Healthy London Partnership

NHS

Social Prescribing in Secondary Care

How to guide

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This document has been prepared by Family Action

family action Building stronger families

This report was prepared by

Family Action

Family Action is a charity committed to building stronger families and brighter lives by delivering innovative and effective services and support that reaches out to many of the UK's most vulnerable people. We seek to empower people and communities to address their issues and challenges through practical, financial and emotional help. We are experienced at running Social Prescribing services and related service models, such as our WellFamily service in both primary and secondary care.

For further information about our services, please see Family Action's website:
www.family-action.org.uk/what-we-do/

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Healthy London Partnership

Healthy London Partnership formed in 2015 and is supported by and delivering for London's NHS, London Councils, Public Health England and the Mayor of London. For further information, please visit: www.healthylondon.org/.

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About Healthy London Partnership

Healthy London Partnership formed in 2015 and is supported by and delivering for London's NHS, London Councils, Public Health England and the Mayor of London. Our aim is to make London the healthiest global city by working with partners to improve Londoners' health and wellbeing so everyone can live healthier lives.

Our partners are many and include London's NHS in London (Clinical Commissioning Groups, Health Education England, NHS England, NHS Digital, NHS Improvement, trusts and providers), the Greater London Authority, the Mayor of London, Public Health England and London Councils.

All our work is founded on common goals set out in Better Health for London, NHS Five Year Forward View and the Devolution Agreement.

About this document

Commissioned by Healthy London Partnership, this Social Prescribing in Secondary Care How to Guide is aimed at NHS commissioners and Senior Managers, as well as those directly in charge of implementation and delivery of the service from both the NHS and voluntary providers.

This document can be used to improve London's health and care by enabling the efficient and effective commissioning, implementation and ongoing delivery of Social Prescribing Services in Secondary Care. The Social Prescribing model allows for increased links between clinical care, social care and voluntary sector networks, enabling people to tackle mental and physical health issues that see them frequently attend or return to Primary and Secondary Care.

Introduction

How to use this guide

In the past, Social Prescribing has primarily been delivered in primary care. Using learning gained from our pilot Social Prescribing Service in Secondary Care ('Family Action's pilot service') Family Action has developed this guide to implementing Social Prescribing in Secondary Care. This guide assumes that a Social Prescribing Service in Primary Care already exists and that a voluntary provider will be commissioned to supply the Social Prescribing in Secondary Care Service.

It is beneficial for the Social Prescribing service to be provided by a voluntary organisation, rather than by the NHS itself, as these organisations often have a number of existing links with services available in the community. Voluntary organisations are also trusted by service users as being separate from the state.

Section 1 contains details on what to consider when deciding if a Social Prescribing service in Secondary Care is right for your situation, and if you do wish to deliver this service, what to be aware of in the initial planning stages. It is intended to support Commissioners and Senior Managers.

Section 2 contains information on how to implement a service once it has been commissioned. It is intended to support managers (from both the hospital and the voluntary provider) who will be directly in charge of implementation and delivery of the service.

Section 3 contains helpful resources to support decision-making and service delivery. It is intended to support all sections and gives further detail on earlier content.

What is Social Prescribing?

NHS England describes Social Prescribing as "helping patients to improve their health, wellbeing and social welfare by connecting them to community services which might be run by the council or a local charity."[1] Community services could range from art classes to walking clubs or support groups. Social Prescribing enables health care professionals to refer people to a range of non-clinical support, often via a Link Worker who coordinates what is available in the community for a social prescription. It is intended to help people to have more control over their lives, avoiding them becoming trapped in a 'revolving door' of services.

[1] NHS England (2018) https://www.england.nhs.uk/contact-us/privacy-notice/how-we-use-your-information/public-and-partners/social-prescribing/

Social Prescribing is particularly suitable for people who:

- are lonely or isolated
- have long-term conditions
- use the NHS the most
- have mental health needs
- struggle to engage with services
- have wider social issues e.g. debt, housing problems, employability issues, relationship problems
- are carers

Policy background

The Mayor of London, Sadiq Khan, is supportive of Social Prescribing, including as a key objective in the draft Health Inequalities Strategy that it "becomes a routine part of community support across London."[2]

Social Prescribing models also support the aims of the NHS Five Year Forward View (2014)[3] to support people more holistically, linking health with social care and other support needs, and ensuring that there is a focus on prevention and early intervention.

The Five Year Forward View, General Practice Forward View (2016)[4] and draft Health Inequalities Strategy all recognise the important role that the voluntary sector and a community based approach can play in supporting wellbeing and reducing pressure on health services. The Social Prescribing model is particularly relevant to this, as not only does it link patients to community activities, but the provision of the service by a voluntary sector organisation also enables them to use their existing community relationships to strengthen engagement with the service by service users.

[2] Greater London Authority (2017) Better Health for All Londoners: Draft Health Inequalities Strategy. p.87 Available from: www.london.gov.uk/sites/default/files/draft_health_inequalities_strategy_2017.pdf

[3] National Health Service England (2014) *Five Year Forward View.* Available from: www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

[4] National Health Service England (2016) *General Practice Forward View.* Available from: www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf

Existing evidence of Social Prescribing's impact in secondary care

A report on a Social Prescribing Service in Brighton and Hove, working in both primary and secondary care, states that 20% of an individual's health outcomes result from clinical treatment, and the remaining 80% comes from determinants such as social networks, physical environments and lifestyle choices.[5] A Health Education England study on Social Prescribing concluded that in order to best integrate an individual's health and care needs, services must move away from episodic care to the more holistic approach that Social Prescribing can form a part of.[6]

Social Prescribing service's enable people to access the right support at the right time[7] rather than seeking primary or secondary care that is not able to meet all their needs, or allowing an issue to escalate to require this level of care. In Bristol, Social Prescribing was shown to meet a variety of needs relating to an individual's wellbeing, such as reduced social isolation, as well as leading to reductions in attendance at GP surgeries8.

There is currently limited evidence on the impact of Social Prescribing in secondary care specifically owing to it primarily being delivered in primary care in the past.

A service in Rotherham running for four years found that there were reduced attendances at Accident & Emergency (A&E) departments, outpatient appointments and inpatient admissions for 80% of those who used the Social Prescribing Service four months after doing so[9]. In Blackpool, the High Intensity User Service, whilst not a pure Social Prescribing model, selects frequent 999 callers to receive telephone calls from an advanced paramedic to discuss and 'de-medicalise' needs. The paramedic then goes on to offer immediate access to appropriate support services. For the 100 callers selected for the pilot over 15 months, A&E attendance reduced by 93% and admissions reduced by 82%.[10] Family Action's pilot service evaluation showed that there were early indications that the service was enabling people to improve their ability to look after themselves, manage their symptoms and feel more

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[5] Community Works, Possability People and Impetus Community Navigation (2017) *Social Prescribing Extended Pilot Interim Monitoring Report.* Available from: www.bh-impetus.org/wp-content/uploads/2017/11/Social-Prescribing-Extended-Pilot-Monitoring-March-2017-Final.pdf

[6] Health Education England. (2016) *Social Prescribing at a Glance, North West England: A Scoping Report of Activity for the North West.* NHS, UK. Available from: www.hee.nhs.uk/sites/default/files/documents/Social%20Prescribing%20at%20a%20glance.pdf

