Norfolk and Waveney, and to identify challenges, enablers, and opportunities that can help improve future implementation, delivery and sustainability of social prescribing initiatives and services.

Objectives for the evaluation:

1. To identify the population who are accessing the social prescribing service.
2. To describe the activity completed and support provided to patients.
3. To explore outcomes for patients, the service and wider system.

Method

Health Innovation East used a mixed method approach. Quantitative data was collected by Norfolk and Waveney Integrated Care Board (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. Qualitative data was collected by Health Innovation East via interviews with staff engaged in design and delivery of the social prescribing service in Norfolk and Waveney ICB.

Quantitative data collection and analysis

This report includes data collected between November 2022 – November 2023. Social prescribers collected data using Joy social prescribing digital software from July – November. Prior to this data was collected in Excel. Data sets have been amalgamated by Norfolk and Waveney ICB and shared as one consistent file for data analysis. Details of how data has been collected and analysed to address each of the evaluation objectives is outlined below.

Objective 1: To identify the population who are accessing the social prescribing service

Objective 2: To describe the activity completed and support provided to patients.

Social prescribers self-reported data at points of contact with service users. These include:

- Patient demographics: Age, Gender, GP, GP Postcode, Index of Multiple Deprivation Rank, Index of Multiple Deprivation Decile, Ethnicity
- Patient needs: Reason for referral; Social Prescribing Activity; key comorbidities (As per CORE20+5)
- Service outputs: PHB Cost, OOPHB (yes/no), Health Outcome (If OOPHB Provided), Goods/Services/Other, Admission Date, Admittance Method, Discharge Location

Objective 3: Exploring outcomes for patients, the service and wider system

- **Service level outcomes**: No. of Hospital Bed Days Saved, No. of other care setting bed days saved, Estimated Cost Benefit bed days, Value of System Saving, Readmission in 2 weeks (yes/no), Readmission Date, Readmission in 3 months (yes/no), Readmission Date, Discharge/Admission Avoidance/Other

The project lead in the ICB consolidated data into appropriate overarching labels where appropriate. Readmission data for patients was calculated at the point of discharge from the Social Prescribing service. Definitions for labels were provided by Norfolk and Waveney ICB as per the service specification and are provided throughout this report.

- **Patient, service, and system outcomes**: A&E attendances, bed-days, cost savings, re-admission rates and staff feedback.

Norfolk and Waveney ICB collated data from a range of sources to provide an overview of outcome data.

A series of economic measures were developed by the ICB to calculate bed days saved and cost implications. These measures utilised NHS Tariff and were based on professional discussions regarding individual patients and circumstances. These conversations developed an understanding of how long usual services would take, whether Social Prescribers and OOPHB would reduce need for services or support patient flow, and whether the service had addressed a gap in provision. This information combined to inform the bed days saved calculations. It should be noted that given the subjective, assumption based, nature of the calculation, this data only provides an indication of indicative costings as opposed to reflecting a direct cost outcome. Re-admission numbers are taken from Norfolk and Waveney ICB clinical systems.

To explore potential wider outcomes of the social prescribing workforce analysis was done to assess whether there was an association between more social prescriber full-time equivalents (FTEs) and fewer Accident and Emergency attendances or lower in-patient costs. Health Innovation East then conducted a regression analysis of social prescribing workforce data, alongside Accident and Emergency attendances and cost of hospital in-patient stays (Appendix 3). This report provides the results of a regression analysis in which the dependent variable is A & E attendance and non-elective in-patient total cost. The independent variables in the model are the PCN, year, quarter, and social prescribers.

In addition, Norfolk and Waveney ICB developed a survey in Microsoft Forms to collect feedback from various staff referring into the social prescribing service. Responses were gathered between 30th June and 14th December 2023. No identifiable information was collected for respondents. This open and non-targeted approach aimed to provide an understanding of the staff experiences and perceptions of the impact on the current workforce and gaps in the service offer to inform future development of social prescribing in Norfolk and Waveney.

Qualitative data collection and analysis

Objective 3: Exploring outcomes for patients, the service and wider system

To develop a more detailed understanding of outcomes for patient's three patient case studies were provided by Norfolk and Waveney ICB Social Prescribing service (appendix 5). Additionally, Health Innovation East conducted 1:1 interviews with eleven staff involved in delivery of the service. 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. Participant roles included social prescribers, nursing staff, advanced practitioners, and management from across the service.

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.

Findings

Quantitative Findings

Over the period being reviewed, November 2022 – November 2023, the service received 382 referrals, which were handled by a team of seven social prescribers (6 FTEs). Findings related to service user characteristics and outcomes for the service and service users, these are outlined below.

Objective 1: Identify the population who are accessing the social prescribing service

In support of objective 1, Table 1 provides summary data for social prescribing patient demographics. Patient referrals were evenly distributed across gender, whilst most patients were White British (92%) reflecting the population of the area as per the 2021 census (94.7% white) (22). Patients comprised the most and least deprived areas (indices 1-10 in areas), most commonly residing in areas reflecting indices 4 and 5 deprived areas. They were also more likely to be from areas of high deprivation than low.

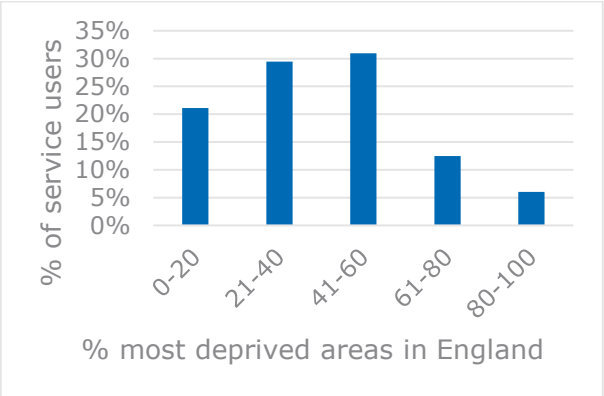
Table 1. Social Prescribing service patient demographics

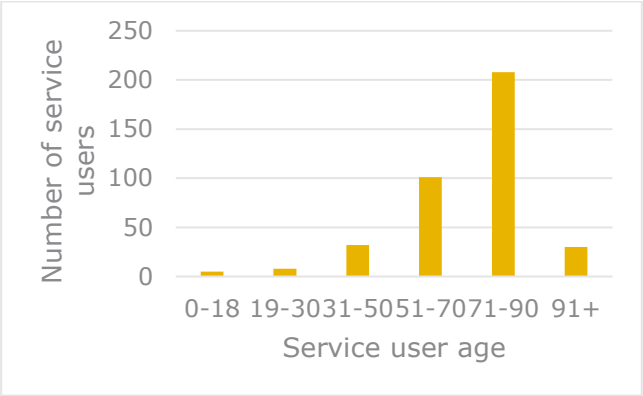
Mean Age (N, Range, SD)		72 (378, 2-99, 17)
Gender N (%)	Female	179 (47%)
	Male	203 (53%)
Ethnicity N (%)	White British	352 (92%)
	White – Any other background	16 (4%)
	Not known	9 (2)
	African	2 (1%)
	Asian / Asian British	1 (0%)
	Irish	1(0%)
	Prefer not to say	1(0%)
Indices of Multiple Deprivation decile* N (%)	1	43 (11%)
	2	37 (10%)
	3	48 (13%)
	4	64 (17%)
	5	74 (19%)
	6	54 (14%)
	7	23 (6%)
	8	19 (5%)
	9	10 (3%)
	10	7 (2%)
	Unmatched	3 (1%)

**1; most deprived area, 10; least deprived area*

Figure 2 shows that 55% of the population receiving a Social Prescribing intervention were between 71-90 years old, though a broad range (2-99 years) of ages accessed the service. When looking at the Index of Multiple Deprivation Ranking, 21% of service user's registered GP surgeries are within the most deprived areas in England. This suggests overall alignment in service provision and priority areas to reduce health inequalities across Norfolk and Waveney Integrated Care Board.

Figure 2: Bar graphs showing distribution of patient age profile and areas of deprivation.





This pilot highlighted the complex profile that many patients accessing the social prescribing service have (objective 1). Patients presented with a range of causes and co-morbidities, many of which meet the ICB and national priorities for reducing health inequalities as identified in the Core20PLUS5. Table 2 shows the top ten referral reasons that 12% of all referrals were categorised as social admissions, and a further 12% as falls; these were the most common reasons given for social prescribing and were also responsible for the highest percentage of admission avoidance (Table 3).

