The role of volunteer involvement in NHS Norfolk and Waveney Integrated Care Board (ICB) social prescribing for people living with dementia: a preliminary formative service evaluation.

Report

A collaborative project funded by NHS England and NHS Norfolk and Waveney Integrated Care Board, commissioned by NHS Norfolk and Waveney Integrated Care Board, undertaken by the Institute for Volunteering Research at the University of East Anglia.

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Executive Summary

Social prescribing is being introduced in England in an NHS nationwide wide effort to put the individual at the centre of health and social care services, as part of offering personalised care.

> "*Many inspirational and hard working professionals have all come to the same conclusion - that we can do better for the person who stands before us.*" (Polley et al, 2017)

Social prescribing in the NHS is a complex system with a range of roles and services connecting to patients and communities. This explorative evaluation set out to describe how social prescribing is currently working in Norfolk and Waveney, with a focus on people living with dementia, and on the role volunteer involvement plays in this. It found a substantive funding commitment and resulting active practice and achievements, however, also remaining practical difficulties, and the need for more comprehensive descriptions of why systems connect to people living with dementia and a more in depth understanding of the role of volunteer involvement.

Social prescribing in Norfolk and Waveney

In the geographical area of the NHS Norfolk and Waveney Integrated Care System, according to NHS Digital (2023) General Practice Workforce statistics for Primary Care Networks in February 2023, a total of 178 individual staff (157.3 FTE) are employed, as Care Coordinators (87.5 FTE), Health and Wellbeing Coaches (22.8 FTE) and Social Prescribing Link Workers (47 FTE), which reflects a substantive funding commitment in social prescribing. Referrals from health care professionals to Social Prescribing Link Workers are under way and being processed, however, it is unclear how far collaborative working and communication between services, other connected roles and sectors has progressed as part of this.

Personalised care for people living with dementia

Social Prescribing Link Workers who took part in this evaluation expressed a shared commitment to services that are shaped around the individual, responding not just to needs identified by health professionals but also to how someone would like to receive their support. However, there might still be practical disconnects, for example, when the depiction of an individual's needs stated in a referral differs distinctly from what that person perceives their needs to be, or when services might not be available.

The role of volunteer involvement in social prescribing enabling personalised care for people living with dementia in Norfolk and Waveney

Volunteer involvement plays a recognised role in social prescribing, as the National Academy for Social Prescribing (2022) puts it: *"People with identified health and social care needs may find volunteering through their link worker."* The findings from this evaluation, however, suggest that for people living with dementia, rather than volunteer involvement for people living with dementia as suggested above, predominantly dementia friendly activities provided by volunteers and non-statutory services are currently offered as a distinct way to extend personalised care.

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1 The project

This is the draft report from a preliminary, formative service evaluation, exploring the role of volunteer involvement in NHS Norfolk and Waveney Integrated Care Board (ICB) social prescribing for people living with dementia.

The evaluation was undertaken as a collaboration between the University of East Anglia (UEA) and NHS Norfolk and Waveney ICB, funded by NHS England and NHS Norfolk and Waveney ICB. The funding was provided as part of work to develop knowledge on personalisation within Norfolk and Waveney focused on “Personalised Care to reduce health inequalities”.

The project was also to align with the National Institute for Health and Social Care Research funded project SPLENDID, with lead applicants Chris Fox and Jane Cross, undertaken in parts by the School of Health Sciences at UEA, which started in January 2023.

A condition of the project funding was completion before 31 March 2023.

1.1 Project Plan

The evaluation was to map and evaluate social prescribing for people living with dementia in Norfolk and Waveney, by comparing available NHS England and NHS Norfolk and Waveney ICB ambitions and anonymised patient referral data, with accounts from staff involved in social prescribing.

1.2 Methodology

1.2.1 Recruitment and sampling

In collaboration with the Norfolk and Waveney ICB, the Integrated Care Systems (ICS) Social Prescribing Lead circulated an email from the evaluation team to Social Prescribing Link Workers in Norfolk and Waveney with a brief description of the project, attaching an invitation to be interviewed and a participant information sheet. Interested potential participants who contacted the evaluation coordinator, were asked to confirm consent and then a time for an online interview was arranged.

Four participants from four different Social Prescribing teams within Primary Care Networks (PCNs), providing services covering rural, urban, and coastal areas, were interviewed. Interview summaries were anonymised and validated with the respondents (see Appendix A).

1.2.2 Data sharing

With a data sharing agreement in place, NHS Norfolk and Waveney ICB provided details on PCNs and Practices in Norfolk and Waveney, anonymised patient referral data and employment statistics for Social Prescribing Link Workers (see Appendix B to D).

1.2.3 Analysis

Using a realist approach (Public Health England, 2021) service data has been mapped, anonymised patient data has been compared with the national picture, and a thematic review of the validated summaries from the interviews was undertaken. The analysis initially suggested a range of themes for analysis: 'ways of working', 'views and experiences of Social Prescribing Link Workers', 'vision for the role', 'link to personalised care for people living with dementia', with further themes emerging (see Table 1).

Ways of working	(see section 2.1)
Methods of engagement	(see section 2.1.1)
Capacity	(see section 2.1.2)
Understanding the role	(see section 2.2)
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Skills for working with people living with dementia and their carers	(see section 3.3)
The role of volunteer involvement in social prescribing for people living with dementia and their carers	(see section 4)
Benefits of volunteer involvement	(see section 4.1)
Challenges of volunteer involvement	(see section 4.2)

Table 1. Summary of themes and sub-themes

These themes have been contrasted with some of the overarching ambitions for social prescribing.

1.2.1 Ethics approval

The project received Ethics approval from the University of East Anglia, Faculty of Medicine and Health Sciences Research Ethics Subcommittee on 11 November 2022 with the Ref: ETH2223-0702, and was completed before this approval expired 31 March 2023.