[7] Community Works, Possability People and Impetus Community Navigation (2017) *Social Prescribing Extended Pilot Interim Monitoring Report.* Available from: www.bh-impetus.org/wp-content/uploads/2017/11/Social-Prescribing-Extended-Pilot-Monitoring-March-2017-Final.pdf

[8] Kimberlee, R. (2013/ *Developing a social prescribing approach for Bristol. Project Report.* Bristol Health & Wellbeing Board, UK. Available from: https://eprints.uwe.ac.uk/23221

[9] Dayson, C. and Bashir, N. (2014) *The social and economic impact of the Rotherham Social Prescribing Pilot: Main Evaluation Report.* Available from: www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

[10] Johnston, M. and Monteith, R. (2015) *Commissioning for Value: Reducing the number of high intensity users of unscheduled services* Available from: www.england.nhs.uk/rightcare/wp-content/uploads/sites/40/2016/11/casebook-blackpool-tackling-frequent-callers.pdf

positive.[11] It also showed that even given the short timescale of the pilot, over six months, the wellbeing related savings for the outcomes achieved for six people totalled £22,965.48.

With demand pressures facing both primary and secondary care, the expansion of Social Prescribing in secondary care models is required in order to ensure that the benefits of the model to both the system and individuals are not missed in this context.

[11] Family Action (2018) *Social Prescribing in Secondary Care Pilot Service Evaluation Report*. Available from www.family-action.org.uk/measuring-evaluation/impact/

1 Service Rationale and Planning

Is Social Prescribing right for your locality?

As stated, this guide is based upon the existence of a Primary Care Social Prescribing Service being provided in your area. This will be a first port of call for many, reducing attendance at secondary care services in some cases and ensuring initial integration work has been carried out with healthcare and the voluntary sector. However, many people do not access primary care for differing reasons and the Primary Care Social Prescribing Service should not just be relied upon as a referral route – it will be unlikely to be able to meet demand; will not be able to support those who have attended hospital outside of location borders; and will not be targeted towards the specific needs of those who access secondary care. It is also likely that it would take longer to embed its use into the hospital system than a specific Social Prescribing in Secondary Care Service.

Other things to consider in order to decide whether a Social Prescribing in Secondary Care Service would be suitable are:

- Do you have high levels of repeat attendances at A&E?
- Do you have a high number of non-elective readmissions?
- Do a high number of A&E users have long-term conditions or low to moderate mental health issues?
- Do you have a high level of discharge delays, resulting from non-medical issues e.g. social care?

The presence of these would suggest that resource savings and shifts, coupled with improved ability to meet targets through reduced demand and improved efficiency across the healthcare system are possible. Social Prescribing aims to do this by:

1. Reducing repeat A&E attendances and non-elective readmissions, allowing resource to be used elsewhere.

Social Prescribing offers a wide range of non-medical short and long-term support through community activities, the attendance at which may in turn:

- improve physical fitness
- improve independence and self-management of long-term conditions
- reduce social isolation
- reduce anxiety and depression and
- improve general wellbeing

From these outcomes it can be expected that individuals are less likely to attend A&E or be readmitted to secondary care on an emergency basis. It is also hoped

that they will require fewer GP appointments, or know when it is more appropriate to seek primary rather than secondary care support.

2. Decreasing the number of bed days a patient requires before discharge

Social Prescribing supports inpatients to transition out of hospital through the use of emotional support in the transition time between hospital and home. It also aims to reduce discharge delays where these are related to support available outside of hospital by coordinating that support. Social Prescribing can offer support to family members where the patient is too ill to liaise with the Link Worker, improving the likelihood the patient is adequately supported in the community following discharge.

3. Improved staff morale and reduced staff sickness

Reducing demand for secondary care services, and delays resulting from this would also be expected to reduce stress on staff, having the potential to improve morale and reduce sickness. Being able to ensure patients are getting the right support for their needs, rather than seeing them frequently return to secondary care would also boost morale. Social Prescribing is also an opportunity to improve the engagement of secondary care staff with what other services there are available to support them and their patients.

4. Improving integration with primary and social care and community support

The integration of primary and secondary care and social support ensures that no one falls through the cracks, or receives medical support, but does not have support to address the underlying social issues. Social Prescribing connects secondary care staff who refer in to the service to community provision for their patients, as well as with primary care staff who would usually receive discharge summaries but may not be able to prevent repeat attendance or readmission to secondary care through clinical support. The use of community activities to improve self-management of long-term conditions can also reduce GP consultation demand, the shortage of which can lead to people seeking secondary care in the first place.

Offering support to families where a patient is too ill to speak to a Link Worker, and referring them to social care and community care where appropriate also ensures that re-attendance at secondary care does not occur because the family as a whole felt unsupported to meet the patient’s needs.

Further details on the Theory of Change for a Social Prescribing in Secondary Care Service can be found in Section 3.

Referral criteria and patient journey

It is suggested that referrals are accepted for anyone over 18 in secondary care, or who has been discharged from hospital within the last three months (or within the last six weeks of discharge if supporting parents of child patients), provided that they are not:

- experiencing a mental health crisis
- actively suicidal e.g. have a plan in place
- severely harming themselves
- individuals with complex needs who require specialist support
- at risk of hospital admission owing to the high/complex level of need

It is useful to rate referrals on a red, amber, green scale (see p16) – up to red could be accepted, with the examples above going beyond 'red'. An example referral form is in Section 3.

Figure 1 (page 8) demonstrates the delivery pathway for a Social Prescribing in Secondary Care Service. Link Workers deliver the service to patients while they are still at the hospital, or in an accessible office sited close to the hospital within the community following discharge. The service can support during the discharge process. Following engagement with community services, Link Workers follow up with the patient to assess how beneficial support has been and whether anything else is required. This continues past the initial attendance at community activities, as patients are not expected to experience an immediate impact across all of their needs. In Family Action's pilot service, the average length of time service users received support for was just over seven weeks.