Table 2. Service user presentation to social prescribing service

*Reason for referral N (% total referrals)	**Social Admission	45 (12%)
	Falls	45 (12%)
	Confusion	22 (6%)
	Infection	21 (6%)
	Substance misuse	19 (5%)
	Cancer	17 (5%)
	Fracture	15 (4%)
	Cardiac	15 (4%)
	Frailty	14 (4%)
	Stroke	14 (4%)
Core20plus5 Comorbidities N (%)	Yes	169 (44%)
	No	213 (56%)
Comorbidities N (%)	Diabetes***	43(25%)
	Respiratory Disease***	39(23%)
	Mental Health***	32(19%)
	Cardiovascular	18(11%)
	Dementia	17(10%)
	Hypertension***	14(8%)
	Cancer	3(2%)

	Early Cancer***	2(1%)
	Frailty	1(1%)

**Reason for referral: these include the top 10 reasons, a full list can be found in Appendix 3.*

***Social Admission: In all cases the concern has been with a persons decline in health leaving them unable to cope at home either physically and/or mentally. In many cases social isolation and loneliness has been sighted during the personalised conversations. In some cases it has been a financial concern where the person has not had adequate access to maintain their health through nutrition, home environment (heating, water)*

****Core20plus5 co-morbidities: these are highlighted conditions within national and local ICB Core20plus5 priorities*

Objective 2: Describe the activity completed and support provided to patients.

Data reflects the social prescribing patients' varying needs, as shown in the differing admittance to care methods in response to their acute needs. Whilst 53% (n=175) of patients initially accessed care via ambulance, 14% (n=46) were non conveyed and 23%(n=77) attended A&E (Table 3).

Table 3. Social Prescribing service involvement

Outcome for service N (%)	Admission avoidance	101 (26%)
	Discharge	281 (74%)
Social Prescribing activity* N	Environment	134 (35%)
	Physical Health	113 (29%)
	Mental Health & Wellbeing	87 (23%)
	Financial	48 (13%)
Admittance Method N (%)	Ambulance	175 (53%)
	A&E	77 (23%)
	Non-Convey	46 (14%)
	Admission Avoidance Mental Health	20 (6%)
	Clinic	11 (3%)
	Emergency Assessment Unity for	1 (1%)

**Environment: Social prescribing is being utilised to support elements, factors and conditions in the persons surroundings which may have an impact on their physical and mental health and wellbeing*

Physical Health: Social prescribing is being utilised to support a person in their ability to perform aspects of daily activities, following acute illness, injury. Helping them to remain independence as determined through a personalised conversation.

Mental Health and Wellbeing: Social prescribing is being used to support someone in improving their mental health and wellbeing.

Financial: Social prescriber supports the person to understand the situation and how it is affecting them, connecting them to voluntary sector and local authority services and/or utilising a OOPHB to allow someone to leave hospital or stay at home in a safe and timely manner.

Table 4 shows that 45% (n=170) of referred patients received a One-Off Personal Health Budget (OOPHB) to support their specific need. Moreover, the support required had a standard deviation between individuals of £286. This reflects the flexibility that social prescribers have to follow person-centred conversations and decision making to use the budget selectively as opposed to routinely. Additionally, 12% (n=45) of patients received advice from the social prescribers. This might have included referrals to other services, support with benefits, health coaching or links to community and highlights the knowledge and links the social prescribers have developed to ensure patient needs are supported.

Table 4: The distribution of OOPHB

OOPHB receipt N (%)	Yes	170 (45%)
	No	212 (55%)
Mean OOPHB cost (N, Range, SD)		£129.03 (170, £1662-£14.99, £286)
Support provided by social prescriber	Goods	139 (36%)
	Services	198 (52%)
	Advice	45 (12%)

Outcome 3: Exploring outcomes for patients, the service and wider system

Outcomes for both the service and service users have been presented and recorded in Tables 5 -9 and Figure 4. The data suggests the service has influenced a wide range of health outcomes, indicating an ability for the service to impact patients across a variety of factors. Table 5 shows the range of patient health outcomes recorded by social prescribers. These outcomes highlight the difference the service has made to patients' quality of life, for example improvements in independence (n=98, 26%), feeling safe (n=120, 32%), able to remain at home (n=23, 6%), and managing a long-term condition (n=24, 6%).

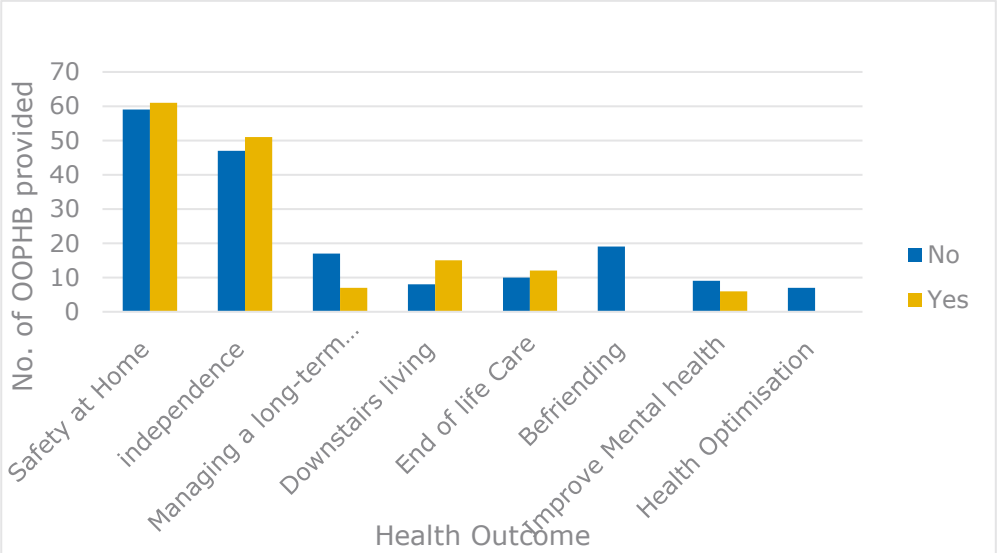
Table 5: The ten most cited health outcomes for patients engaging in the service.

Health Outcome N (%)	Safety at Home	120 (32%)
	Independence	98 (26%)
	Managing a Long-term condition	24 (6%)
	To remain at home	23 (6%)
	Downstairs living	23 (6%)

	End of life care	22 (6%)
	Befriending	19 (5%)
	Improve mental health	15 (4%)
	Rehab at home	13 (3%)
	Health optimisation	7 (2%)

Figure 3 reflects the budget across patient outcomes. It is evident that besides befriending, which required no budgets, there is a split of OOPHB requirements across health outcomes. This further reinforces the individual nature of the budget provision based on circumstance, as opposed to the inclination for budget expense to be skewed towards specific needs and outcomes.

Figure 3: OOPHB provision based on patient intended health outcome.



Tables 6 and 7 show re-admission rates and the calculated costs respectively. The data provided by Norfolk and Waveney ICB suggests that secondary care services have benefitted from an average of 5.3 bed days saved per referral, a total of 2032 bed days were saved because of the service. Moreover, the range shows that the system benefitted from 42 bed days saved in one case. The bed days calculation is inclusive of the referral criteria of a minimum of 2 bed days saved for the patient. In addition, only 7% (n=17) of service users were re-admitted to hospital within the 3 months after discharge, whilst 3.5% (n=9) passed away. These compare positively against all Norfolk & Waveney emergency re-admissions within 30 days, which was 12.6% and 12.7% in 22/23 and 23/24 respectively.

Table 6: Re-admission rates within patients

Re-admission in 2 weeks N (%)	Yes	11 (4%)
	No	300 (95%)

	RIP	3 (1%)
Re-admission in 3 months	Yes	17 (7%)
	No	230 (90%)
	RIP	9 (3%)
	Declined crew*	1 (0%)

**Declined crew: service user refused convey to hospital*

Table 7: Calculated economic outcomes of the social prescribing service.

Mean hospital bed days saved (Sum, Range, SD)	5.3 (2032, 42-1, 6.1)
Mean estimated cost benefit of bed days saved (Sum, Range, SD)	£4582 (£989,736, £33,642 - £801, £5209)
Mean value of system saving (Sum, Range, SD)	£4539 (£975,989, £33,642-£119, £5226)

A linear regression analysis was conducted to understand any associations between Social Prescribing FTEs and A and E attendances or in-patient costs. Association is a very general relationship between two variables: one variable provides information about another. We can see that, the PCN, year, and quarter all have significant impacts, unlike social prescriber FTEs, for both cost and attendance (Table 8 & 9, Rows 1-6). However, for both, social prescribers have a significant association with year (Row 8, Table 8 & 9) and a significant association with quarter two for costs (Table 9, Row 10). These results suggest that whilst social prescribers don't have a significant impact on their own, they do have a significant association with the outcomes when the interaction with year is considered. Coefficient is a statistical measure of the strength of a linear relationship between two variables. In both cases, the coefficient of the interaction is negative, suggesting the increase in cost and attendance associated with more recent years is somewhat mitigated by greater social prescriber FTEs. An interaction occurs when an independent variable has a different effect on the outcome depending on the values of another independent variable. Therefore, there is the potential to suggest that the maturation of the social prescriber program has increased its effectiveness by reducing A and E attendances and the cost of hospital in-patient stay, but more data is needed to support this claim. Full results of the regression analysis and explanations of terms can be found in Appendix 3.