1.3 Definitions

1.3.1 Social prescribing

NHS England guidance on social prescribing provides the following explanation for the term ‘Social Prescribing’:

> *“It is an approach that connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing.*
>
> *In social prescribing, local agencies such as local charities, social care and health services refer people to a social prescribing link worker. Social prescribing link workers give people time, focusing on ‘what matters to me?’ to coproduce a simple personalised care and support plan, and support people to take control of their health and wellbeing.”* (NHS England, 2023a)

1.3.2 Social Prescribing Link Worker

NHS England guidance which includes core competencies for the role of ‘Social Prescribing Link Worker’ and links to resources to support employers to recruit and embed them, provides the following explanation about the term ’Social Prescribing Link Worker’:

> *“[Social Prescribing Link Workers] give people time over several sessions to offer a person-centred conversation based around asking, “what matters to you?”…*
>
> *…Support people by connecting them to non-medical community-based activities, groups and services that meet practical, social and emotional needs, including specialist advice services and the arts, physical activity, and nature…*
>
> *People can be referred to SPLWs [Social Prescribing Link Workers] from a wide range of local agencies including NHS services, local authority services, pharmacies, emergency services, job centres, housing associates, VCSE [Voluntary Community and Social Enterprise] organisations and self-referral.*”
>
> (NHS England, 2023b)

1.3.3 Other roles linked with social prescribing

NHS England guidance already suggest connections to other roles especially ‘Health and Wellbeing Coaches’ and ‘Care Coordinators’, however the guidance does not currently appear to directly linking Social Prescribing Link Worker to the work of other potentially relevant staff, for example in the High Intensity Use (HIU) programme.

Health and Wellbeing Coaches

NHS England guidance for the role of 'Health and Wellbeing Coaches' provides the following explanation:

> "*Health and wellbeing coaches work with people with physical and/or mental health conditions, people with long-term conditions and those at risk of developing them. They focus on improving health related outcomes where lifestyle modification and self-management have a significant impact on outcomes and prognosis, by working with the person to set personalised goals.*" (NHS England, 2023c)

Care Co-ordinators

NHS England guidance for the role of 'Care Coordinators' provides the following explanation:

> *"Care co-ordinators work with people to build trusting relationships and listen to what matters to them. They work with a range of people, particularly those with long-term conditions, multiple long-term conditions, and people living with or at risk of frailty. They help people co-ordinate and navigate their care across the health and care system and can support people to become more active in their own health and care." (*NHS England, 2023d)

High Intensity Use (HIU) programme

Amongst other approaches this programme is to collaborate with local voluntary and community organisations, suggesting a strong connection with the activities of the Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Co-ordinators. NHS England guidance for the programme provides the following explanation, extracts for illustration:

> "*The High Intensity Use (HIU) Service has been designed and developed with people who have lived experience of accessing healthcare regularly. The services are commissioned and delivered at local level, regionally led and supported at national level.*"
>
> ***"Discharge from the project to community or voluntary support services.*** *Community or voluntary support services are available when the individual needs on-going support but not at the intensity or level of the HIU Lead. Many are reconnected to their community with renewed friends and purpose."* (NHS England, 2023e)

1.3.4 Voluntary, Community and Social Enterprise (VCSE)

While commonly used this term is not well understood and often used interchangeably with terms such as ‘Third Sector’, ‘Charitable Sector’ ‘Voluntary and Community’ sector. It has no agreed definition but generally includes organisations, whether or not incorporated, operating for a social purpose. It can include charities, co-operatives or community interest companies, and all forms of unincorporated associations. There term has been extended and is now also used including faith-based organisations as ‘Voluntary, Community, Faith and Social Enterprise (VCFSE)’.

1.4 Limitations

This project was commissioned and undertaken within a compressed timescale coinciding with ongoing disruption in communities and reduced capabilities of respondents to engage, for example, during strike action within the health service. Fewer than 40% of the expected respondents took part. It is assumed that this is due to work pressures on the respondents and disruptions including strike action in various sectors. Patient referral data and Social Prescriber Link Worker data are not comprehensive.

2 About ‘social prescribing’ in Norfolk and Waveney

According to data from the Census 2021, East Anglia was the region with the largest population increase in England. While in North Norfolk, for example, the population size has increased by 1.5%, areas such as Breckland and Broadland experienced larger increases of 8.4% and 5.7%, respectively (Office of National Statistics, 2022). This illustrates diverse geographies and socio demographics, subject to uneven changes.

Based on data from 85% of all GPs who have 1,085,614 patients registered, we estimate a total of approximately 1,290,000 patients registered in Norfolk and Waveney. Based on data from 85% of all GPs who have 8,687 patients with a diagnosis of dementia, we estimate approximately 10,000 people living with dementia, currently diagnosed in Norfolk and Waveney, approximately 0.8%. This appears to be fewer than what data from Alzheimer Research UK about people living with dementia in the UK suggests (Alzheimer Research UK, 2023). Together with the projection of an ageing population this indicates the potential of increasing demand.

According to data by the Charity Commission in Norfolk and Suffolk over 6000 charities are registered with a total income of over £1 billion per annum. This compares to over 180,000 charities with a total income of £80 billion across England and Wales and suggest a lower income in the East of England. London alone has double the number of charities registered and charities in the City of London and City of Westminster have a combined income 70% higher than Norfolk and Suffolk combined. Furthermore, the top ten earning charities in Norfolk and Suffolk received approximately 25% of this, the entire charitable income in the region, whereas 45% of charities receive less than £ 10,000 a year (Charity Commission, 2023). This suggests general geographical diversity and that much of the activities of charities in Norfolk and Suffolk will be volunteer led.

