

National
Academy
for Social
Prescribing

The impact of social prescribing on health service use and costs

Examples of local evaluations in practice

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About The National Academy for Social Prescribing

The National Academy for Social Prescribing (NASP) is a national charity that champions social prescribing. We support and connect people, communities and organisations so that more people across the UK can enjoy better health and wellbeing.

Evidence and Evaluation at NASP

NASP's Evidence and Evaluation team is working to build the evidence base for social prescribing and ensure that social prescribing work is evidence-led. We support research which measures the impact of social prescribing on mental and physical health, wellbeing, and the health system.

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Key Findings

1. Evaluations carried out in nine local health systems across England found that social prescribing can substantially reduce pressure on the NHS, including through reduced GP appointments, reduced hospital admissions and reduced A&E visits.
2. In Tameside and Glossop, an evaluation of 1,751 people referred to social prescribing reported a 42% reduction in GP appointments for those patients.²
3. In Kent, an evaluation of 5,908 people seen by a social prescribing Link Worker reported that their A&E attendances reduced by up to 23%.³
4. Reductions in demand for health services were particularly high for frequent service users. In Kirklees, social prescribing support for frequent users reduced GP appointments by 50% and A&E attendances by 66%.⁴ Similar results were reported in Rotherham, where frequent users' A&E attendances were reduced up to 43%.⁵
5. Social prescribing can also have a positive economic impact. In Newcastle, secondary care costs in 2019-20 were 9% lower than a matched-control group where social prescribing was not available.⁶ In Rotherham, a pre and post analysis on frequent users reported a reduction in costs up to 39% for A&E attendances.⁷

“There is an increasingly strong evidence base to support bringing a broader array of interventions into community and primary healthcare settings, ranging from social prescriptions to diagnostic equipment.”

2024 IPPR The Commission on Health and Prosperity¹

Introduction

Social prescribing is now a key part of Personalised Care in England, since it was included as part of the NHS Long Term Plan in 2019.⁸ There are now more than 3,500 Social Prescribing Link Workers employed as part of primary care teams, who have received more than 2.7 million referrals since 2019. Link Workers are able to take a personalised approach, focusing on each patient’s needs and preferences, and helping them find non-clinical support in their communities. Increasingly, acute hospitals, secondary and specialist care services are implementing the approach, and the National Academy for Social Prescribing (NASP) is working with a range of trusts, providers and Integrated Care Boards to support this.

There is also widespread support from NHS front-line staff and clinicians, national leaders and policy-makers, local government and communities, the voluntary sector, charities and social enterprises, and organisations working across the arts, sport and leisure, and natural environment sectors. The 2023 NHS Workforce Plan commits to almost tripling the number of Link Workers to 9,000 by 2036-7.⁹

A recent analysis of data from a major social prescribing software provider looked at who get referred to social prescribing (n=160,168). It found that, in England, 61% of referrals were female, over 20% were aged 60-69, and people referred were more likely to live in deprived areas. Regarding referrals, the same analysis found that 85.3% were via medical routes of referral, and the most common reasons for referral were mental health and wellbeing (33.5%), practical support (26.1%) and social relationships (22.5%).¹⁰

Evidence of the impact of social prescribing is growing rapidly: on improvements in mental health and wellbeing, reductions in loneliness, on use of community infrastructure, and moderation of avoidable demand for GPs and hospital emergencies.¹¹ A 2023 NASP rapid evidence review on the economic impact of social prescribing identified evidence that social prescribing can save money and have a positive social impact, with a social and economic value of between £2.14 and £8.56 for every £1 invested.¹²

Over the past year, further studies have reported returns of a similar scale, including the evaluation of the cross-government Green Social Prescribing programme, which reported an estimated social return on investment of £2.42 per £1 invested by central Government, including statistically significant improvements in participants' wellbeing measured using ONS4.¹³ Large-scale international studies are finding similar results. A recent Canadian study estimated that the Social Return on Investment for a nationwide implementation of social prescribing in Canada would be \$4.43 (range of \$2.97 to \$5.89) for every dollar invested (through improved wellbeing and reduced costs incurred).¹⁴

This growing evidence base for social prescribing is showing positive impacts, but we know that there are still gaps. NASP and its academic partners have compiled a series of evidence reviews. However, most reviews rely on published studies and miss local analysis taking place in practice.