Table 8: Regression analysis of A&E attendances in association with PCN, Social Prescriber FTEs, year and quarter.

		Coefficient	T value	Significance
1	PCN_attendances	0.93817	17.964	***
2	SPs	-0.01452	-0.349	
3	Year	0.14490	6.559	***
4	Q_Mar	-0.14483	-5.569	***
5	Q_Jun	-0.01749	-0.776	
6	Q_Sept	0.08451	3.741	***
7	PCN_attendances: SPs	0.10943	1.638	

8	SPs:Year	-0.06711	-3.067	***
9	SPs: Q_Mar	0.02579	1.156	
10	SPs: Q_Jun	0.02277	1.085	
11	SPs: Q_Sept	-0.01812	-0.878	

*Significance codes; 0'***', 0.001 '**', 0.01 '*'*

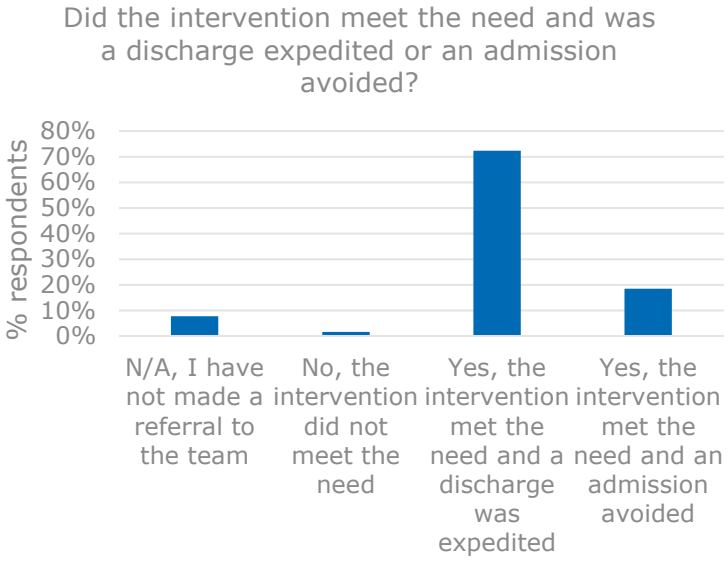
Table 9: Regression analysis of in-patient costs in association with PCN, Social Prescriber FTEs, year and quarter.

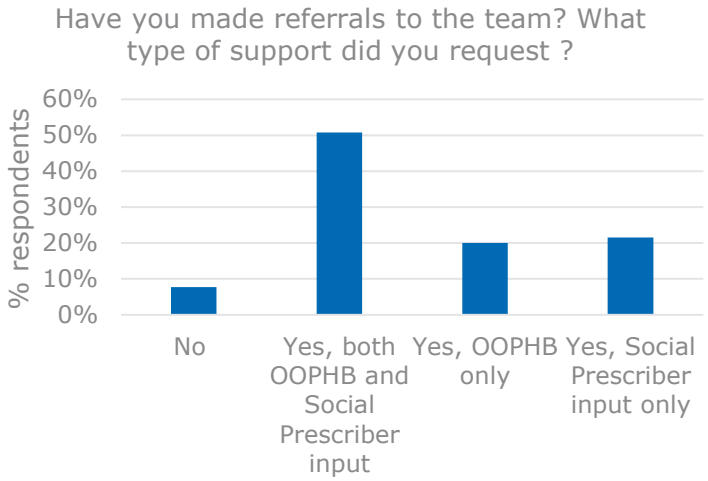
		Coefficient	T value	Significance
1	PCN_cost	0.855569	18.289	
2	SPs	0.006903	0.190	
3	Year	0.413939	11.671	***
4	Q_Mar	0.306338	-7.334	***
5	Q_Jun	-0.123459	-3.412	***
6	Q_Sept	-0.012206	-0.336	
7	PCN_cost: SPs	0.020386	0.507	
8	SPs:Year	-0.070781	-2.019	*
9	SPs: Q_Mar	0.038625	1.078	
10	SPs: Q_Jun	0.071053	2.108	*
11	SPs: Q_Sept	0.005214	0.157	

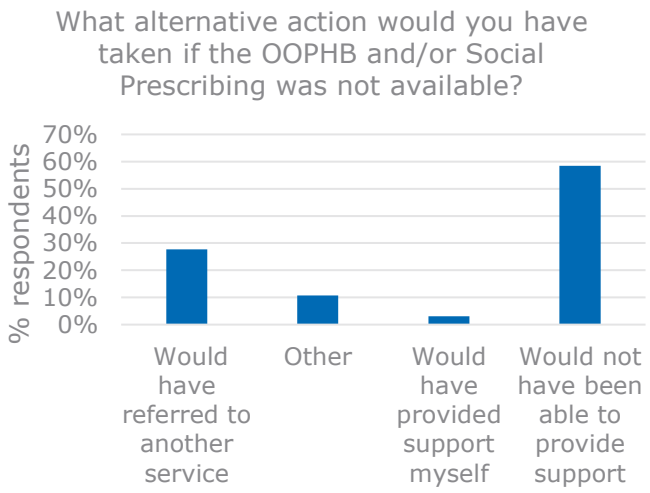
*Significance codes; 0'***', 0.001 '**', 0.01 '*'*

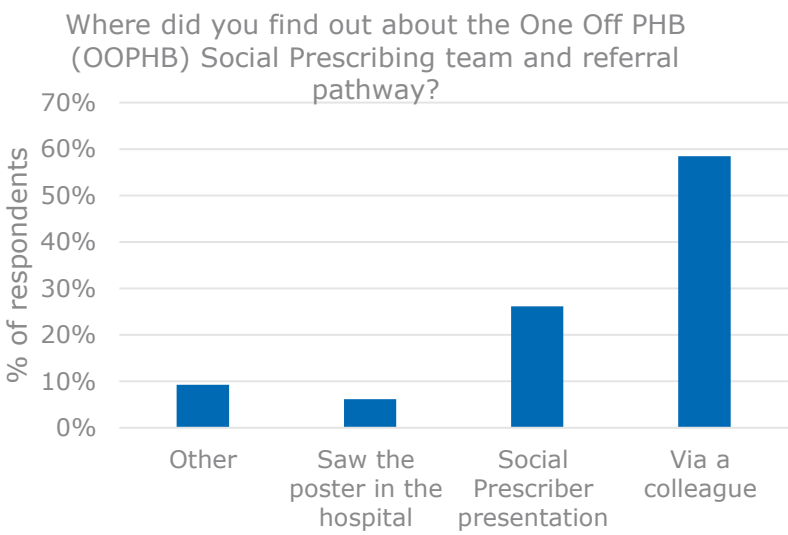
The staff feedback survey conducted by Norfolk and Waveney ICB received 65 responses from secondary care staff, 51 of whom had referred patients to the social prescribing service during the pilot (Figure 4). Survey responses showed that 90% (n=59) of referring staff felt that their needs were met. Only one respondent reported unmet needs, categorised as expedited discharge and admission avoidance. Of those reporting needs were met 20% (n=12) said an admission was avoided and 80% (n=47) said a discharge was expedited; this aligns with the service's objective for a reduction in admissions (projected 101 admission avoidances). The majority (58% (n=38) of respondents reported finding out about the service via a colleague (word of mouth), suggesting that growth was organic and highlighting the potential for increased engagement as the service becomes embedded into the system. Of those who had made referrals to the team, 55% (n=33) were requesting both OOPHB and Social Prescriber input, 22% (n=13) OOPHB only and 23% (n=14) social prescriber support only. Further explanations of staff experiences from the survey can be found in Appendix 4.

Figure 4: Bar graphs reflecting the staff experiences of the social prescribing service.