According to NHS Digital (2023) General Practice Workforce statistics for Primary Care Networks in NHS Norfolk and Waveney in February 2023 a total of 178 individual staff (157.3 FTE) are employed, as Care Coordinators (87.5 FTE), Health and Wellbeing Coaches (22.8 FTE) and Social Prescribing Link Workers (47 FTE). Additional data from NHS Norfolk and Waveney ICB states that currently a total of around 250 to 300 individual staff are involved in social prescribing in a number of teams covering all 17 PCNs in Norfolk and Waveney (See Figure 1 and Appendix D). According to the ICB social prescribing roles are funded through ‘NHS Additional Roles Reimbursement Scheme (ARRS) Primary Care Networks’. According to information from the ICB currently training, development and community engagement is still likely to vary greatly across Norfolk and Waveney and depends on where the contract is held. According to information from the ICB, specialist services for people living with dementia are usually provided through ‘Mental Health Services’.

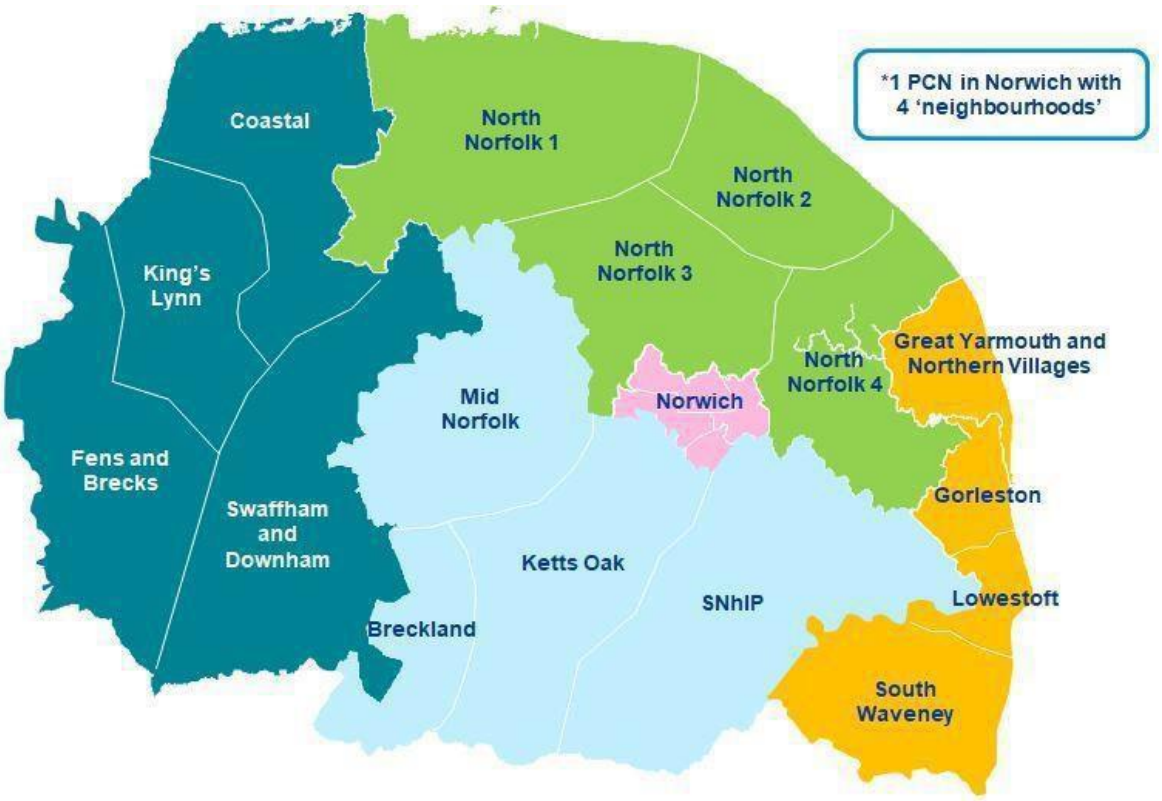

Figure 1: Map of Primary Care Networks (PCNs)
(Norfolk and Waveney Integrated Care System, 2023)

2.1 Ways of working

Responses from Social Prescribing Link Workers who took part in this evaluation (interviewees) highlighted how versatile and responsive the Social Prescribing service can be, both in the variety of the referral routes and different modes of engaging with patients. The interviewees indicated an aspiration to have an increasingly broad range of partners to increase the number and type of referral routes, so that social prescription could be utilised by other services, across health and other sectors, such as police, councils, voluntary agencies. The relationship was also perceived to be two-way, with interviewees describing the need to always increase their knowledge of options for appropriate referral onwards as possible, again including both statutory and voluntary sector agencies. The importance of working relationships and networks, such as with councils, to share information about services was also mentioned.

All the interviewees worked with PCNs and took referrals from GP surgeries and a range of other health professionals including PCN pharmacists, Health Care Assistants, nurses, Occupational Therapists, Assistant Practitioners, nearby hospital staff, local councils and social care services, the police and voluntary sector such as foodbanks and other agencies. One team described how the list of partners and referrals was continually growing as awareness of the social prescription service spread.

2.1.1 Methods of engagement

The interviews revealed a variety of ways of working in terms of the delivery of social prescription service across the counties. These methods of engagement with patients ranged from offering remote communication, telephone, not generally online, or face-to-face. This might happen in the patient's own home in the case of one of the teams, but for other teams would only be in a GP surgery or community space. Some of the social prescribing teams used a mix of these approaches across the appointments, for instance starting with an initial phone assessment then agreeing the preferred type of engagement with each patient individually. One interviewer described how when their team were referred people who were living with dementia and those that cared for them, they usually ended up working with both individuals to address the various needs, despite it likely be being described as one case.