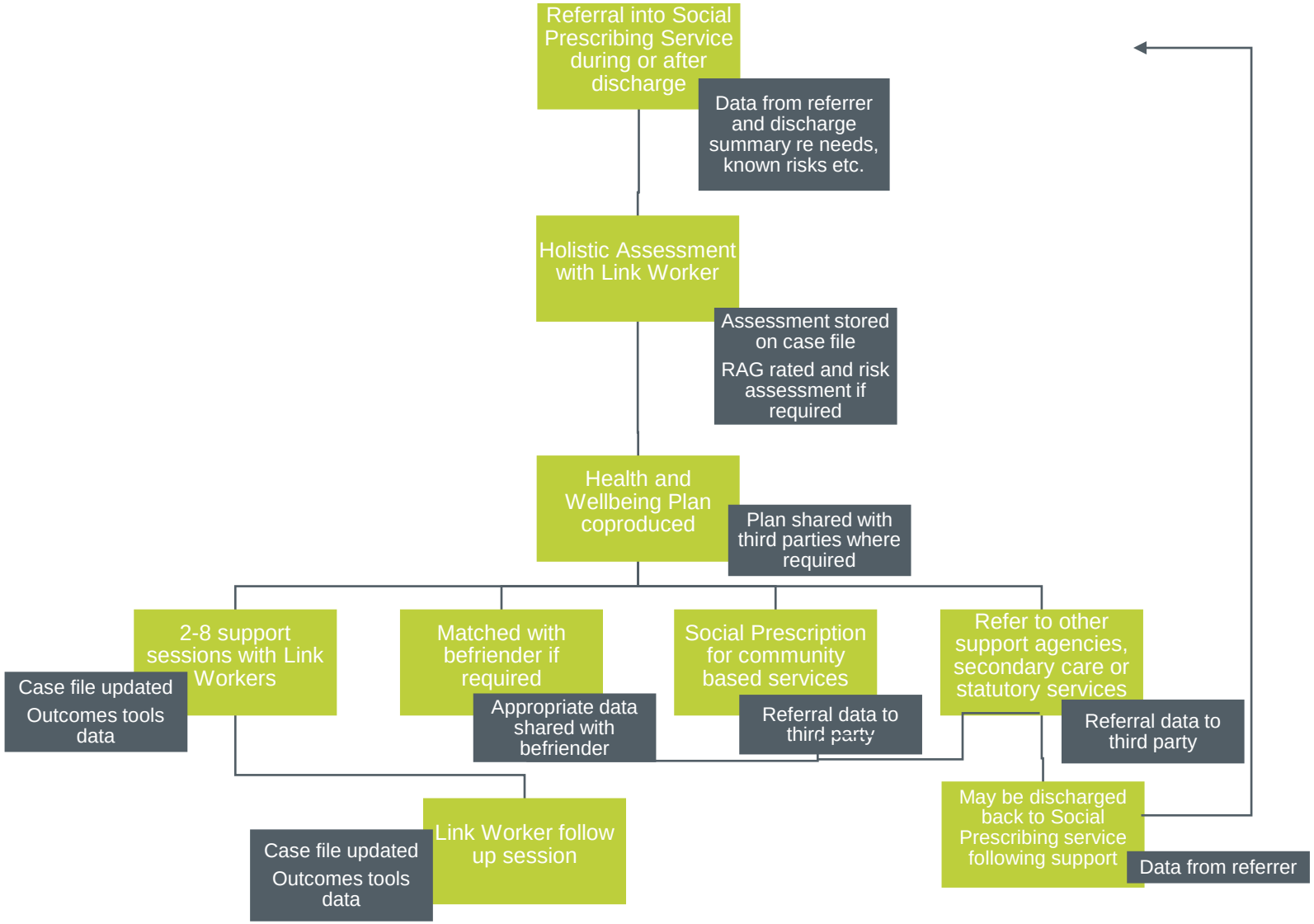


Figure 1: Delivery pathway for a Social Prescribing in Secondary Care Service

Figure 2: Example referral routes into a Social Prescribing in Secondary Care Service

Link Workers receive referrals from a wide variety of people, often including secondary care staff such as occupational therapists, physiotherapists, the discharge team and hospital based social workers. It is key that staff working on wards are engaged with the service's purpose and refer appropriately. Figure 2 demonstrates the various referral routes.

Key partnerships and commitments required

For the service to function well a number of people need to be committed, both within and outside of secondary care. An example project plan and RACI chart are both provided in Section 3.

Family Action's pilot service worked with a number of different staff in order to set up and continue to adapt delivery of the service. These included:

- Hospital CEO
- Divisional Operations Director
- Clinical Lead in Emergency Medicine
- Long-Term Conditions Clinical Lead
- Head of Integrated Discharge Management, Discharge Coordinators
- Integrated Independence Team
- Senior Nurse Emergency Services
- Improving Emergency Care Project Manager
- Urgent Care Programme Board

- Social Workers Integrated Independence Team
- Elderly Care Unit
- Community Mental Health Team
- CCG Acute Conditions Board
- CCG Communications Manager
- Non-clinical navigators
- Other hospital departments e.g. occupational therapy and maternity
- Primary Care staff

Before the Social Prescribing Service starts there needs to be agreement from clinical staff, senior management at the hospital and other services working within and related to the hospital regarding:

- Referral pathways and criteria
- Referral and case management systems
- Data sharing agreements and consent requirements
- Location of the Social Prescribing Service delivery
- Level of access Social Prescribing staff will have to non-public areas of the hospital

This ensures all are clear on how the service can be used, that it requires minimal staff time to do so, and Social Prescribing workers are recognised by other staff and have the most efficient access to patients. Existing services provided by and referred to from the hospital should be mapped by the appropriate secondary care staff in order to be clear on any potential overlaps and address these via clear referral criteria.

Commitment from senior level staff (both within the hospital structure and as heads of their staff teams) needs to be ongoing – it is not enough to support the creation of the service, but have no further involvement. Senior leaders need to cascade the importance of the service through the NHS hierarchy, continuing to communicate with staff about the purpose of the service and its benefits, and oversee the number of referrals to the service as part of performance management. They should also be ready to become involved should amendments to hospital processes need to be considered in order to facilitate the smooth delivery of the service.

Cultural change is required in secondary care in order to deliver an integrated Social Prescribing service, and this is likely to require staff training on the benefits of the service and how it sits within hospital processes. The independence of the service can be beneficial in relation to existing NHS hierarchies, where Social Prescribing staff are not so embedded in these that they are queried for talking to more senior staff where necessary in order to ensure the smooth running of the service.

It is helpful to consider whether systems can provide reminders to secondary care staff to utilise the service, such as through pop ups in the case recording system that ask if someone is suitable for Social Prescribing.

A steering group is a helpful way to ensure that all views and needs are represented during service set up and avoids miscommunication about the service. Once the service is set up it should ideally report directly in to an appropriate Board, such as the Urgent Care Programme Board to maintain strong relationships with key stakeholders, provide updates from monitoring data and agree any actions required as a result.

Timing and costs

It takes time to set up and embed a pilot service in a complex environment such as a hospital setting – implementation can take up to three months, and embedding of the service into secondary care pathways may take up to six months. The initial contract duration of the service must also take into account that a key part of Social Prescribing's effectiveness is a result of trust between the patient and their Link Worker; establishing this trust enables a person to take control of their circumstances, but this takes time to build.[12]

Logistics and Information Governance

For a Social Prescribing Service in secondary care to run most efficiently and effectively, space is required within the hospital setting for service staff to be able to visit patients on wards easily. This is also useful for hospital staff to be able to quickly and easily access workers when they think a patient may benefit from the service. Additional office space in a community setting that is easily accessible from the hospital may be beneficial.

Social Prescribing staff require access that enables them to move around the hospital freely - this aids partnership working and ensures patients can be visited for initial assessments. Key hospital staff working in departments that link in with Social Prescribing need to have been informed about this requirement.