Summary of quantitative findings

- Synergy with ICB's Core20PLUS5 priorities: 21% of service users are from the 20% most deprived areas in England and 76% of reported patient co-morbidities align with target co-morbidities.
- Decreased burden on services:
  - Data shows successful admission avoidance and expedited discharge.
  - A total of 2032 bed days have been saved by the service leading to cost savings.
- Positive staff feedback: Staff utilising the service expressed satisfaction and identified gaps in provision if the social prescribing program is discontinued.
- Practical solutions with OOPHB: The availability of the OOPHB allows for need-based, person-centred approaches within the service.
- Holistic approach to user needs: Data highlights that over 34% of social prescribing activities/support during the pilot related to service users' environment, and an additional 13% addressed financial needs

Qualitative data from staff conversations

Objective 3: Exploring outcomes for patients, the service and wider system

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) planning and preparation; (iii) stakeholder involvement; (iv) challenges and successes; (v) lessons learnt; and (vi) sustainability and future plans.

(i) Goals and objectives

When asked to provide an overview of the goals and objectives they had in mind for the social prescribing service participants consistently highlighted the primary areas of focus as reducing hospital admissions, early discharge and supporting flow through the hospital. Participants reported that it was a primary aim to minimise the reliance on acute care services by addressing the root causes of health issues via social prescribing interventions, thereby **lowering the frequency of hospital admissions**.

> *'goals and objectives would be that we have people who get conveyed to ED because of a primary social care need. […] So that is one, not a good experience for the patient because going to ED is not going to sort out your social care needs, and also that's an avoidable conveyance. So, we're not offering the right quality of care to these patients. So that was kind of the background to how can we avoid or reduce avoidable conveyances but also give the people the quality that they are getting immediate care to meet their social needs.' (P01)*

Streamlining and supporting early discharge was mentioned by all participants as a goal to facilitate a smoother transition from hospital to community-based support, placing the focus on personalised interventions to enhance the discharge process and contribute to a more efficient and patient-centric continuum of care.

> *' [P03] wanted to see a more streamlined approach to discharge, a more coordinated integrated discharge route, for example, if somebody who's outside of a catchment area needed a key safe […] that could be provided to facilitate discharge so a microwave to heat up meals, environmental visits. They often do environmental visits now to help the discharge process. It's whatever they could do to speed up and support discharges and cut down bed days.'* (P03)

The concept of patient-centric care was also carried through into the goal of supporting flow through the hospital. Participants described focus being placed on optimising resource use by providing personalised support that enables individuals to be discharged from the hospital earlier but also to manage their own health conditions in the long-term, ultimately reducing the number of bed days and promoting cost-effective patient care. This was discussed in terms of being able to spend more time with patients to understand their needs and the barriers to them returning home.

> *'We don't just deal with the immediate issue. It's about that bigger question and supporting somebody to not be admitted or to be discharged, but it's about that longer term prevention and somebody not being readmitted.'* (P08)

Participants expressed additional goals of **alleviating NHS service pressure**, **ensuring equitable access**, and **fostering multi-disciplinary collaboration through social prescribing**. These aimed to address wider determinants of health to minimise

frequent medical interventions, tailored support, and to focus on equal access and inclusivity for health care.

> *'The social prescribing service, you know is much wider than that […]. It was equitable that there was best practice, that the workforce were trained, supported, that they were getting peer support. It was taking the learning of what we knew that social prescribers were able to do to support patients and asking those questions.'* (P02)

(ii) Planning and preparation

In the planning phase of the social prescribing service, participants emphasised a strategic approach, focusing on building relationships, raising awareness, and establishing efficient processes for seamless integration into the healthcare system. Activities included networking, stakeholder engagement, enhancing visibility across the hospital, and developing referral pathways and process maps; these were identified as key to ensuring alignment with organisational goals and operationalising delivery. A streamlined referral pathway was established to facilitate a quick and easy process for healthcare professionals to connect patients with social prescribing services.

(iii) Stakeholder engagement and involvement

Social prescribers, and the wider team, prioritised visibility by actively engaging with hospital staff in acute settings, walking the wards, distributing posters, and delivering presentations and training to raise awareness and understanding of personalised approaches to care. As the following quotes describe, the placement of prescribers in key locations aimed to foster collaboration, build trust, and promote service utilisation among both healthcare professionals and patients.

> *'I literally went around the whole hospital for about two months, just handing out posters, telling people who I was, what we're there for; […] it was just really making our presence known and that we were there.'* (P00)

> *'I try and go out and about as much as I can […] so people can see my face and see who I am.'* (P05)

> *'It's something which is always ongoing, is that constant re-educating, reminding, and updating other stakeholders on our success stories as well, really talking about the effectiveness of the service.'* (P06)

Stakeholder involvement in social prescribing services was diverse, encompassing professionals from various healthcare disciplines and organisations such as social care, occupational therapists, physiotherapists, doctors, nurses, social enterprise organisations, and the local authority. Participants reported that once professionals understood the nature and potential benefits of social prescribing and recognised its value, they were keen to be involved, reflecting a shared commitment to improving patient outcomes and overall healthcare delivery.

> *'We've been out and done work with some of the VCSE organisations to talk to them what we do. District direct, who are one of the key people we work quite closely alongside within N&N. People strategically within the N&N who are responsible for that urgent and emergency care element, and likewise those colleagues within the ICB.'* (P08)

(iv) Challenges and Successes

The implementation and delivery of the social prescribing service was reported as having encountered several notable challenges, reflecting the complexity of integrating an innovative approach into established healthcare systems. The most frequently cited challenges amongst staff related to information governance, and limited understanding of social prescribing, contracts, and support. The key challenges identified are summarised below:

Information Governance (IG) and IT Issues
Participants highlighted challenges in information governance, especially regarding sharing forms and creating a smooth referral pathway. Balancing privacy compliance and efficient information flow proved challenging, causing delays in the pilot with a tight timeline. Setting up the required IT infrastructure faced similar challenges, including integration, and ensuring patient information security, adding complexity to the implementation phase.

Limited Referrals
Participants highlighted a lack of referrals to the social prescribing service initially. They suggested that referrals increased as the pilot progressed, and this was attributed to time needed for healthcare professionals (HCPs) to develop their understanding of social prescribing and to recognise the potential impact on patient outcomes. Addressing this knowledge gap among healthcare professionals emerged as a crucial aspect of overcoming the referral bottleneck.

> *'Some of the cultural change was about resistance to the service, because they weren't sure of the benefits or threats […] some of it was about what are the boundaries.'* (P10)

Recruitment and Fixed-term Contracts
Participants spoke of how the recruitment process, especially with fixed-term contracts, presented challenges related to onboarding and team dynamics and staff retention. Stepped recruitment, with individuals joining the team at different points, led to variations in the levels of experience and seniority, and in some cases junior staff starting before senior members.

> *'One of the things that was a bit difficult was the stepped recruitment because we had a long period of trying to get people in post. And with a short project, it was a challenge at the beginning because we had everybody onboarding in different points. We had in some cases junior staff starting before the senior staff.'* (P08)

Organisational and System Buy-in
Participants discussed how the success and sustainability of the social prescribing service hinge on the buy-in from stakeholders, the Integrated Care Board (ICB) and wider system. Achieving this buy-in was identified as a vital factor for the project's continuation.

Successes
The key success of implementing social prescribing services, as reported by all participants, was achieving early discharge and admission avoidance through a holistic approach that considers the patient's overall needs. This involved utilising the OOPHB for to purchase interventions, like deep cleaning, and essential items to support early discharge and potentially prevent readmissions. Participants highlighted that success extended beyond individual patients, to positive impacts for the community and hospital by freeing up resources and beds within the broader healthcare system.

> *'Stuff like that, that would take weeks to sort out […] being sorted out within 24 hours of the request going in, and so actually the impact on patients is absolutely massive. One discharge affects five different people from the request going in, so actually the impact is absolutely massive. Within the hospital and within the community, if you got a discharge out of a bed somebody from the assessment unit goes into that bed, somebody*

from Emergency Department (ED) will go into the assessment bed, ED will take some of the ambulance and then the ambulance can go out to the community […] it's integral now to the role of the complex discharge chain. There's five people affected by 1 discharge.' (P03)

Participants described how another notable success lies in the bottom-up approach adopted by the social prescribing service.

'a bottom-up approach is the only reason we've been so successful.' (P07)

This approach was described as streamlining the referral process, making it straightforward and quick for healthcare professionals referring individuals into the service. Importantly, participants reported that this efficiency has not increased the workload of those making referrals, demonstrating that the integration of social prescribing can be achieved without placing additional burdens on healthcare professionals.

'I haven't had to do very much at all […]. It's great. Someone's just given me somebody that's done an amazing job which never happens, in fact it's the only time it's ever happened.' (P04)

(v) Lessons learned

Reflecting on the implementation of the social prescribing service, service leaders, healthcare professionals and social prescribers have identified key areas where they felt adjustments could enhance the overall effectiveness and efficiency of the service and may be useful to consider in relation to sustainability of the service:

Timing of introducing social prescribers to specialist teams - Service leaders expressed the desire to integrate social prescribers into specialist teams, such as therapy, palliative care and clinical coordinators on the wards, earlier in the process, recognising the potential for more seamless collaboration and improved coordination of care for patients.