This range of approaches described was tied to the aspiration to make the service bespoke, tailored to the preference and needs of the individual case and responding to their preferred contact style. A further aspect of the bespoke approach was evidenced in the discussions about the regular, usually weekly, team meetings to decide how cases would be allocated. In one team Social Prescribing Link Workers were expected to cover all areas but tending to have an area of specialism. Where possible, cases were designated based on these specialisms, but this depended on feasibility and other factors such as workload or holidays. In another team the assignment of cases was similar but described as aiming to match the needs of the patient with a team member's strengths, skills, or interests. The third team, which is working in the context of an inherited backlog of cases, has set up an additional triage system which each week has a meeting to look at the new referrals received the week before and respond to all urgent enquiries that require onward referrals by calling these through to the appropriate service, such as carer's support agencies, Mental Health, or Occupational Therapy. In all teams there was mention of how colleagues learn from each other's experiences and specialisms at the team meetings.

2.1.2 Capacity

Two of the interviewees emphasised the challenges of being understaffed, time pressured and having large rural geographic areas to cover. The team with the backlog of referrals said that this has meant that by the time contact occurs around 20% of people had been able to resolve their initial crisis and no longer need to engage with the service, however another proportion of people may sadly have seen their situation worsen, or in some cases even have died, in the interim. This team felt the waiting time was far too long and that there is an urgent need to increase the number of workers and thus increase the team's capacity to deal with more cases swiftly.

NHS guidance at the moment does not appear to take into account geographical difference and socio demographic difference within geographies into account.

> *"The maximum safe caseload is 200-250 per year and may be less, based on the complexity of cases and the maturity of the social prescribing service."* (NHS England, 2023b)

2.2 Understanding the role

Interviewees described their role as being about relieving the pressure on Primary Care by supporting people with their non-medical needs. They felt that working with people on what matters most to them, creating a relationship from the start where the person referred can express their needs and wants, and then working together to create solutions was very important to them. They suggested that Social Prescribing Link Workers signpost to support and may either make the call on behalf of or with the person, or encourage and support them with directly making the contact themselves. Examples given by interviewees included support with accessing social care, and mental health services, resolving benefits or housing issues, as well as signposting to positive activities in the person's local area.

Knowledge of what is available was described as a key attribute of the role. Interviewees alluded to the need to have as many options as possible available to enable them to discuss current possibilities. Keeping up with changes in the available services, both in the statutory and the voluntary and community sectors is in itself time-consuming, and networking across the sectors is vital to ensuring information is up-to-date.

2.2.1 Navigating challenges

One interviewee described tensions, at times, between what the professional making the referral thinks the person would benefit from compared with what the person might think or want, or not want, for themselves. A further tension was identified about the need to be realistic with regard to expectations, as what a person may want may not be achievable for a range of reasons. Such reasons might include services not being available, or the person might not reach the thresholds set for an intervention. At times a Social Prescribing Link Worker might need to provide a space for individuals to express and process difficulties whilst waiting for other services. Another challenge mentioned was around navigating social care when individuals do not want to disclose financial information. All of these point to the Social Prescribing Link Worker's role in navigating such tensions through building of relationships, so that trust can be built, and workable compromises can be reached.

2.2.2 Vision for the role

In discussion about their understanding of the Social Prescribing Link Workers role, one of those interviewed discussed how through their work with people who make repeat calls for ambulance service or repeated attendance at A&E, they have identified that these crises are often triggered by the person not managing existing health condition or health anxieties that social prescription could do more work to prevent these crises arising if they were referred the cases earlier. This participant felt strongly that Social Prescribing Link Workers should be working across an even broader range of services, they gave examples including hospitals, prisons and probation services and Dementia Cafes. This team are setting up Walking and Talking groups for some of the people they work with. These are invite-only groups that aim to give ongoing support by promoting physical activity and building social networks. This expands the vision of the role to being

active in creating ongoing support systems.

2.3 Summary and conclusion

In the area of the NHS Norfolk and Waveney Integrated Care System an estimated 250 members of staff have been recruited to be involved in social prescribing, as Care Coordinators, Health and Wellbeing Coaches and Social Prescribing Link Workers. With over 150 full time equivalent (FTE) posts, this reflects as substantive funding commitment. Referrals from health care professionals to Social Prescribing Link Workers are under way and being processed. However, it is clear that geographic diversity, uneven availability, and varied working practices are, and will continue, to affect whether and how social prescribing can be delivered across the NHS Norfolk and Waveney Integrated Care System.

3 About ‘social prescribing’ for people living with dementia in Norfolk and Waveney

A common thread that emerged from the interviews related to the role that social prescribing is perceived to play in supporting bespoke, personalised care for people living with dementia and carers. Social prescribing was also considered to enable a comprehensive and integrated approach that recognises patients’ diverse social needs and contexts.

3.1 Enabling personalised care

The “big question” that interview participants viewed as guiding social prescribing was: “what matters most to the person?” Interviewees shared a common view that social prescribing places the patient at the centre, prioritising the needs of people living with dementia and carers from the very start of their engagement with the service. Interviewees felt that questions such as “what is going well for the patient, and what is not going so well?” were important. They described how the breadth of their knowledge about services in the local community enabled them to match the needs of people living with dementia and carers to the most appropriate support. Interviewees imagined their role as akin to having a “*basket full of knowledge*” (SP002), from which they take out pieces of information that are most relevant to a patients’ needs and goals. They suggested that Social Prescribing Link Workers can distil information about local services and support for patients through personalisation, providing information based on what is most relevant to the patient.

Working with patients to identify what they see their needs to be, and what is important to them was seen as most important when matching patients with relevant services in the community as part of social prescribing. In doing this, Social Prescribing Link Workers may have to navigate other viewpoints, distinguishing the patient’s perception about what they think their needs are from the views of other professionals. One Social Prescribing Link Worker reflected on instances in which the depiction of the persons’ needs stated in a referral, in that case from a GP service, differed greatly to what the patient perceived their needs to be, upon meeting with the patient for the first time. Such experiences were thought to further validate the need to start with asking, and not presuming what the person says they need and want from the outset, as a key tenet of personalised care.