Social Prescribing needs to be added to the hospital's case management system as a referral option, in order to support hospital staff to make referrals quickly and easily. If access to the case management system is not possible, a dedicated telephone line and email address will be required for the Social Prescribing Service to receive referrals. The Social Prescribing Service will also require an electronic case management system that enables service user data to be stored safely and securely, in a format that enables it to be anonymised for data analysis by the

[12] Polley, M.J., Fleming, J., Anfilogoff, T. and Carpenter, A. (2017) *Making Sense of Social Prescribing*. Technical Report. University of Westminster, London. Available from: http://westminsterresearch.wmin.ac.uk/19629/

organisation providing the Social Prescribing service, or any third party that is evaluating the service. It is ideal if this case management system is the same as that used by the hospital to enable joint electronic case management – in this way clinical staff in both primary and secondary care can see what outcomes have been achieved for the patient without relying on feedback from Link Workers, and Link Workers will already have access to the full data required at referral, such as known risks.

A confidentiality and consent policy and procedure that is agreed with key health professionals and the Social Prescribing staff helps to make it clear to all the basis for sharing data and what exactly can be shared. This ensures referral data is as comprehensive as possible, other factors are known, and outcomes in relation to attendance at secondary care will be able to be measured by the Social Prescribing service. This requires time to create, as the process is complex given that the Social Prescribing service is provided by a third party organisation which will be referring on to others.

2 Service Implementation and Delivery

Further details and supporting documents related to the content of this section can be found in Section 3.

Staffing

In order to ensure safer recruitment procedures can be followed, recruitment timescales of up to three months should be factored into the implementation process, dependent on scale of the service. Clinical supervision should be provided on a group basis once service delivery starts.

Table 1 (page 14) gives further information on a possible staffing structure. The Operational Manager's role is especially important for the staff team as a whole, as this ensures that their issues are heard, and meetings with key hospital staff can occur to alleviate any of these where possible, without impacting upon the amount of time available for service delivery and standard management functions, like individual supervision.

A Link Worker working within a well established Social Prescribing Service in Secondary Care for 40 weeks a year (to take sickness and annual leave into account), with referrals received at capacity throughout delivery could conduct up to 800 patient assessments. However, this figure is dependent upon where the service is based (as this affects travel time) and the time required to enter data into the case management system.

An example schedule for a Link Worker may be:

- Early morning: meeting at office, following up emails and planning the day.
- Mid-morning: hospital visits, meetings with hospital social work and discharge team, multi-disciplinary team (MDT) meetings.
- Afternoon: assessments, phone calls to service users and third parties, administration, MDT meetings.

A Link Worker should also have set days for sessions with service users and space within the diary set aside for urgent appointments, should they be required.

Table 1: Example Staffing Structure for a Social Prescribing in Secondary Care Service.
**Suggested pay rate does not take into account any London weighting*

Role	What they do	Level of support can deliver	Line managed by	Suggested pay rate*
Operational Manager 0.2 FTE	Oversee implementation Oversee quality of service delivery Ensure service aligns strategically with provider's other services and the hospital's needs	Supervise Service Manager. Time requirement increases should the service be big enough to require a coordinator as well as a manager	Senior Manager	NHS Band 7 pt 32-34 (£39,070-£41,787)
Service Manager 1 FTE	Oversee quality of service delivery Recruit and support Link Workers and befrienders Facilitate and continue engagement with hospital staff and other marketing efforts	Supervise max 6 Link Workers	Operational Manager	NHS Band 6 pt 24-27 (£29,626-£32,731)
Link Worker 1 FTE	Carry out assessments. Coordinate menu of support and ensure safe transition to accessing these	20 assessments per week Manage up to 6 befrienders, matching to cases	Service Manager	NHS Band 5 pt 20-23 (£25,551-28,746)
Volunteer Befriender	Assist service user to attend prescribed activities/support via emotional and practical support Add capacity to service	Dependent on needs of service user	Link Worker	Travel and lunch expenses, training and management costs

Assessment and safeguarding

Once referred to the service, an allocated Link Worker will contact the patient and carry out a holistic assessment – in Family Action's pilot service this was done within four working days. This may be within the hospital, at a convenient office location nearby or in the home.

The holistic assessment should look at:

- Age and particular needs that being very young or elderly may relate to
- Ethnicity and any adaptations that different cultural or language needs may require e.g. an interpreter
- Gender
- Occupation/source of income
- Key personal contacts
- Key professionals involved in care
- Physical and mental health conditions
- Reason for referral and referral origin
- Any additional needs not indicated at referral
- Details of any substance misuse and impact on the service user
- What is working well for the service user
- What the service user would like to change
- Initial scores on outcomes tools

As part of the assessment process, Link Workers should also ask safeguarding questions. Safeguarding questions asked during assessment in Family Action's pilot service are:

- Has the service user been a victim of violence or abuse?
- Has the service user been a perpetrator of violence or abuse?
- Has the service user been a victim or perpetrator of any other harmful practices?
- Is the service user a risk to themselves or others?

If the answers to these questions, and any others from the assessment lead to a case being RAG (red, amber, green) rated amber or red, this should require a full risk assessment to be carried out. Risk assessments should include what the risks are, who is at risk, and any action taken in order to manage the risk(s). Risk assessments should be submitted to the Service Manager for approval, and added to the case file. These should be reviewed regularly, as well as any time there is a change in risks. With red cases, relevant social services should be contacted to make sure they are involved. Concerns should also be shared with any third party organisation that is known to be involved with the service user.

In terms of RAG rating, Family Action's pilot service follows these guidelines:

- GREEN: where there are no identified safeguarding concerns (all cases are considered green at point of referral before an assessment is carried out).
- AMBER: where there are some concerns about a case and it needs to be monitored very closely in case of a need to escalate.
- RED: where a case already has social services involved and there is significant concern e.g. a referral has been made to children's social care for a Section 47 enquiry which has resulted in a case conference & Child Protection Plan or a safeguarding alert has been made for an adult suffering from abuse from a partner.

Monitoring and impact measurement

As discussed above, the holistic assessment of patients produces lots of useful management data. Other data that should also be recorded about a case includes:

- referral date and date case active from
- reasons referrals are rejected
- case closure date
- case closure reason
- cases escalated
- RAG rated caseload over time
- disengagement reason – e.g. where a patient has died or feels that the service is not right for them

In addition to the holistic assessment, this data may be collected through detailed recordings, review sessions, risk assessments and closing summaries. It can show trends in who does and does not access the service, where referrals are commonly received from and for how long someone typically requires the service. Any unexpectedly low figures in the data should also be investigated e.g. where demographic data do not match the local area data, or referral figures are low, but hospital staff have previously stated that they would use the service frequently. This data may show that there are barriers to using the service. Data on time taken between referral and support is also useful in order to see if there are any barriers to following up on referrals, or actions that make this particularly successful.

Output data that should be collected includes:

- the number of sessions/home visits received
- specific services provided

- the number of social prescriptions given
- which community services social prescriptions have been given for
- the number of families supported where these have not become cases on the system/are related to disengaged service users

Outcomes data

The level of detail and number of long-term outcomes that can be measured will depend on the budget for evaluation of the service, and the relevant data able to be shared by the NHS. It should also be kept in mind how long it will require for a service user to complete a monitoring tool or piece of data collection in order to ensure this is balanced with the time available for service delivery. Table 2 shows expected Social Prescribing outcome and possible ways to measure this – further details of possible outcomes tools to use are given in Section 3.