'I might have started to introduce them around the specialist teams a lot earlier than I did. I think that's something I regret because we should have really advertised what they did and got them onto those team meetings sooner, got them up and running a lot quicker than we did.' (P03)

Staffing structure and approach - There was recognition that technology, like the Joy app, facilitates efficient data capture and reduces requirements for additional reporting. This streamlined data collection process would, in turn, liberate valuable time for social prescribers, enabling a greater focus on direct patient interactions and support. There was a suggestion that this may provide an opportunity to consider the staffing structure and staff banding.

'We need the boots on the ground to do the doing, so to speak, and get out there […] we've got a digital process in place now which has transformed things, bringing in the Joy app, so all the data and capturing of information is now far more fluid.' (P07)

Timelines for set up and expectations - The challenges related to information governance and IT setup taking longer than anticipated were acknowledged. Service leaders recognised that this had impacted delays in the overall delivery time of social prescribing services, prompting a re-evaluation of the initial timelines and expectations.

Access to more patient information - emerged also as a need for social prescribers.

Time needed to embed the service and realise benefits - Participants expressed a collective sentiment that more time was needed for the project to fully realise its potential. This recognition considers the time required for setup, staff learning and the production of conclusive results demonstrating the efficacy of social prescribing in improving patient outcomes.

> *'It's only a year-long project, so you have very little time. So there needed to be a slightly longer lead time to do all the mandatory training and the inductions, and then be ready.'* (P10)

(vi) Sustainability and future plans

Participants emphasised several key strategies to ensure the continued success and expansion of the program.

Ongoing Funding - Participants highlighted the critical need for securing continuous funding to sustain and extend social prescribing services. The goal is to broaden the scope of the program, encompassing not only the acute setting but also extending into the unscheduled care coordination hub and community hospitals. A robust funding strategy is seen as essential to maintaining and expanding the reach of social prescribing across diverse healthcare settings.

> *'I absolutely think it's a really valuable service and I think we're so desperate that it continues […] it absolutely needs to be across the board. I think that's the first thing. And it does need to be in the acutes, all the different systems, but I think we are perhaps missing a little bit of a trick at the moment in terms of some of those community hospitals, some of those other beds where that does support that flow; people coming out of the acutes and going into the community hospitals or the beds within some of the care homes.'* (P08)

Improved recording and understanding of costs - Participants expressed a desire for a more nuanced understanding and effective recording of cost savings associated with social prescribing. This includes developing a robust method for capturing the financial impact of the service, not only in terms of immediate healthcare cost reductions but also in long-term benefits, such as preventing hospital readmissions and improving overall community health. A clearer understanding of the economic impact is seen as crucial for demonstrating the effectiveness of social prescribing and securing ongoing support. For example, the following description highlights some of the potential cost savings that are currently not captured:

> *'Over time measuring it […] there's some things we've done and the support workers I'm working with have said, "Well, actually the fire service hasn't been called out three times this month." There's been no extra support workers put on to provide extra care. The ambulance hasn't been called, the police haven't been out, the locksmith haven't been out. So, the savings are there.* (P10)

By focusing on these key elements, participants envision a sustainable future for social prescribing services that extends beyond the acute setting, incorporates multiple healthcare providers, and is supported by a well-defined funding strategy. The emphasis on strategic conversations and robust data collection reflects a commitment to future-proofing the service, ensuring its enduring impact on patient care and the healthcare system.

Discussion

This evaluation aimed to gain an understanding of the implementation and ongoing aspects of social prescribing delivery within secondary care in Norfolk and Waveney, including who accesses the service and for what reasons. The implementation of the social prescribing service in Norfolk and Waveney has provided valuable insights, revealing a spectrum of successes and challenges that offer crucial lessons for refinement and sustainability strategies.

Staff feedback identified that the key drivers for the social prescribing service was to reduce hospital admissions, expedite discharges, and reduce bed days. The greatest success cited by all interviewed participants was achieving early discharge and admission avoidance. This success is also reflected within the quantitative data which showed admission avoidance (n=101, 26%) and expedited discharge (n=281, 74%). Moreover, the regression analysis suggests that the Social Prescribing roles may mitigate increases in A and E attendance and in-patient costs when considered alongside the year. This highlights the potential for the service to reduce bed use and lead to cost-savings.

The use of OOPHB set the social prescribing service apart from other reported social prescribing models and facilitated a diverse range of support to be provided by the service. Examples included financial assistance to meet housing and physical and mental health needs. The documented health outcomes for service users were equally diverse, encompassing increased independence, social connection through befriending initiatives, and enhanced safety at home. These findings align with previous evidence(16,17) as well as the wider determinants of health model(7) asserting that health outcomes are intricately linked to the social, economic, and environmental factors individuals encounter. Regarding patient outcomes and system priorities, the data shows that patients benefitting from the service meet many of the ICB Core20plus5 priorities.

Challenges encountered during implementation included navigating information governance concerns, especially in sharing forms, establishing a seamless referral pathway, and integration with existing IT systems. These challenges are reflected within the social prescribing literature (11,12) and are not unique to the Norfolk & Waveney service. However, this highlights the time and resources needed to plan for and implement a new initiative. It is also important to note that the addition of the Joy app in June has helped to streamline the referral pathway and gather consistent data to realise the integrated discharge approach. Moreover, the platform offers the potential to improve data capture and data management, and going forward may address some of the challenges of IT integration and the use of data to monitor and evaluate the service. The recruitment process, particularly with fixed-term contracts, presented challenges related to onboarding, team dynamics, and staff retention. The stepped approach to recruitment reflected the stepped approach to funding the programme over time, as opposed to in one initial budget, meaning the team was built concurrently alongside the development of the programme. The benefit of this approach was the ability to build on already learned lessons and successes and ensure that the right people were recruited. Integrated Care Board buy-in was identified as essential for the project's success and sustainability, with challenges posed by the short timeframe and the complexity of demonstrating long-term benefits.

Staff expressed the need for a nuanced understanding and effective recording of cost savings associated with social prescribing. This is crucial for demonstrating effectiveness and securing ongoing support. Limitations in resource allocation for data collection and the impact of this on the ability to fully evaluate the economic impacts of interventions is a concern highlighted in

other Social Prescribing literature (9,11). This is an area that should be prioritised in future evaluations of social prescribing services.

Staff shared that key implementation activities included networking with key stakeholders, and engaging with and involving senior management, grassroots staff, and patients in the service design. The emphasis on visibility within the hospital, achieved through direct engagement with healthcare professionals, walking the wards, distributing posters, and delivering presentations, was crucial for raising awareness of the service, building trust, and fostering collaboration. The staff feedback survey highlighted that most staff learned about the service from colleagues (58%) or through presentations (32%), posters (6%), or other (9%). Over time, increasing awareness and staff buy-in would be expected to contribute to increased referral rates. These findings highlight the importance of engagement strategies, aligning the service with staff and patient needs, and fostering organic, experience-based promotion when implementing a new service. Further, the findings highlight the importance of communication and relationships between social prescribers and partners, and the time needed to embed a service. This is valuable understanding for successful future implementation of social prescribing programmes.

Strengths and Limitations of the evaluation

The introduction of the Joy software in July has allowed for consistent monitoring and case management. This provides a useful tool to ensure data is captured consistently; this was a strength in the approach adopted and will provide valuable efficacy data moving forward. Data that was collected and reported manually by staff was constrained by staff time and resources, and as a pilot service, there were some challenges with embedding consistent data collection methods across the programme. One result of this is a lack of pre and post data, limiting information relating to patient outcomes to social prescriber perceptions. Challenges of manual data reporting have also limited the rigour within some of the data provided for analysis, for example, data concerning costs and savings was limited, and how some of the data was categorised lacked consistency. However, triangulation of data using both quantitative and qualitative methodology has strengthened the robustness of findings. A key strength of the evaluation was the use of interviews to better understand the story behind the data, which adds valuable understanding to the implementation journey of Social Prescribing services.