An important way in which personalised care is enacted, in which social prescribing services are shaped around the patient, is by exploring how the patient would like to receive support. This involves the patient deciding on the level of contact they would like to receive from the social prescribing team, such as in terms of when and how often they would like to have a meeting, as well as deciding the point at which they no longer need support. The location at which Interviewees meet with the patient is also directed by what the patient would prefer. It may be in a community centre, having a telephone call, and some teams offer home visits. Interviewees could generally take a flexible, case-by-case approach to personalise how they engage with patients, such as by keeping lines of contact open for those who previously used the service and occasionally checking-in.

While some teams offered a typical level of contact, for example, between 6-12 meetings, others had what was described as "*the luxury of time*" (SP002). For teams based in one PCN, limits were not always placed on how long Social Prescribing Link Workers can work with a patient, thereby enabling teams to have ongoing contact with patients where required.

Relatedly, some interviewees suspected that their contact with people living with dementia tended to extend over a longer period. This was because, firstly, these individuals would not 'recover' from this illness and, secondly, what the patient needs and the problems they encounter might alter drastically or gradually over time, as their dementia progresses. As a result, people living with dementia may require support from other services for different needs in the future, at which point re-accessing social prescribing services might be beneficial. With this flexibility around the amount of time that teams can offer patients, people living with dementia and carers can access support from Interviewees in a way that suits their needs as these evolve. Offering meetings for people living with dementia over longer periods also enabled time to build relationships and trust with patients and their families. Social Prescribing Link Workers discussed how being able to build relationships and trust is an integral part and distinct strength of their role, especially when working with 'hard-to-reach' or excluded communities.

In some cases, social prescribing services may not be directly accessible to people living with dementia. One interviewee reported that their team does not accept referrals or provide support for people who are deemed to lack capacity to be able to consent to and engage with the service, which includes people who have received a dementia diagnosis. Yet, there have been cases in which some individuals who have accessed the service show early, typically milder, signs of dementia, for which they had not been assessed or diagnosed. For example, clients may have divulged information about confusing close relatives with one another or forgetting their names. In such situations a Social Prescribing Link Worker may gently suggest that the person speak to their GP to perhaps request a memory assessment. They may also draw upon their training of supporting people living with dementia from a previous role, to suggest coping strategies for everyday life, such as wall calendars and speaking to family about their difficulties. The service does, however, provide in-direct support for people living with dementia. For example, by spending one day a week in a GP service, the Social Prescribing Link Worker provides information to staff to share with patients and carers about local dementia-friendly activities, and to families of people living with dementia in situ.

Finally, interviewees acknowledged that the principle of personalised care, which prioritises the needs of the patient, must be balanced with other important considerations. Such considerations pertain to, firstly, managing patients' expectations and being realistic about what is possible for social prescribing to help with. As one interviewee expressed it "*being realistic about expectations, as what a person wants may not be achievable sometimes*" (SP001). Secondly, another interviewee noted that the only time the social prescribing service is not guided by what the person wants is when this raises an apparent safeguarding need, which would take priority. Another aspect highlighted was the importance of being clear about role boundaries which could be challenging, as the Social Prescribing Link Worker job is a non-clinical role and is not a short-cut to specific medical services.

Overall, Social Prescribing Link Workers work closely with people living by dementia to find out what matters most to them, as described in their own terms, to provide information about local services that is personalised to the patients' needs and goals. This is a process that requires Social Prescribing Link Workers to navigate differing viewpoints among patients and professionals about what is needed, to manage patient expectations, and prioritise safeguarding needs, if need be reporting concerns. One interviewee explained that they observed issues and reported them "*to adult safeguarding for escalation*" (SP004).

3.2 Enabling a comprehensive and integrated approach

3.2.1 Supporting family carers of people living with dementia

For some teams, social prescribing for family carers who support a person living with dementia, such as a partner, who might be in older age, rather than people living with dementia themselves, tends to form a larger proportion of their caseload. Social Prescribing Link Workers repeatedly returned to the importance, in their view, of considering and addressing the needs of, and what matters to carers, as well as the person living with dementia. Interviewees suggested that relieving the stresses of family carers, and supporting them to cope, can help to improve the lives of people living with dementia. As one participant expressed it "*if carers are OK, the person they care for will likely be OK*" (SP002).

Interviewees recognised that family members who care for people living with dementia also have needs and wishes that need to be considered. This is especially the case for older people who care for a family member living with dementia, as these individuals are also likely to have a range of potentially complex health conditions and medicinal needs, which need to be managed effectively for them to support a person living with dementia. For example, interviewees discussed how carers can become confused and overwhelmed with managing their own medications along with the person's living with dementia they care for. In such situations, interviewees have intervened and liaised with community pharmacies to get carers help with organising medications.

Interviewees also noted that, in some cases, family carers take telephone calls with them in a different room, out of the hearing of their relative living with dementia, or they might request a face-to-face meeting alone with the Social Prescribing Link Worker, so they can speak honestly and openly about their needs and difficulties. This was thought to further indicate the need for comprehensive and integrated support that considers the information and support needs of those who care for people living with dementia. However, a possible limitation of undertaking telephone meetings is that Social Prescribing Link Workers will not have direct contact with people living with dementia, particularly as conversations tend to take place with the person's family carer, once their permission has been gained.

3.2.2 Recognising social needs and contexts

Interviewees alluded to the idea that social prescribing enables comprehensive and integrated personalised care by recognising that a person's physical health is affected by their social situation, including their socioeconomic position, housing arrangements, and their mental and physical health. In this sense, the term "holistic" was explicitly used by interviewees to describe the way in which social prescribing works to address social issues and "*non-medical needs*" (SP001), whilst working alongside medical approaches. Interviewees described a range of non-medical services they are linked to, reflecting their appreciation for a person's social needs, for example, services for social care, social security benefits, housing, and even local foodbanks and the police.