Data on short-term service user outcomes should be able to be collected regardless of the size of the service budget and service set up. However, the duration of the service will need to be long enough to collect pre and post data – change will not be instant for service users, and at least three months are likely to be required between initial assessment and case closure.

For other short term outcomes, these should also be able to be measured in most services. Access to data from the hospital about repeat attendances/readmissions to secondary care is needed in order to be able to measure whether the Social Prescribing service has any impact on reducing demand for NHS services – this cannot be measured by the Social Prescribing Service directly.

For long-term outcomes, these are likely to be much more difficult to measure, and reliant on larger budgets and/or Social Prescribing services running for a longer period of time.

User satisfaction data from patients and stakeholders should be collected frequently to ensure the service is being delivered effectively, as output and outcomes data may show that activity level is as expected, but this does not mean the service is truly delivering what is expected from it.

Table 2: Data collection to demonstrate outcomes

Short or Long-term	Outcome	Example measurement method
Short	Improved wellbeing of service users	Well-being Star
Short	Reduced anxiety and depression of service users	WSAS, EQ5D
Short	Reduced social isolation of service users	Well-being Star
Short	Improved physical fitness of service users	EQ5D, Well-being Star
Short	Improved independence and self-management of long term conditions	Well-being Star
Short	Greater awareness of service users of alternative support available	Service user survey NHS data per service user on repeat attendance/admissions and GP appointments
Short	Integration of primary, secondary and community care	Stakeholder survey at two points in time Referral origins and numbers
Short	Reduced demand pressure on secondary care	PAM NHS data on repeat attendance/admissions NHS data on general A&E attendance and waiting times
Short	Reduced discharge delays	NHS discharge data
Short	Reduced demand pressure on primary care	NHS data on GP appointments per service user
Long	Greater resilience of service users and ability to avoid future crises	NHS data on repeat attendance/admissions A&E High Intensity User Dashboard

Short or Long-term	Outcome	Example measurement method
Long	Reduced reliance on/more appropriate use of specialist interventions by service users	PAM NHS data on repeat attendance/admissions Patient data on ongoing needs NHS data on waiting times for specialist care NHS data on delayed discharge A&E High Intensity User Dashboard
Long	Improved staff morale and reduced sickness from stress	Staff surveys/interviews Sickness records
Long	Wider social value	Cost benefit analysis based on unit costs and patient journey data (voluntary sector and NHS) A&E High Intensity User Dashboard

3 Resources

Top five things to consider when implementing the service

1. Is there a high level of repeat demand for secondary care in your locality, suggesting a need for Social Prescribing?

2. Ensure that senior staff commitment extends beyond implementation into continued support and communication to staff about the need to use the service during delivery.

3. Ensure that hospital systems include the Social Prescribing Service as a referral option so that it is quick and easy for secondary care staff to use.

4. Site the service within the hospital or close by so that it is fully integrated into the system and can support during the discharge process.

5. Obtain data sharing agreements so that the outcomes of the service on primary and secondary care can be measured in relation to outcomes for service users, and staff are reassured about sharing data with a voluntary sector provider.

Example top level Project Plan

Phase 1 – Service Implementation

The Operations Manager (in conjunction with the Service Manager if they are already in post) should manage the implementation of the service and be the 'named person' at a local level to lead on agreeing the final comprehensive service specific Project Plan – this should include SMART objectives, key milestones, timescales, resource implications and an ongoing risk register.

The Implementation phase will focus on:

- Communication with all staff in the locality who are directly involved in the development of the services – to open an immediate line of communication.
- Recruitment, training and induction of Service Manager and Link Workers - to begin immediately.
- Recruitment of Volunteer Befrienders – to begin immediately.
- Service Manager and Link Worker to meet with Proactive Care Programme Lead and A&E Lead.
- Carry out a mapping exercise of community activity and provision.
- Use this mapping to outline initial Social Prescription menu for the locality to A&E teams, Primary Care teams and community and voluntary service – this will be added and amended throughout service delivery to meet service user needs and take into account other services opening and closing.
- Agree data recording/monitoring system and ensure training of Service Manager (if required) and Link Workers as soon as possible.
- Design and agree promotional material and Introductory Sessions for health care professionals.
- Begin commissioning process for external evaluator if required – depending on length of service delivery this may come later to allow data collection tools to be tested and amended first.
- Revise Risk Log throughout implementation.

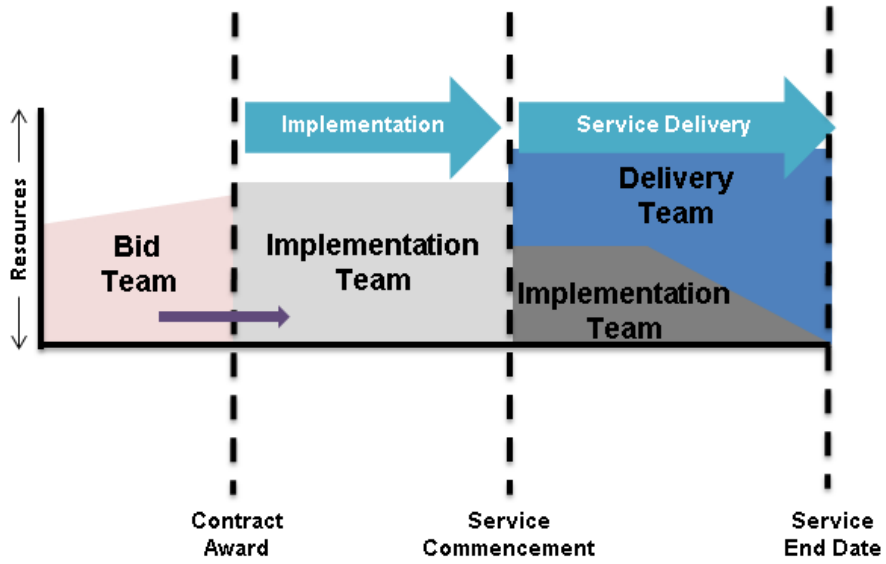


Figure 1: Phases of Project Plan

Phase 2 – Service Delivery

- Establish Performance Management and Quality Assurance systems
- Deliver induction and training for new volunteers as they are recruited.
- Locate staff safely and effectively within A&E department (or office space close to the hospital if this is not available), ensuring effective IT delivery and access to any systems required.
- Deliver a rolling programme of support for hospital staff to ensure effective identification of patients and appropriate referrals.
- Take referrals and start work with service users.
- Commence evaluation activity with external evaluator if required.
- Regular communication with commissioners about service progress.
- Update Risk Log as required.

Example RACI chart

Note that for all tasks in Family Action's pilot service, the commissioners were informed, however the level of reporting may differ depending on the length of service contract. Monthly or quarterly monitoring reports would be likely to inform commissioners that each task below has been completed.