Conclusion

The evaluation of the social prescribing service in Norfolk and Waveney reveals a nuanced understanding of its implementation, successes, challenges, and strategies for sustainability and reflects a comprehensive and collaborative effort to address community needs and challenges. The findings suggest improvements in supporting early discharge, admission avoidance, efficient referral processes, and effective utilisation of OOPHB, and that these have enabled a transformative impact on patient care and healthcare outcomes in Norfolk and Waveney. Challenges were encountered in the implementation and ongoing operations of the social prescribing service, including information governance, limited referrals during early implementation, and recruitment hurdles, however, these are shared experiences across social prescribing programmes. Lessons learned emphasise the importance of early integration with stakeholders, and the necessity for a sustained focus on healthcare professionals' understanding of social prescribing. These lessons learned particularly a better cultural understanding of personalised approaches, are believed to encourage the person-centred conversations being adopted as opposed to the current medicalised approach to discharge. Future sustainability strategies focus on funding, strategic conversations, and prioritising a standardised evaluation

process and improved cost savings recording to ensure the continued impact of social prescribing on patient care and the broader healthcare system. The implementation of social prescribing both locally and nationally shares successes and challenges that are integral considerations for sustaining the services. As it stands the Norfolk and Waveney service has positively influenced patient care and the wider system by supporting flow through the hospital. A strong foundation is in place, and alongside the findings within the report provide a positive opportunity to continue making a difference in the system and local communities.

Recommendations

Future implementation:

- Address the knowledge gap and culture among healthcare professionals around what social prescribing is and the service it provides.
- Onboard and introduce social prescribers to key services they will be working with at the earliest opportunity.
- Implement a thorough and standardised evaluation process, so that stakeholders can gather valuable insights into the long-term effectiveness and cost-saving potential of social prescribing, particularly considering patient outcomes.

Strategic planning:

- Develop a robust funding and implementation strategy for social prescribing services.
- Continue to develop services that support the wider determinants of health.

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Appendices

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Appendix 2: NHS England Standard model for social prescribing

1. Collaborative Commissioning and Partnership Working

a. Are you working with all partners, including VCSE sector leaders, local infrastructure organisations, CCG, local authority commissioners, primary care networks, referral agencies and local Health & Wellbeing Board to create a clear local plan for Social Prescribing?

b. Are you building strong local relationships with VCSE sector organisations and community groups? Are VCSE sector leaders and local infrastructure organisations involved as trusted partners?

c. Are local Primary Care Networks using their Social Prescribing link worker funding to commission link worker support from existing Social Prescribing schemes?

2. Easy referral from all local agencies

a. Do you have a wide range of local agencies confident to make referrals to the Social Prescribing link workers?

b. Before being referred to Social Prescribing, is the service fully explained and are people given choice about whether to be referred?

c. Are all GP practices using the new national Social Prescribing SNOMED CT codes? d. Are link workers valued as part of the general practice and primary care network team?

3. Workforce development

a. Is there training and support for local agencies to understand link worker roles?

b. Do link workers have access to regular 'clinical' supervision?

c. Do link workers have access to accredited learning and qualifications?

4. Link workers employed to give time

a. Do link workers have empathy, listening and coaching skills to motivate people, based on the 'what matters to me'?

b. Are link workers given time and flexibility to undertake home visits and build trust with people? Is this reflected in their caseloads?

c. Do link workers take people to groups and introduce them, ensuring they are comfortable and included?

5. What matters to you? Personalised support plans

a. Do link workers create a simple, personalised support plan with people about what support they can expect from services and what they can do to improve their own wellbeing?

6. Support to Community Groups

a. Funding – is funding available locally to commission VCSE organisations receiving referrals? Are community groups supported through grants? Is development support/funding available to fill gaps in local provision?

b. Safe referrals – are community groups and VCSE organisations supported to receive referrals safely, checking that they are insured, have first aid training (including mental health), basic health and safety, lone working, data protection, food handling certificates and DBS checks when working with vulnerable citizens?

c. Is support available locally to nurture and develop new community groups, including at local neighbourhood levels,

7. Common Outcomes Framework

a. Is the Common Outcomes Framework used to assess the impact of Social Prescribing on the person, the NHS and community groups receiving referrals?

b. Are CCG analysts able to work with local partners through data sharing agreements to track the person's use of the NHS, using their NHS number (with appropriate consent)?

Appendix 3: Quantitative methodologies

Data capture headings

Age; Gender; GP; GP Postcode; Index of Multiple Deprivation Rank; Index of Multiple Deprivation Decile; Ethnicity; Religion; Reason for referral; Social Prescribing Activity; Any key comorbidities? As per CORE20+5; PHB Cost; OOPHB Y/N?;Health Outcome (If OOPHB Provided);Goods/Services/Other; No. of Hospital Bed Days Saved (+2 Added for referral criteria); No. of other care setting bed days saved; Estimated Cost Benefit; bed days (Manual entry); Value of System Saving; Admission Date; Admittance Method; Discharge Location; Readmission in 2 weeks Yes/No?;Readmission Date;Readmission in 3 months? Yes/No; Readmission Date2; Discharge/Admission Avoidance/Other

Full lists

All recorded reasons for referral;

Amputation; Anxiety; Asthma; Bilateral Leg Ulcers; Brain Tumour; Breathing difficulties; Cancer; Cardiac; Cellulitis; Collapse; Confusion; COPD; Covid; Cystic Fibrosis; Delirium; Dementia; Depression; Diabetes; Domestic Violence; Eating Disorder; Failed discharge; Falls; Fracture; Frailty; Heart Failure; Homelessness; Homelessness, rapid decline in health; Hypertension; Hypothermia; Infection; Malnutrition; Mental Health; Mental Health crisis; Mobility; Multiple Sclerosis; Pancreatitis and Cholecystitis; Parkinsons; Planned Surgery; Poor Mobility; Post Op Hip; Post surgery; Pre Op; Pressure Ulcers; Rapid deterioration; Respiratory exacerbation; Safeguarding; Schizophrenia; Seizures; Sepsis; Severe Spondylitis; Shortness of Breath; Sleep Apnoea; Social Admission; Stroke; Substance misuse; Unknown; Victim abuse

All recorded Health Outcomes; Befriending

Caring responsibilities; Detox; Downstairs living; End of life Care; Health Optimisation; Improve Mental health; independence; Maintain Hygiene; Managing a long-term health condition; Nutrition uptake; Out of County; Rehab at Home; Return to Caring responsibilities; Safety at Home; Specialist child's chair; To remain at home

Regression analysis

The statistical analysis of social prescribing workforce data, alongside A&E attendances and cost of hospital in-patient stays, aimed to assess whether there was an association between more social prescriber full-time equivalents (FTEs) and fewer A&E attendances or lower in-patient costs. The Social Prescriber FTEs were sourced from the PCN Workforce series. The cost of non-elective in-patient stays and the number of A&E attendances were sourced from HES and ECDS respectively, both using a platform called Vantage. These metrics were both considered for just conditions most associated with social prescribing as per Norfolk and Waveney ICB, namely COPD, Diabetes, Stroke, Dementia, Incontinence (only A&E attendances), Sepsis, UTI, Osteoarthritis, Asthma and Fractures. Further data was sourced from Patients Registered at a GP Practice series, for population figures to be used for converting other values to a per 10,000 population rate, and ePCN (September 2023) to assign GP practices to PCNs and PCNs to ICBs. All the data was considered by PCN looking at the 17 PCNs in Norfolk and Waveney. The data was considered quarterly from June 2020 to March 2023. Linear model analysis was used to explore these variables including their interaction

with the number of social prescriber FTEs and significance was assessed through t values. Before running the analysis, the following pre-processing was applied:

Variables	Short Name	Type	Description
A&E attendances	Attendances	Output/ dependent	Rate per 100,000 population, Scaled (mean = 0, SD = 1)
Non-elective in-patient total cost	Cost	Output/ dependent	Rate per 100,000 population, Scaled (mean = 0, SD = 1)
PCN Code	PCN_cost PCN_ attendances	Input/ independent	Mean of dependent variables for that PCN, aka mean replacement**, then Scaled (mean = 0, SD = 1)
Year	Year	Input/ independent	Scaled (mean = 0, SD = 1)
Quarter	Q_Mar Q_Jun Q_Sep	Input/ independent	Dummy encoded* (omitting Dec)
Social prescribers FTE	SPs	Input/ independent	Rate per 100,000 population, Scaled (mean = 0, SD = 1)

*Dummy encoding: replace a categorical variable with n – 1 binary variables

**Mean replacement: replace a categorical variable with the mean for that category

Accident and Emergency attendances and cost of hospital in-patient stay metrics were considered for conditions most associated with social prescribing: COPD, Diabetes, Stroke, Dementia, Incontinence (only A&E attendances), Sepsis, UTI, Osteoarthritis, Asthma and Fractures. The Social Prescriber FTEs were sourced from the PCN Workforce series (22). The cost of non-elective in-patient stays and the number of A&E attendances were sourced from Hospital Episode Statistics (23) and Emergency Care Data Set (24) respectively (via Vantage platform). Further data was sourced from Patients Registered at a GP Practice series, for population figures to be used for converting other values to a per 10,000 population rate, and ePCN, a Primary Care Network data series (September 2023) to assign GP practices to PCNs and PCNs to ICBs. All the data was considered by PCN looking at the 17 PCNs in Norfolk and Waveney. The data was considered quarterly from June 2020 to March 2023. Linear model analysis was used to explore these variables including their interaction with the number of social prescriber FTEs and significance was assessed through t values.