This report summarises the analysis of social prescribing evaluation data from nine local health systems. The data is drawn from publicly available evaluations of social prescribing in England and case studies identified through NASP's ongoing work with Integrated Care Systems. We acknowledge that the evaluations vary in methodology and quality, and we have excluded evaluations with a sample size of less than 100.

Summary

Evaluations of social prescribing services have found reductions in the number of GP appointments, secondary care use, A&E attendances and costs.^{2,3,4,5,6,15,16,17,18,20} This includes an evaluation of 1,751 people referred to social prescribing in Tameside and Glossop, which reported a 42.2% reduction in GP appointments for those patients²; and a large-scale evaluation in Kent of 5,908 people seen by a Social Prescribing Link Worker, which reported A&E attendances reduced by 15.4%-23.6% for those patients.³

Data from Sussex compares health service use for those who had support from a Social Prescribing Link Worker over 12 months ago to those who are just starting receiving support in the last 12 months. They found that those who received support over 12 months ago had lower GP and hospital usage'.^{15,16}

Some evaluations were able to segment population groups to understand the impact of social prescribing on those people who used health services more frequently (i.e. those more costly to the NHS) before their referral. Evaluations of social prescribing in Kirklees found that for frequent service users, social prescribing could reduce GP appointments by 50% and A&E attendances by 66%.⁴ Similar results were reported in Rotherham, where frequent service users' A&E attendances were reduced by 39-43%.⁵ Despite decreases for more frequent health service users, increases in health service use were found overall for Kirklees and Rotherham. This may be due to social prescribing enabling people to access appropriate services who previously did not. The Rotherham analysis looked at this and found over 70% of patients had zero or one inpatient or A&E visits in the 12 months prior to referral.⁵

Cost savings were reported in Newcastle, Calderdale and Rotherham. In Newcastle, they found secondary care costs to be 9.4% lower when compared to a matched-control group⁶. In Calderdale, a £350 reduction in hospital cost per patient per year was reported; with those just starting to receive social prescribing having average year costs of £1,211 compared to £861 for those who received social prescribing over a year ago.¹⁷ A pre and post analysis in Rotherham also reported a reduction in costs ranging from 29-39% for A&E attendances.⁷

A summary of the impact of social prescribing on service use and costs can be seen in Table 1 over the page.

Table 1: Summary of impact on service use and costs

Area(s)	Population	Type of evaluation	Impact on service use and costs
Calderdale	4,170 patients from across Calderdale who has access to a Social Prescribing Link Worker	12 months prior compared to 12 months post	A £350 reduction in hospital cost per patient An average reduction of four GP contacts per patient ¹⁷
Frome	Population of Frome (n=28,510) which had access to an enhanced model of primary care and compassionate communities (which included social prescribing)	Observational data comparing Frome to Somerset as a whole	Unplanned hospital admissions in Frome reduced by 14%, compared to an increase in Somerset as a whole of 28.5% ¹⁸
Kent	Patients seen by Social Prescribing Link Worker, split into four groups (more detail in text) (n=5,908)	6 months prior compared to 6 months post	A&E attendance reduced by 15.4-23.6% Unplanned inpatient stays reduced by 2.8-8.3% ³
Kirklees	Frequent health service users who accessed social prescribing (GP n=199/A&E n=125) Whole social prescribing service cohort (GP n=993/A&E n=495)	3 months prior compared to 3 months post 9 months prior compared to 9 months post	50% reduction in GP attendances 66% reduction in A&E attendances ⁴ GP appointments: 50% of patients saw an increase, 39% saw a decrease and 11% saw no change A&E attendances: 46% saw an increase, 41% saw a decrease and 13% saw no change ¹⁹
Newcastle	Way to Wellness full eligible cohort in the West of Newcastle (n = 14,652)	Comparison over 12 months to matched 'counterfactual' group in an area with no access to the service	Secondary care cost per patient was 9.4% (£107 per head) lower than the comparison cohort, equating to an annual cost reduction of £1.56 million. The authors estimate a 27% lower cost per head than the comparison cohort if only focusing on patients engaging with social prescribing ⁶
Rotherham	Frequent users referred to a Social Prescribing Link Worker (inpatient spells n=352/A&E attendances n=332)	12 months prior compared to 12 months post	Non-elective inpatient spells were reduced by 33-40% A&E attendances were reduced by 39-43% ⁵ 20-42% reduction in average costs for non-elective inpatient spells (n=327) 29-39% reduction in average costs for A&E attendance (n=204) ⁷