3.3 Skills for working with people living with dementia and their carers

On the theme of training tailored to supporting people living with dementia, interviewees described a range of training and skills from previous work experience, as well as first-hand lived experience of carers' roles within their own families. Training accessed included mandatory induction courses and annual refreshers on topics such as the Mental Capacity Act. Some of the training was from the NHS and on one occasion a local GP surgery. They also mentioned literature resources available from Norfolk and Waveney NHS. One interviewee said that there were limits to how much could be learnt or understood from classroom-based training on this topic, and interviewees highlighted that they benefited from working alongside team members who had previous experience in working with people living with dementia. One had worked for the Alzheimer's Society while another had worked with people living with dementia in care settings, and yet another participant had a colleague who had previously worked in care homes. In most cases, those team members were initially more likely to be allocated cases with people living with dementia, as their specialism, but as their colleagues' confidence increased, and workloads also, the cases have been distributed more evenly. The support that team members gave each other in this learning process was seen as paramount. One interviewee described doing home visits in pairs, and another said that file discussions during team supervisions were invaluable for increasing understanding.

The essential training for the Social Prescribing Link Workers role has come online now and aims to increase the qualifications and skills within the teams. One of the interviewees said that the training for the role needs to cover a broad range of topics including finance advice, Mental Health and Dementia and highlighted that increasing the development of the role through building its skill base is important for the service going forward.

3.4 Summary and conclusion

Social Prescribing Link Workers who took part in this evaluation expressed a shared commitment to services that are shaped around the individual, responding not just to needs identified by health professionals but also to how someone would like to receive their support. However, there might still be practical disconnects, for example, how far collaborative working and communication between services, other connected roles and sectors has progressed as part of this or what happens when the depiction of an individual's needs stated in a referral differs distinctly from what that person perceives their needs to be, or when services or volunteering opportunities might not be available and expectations need to be managed or concerns need to be reported.

4 The role of volunteer involvement in social prescribing for people living with dementia and their carers

Social Prescribing Link Workers who took part in this evaluation noted that many organisations, to whom they refer patients, are run by teams of volunteers. Whilst these organisations might have some paid roles, they are predominately volunteer-led, including those for people living with dementia and their family carers.

4.1 Benefits of volunteer involvement

Volunteer involvement was deemed an integral part of social prescribing, particularly for people living with dementia and their family carers. Interviewees described a range of activities that are available in some localities for people living with dementia, such as a dementia café, a singing group, and seated exercise classes. One interviewee thought that a key strength of volunteer involvement in social prescribing was the level of flexibility that is possible, in which opportunities can be shaped to fit the person, rather than being tied to delivering a specific statutory service. In this way, volunteers can offer an informal space for individuals to chat about everyday life and things outside of dementia, in a non-professional or medical environment, for example, over a cup of tea. Interviewees highlighted the need for a large range of organisations and opportunities to be able to find the right activity for someone, as social prescribing is not a one-size-fits-all service.

4.2 Challenges of volunteer involvement

Despite the contribution of volunteer involvement to social prescribing, interviewees discussed a range of shortfalls and capacity challenges. Interviewees noted the ways in which volunteer-led organisations operated, and the kinds of volunteer involvement opportunities they offered, had changed because of the Covid-19 pandemic. They felt that volunteers continued to only offer telephone calls, such as for befriending, yet interviewees thought that many older people would prefer to see somebody face-to-face for a range of reasons. Where volunteers have continued to be involved in-person, these opportunities might be difficult to access depending on where an individual lives. For example, individuals living in villages might not be able to access such opportunities. Interviewees also noted that the number of volunteers seems to have declined in the current climate. This suggested capacity challenges with volunteer involvement.

Interviewees reported an overall lack of volunteer opportunities and support for people living with dementia, such as respite for family carers and support for younger people living with dementia. Interviewees suggested that a greater level of volunteer support for carers would be beneficial, so that carers can have time for themselves to participate in activities that matter to them. However, they recognised that some people living with dementia may not want support from a volunteer, and carers often feel

compelled to accept these wishes. To remedy this, carers sometimes need to think creatively about how to meet their own needs and respect those of the person living with dementia. One interviewee gave an example of a carer who paid someone to give their partner living with dementia an exercise class for an hour and half, whilst she went to an exercise class on her own for one hour.

These reflections from interviewees suggest that volunteer involvement plays an important role in supporting the needs of people living with dementia and their carers, by offering activities that matter to them, particularly around wellbeing. However, volunteer involvement opportunities are not evenly spread geographically, so there will be physical gaps in volunteer involvement opportunities as well as gaps in the types of volunteer involvement opportunities that are available. There are wider capacity challenges around funding and continuity of volunteer involvement and in terms of connecting to new volunteers. Despite these limitations, all interviewees emphasised the vital part that volunteer involvement plays in supporting people living with dementia and their carers.

4.3 Summary and conclusion

The findings from this evaluation suggests that for people living with dementia, not just volunteer involvement for themselves, but also additional dementia friendly activities provided by volunteers and non-statutory services offer a distinct way to extend personalised care. However, it is clear that volunteering opportunities cannot be universally relied upon and may not be able to meet rising demand.

5 Case examples

Building on the findings around the ways that social prescribing can enable personalised care and a comprehensive and integrated approach for people living with dementia and their carers, the following section summarises case examples to illustrate how social prescribing has supported patients in Norfolk and Waveney.