Regression analysis of A&E attendances in association with PCN, Social Prescriber FTEs, year and quarter.

	Estimate	Std. Error	T value	Pr (>ltl)	
(Intercept)	0.01482	0.03262	0.454	0.650121	
PCN_attendances	0.93817	0.05222	17.964	<2e-16	***
SPs	-0.01452	0.04162	-0.349	0.727584	
Year	0.14490	0.02209	6.559	4.88e-10	***
Q_Mar	-0.14483	0.02601	-5.569	8.54e-08	***
Q_Jun	-0.01749	0.02253	-0.776	0.438647	
Q_Sept	0.08451	0.02259	3.741	0.000242	***
PCN_attendances: SPs	0.10943	0.06679	1.638	0.102961	
SPs:Year	-0.06711	0.02188	-3.067	0.002471	***

SPs: Q_Mar	0.02579	0.02231	1.156	0.249061
SPs: Q_Jun	0.02277	0.02099	1.085	0.279354
SPs: Q_Sept	-0.01812	0.02064	-0.878	0.381028

*Significance codes; 0'***', 0.001 '**', 0.01 '*'*
Adjusted R-squared: 0.694
F-statistic: 42.85 on 11 and 192 DF, p-value: <2.2e-16

Regression analysis of in-patient costs in association with PCN, Social Prescriber FTEs, year and quarter.

	Estimate	Std. Error	T value	Pr (>ltl)	
(Intercept)	0.027008	0.037274	0.725	0.469594	***
PCN_cost	0.855569	0.046781	18.289	<2e-16	
SPs	0.006903	0.036256	0.190	0.849206	
Year	0.413939	0.035468	11.671	<2e-16	***
Q_Mar	0.306338	0.041768	-7.334	6.09e-12	***
Q_Jun	-0.123459	0.036186	-3.412	0.000787	***
Q_Sept	-0.012206	0.036304	-0.336	0.737068	
PCN_cost: SPs	0.020386	0.040227	0.507	0.612887	
SPs:Year	-0.070781	0.035059	-2.019	0.044884	*
SPs: Q_Mar	0.038625	0.035832	1.078	0.282407	
SPs: Q_Jun	0.071053	0.033720	2.108	0.036404	*
SPs: Q_Sept	0.005214	0.033181	0.157	0.875306	

*Significance codes; 0'***', 0.001 '**', 0.01 '*'*
Adjusted R-squared: 0.7382
F-statistic: 53.05 on 11 and 192 DF, P-value: <2.2e-16

Appendix 4: Staff survey qualitative responses

(social prescriber) has been extremely forward thinking, positively supporting patient discharge experience. *(Social Prescriber*) is very approachable and a valuable member of the discharge planning team.
(social prescriber) is a joy to work with and works tirelessly exploring all possible options to support patients that i refer to her. I am not sure where i would refer if i didn't have her to provide SP services and PHB funding. She is approachable and supportive, and always willing to speak to patients and understand needs
(social prescriber) was very supportive and expedited a safe and early discharge
Very easy referral process. Team very helpful. Excellent communication. Made my job so much easier.
Response from the social prescriber i have contacted has been good, but there has been issues in regards to continuity of care when they have been unavailable, and communication has prevented a speedy service.
They responded quite quickly
Always positive & knowledgeable.
I found the Social Prescriber very approachable and most helpful. It was great to have another pair of helping hands on board
Fantastic. Very quick turn around. Friendly staff. Very good service.
(social prescriber) based at the *(….Hospital*) is always helpful, informative and very supportive. We always appreciate his input.
It took longer than expected to get the result for the patients needs
(social prescriber) is always available to offer support suggestions or practical input. I've avoided admission and expedited discharge with his support!! Thanks
I have never had any reason to refer to the service so cannot comment if the service is effective since commencement of this position
N/A I have not yet come across a patient to refer.
I have had mixed experiences - on some occasions the responses have been speedy and have supported with quick and timely discharges. On another occasion, for a patient who was Fast-Track, the response was incredibly slow and disorganised, and the patient's discharge was delayed by at least a week.
Provided a good service for the patient to return home but received numerous emails requesting infromation which had already been
Helped to fund a deep clean and move furniture with expedited discharge.
(social prescriber) always responds quickly to referrals & gives feedback if unable to help
Timely responses, good communication
THe personal health budget has been valuable in facilitating discharges for patients when they need to purchase equipment or items eg microwaves, beds for downstairs, and even transport in some cases. it reduces length of stay and takes pressure off services.
Have used via our case manager to help pay for a taxi for an out of area pt to get home so no direct contact but I had a call between *(social prescribers)* to learn more about the

hospital social prescribing service which was really useful and I now understand the criteria better so this prevents me sending inappropriate referrals.

I worked alongside *(social prescriber)* to facilitate a hospital discharge which involved a gentleman returning back to his caravan. Without this support, discharge would have been delayed and services would have proven difficult to assist this gentleman taking into consideration his living conditions. Gentleman was able to return to his caravan as he wished. Communication with *(social prescriber)* was consistent and always willing to assist and support where she could.

I have found all social prescribers helpful, resourceful, approachable,.
I have no feedback to improve

my experience of working with the social prescribers has been excellent. I have mostly spoken with *(social prescriber)* and she has always been quick to respond to emails, happy to talk things through with me and offer me advice. Always polite and helpful!! I have really come to rely on the support of the social prescribers and I really hope it is able to continue.

great team very helpful,

All my interactions have been very positive. As an occupational therapist I have worked on several occasions with the team to facilitate discharges and improve the quality of life for patients who are palliative or at the end of life. I have liaised with *(social prescribers)* - they have both responded quickly and given me easy ways to contact them- It is very helpful not to have to complete time consuming and lengthy forms for referrals. I hope the service continues.

Good Experience with Social Prescriber. Good Service but I think better communication of what they offer and how they work would have been beneficial.

Incredibly helpful and informative. *(social prescriber)* has been invaluable to the referrals that i have made and have acted on it quickly and efficiently. Support provided has made a huge impact on the patients and family in need of the further support.

Very kind and helpful x

Very quick response, very helpful service which has enabled many discharges in a much quicker time frame than if we didn't have use of the service. *(social prescriber)* from the PHB team is always efficient and helpful often going above and beyond to help us make arrangements for discharges. He also helps with contacting families when we are extremely busy.
(social prescriber) has also been very helpful with discharges. I have found him to be very responsive, great communication and quick results.
Very much an important service which will have a detrimental effect on discharges if we lose this invaluable service

(social prescribers) are both fantastic social prescribers, always a quick response, have helped with admission avoidance and delayed discharge! Without their help we could've delayed a lot of discharged! They are both very friendly and helpful!

The social prescribers have been extremely helpful and flexible, with a good understanding of Recovery focussed practice that has allowed them to work to service user need.

My team hav used this many times and it has been invaluable to clients

(social prescriber) has ben so helpful and really good with her communication and availability

All contact has been professional and timely.

The Social prescribing team are always willing to help and support. Did all they could to achieve a discharge for the patient, kept the team updated and liaised with the patients family. A valuable team.

I would have needed to access other sources of support e.g via charities which would have taken much time and meant I could not move on to other priorities. Or referred to our complex discharge team for input as it was concerned with obtaining domestic equipment such as beds and chairs. I have found the service to be responsive and immediate: whilst prescriber has been available on site. I have team members who have used the service for social prescriber

My SU has been thoroughly enjoying their support with the gym and I have seen huge improvements with their confidence because of this.

They have been able to 'unblock' a discharge by funding the provision of an item or service which is simply not available through the NHS or Social Services at all or not accessible in a timely enough way to allow for a discharge to go ahead as planned. We would frequently have ended up trying to place a patient in some form of short term bed, necessitating a long delay in discharge, without the budget and/or the input of a Social Prescriber to allow them to go home as planned.

Helpful and efficient. Quick to respond to situation. Am also working with patient who has a social prescriber involved for an item that I would not have otherwise been able to provide and is going to have a big positive impact upon patient at home.

The service provided by the team is absolutely incredible. They have gone above and beyond to help patients. Communication is amazing and often patients are seen within a matter of hours of referral. Such a relief to refer to a service knowing that the team have the patients' best interest at heart and the service is fast efficient and prevents admission avoidance as well as getting patient's home safely and in a timely manner.