Area(s)	Population	Type of evaluation	Impact on service use and costs
Sussex (Mid Sussex Healthcare part of Burgess Hill & Villages PCN)	Had support from Social Prescribing Link Workers over 12 months ago (n=150) and those who had started support from Social Prescribing Link Workers in the last 12 months (n=164). (Note: the category 'starting support in last 12 months' may include service use before first contact with social prescribing.)	12 month period compared to previous 12 months and comparison between groups	15% increase in hospital admissions for people supported by social prescribing over 12 months ago, compared to a 57% rise for those who are starting social prescribing support ^{20,15} 25% fall in demand for GP appointments among those supported by social prescribing over 12 months ago, compared to 78% rise in those starting support ¹⁵
Sussex (Mile Oak Medical Centre)	Had support from Social Prescribing Link Workers over 12 months ago (n=231) and those who had started support from Social Prescribing Link Workers in the last 12 months (n=172). (Note: the category 'starting support in last 12 months' may include service use before first contact with social prescribing)	12 month period compared to previous 12 months and comparison between groups	6% fall in demand for GP appointments among patients who received social prescribing support more than 12 months ago, compared to 56% rise in those starting support 23% (0.28 to 0.21) fall in average hospital admissions for people supported by social prescribing over 12 months ago, compared to a 208% (0.07 to 0.22) rise for those starting support ¹⁶
Tameside and Glossop	1,751 referrals to Social Prescribing Link Worker	Compared to control group (who were referred but did not take up the offer of social prescribing) after 12 months	42.2% reduction in GP appointments compared to 5.6% reduction in control group ²

Examples from practice where social prescribing has reduced health service use and/or saved costs

Calderdale

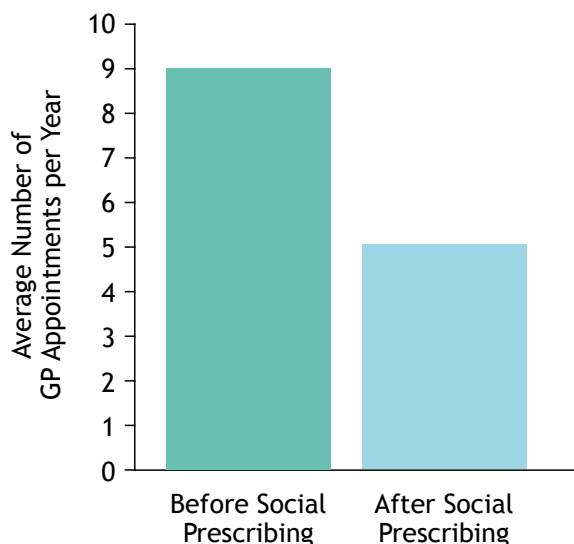
Service and referrals

The National Association of Primary Care evaluated the impact of social prescribing in Calderdale. The evaluation was of a well-established social prescribing-led preventative care model, which supported 4,170 patients from 2020-2022.¹⁷

Impact

The evaluation looked at patients pre and post social prescribing and reported that there was an average of nine GP contacts per year before social prescribing and an average of five GP contacts per year afterwards. They also found that social prescribing was linked to lower hospital costs, with those just starting to receive social prescribing having higher average year costs of £1,211 compared to £861 average year costs for those who received social prescribing over a year ago; potentially saving £350 per patient per year. Furthermore, they reported sustained reductions in body mass index (BMI) for patients who were obese (BMI>30), where patients starting social prescribing had a 0.2 point drop in BMI, while patients supported two years ago saw a 0.9 point drop.¹⁷

Evaluation of Service Use by Patients Accessing Social Prescribing in Calderdale (Year Before and Year After)



Frome

Service and referrals

Abel et al., 2018 evaluated a complex intervention of an enhanced model of primary care and compassionate communities (which included social prescribing) in Frome Medical Practice.¹⁸ Frome Medical Practice is a single general practice in Frome, Somerset, which provides primary care for 28,510 people.