Initial Planning Tasks	Responsible	Accountable	Consult	Inform
Draw up granular, weekly Project Delivery Plan to support tracking of timeframes for all tasks	Operational Manager	Provider's senior leaders	Hospital leaders	Commissioners
Create detailed Communications Plan	Operational Manager	Operational Manager and Head of Marketing and Comms	Provider's Marketing and Comms team	Commissioners
Establish Performance Management and Quality Assurance systems	Operational Manager	Provider's senior leaders	Commissioners	Service Manager, key stakeholders
Carry out a mapping exercise of community activity and provision.	Service Manager	Operational Manager	VCS network	Hospital key staff
Outline initial Social Prescription menu for the locality to Secondary Care teams, Primary Care teams and voluntary and community services – this will be added and amended throughout service delivery to meet service user needs and take into	Service Manager	Operational Manager	Secondary Care teams, voluntary and community sector services	Primary Care teams

Initial Planning Tasks	Responsible	Accountable	Consult	Inform
account other services opening and closing				
Revise Risk Log throughout implementation	Service Manager	Operational Manager	Hospital leaders	Commissioners
Staffing and Volunteers tasks	Responsible	Accountable	Consult	Inform
Advertise for Service Manager	Operational Manager, providers HR team	Provider's senior leaders	Provider's Marketing and Comms team	
Review applications and arrange interviews	Operational Manager	Provider's senior leaders	Provider's senior leaders	HR team
If successful, complete all safer recruitment checks and agree start date.	Operational Manager, provider's HR team	HR team	Referees, DBS	Commissioners, Payroll
If unsuccessful put out advert again	Operational Manager	Provider's senior leaders		Commissioners
Advertise for Link Workers	Service Manager/HR team	Operational Manager	Operational Manager	
Review applications and arrange interviews	Service Manager	Operational Manager	Operational Manager	

Initial Planning Tasks	Responsible	Accountable	Consult	Inform
If successful, complete all safer recruitment checks and agree start date.	Service Manager, provider's HR team	HR team	Referees, DBS	Payroll
If unsuccessful put out advert again	Service Manager	Operational Manager		Commissioners
Induction of Link Workers in month before service delivery starts	Service Manager	Operational Manager	Provider's HR team/training team	
Training of Service Manager and Link Workers	Provider's training team	Operational Manager/Service Manager		
Advertise for volunteers for the service	Service Manager	Operational Manager	Provider's Marketing and Comms team, HR team	
Schedule induction and training date for volunteers to be completed for launch date	Service Manager	Operational Manager	Provider's volunteer support staff	Link Workers
Continue recruitment of Volunteers	Service Manager/Link Workers	Operational Manager	Provider's volunteer support staff	Commissioners
Deliver induction and training for new volunteers as they are recruited	Provider's training team, Service Manager	Operational Manager	Provider's volunteer support staff	Link Workers
Logistics and delivery tasks	**Responsible**	**Accountable**	**Consult**	**Inform**

Initial Planning Tasks	Responsible	Accountable	Consult	Inform
Locate staff safely and effectively within A&E department (or office space close to the hospital if this is not available)	Provider's and Hospital's Facilities Managers	Senior leaders	Hospital Leaders, Operational Manager	Service staff, Commissioners
Set up phone line and IT delivery, including access to relevant systems	Provider's and Hospital's Facilities Managers	Senior leaders	Provider's Systems and IT teams, Hospital IT teams	Service staff
Order lone working devices and mobile phones	Service Manager	Provider's Facilities Manager	Provider's Facilities staff	Operational Manager
Incorporate service into hospital referral systems	Hospital Systems Manager	Hospital Leaders	Hospital key staff	Service staff
Update Risk Log as required	Service Manager	Operational Manager	Link Workers, Hospital staff, Commissioners	Commissioners, Link Workers
Monitoring and Evaluation tasks	**Responsible**	**Accountable**	**Consult**	**Inform**
Agree outcomes tool(s)	Service Manager, Provider's Impact team	Operational Manager	Commissioners, Operational Manager	
Agree data recording/monitoring system and ensure training of Service Manager (if required) and Link Workers as soon as possible	Operational Manager, Provider's Systems team/Impact team	Provider's Systems team, Provider's senior leaders	Service Manager	Link Workers

Initial Planning Tasks	Responsible	Accountable	Consult	Inform
Establish Performance Management and Quality Assurance systems	Operational Manager	Provider's senior leaders	Commissioners	
Regularly review any casework undertaken to ensure tools are being used and management information completed correctly	Service Manager, Provider's Impact team	Operational Manager	Link Workers	
Agree data sharing protocols	Operational Manager, Hospital Leaders	Senior leaders	Legal/Data Protection teams	Commissioners
External Evaluation				
Draw up evaluation specification	Provider's Impact team	Head of Impact	Service Manager, Operational Manager	Commissioners
Put specification out to tender	Provider's Impact team	Head of Impact	Service Manager, Operational Manager	Commissioners
Interview potential suppliers	Provider's Impact team, Service Manager	Head of Impact	Operational Manager	Commissioners
Confirm who will be evaluating the service	Provider's Impact team	Provider's senior leaders	Provider's legal team, Commissioners, Service Manager,	

Initial Planning Tasks	Responsible	Accountable	Consult	Inform
			Operational Manager	
Inception meeting with chosen evaluation service to agree evaluation project plan and data collection methods	Provider's Impact team, Service Manager	Head of Impact	Commissioners, Key hospital staff	Link Workers
Regular evaluation progress updates	Evaluator	Provider's Impact team	Service staff	Commissioners, key hospital staff
Final report	Evaluator	Evaluator and Provider's Impact team	Service staff, Provider's Impact team, secondary and primary care staff, Commissioners	Stakeholders, Provider's Marketing and Comms team, all provider senior managers

Example Communications Plan

Implementation Phase - Comms	Responsible	Accountable	Consult	Inform
Communication with all staff in the locality who are directly involved in the development of the service – to open an immediate line of communication	Operational Manager	Provider's senior leaders	Hospital leadership and Commissioners	Secondary Care Staff
Email key partners in Foundation Trust, CCG Acute Conditions Board, GP confederations arranging initial meeting	Operational Manager	Provider's senior leaders	Primary and Secondary Care leaders	Commissioner
Email Community and Voluntary Services, Social Care, Public Health, PALS and Healthwatch to inform about the service	Operational Manager/Service Manager	Operational Manager	Local Voluntary Services Council Provider's Marketing and Comms team	Commissioner
Contact CCG Urgent Care Board, Ward Leads and Winter Care Lead to inform about the service and set up meetings as required	Operational Manager/Service Manager	Operational Manager		
Agree with A&E Co-ordinator support for communication, links and networks.	Operational Manager/Service Manager	Operational Manager	Provider's Marketing and Comms team	Commissioner
Review communications plan and complete any outstanding tasks or add further opportunities.	Service Manager	Operational Manager	CCG/FT Communications Staff	Commissioner