Brilliant. Always happy to help, or direct me to someone who can. Very knowledgable and a great service.

Very positive experience, very knowledgeable and were able to support the patient with practical support that was essential for discharge and improve quality of life. A much needed and appreciated service

The social prescribers team have been very helpful in regards to aiding with patient's discharge. I have had multiple patients that have benefitted from their support. *(social prescriber)* has been a great support, always able to help. The service is very prompt with referrals and putting interventions in place.

I work alongside *(social prescribers)* at the *(…..Hospital*). I have found them both to be extremely helpful, professional and friendly. I have used the service several times and have always been very happy with the service they have provided. I have never had a discharge delayed due to the support they have given.

Brilliant service and such a support for the hospital.
Very versatile and able to accommodate most requests to get patients back home without delay. Always happy to help and the patients and ward are grateful to have this service available to us.

Brilliant

Its been amazing. Patients have hugely benefitted**,** and it would be so devastating to lose this process. *(social prescriber)* has been so good and its been brilliant to have worked with her.

A great service to have access to in the community hospitals. The consistent support is helping to discharge patients in a timely manner. Thank you all again.

The SP response to referrals was very quick, communication was kept up to date and engagement was very professional. ASC frequently use the Social Prescribing service and often recommend other professionals to the service More Social Prescribers in all the areas are required as it is a most valued service.

(social prescriber) has dealt with some very complex cases recently, without her involvement and advice i am unsure how some patients would get discharged. The patients have required input from a number of services, and *(social prescriber)* has coordinated the responses and managed the situations very well. *(social prescriber)* has great personal skills, and is always willing to help where she can. Even if cases cannot be supported with PHB/Social Prescribing, she will still offer advice and assist. *(social prescriber)* has a 'can do' attitude and will be creative in looking for solutions. *(social prescriber)* is a wonderful asset to the team and it is a joy to work with her, thank you.

service is amazing, referrals picked up so quickly and job done immediately. If there is an issue team contact us straight away without any delay.

overall good communication, great feedback in a timely way, reduced discharge timespan as well as offered face to face contact with patient.

Always had positive outcome with Social Prescribers whenever I have needed them to support with discharge planning. Having this service on tap for discharge planning has been invaluable for patients and family alike

I think the team/service is a great idea, however little is known about the team/services available/services not available...some accessible flyers for practitioners & families would be very welcome :-)

Very helpful in taking direct action to resolve issues, and also in signposting/referring to other services

We recently were made aware of Social Prescribing when *(social prescriber)* visited our unit. Since then we have used the service, twice to expedite discharges. We are an amputee rehabilitation unit and our patients have very complex needs, which can impact timely discharges. The service has been flawless in it's delivery and has supported these patients to be discharged. Thank you so much.

the service has made so much difference to our patients, as a complex discharge planning sister, this service is so valuable to support safe, quick discharge from the acute setting. *(social prescriber)* is totally amazing, nothing is to much to ask, she supports the patients and a wonderful colleague to work with too

The social prescriber has been pivotal in providing support for discharges from the trust. Without this service the length of stay within the acute would be considerably delayed.

I have referred many times to the social Prescriber at the *(…hospital*). She has always been able to support and has always gone out of her way to support the discharge. In one week alone I alone referred at least 3 times and they have resulted in the patient being able to be discharged. This is an invaluable service and without it we would be keeping patients in hospital needlessly, sometimes for many days.

Quick response to referral and *(social prescriber)* provided great communication throughout keeping us up to date. *(social prescriber)* is always on hand to answer queries and support where possible.

When referring to the social prescriber, the referral was responded to quickly and efficiently. Very well explained and helpful. Great service

Appendix 5: Case Studies

Case study 1:

Admitted during winter pressures with blood sepsis, and other infections, reoccurring, resulting in multiple admissions, pt was required to have hyperbaric therapy treatment, which is only available at the JPUH, and Pt lives in [….]. Pt was medically fit, and didn't require being in an acute hospital bed, however needed the treatment once daily for 34 days, and unable to travel back and forth due to not being able to drive and cost it would have to them.

- Needed transport to and from home address to [….] for 34 days.
- Unable to arrange transport, due to limited funds, and distance.
- Pt's health unable to allow for public transport.
- Would have had to stay as an inpatient for 34 more days.

What we did:
We explored all voluntary options, friends, and family, and were unable to get an outcome from any of these.

- Got quotes from multiple taxi companies and around [….]and [….].
- Tried other funding options, red cross, Age uk, etc.
- Used a local taxi company who gave a block deal.
- Gave patient choice around taxi's, public transport, fuel substitution. (They chose taxi).

Patient's desired personalised health outcome(s):
Pt was able to attend [….] each day for the period in which they needed treatment. Having an impact on their overall health, reduced the risk of infection reoccurring. Pt was able to be in own home during this period which had a positive impact on their mental health.

- Able to remain at home.
- Able to attend treatment.
- Allowed a hospital bed to be free sooner if the OOPHB was not available.
- Pt had a personalised experience.

Cost:

- Taxi service cost - £9,000.00
- Estimated system saving - £14,250.00

Impact on Health Services:

- Short term impacts:
  - No. of Hospital Bed Days Saved: 34
  - No. of other care setting bed days saved: 0
- Longer term impacts
  - Patient has not been readmitted due to infection.
  - Mental health has greatly improved.
  - Patient remains living in own home.

Impact on Patient/Feedback – Pt was very happy with the service and outcome and was pleased to have been at home over the winter period rather than in bed in a hospital.

Case study 2:

- Service user had been temporarily removed from the waiting list for hip replacement surgery due to becoming deconditioned while waiting for treatment and putting on weight.
- She reported recently having a painful fall in a car park and said she needed to purchase a rollator but did not have the financial means to do so.
- Service user had been referred by her GP for dietary change support however said she had not heard anything for a while.

What we did:

- Service user was referred to 'Broadly Active' for advice and access to exercise facilities and has been attending seated exercise classes and aqua aerobics, which will not put too much pressure on the knee joint.
- With regards to dietary support, after several phone calls with her Social Prescriber, she agreed to self-refer to Slimming World which she can attend locally.
- To address the issues of falling in public, a One Off Personal Health Budget (OOPHB) was successfully applied for to purchase a rollator with a seat which Sally can use when out shopping.

Patient's desired personalised health outcome(s):

- To live more independently with a reduced risk of falls
- To manage her condition better on a day-to-day basis and condition her muscles around the knee joint.
- Qualify for hip replacement surgery through weight loss

Cost:

- £97.19

Impact on Health Services:

- Short term impacts:
  - No. of Hospital Bed Days Saved: 2 (based on the cost of a potential admission following a fall)
- Longer term impacts
  - Patient will be able to be receive treatment through losing weight, therefore allowing for the eventual reduction in waiting times routine knee surgery.
  - Other longer-term heath impacts from losing weight and exercise

Impact on Patient/Feedback

The patient has been given access to tools to manage her own health outcomes and make decisions to best address non-clinical issues impacting on her overall wellbeing. This patient has also been purchased equipment to live more confidently and independently on a day-to-day basis, which she otherwise would not have had the financial means to purchase.

Case study 3:

Case Study

Improving lives together
Norfolk and Waveney Integrated Care System

This is **Bob,** who has had several admittances over the past year due to falls and an diagnosis of cancer. He lives independently on a permanent traveller mobile home site. His deterioation has caused concern around his living arrangements and it was discovered that he had a rat infestation and a very cluttered caravan. Some of this was attributed to a another traveller he had been allowing to live with him who has now moved on.

Supporting MDT:
Red Cross
Discharge Team
Fire Safety Company
Social Services
Pest Control Company
Environmental Health
Neighbours
Dell House Care Home

Social prescriber had a **personalised, shared decision making conversation** with him and he expressed his concern about the state of his home but he still wanted to carry on living independently. He was worried about the flooring in his home as he didn't want to fall and if his rent was being paid as he had such a long stay in hospital.
Through working collaboratively, Bob was supported to have the rat infestation dealt with, take advice from environmental health and a fire safety check on his home to ensure that gas pipes had not be compromised by the rats. Bob was also supported with communication with his neighbours who organised the clean up of his van and new flooring to be laid, enabling Bob to return home safely. Red Cross supported with welfare advice and communication with hi landlord

Data:14 bed stays saved at a cost of £9,800.
OOPHB Cost:£310.00

Feedback: " I am so pleased to be back in my own home and being near nature that I love and haven't been able to having such a long stay in hospital. I am very thankful for all the support that has been put in and keeping me up to date. I was worried about my rent not being paid but that has all been sorted now, thank you"