5.1 Supporting independent physical activity for a person living with dementia.

One interviewee described an example of supporting a person living with dementia to access opportunities to engage in a physical activity that mattered to them. The interviewee described how, for this person living with dementia, fitness and staying healthy was very important and that they had attended a gym regularly. Since receiving their dementia diagnosis, they stopped going to the gym, as they were concerned about forgetting how to use the exercise machines and equipment. The Social Prescribing Link Worker linked this individual with a local gym that could provide physical printouts with clear instructions about how to use the equipment, which the person could keep to hand. Linking the person to this dementia-friendly provision enabled them to independently participate in a form of physical activity that was meaningful and important to them.

5.2 Tailoring support for a couple who were processing a dementia diagnosis.

Another interviewee supported a husband and wife who had recently received a dementia diagnosis and were referred for social prescribing due to difficulties related to low mood, social isolation, and financial stress. The couple chose to meet with them at a community centre, as they initially needed time and space to talk through the life-changing adjustments they were having to make. The Social Prescribing Link Worker delivered personalised care by organising a meeting with Citizen's Advice Bureau to help sort their finances. The person living with dementia agreed to meet with a Mental Health Support Worker and expressed interest in joining a Men's Shed and men's craft group. The Social Prescribing Link Worker also linked the person's partner to a local carer's support service.

5.3 Enabling a person living with dementia to stay living at home by linking their partner/carer with support services.

Another interviewee encountered a situation of a person living with dementia who feared being put into a care home, but whose partner could no longer cope with supporting them. The Social Prescribing Link Worker worked with both the person living with dementia and their partner to understand each of their rights and needs, factoring in mental capacity and what options were available. The Social Prescribing Link Worker was able to arrange for professional carers to come into the person's home to relieve some of pressure from their partner, enabling the person living with dementia to continue living in their home.

5.4 Listening to and supporting carers' needs

Interviewees also gave two key examples which conveyed the role of Social Prescribing Link Workers in listening to carers' needs in the context of supporting people living with dementia.

In the first example, a Social Prescribing Link Worker supported a carer whose partner living with dementia wanted only their partner to look after them, not any professional carers. Their partner's behaviour was deemed risky, for example, they would not turn off the gas hob, and therefore they could not be left alone. The Social Prescribing Link Worker started to have conversations with the carer to help them to understand that their own needs and feelings matter, and that services are available to support them so they can make an informed decision about what is best for them.

In the second example, a Social Prescribing Link Worker supported an older family carer who was experiencing feelings of guilt about the prospect of moving her partner living with dementia into a care home. After the person's partner unfortunately died, the Social Prescribing Link Worker continued to support the person to deal with their feelings of guilt and bereavement, by offering a space to talk and putting things in place for her to take care of her own mental health and wellbeing, such as going on dog walks with a friend.

6 Summary and conclusion

6.1 General

6.1.1 An institutional commitment to personalised Health and Social Care

Social prescribing is being introduced nationwide in England, with over 7000 members of staff employed, and with the recently published 'Workforce development framework: social prescribing link workers' (NHS England, 2023b) providing detailed guidance for staff and the organisations employing them. This is part of a deliberate institutional commitment to the concept of personalised health and social care.

6.1.2 A funding commitment to social prescribing in Norfolk and Waveney

In the area of the NHS Norfolk and Waveney Integrated Care System the introduction of social prescribing is well under way with an estimated 250 individual members of staff, at over 150 FTE, having been recruited by early 2023. This reflects a substantive funding commitment. However, it is unclear from this evaluation how far collaborative working and communication between sectors has progressed, in particular between the employers of Social Prescribing Link Workers, which in Norfolk and Waveney are mostly Primary Care Networks (PCNs), and the volunteer involving organisations which are, or are intended to become, part of social prescribing.

6.1.3 A personal commitment to personalised care for people living with dementia

Social Prescribing Link Workers who took part in this evaluation expressed a shared commitment to services that are shaped around the individual, responding not just to needs identified by health professionals but also to how someone would like to receive support. This reflects a personal commitment to personalised care and has the potential to reduce health inequalities. The purpose of social prescribing is perceived as relieving the pressure on Primary Care by supporting people with their non-medical needs. However, there might still be practical disconnects, for example, when the depiction of an individual's needs stated in a referral differs distinctly to what that person perceives their needs to be or when their expectations need to be managed.

6.1.4 Volunteer involvement in social prescribing enabling personalised care for people living with dementia

The findings from this explorative evaluation suggest that for patients living with dementia not just volunteer involvement for themselves but also additional dementia friendly activities provided by volunteers and non-statutory services offer a distinct way to support personalised care. This could also extend to support for carers. The findings suggest a distinct role for volunteer involvement in social prescribing enabling personalised care for people living with dementia. However, it is unclear from this evaluation whether this distinct contribution is currently explored to its full potential and whether support is likely to be able to meet potential demand evenly.

6.2 Implications for policy and practice

This evaluation identified a number of areas which might be relevant for further consideration in policy and practice development, in particular around relationships and collaboration within the ICB and within the local volunteer involvement landscape.

6.2.1 Forward together

The low uptake of participation in the evaluation suggests a number of possible causes related, for example, to workload but also potentially related to the relationships and connection between the ICB central administration and the operations of the employers of the Social Prescribing Link Workers, predominantly Primary Care Networks (PCNs). It might be helpful to undertake activities in order to generate a shared vision amongst decentralised Social Prescribing Link Workers and the centralised administration in NHS Norfolk and Waveney Integrated Care System.

6.2.2 Understanding local volunteer involvement opportunities

Personalised care is by its nature usually provided locally. To match local volunteer involvement opportunities with local need requires detailed knowledge of such opportunities. It will be challenging for Social Prescribing Link Workers to familiarise themselves with the full range of opportunities and to keep abreast of changes. It might be helpful to work with local partners or have easy access to curated and updated information. To get to know possible partners it might be helpful to undertake activities which brings together local Social Prescribing Link Workers with the local volunteer involvement partners.