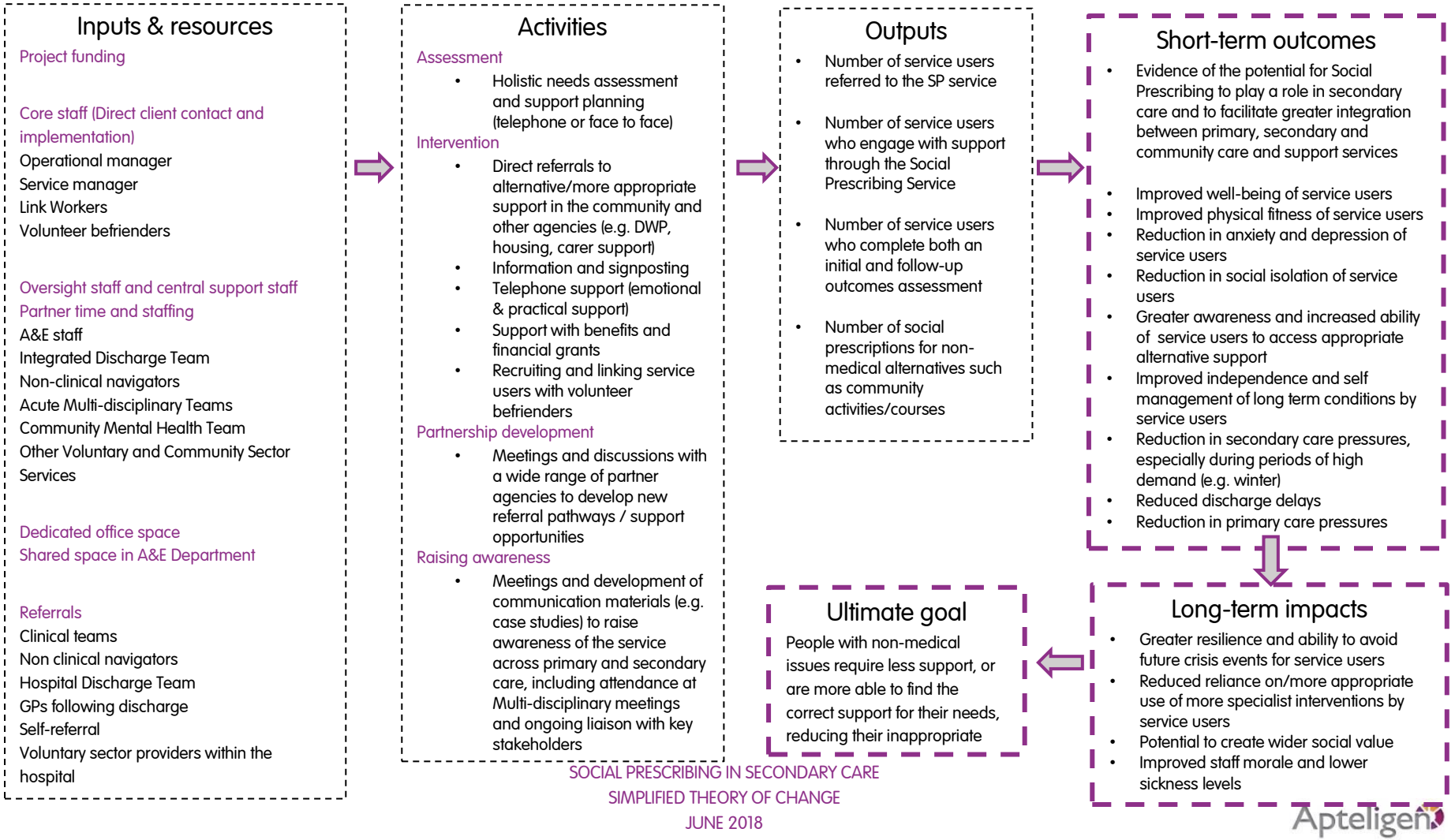
Implementation Phase - Comms	Responsible	Accountable	Consult	Inform
			Provider's Marketing and Comms team	
Agree delivery plan for a rolling programme of support for health care staff to ensure effective identification of patients and appropriate referrals	Service Manager	Operational Manager	Primary and Secondary Care stakeholders Provider's Marketing and Comms team	

Implementation Phase - Promotion	Responsible	Accountable	Consult	Inform
Gain Commissioners Branding and Guidelines	Service Manager/ Provider's Marketing and Comms team	Operational Manager, Head of Marketing and Comms	Commissioners	
Liaise with Commissioners and other key stakeholders on communication they may be able to provide e.g. articles in newsletters, space on noticeboards	Operational Manager/Service Manager, Provider's Marketing and Comms team	Operational Manager, Head of Marketing and Comms	Commissioners	Provider's Marketing and Comms team

Implementation Phase - Comms	Responsible	Accountable	Consult	Inform
Develop press release/letter to editor for local media	Provider's Marketing and Comms team	Head of Marketing and Comms, Service Manager	Service Manager, Commissioners	Key stakeholders
Plan social media messaging	Provider's Marketing and Comms team	Head of Marketing and Comms	Service Manager	Key stakeholders and Link Workers
Develop electronic (and printed if budget allows) promotional materials	Provider's Marketing and Comms team and Service Manager	Head of Marketing and Comms	Operational Manager	Hospital leaders and Link Workers
Order small amount of marketing give-aways dependent on budget for launch date.	Provider's Marketing and Comms team	Head of Marketing and Comms	Service Manager	Link Workers
Launch	**Responsible**	**Accountable**	**Consult**	**Inform**
Finalise plan for launch within month before service delivery starts	Operational Manager	Operational Manager/Provider's senior leaders	Commissioners, hospital leaders Provider's Marketing and Comms team	Service Manager, Link Workers, Volunteers
Launch service with stall within hospital actively hosted through the first week to distribute information to staff and	Link workers	Service Manager	Hospital leaders	Hospital staff, Volunteers

Implementation Phase - Comms	Responsible	Accountable	Consult	Inform
patients. Actively use stall as opportunity to make appointments with service users who would like to self-refer and meet with teams			Provider's Marketing and Comms team	
Send out electronic promotional materials to all key stakeholders, upload to social media and seek press attention	Service Manager, Provider's Marketing and Comms team	Operational Manager, Head of Marketing and Comms	Hospital leaders	Commissioners
Delivery Phase	**Responsible**	**Accountable**	**Consult**	**Inform**
Regular communication with commissioners about service progress	Service Manager	Operational Manager	Commissioners	Provider's Senior leaders
Design introductory sessions for healthcare professionals to explain the purpose and referral criteria for the service	Service Manager	Operational Manager	Hospital team leaders Provider's Marketing and Comms team	Healthcare professionals, Link Workers

Social Prescribing in Secondary Care Theory of Change



Service requirements table

Processes	Organisation structure	Technology	Information/data
Implementation plan Base at hospital (if possible) Regular and ongoing meetings with health professionals and third sector organisations and statutory agencies Assessment then offer up to 8 sessions with Link Worker Monthly managerial supervision Monthly clinical supervision Monthly team meeting Reflective team session Risk management High quality case management processes and procedures	Operational manager Service manager Link Workers Volunteer Befrienders Service provider's core function support e.g. HR, IT, finance Secondary Care staff required in implementation of service Secondary Care staff engaged and referring to service Community Organisations to prescribe to	Electronic referral template Service available as referral option on EMIS Web or other Hospital referral system Case management system – ideally same as hospital system Tools for outcomes licensed and incorporated into case management system Laptops/desktops for service staff Mobile telephones for service staff Lone working devices for service staff if required	Referral criteria and information Demographic data Assessment details and RAG rating Risk assessment details Detailed case recording Health and wellbeing plan /goals Review details Closure summaries Discharge summaries Third party referrals and information Outcomes tools pre and post data Incident/chronology Time logs – e.g. case work, letters , reports Third party resource

Processes	Organisation structure	Technology	Information/data
Robust protocols and procedures in place e.g. data sharing Lone working and risk management of challenging cases Volunteer and worker safer recruitment and training			NHS data on secondary care attendance and admissions for service users GP data on attendance

Example Referral form

Client Details

Name:

DOB:

Address:

GP details:

Client consent to share information

I give my consent for my referrer to share the information collected in this form with the Social Prescribing Service in Secondary Care:

Yes ☐ No ☐

I give consent for the Social Prescribing Service in Secondary Care to share information between my GP/health care providers:

Yes ☐ No ☐

Third party consent:

Yes ☐ No ☐

Signature:.....