Impact

An analysis was done on all those cared for by Frome Medical Practice compared to the rest of Somerset from April 2013 to December 2017. The report found there was a 14% reduction in unplanned hospital admissions in Frome (95% confidence interval [CI] = 2.8 to 13.1, P = 0.006) compared to a 28.5% increase in unplanned admissions in Somerset as whole (95% CI = 152 to 320, P<0.001).¹⁸

Please note this is an observational study: these findings cannot prove this reduction was due to the intervention (it is an analysis of Frome population as whole, not an analysis of the data of only those that received the intervention).

**14% reduction in unplanned hospital admissions
- Frome Medical Practice**

Kent

Service and referrals

In 2023, an evaluation by Involve Kent looked at the impact of social prescribing in West Kent. The 5,908 people who used the service were split into four groups. The first group was unpaid adult carers (n=1,486).³ The second group were aged over 55 with complex health or frailty. This group typically had multiple long-term conditions and an average age of 77 (n=2,579). The third group were aged 18-55 years with ill-health; of these, 90% had multiple health conditions, 38% lived in the most deprived areas of West Kent and 98% were not in employment (n=339). The final group were patients supported by Primary Care Network Link Workers. These patients were typically less complex and referred into the social prescribing service by their GP or an Additional Role Reimbursement Scheme funded Link Worker (n=1,504).³

Impact

The evaluation found that comparing six months prior to six months post, A&E attendances reduced by 15.4-23.6%, with the biggest impact on over 55s with frailty/complex health (group 2). A reduction in unplanned inpatient stays was also reported ranging from 2.8-8.3%; with the biggest impact on patients supported by Primary Care Network Link Workers (group 4).³

15.4% - 23.6% reduction in A&E attendances for people referred to social prescribing

Kirklees

Service and referrals

Kirklees Council Personalised Care services⁴ focused on “what matters to individuals” and helped make positive changes for an improved quality of life. Of 4,927 referrals into the service (October-December 2023), 85% of appointments were for social prescribing. There were gaps in reporting (due to some data not being captured) but from the data obtained, the majority of referrals were female (52%) and heterosexual (63%). The ages of users were spread across age groups, with the most common aged 50-59 (16%), 60-69 (13%) and 30-39 (13%). Regarding employment status, the largest proportion were retired (23%), followed by unemployed (19%), employed (13%) or on long-term sickness (9%). 35% of all referrals were for people living in the top 20% most deprived areas in Kirklees. 25% of patients referred had two or more long-term health conditions. Referral reasons included: to improve mental and social wellbeing (41%); housing, financial or employment issues (39%); and to improve lifestyle (21%).

Impact

Kirklees Council have completed two analyses on their service data: the first analysis was on frequent users three months pre and three months post social prescribing referral⁴; and the second analysis was specifically looking at GP appointments and A&E attendances for the whole service cohort, nine months before and nine months after social prescribing.¹⁹

The first analysis found that frequent users (199 patients who had three or more GP attendances in the three months prior to their referral) referred to social prescribing were shown to have an overall 50% reduction in GP attendances three months after being referred. The impact of social prescribing on A&E attendances found frequent users (125 patients who had three or more A&E attendances in the three months prior to their referral) had a 66% reduction in A&E attendances three months after being referred.² It was also reported that social prescribing helped patients achieve goals around: improved mental wellbeing (31%); social isolation (20%); managing personal health (18%); managing finances (16%); solving housing problems (8%); and improved mobility/independently managing own care (7%).⁴

The second analysis, of the whole service cohort, found overall A&E and GP appointments increased in the nine months following the intervention compared to the nine months prior (this was a significant increase for GP appointments ($p=0.01$)). The analysis of 993 patients found that 50% of patients saw an increase in GP appointments, 39% saw a decrease in appointments and 11% saw no change.

The analysis found that factors for decreased GP appointments included: ethnicity identified as “Other White” (72% more likely to see a decrease), living in deprived areas (61% more likely to see a decrease), and those with depression (60% more likely to see a decrease). Regarding A&E attendances, the analysis of 485 patients found that 46% saw an increase, 41% saw a decrease and 13% saw no change in their A&E attendances. The analysis found factors for decreased A&E attendances included: living in less deprived areas (60.8% more likely to see a decrease) and being aged 60-69 (57.6% more likely to see a decrease). Analysis on frequent users was not completed in the second analysis. The authors suggest social prescribing may be supporting people to access appropriate healthcare services, who may not have done so previously and that these short-term increases could yield long term benefits not identified in this analysis as it is limited to nine months.¹⁹

Newcastle upon Tyne

Service and referrals

Ways to Wellness is a social prescribing programme for people with long-term conditions in Newcastle. Between April 2015 and March 2021, the programme received 7,700 referrals (mainly from GP practices) of which 5,800 people engaged with the service (75%).⁶ The most common forms of support that clients were signposted to were: 27% healthier behaviours (e.g. exercise, healthy eating, weight loss); 18% financial or benefits advice; and 11% support for long-term condition management.

Impact

Ways to Wellness evaluated their service and analysed secondary care costs by comparing the costs of A&E, out-patient, and in-patient (day case, elective and non-elective) use for the Ways to Wellness full eligible cohort (14,652 patients in the west of Newcastle) to a matched group of patients that did not have access to service (in the north and east of Newcastle). The group was matched on age, GP practice, average index of multiple deprivation, gender and long-term conditions.

The cost difference per head was measured across the service and control cohorts. They reported that in the year 2019-2020, secondary care cost per patient across the full eligible Ways to Wellness cohort was 9.4% (£107 per head) lower than the comparison cohort. The authors note that of the eligible cohort only 5,800 were engaged in the service, so the impact on the Ways of Wellness cohort could be higher: the authors estimate the costs per head could be 27% lower than the comparison cohort.

A further analysis of 2,888 clients who engaged with the social prescribing service showed that 86% experienced improved wellbeing in at least one domain of wellbeing when comparing baseline to six months later.⁶

27% lower costs for secondary care per patient accessing social prescribing

Rotherham

Service and referrals

Academics at Sheffield Hallam University have been evaluating the impact of Rotherham Social Prescribing service since 2013, focusing on the long-term conditions component of the service. The most recent report explored data from April 2016-March 2022.⁵ Of 4,840 patients: the most common age groups were those aged 81-90 (35%) and 71-80 (21%); 61% were female and 97% were white. Local voluntary and community sector (VCS) organisations were commissioned to provide support and these referrals made up 68% of all the referrals, with the most common being: information and advice benefits (28%), enabling to access support (14%) and carer respite (9%). Referrals were also to non-VCS organisations and included occupational therapy assessments (20%), grab rails (10%) and assistive technology (9%). Of the patients who used the service the majority were considered low frequency users, with 74% having zero or one inpatient spell in the 12 months prior and 73% having had zero or one A&E visits in the 12 months prior to their referral.⁵

Impact

An analysis was completed on 2,365 service users' hospital admissions and A&E attendances 12 months before and 12 months after social prescribing. Before segmenting the data by low and high frequency users, an overall small, negligible increase (0.01) was found in both inpatient spells (1.24 in the 12 months before compared to 1.25 in the 12 months after) and A&E attendances (1.17 in the 12 months before compared to 1.18 in the 12 months after). This data included those that previously had zero attendances.⁵

When the cohort was segmented to identify the impact on more frequent users (3-5 attendances in the past 12 months), it was found that the average non-elective inpatient spells were reduced by 33-40% after one year (n=352) and A&E attendances were reduced by 39-43% in one year (n=332)⁵. An earlier evaluation of the same service from April 2016-March 2018 also reported cost savings for frequent users, which ranged from 29-39% reduction in average costs for emergency attendances at one year (n=204) and a 20-42% reduction in average costs for non-elective inpatient spells at one year (n=327).⁷ Regarding wellbeing outcomes, they reported that, where a follow-up score was available, the biggest improvements were seen in terms of: money, feeling positive and work volunteering and other activities.⁵

**Impact of social prescribing on frequent users of health services:
33%-40% reduction in non-elective inpatient spells
39%-43% reduction in A&E attendances**

Sussex

Service and referrals

Sussex Health and Care's commissioned Social Prescribing Link Worker services received 5,265 referrals in 2022-2023.²⁰ However, there are variations in social prescribing referral across Sussex, with those in West Sussex twice as likely as those in East Sussex to be referred to social prescribing (although West Sussex has higher numbers of people who do not take up the referral). The majority of referrals to social prescribing were female and older. Evaluations of Mile Oak Medical Centre and Mid Sussex Healthcare, part of Burgess Hill & Villages PCN, were completed by the National Association of Primary Care (NAPC), who analysed data from three groups: local population; starting support from Social Prescribing Link Workers; and had social prescribing support. These groups are detailed in Table 2.