Hospital Admission / Services

Admission date:

Third Party e.g. parent of child?

Is the client currently engaging with CMHT or CAMHS?

If yes, please provide details of which team:

Does the client have a CPN/social worker/care coordinator?

Is the client engaging with community support e.g. Drug and Alcohol services?

Please provide an outline of the client's presentation at referral and brief reason for referral:

.....

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.....

Brief description of any risks associated with the client (e.g. risks posed by client to themselves, or risks posed to others).....

.....

.....

Suggested staffing requirements

It is ideal for the Service Manager and Link Workers to have:

- Background in therapeutic work or a social care or health qualification/background.
- Experience working holistically to offer support with practical and emotional issues.
- A sophisticated understanding of Social Prescribing and the types of needs common amongst Social Prescribing service users.
- Ability to facilitate quality partnership and joint working between primary and secondary care staff, a wide range of voluntary and community groups, and/or social care.
- Resilience in the face of a sometimes isolating and demoralising role owing to its uniqueness in the hospital environment and the level of need of some patients

Where possible, the Service Manager should have extensive knowledge of available health, social care and community sector services in the CCG or Foundation Trust area, and how these link together.

Where possible Volunteer Befrienders should match the ethnic diversity of an area, with additional languages being beneficial where appropriate.

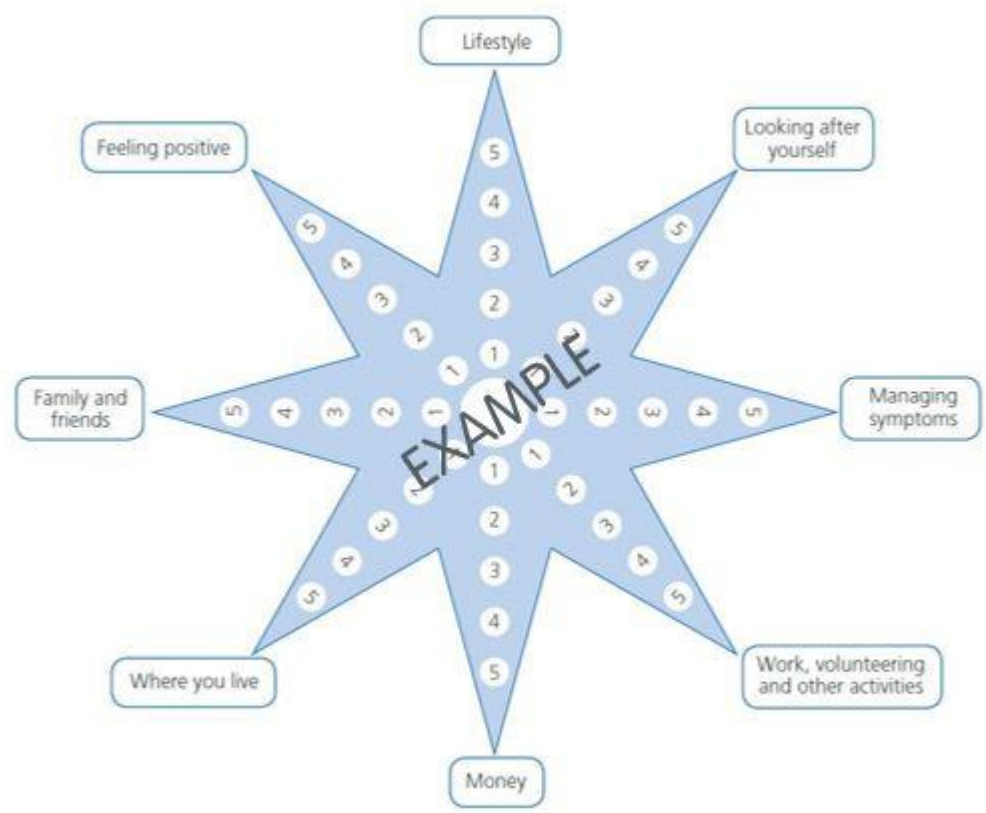
Example outcomes measurement tools

There are many different tools that may be appropriate for Social Prescribing in Secondary Care Services, depending on circumstances in your locality. Examples include:

Well-being Star (long-term conditions) - ©Triangle Consulting Social Enterprise Ltd

Further details can be found here: www.outcomesstar.org.uk/well-being-star/

The Well-being Star is intended for those with long-term conditions and has eight domains that affect an individual's quality of life, as shown in Figure 1. It uses a five-point scale – starting at 'one' where people may not have got to grips with their health condition, through to 'five', where people are doing everything they can to manage this aspect of their life well.



EQ-5D-5L – EuroQol

Further details can be found here: www.euroqol.org/eq-5d-instruments/how-can-eq-5d-be-used/

EQ5D has five dimensions: mobility, self-care, usual activities, pain/discomfort and anxiety/depression. Each of these is divided into five levels - no problems, slight

problems, moderate problems, severe problems, and extreme problems. A unique health state is defined by combining one level from each of the five dimensions. The tool records the respondent's self-rated health on a vertical, visual analogue scale with either end labelled as 'the best health you can imagine' and 'the worst health you can imagine.'

Patient Activation Measure (PAM) – Insignia Health

Further details can be found here: www.insigniahealth.com/products/pam-survey

PAM is said to be able to predict future A&E visits, hospital admissions and readmissions and medication adherence by identifying where an individual falls within four different levels of 'activation'. For the score, each point increase means a 2% decrease in hospitalisation and 2% increase in medication adherence.

Work and Social Adjustment Scale (WSAS) – Mundt, Marks, Shear and Greist

Further details can be found here: www.bjp.rcpsych.org/content/180/5/461

A five item self-report measure on the impact of a disorder from the patient's point of view. It looks at how the disorder affects the patient's ability to function day to day with depression and/or anxiety as well as phobic disorders. Questions relate to:

- ability to work
- home management
- social leisure activities
- private leisure activities
- close relationships

A&E High Intensity User Dashboard – Midlands and Lancashire Commissioning Support Unit

Further details can be found here: www.england.nhs.uk/wp-content/uploads/2017/02/business-intelligence-aristotle-appx4.pdf

The dashboard uses secondary care data to show the top 150 A&E high intensity users by attendances per CCG/GP practice for a given time period, alongside the outcome. A patient profile report shows specific outcomes for individuals against cost.

Self-Management Resource Center

A range of free to use rating scales for chronic disease self-management are available from www.selfmanagementresource.com/resources/evaluation-tools/english-evaluation-tools