The group that *have received support from Social Prescribing Link Workers* potentially show the longer-term impact of social prescribing (as they received support over 12 months ago). The group *starting support from Social Prescribing Link Workers* might have seen their GP or attended hospital more frequently prior to their referral to social prescribing (from practice, we understand that it is these contacts with health services that often prompt a referral to social prescribing) and this data would be included in the 12 months of data for this group.

Table 2: Sussex Evaluation Groups

Evaluation Group Name	Description
Group 1: Local Population	All of the patients registered at Mile Oak Medical Centre or Mid Sussex Healthcare. This group includes children, those that are healthy, those that are unwell, as well as those receiving and starting social prescribing support.
Group 2: Starting support from Social Prescribing Link Workers	Patients who started receiving support from Social Prescribing Link Workers in the last 12 months. This patient data for the last 12 months would include some data <i>before</i> starting social prescribing and some data <i>after</i> starting social prescribing. Therefore, the amount of social prescribing received varied between patients in this group.
Group 3: Have received support from Social Prescribing Link Workers	Patients who were supported by Social Prescribing Link Workers over 12 months ago

Mile Oak Medical Centre

In Mile Oak Medical Centre, 231 patients *had received support from Social Prescribing Link Workers*. Of these: the majority were female (67%) with an average age of 52 years, 63% were smokers, 26% had hypertension and 12% identified as an ethnic minority. The group *starting support from Social Prescribing Link Workers* (n=172), were mainly female (63%) with an average age of 52 years, 53% were smokers, 32% had hypertension and 18% identified as an ethnic minority. Of the *local population* (n=8,579): 52% were female, the average age was 40 years, 35% were smokers, 16% had hypertension and 16% identified as an ethnic minority.¹⁶

Mid Sussex Healthcare part of Burgess Hill & Villages PCN

In the Mid Sussex Healthcare part of Burgess Hill & Villages PCN, 150 patients *had received support from Social Prescribing Link Workers*. Of these: the majority were female (60%) with an average age of 74.6 years, 25% were smokers and 56% had hypertension. The group *starting support from Social Prescribing Link Workers* (n=164), were mainly female (66%) with an average age of 69.4 years, 31% were smokers and 41% had hypertension. Of the *local population* (n=20,692): 51% were female, the average age of 44 years, 20% were smokers and 15% had hypertension.¹⁵

Impact

Although impact data was collected by Social Prescribing Link Workers in Sussex, there was no established way to routinely report, collate and analyse data at Sussex County level. To understand the impact locally, Sussex Health and Care commissioned an evaluation by the National Association of Primary Care (NAPC). The NAPC evaluated the impact of social prescribing in the Mile Oak Medical Centre and the Mid Sussex Healthcare part of Burgess Hill & Villages PCN. The evaluations compared the current year and previous year for three groups (detailed above in Table 2) for GP appointments, hospital admissions* and patient wellbeing.

*To analyse hospital admissions data from primary care datasets is challenging due to data quality and coding. Discharge letter is routinely recorded in primary care datasets when a person has been admitted and subsequently discharged from hospital. Therefore to identify and analyse hospital admissions in these evaluations, a proxy of discharge letter was used for the analyses.

Mile Oak Medical Centre

Comparing the current year to the previous year the evaluation reported a 6% (19.3 to 18.3) reduction in average GP appointments for those who had social prescribing support. Those *starting support from Social Prescribing Link Workers* saw a 56% rise (10.2 to 15.9) and in the local population there was a rise of 8% (6.4-6.9) in GP demand.¹⁸ Regarding hospital demand, the evaluation found those who *had received support from Social Prescribing Link Workers* saw a 23% (0.28 to 0.21) reduction in average admissions in the year after they were seen. The group *starting support from social prescribing* saw an increase of 208% (0.07 to 0.22) and the *local population* saw an increase of 27% (0.08-0.10). Furthermore, a 17% reduction in anxiety and depression was reported for those who *had received support from Social Prescribing Link Workers*, along with small health improvements in BMI, asthma control test scores and cardiovascular disease risk, although definitive conclusions cannot be drawn due to challenges in data collection.¹⁶

Mid Sussex Healthcare part of Burgess Hill & Villages PCN

The evaluation showed an average 25% (20.8 to 15.5) fall in demand for GP appointments in the group *who had received support from Social Prescribing Link Workers* (n=150). The group *starting support from Social Prescribing Link Workers* (n=164) saw a 78% rise (12.2 to 21.7) and the local population (n=20,692) saw a 24% rise in GP demand.¹⁵ For hospital admissions, the evaluation found in the group *who had received support from Social Prescribing Link Workers* there was an average 15% (0.26 to 0.30) increase in hospital admissions. Those *starting support from Social Prescribing Link Workers* saw an increase of 57% (0.21 to 0.33) in hospital admissions and the local population saw no change in the same period.¹⁵ Patients who *had received support from Social Prescribing Link Workers* demonstrated a large drop in reported levels of anxiety and depression (62% drop from previous year). Those *starting support from Social Prescribing Link Workers* saw a smaller drop in levels of anxiety and depression (20% drop from previous year).¹⁵

Tameside & Glossop

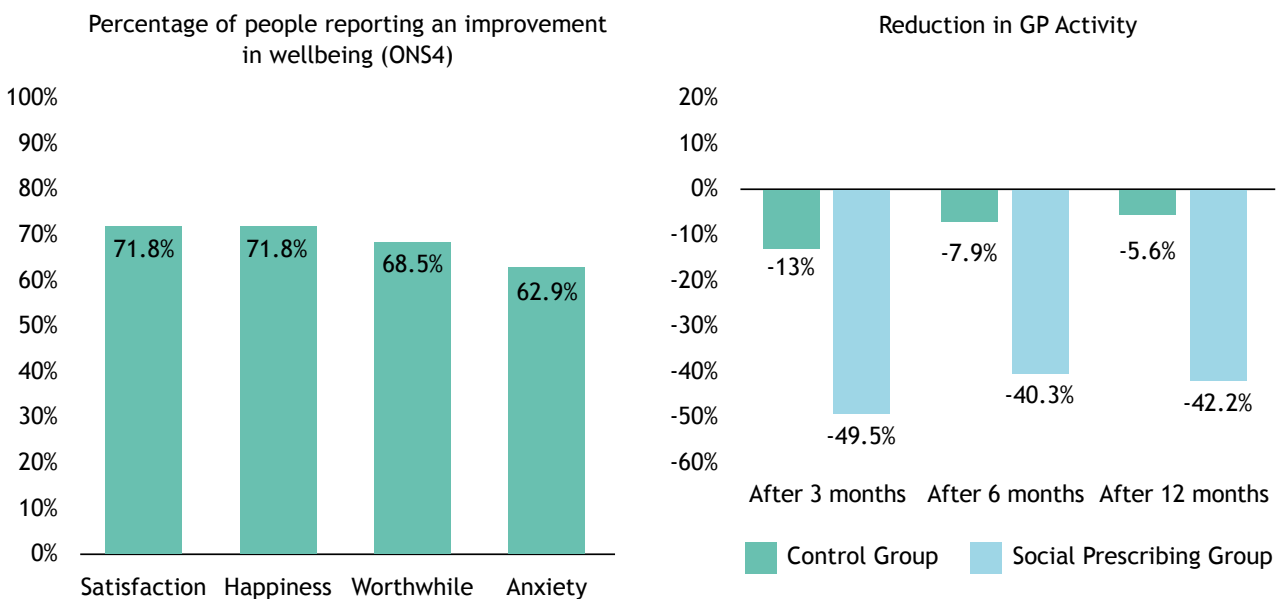
Service and referrals

Tameside & Glossop social prescribing service received 1,751 unique referrals in 2019-2020, with 62% from GP practices. The most common reasons for referral were mental health, isolation, physical inactivity, difficulty coping and difficulty getting out.

Impact

The evaluation included in the impact report by Tameside Action Together found reductions in GP visits at 3, 6 and 12 months after referral to a Social Prescribing Link Worker of 49.5%, 40.3% and 42.2%, compared to reductions of 13%, 7.9% and 5.6% in a control group (who were referred to a Social Prescribing Link Worker but did not take up support).² In a deep-dive analysis of 543 high attending patients, savings were estimated to be £600,000 per annum for GP appointments, £1.6 million per annum for A&E attendances and total estimated saving of £2.2 million, which equated to £3 return for every £1 invested, although the methodology used to estimate these figures is not clear. There were also reported improvements in the ONS4 categories with: 71.8% reporting improvements in satisfaction, 71.8% in happiness; 68.5% in life feeling worthwhile and 62.9% reporting improvements in anxiety.

Impact of social prescribing in Tameside and Glossop



Conclusion

This report summarises findings from nine evaluations of social prescribing across England. Overall, they found that social prescribing can reduce costs and health service use. Despite different approaches to undertaking evaluations, reductions in health service use were reported in most studies, particularly for those people that frequently used health services before they engaged with social prescribing.

Limitations

It is important to note that the data presented in this report is from evaluations of social prescribing in practice, which vary in methodological approach and quality. With the exception of Frome, they are not peer-reviewed, published research studies. The objective of this report was to identify case studies where social prescribing has worked in practice. However, no negative case studies were identified and purposefully excluded from this report. Furthermore, where what could be considered as negative findings were reported in evaluations, these are included in the report (e.g. the overall Rotherham and Kirklees analysis finding increases in service use without segmenting the cohort to low and high frequency users, and some reported service use increases in Sussex).

The process to identify these case studies was not systematic and was opportunistic based on publicly available evaluations of social prescribing known to the authors, as well as case studies where the author has worked with colleagues across England to understand the impact of social prescribing in their Integrated Care Systems.

Additionally, the evaluations presented in this report are limited by data availability; some evaluations only had access to service user data, making control group analysis problematic. Due to Information Governance, some findings from evaluations could not be shared in detail or at all. Most areas were only able to share high level findings (if they had not made their own detailed service evaluation available in the public domain).

The most common analysis completed when evaluating services was pre and post service use, but there are limitations to this design. Firstly, if there is a short follow up interval, analysis is potentially more vulnerable to being impacted by external pressures such as 'winter pressures' or 'covid waves' where the demand for health services tended to increase.²¹ Secondly, for pre/post analysis that segments the data by service usage, the statistical phenomenon where, after repeat testing, high values are likely to move closer to the mean (regression to the mean) may occur.²² Some analysis did use comparison groups in analyses. However, these groups did not include randomisation to a control and intervention group, so there could be a risk of selection bias, which means that results could be less generalizable. It also needs to be acknowledged that the data included in the evaluations or approaches to data collection were not quality checked by the authors, so it is unclear whether the quality of data collected could have impacted results.

This report includes nine case studies from across England. We are conscious that there will be evaluations of social prescribing that we are not aware of or have not yet been completed, so subsequently will not have been included in this report. At NASP we are always interested in evaluations of social prescribing, so please contact us at evidence@nasp.info if you have evaluations to share.

What do we still need to understand?

It is important to understand the impact of social prescribing on health service use, across multiple sites, alongside other outcome measures, so that its benefits can be more fully understood. A multi-region National Institute of Health and Care Research-funded evaluation of Social Prescribing Link Workers in primary care is underway and is being led by the University of Manchester. This evaluation will conclude in 2025 and includes a work package on economic sustainability. There is also an increasing use of modeling being used to understand benefit realisation in patient activation linked to personalised care. One report using forecasting from NHS England London region reported that patient activation from personalised care can reduce pressure on health services and deliver a return on investment.²³

Despite modelling and evaluations taking place, further planning, system working and information governance agreements are still needed for evaluating social prescribing in practice. At an Integrated Care System and national level, further work is needed to help utilise data on health service usage and social prescribing needs. There is a need to have aggregate data available, to allow data to be interrogated at a national level and reduce gaps in our understanding around social prescribing.

Addressing these needs around data availability and quality would reduce the reliance on local system evaluations and allow us to understand the impact of social prescribing at a national level. Further addressing these data needs could also help us to understand the long-term impact of social prescribing and answer questions around whether appropriate short-term increases in health service use can yield benefits in the longer term and potential implications of this for NHS prevention programmes of work.

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