6.2.3 Strengthening understanding of health professionals

There were some suggestions that referrals from health professionals might not always be a direct match to what might either be sought by the individual referred or to what is available locally. It might therefore be helpful to undertake activities which bring together local Social Prescribing Link Workers with the local health professionals to gain a shared vision and understanding of volunteer involvement opportunities.

6.2.4 Resourcing and supporting local volunteer involvement opportunities

The funding commitment to social prescribing is evident from the employment of Social Prescribing Link Workers, however, this commitment does not appear to extend to support for the volunteer involvement opportunities which are required to effectively match opportunity with need, supporting personalised care.

6.2.5 Monitoring and evaluation

Monitoring and evaluating social might be challenging given the diversity of providers and the way they operate. It could be helpful to develop a shared understanding, for example, by jointly developing a theory of change, see also NHS on sustainable change (NHS England, 2023f).

6.3 Implications for further research

This project has contrasted the overall ambition of and investment in social prescribing with the practical achievements and potential obstacles to making this ambition a reality. From the limited data available it would appear that the existing commitments to make it work, both from the funding bodies and the link workers, offer an opportunity for sustainable change, however, the evidence also suggests that any activities are likely to reflect an uphill struggle with resources for key partners limited and potentially shrinking, demand expected to rise and support availability geographically uneven, putting pressure on the way social prescribing can be delivered.

6.3.1 Funding commitment

There is a clear funding commitment expressed by the number of staff already working within social prescribing. However, it seems unclear whether allocations are commensurate with the service needs based on patients' data, for example, will Social Prescribing Link Workers have enough time to improve personalised care for each referred individual. There are early indications of waiting lists not just to see the Social Prescribing Link Worker but also for services that individuals might be linked with, which in turn might lead to rationing or a deterioration of the service. The question this raises is what funding might be required to enable reliable and geographically-even social prescribing, i.e. what is a reasonable case allocation in a rural versus an urban area, and how can local volunteer involvement be strengthened in areas where it is weak.

6.3.2 Commitment to collaborative working

Social prescribing with volunteer involvement, while in some parts purely transactional, relies in the most part on relationships and trust which need to be built between Social Prescribing Link Workers and volunteers and those who involve volunteers. It is expected to be rare that volunteer involvement opportunities have to be provided as part of a contractual agreement, so it is essential that Social Prescribing Link Workers, volunteers and those who involve volunteers have trust that the other will act collaboratively and in good faith.

6.3.3 Commitment of referring healthcare professionals

The introduction of social prescribing might be problematic with health care professionals. Evidence from this evaluation points to potential problems with the detail in referrals but it is likely to extend further. It might be relevant to understand what can support buy-in of referring healthcare professionals and how ICBs can support this.

6.3.4 Skills survey and service mapping

It appears that practice of Social Prescribing Link Workers, albeit now with some national guidance, is uneven. To understand the needs of Social Prescribing Link Workers it appears necessary to map their skills or at a minimum what they perceive as a need. At the same time each Social Prescribing Link Worker will operate in a different landscape of volunteer involvement. It is probably not feasible to map that landscape

comprehensively across even a single PCN, let alone an entire ICB area, however, it might be helpful to explore what Social Prescribing Link Workers can do to map opportunities on their patch.

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8 Appendix

A: Validated summaries

Anonymised summary SP001

Service profile and ways of working:

- Works remotely (telephone, email). Face-to-face meetings offered where appropriate or preferred by patients, taking place in a community setting/surgery. No home visits.
- Referrals come mainly from GP surgeries (GPs, HCAs, nurses, PCN pharmacy team) and sometimes from local council or community settings.
- Team members can cover all areas but tend to have an area of specialism. Where possible, cases are designated based on these specialisms, but this depends on feasibility and other factors (workload, holidays).
- Colleagues learn from each other's experiences and specialisms at daily meetings.

Role of social prescribing in general:

- The big question is always what matters most to the person.
- Allows the person to express what matters to them from the very start.
- A tension between what the professional referring thinks the person would benefit from and what the person thinks and wants/does not want.
- Signposting to support and encouraging people to contact services themselves.
- Being realistic about expectations, as what a person wants may not be achievable.
- Relieving pressure on primary care by supporting those with non-medical needs.

Enabling personalised care:

- Helps a person to identify what they need and what is important to them.
- Supports people to make choices based on what is available to them.
- Offers a single, direct point of contact to access relevant information and support.
- Considers carers' support needs. E.g., linked a carer with a pharmacist to organise theirs/their mother with dementias' prescriptions when confused/overwhelmed.

How social prescribing works for people with dementia and carers:

- Mostly telephone meetings: people with dementia often feel unable to leave the house or they access other services and solely need information.
- Referrals can be for carers and/or people with dementia. Most contact is with the person's carer, though if the referral is for the person with dementia, the participant will gain consent from the person for the carer to speak to them.
- Support for carers tends to be what is required most.
- Person who requires support decides on their contact moving forward.
- Contact with people affected by dementia tends to be longer, as they will not recover from this illness and their needs/issues might alter, so other support might be needed.
- Nature of contact varies case-by-case. E.g., participant has ongoing contact with a

carer to offer relief and signposting to services. Yet, they may not hear from others once a link has been made, or support might be requested again in the future.

Positive impacts for people with dementia and carers:

- Encouraging the person with dementia to go out (including those in early stages).
- Finding opportunities to stay healthy. Participant linked a person with dementia who wanted to keep fit with a gym that provides a printout about how to use equipment.

Professional knowledge and experiences of dementia:

- Participant came to the role with prior experience/training (e.g., worked for the Alzheimer's Society; and family experiences of dementia).
- Because of their prior experience, participant tends to take most dementia referrals.
- Team has access to courses about dementia if they require it (e.g., NHS courses).
- Important to be clear about role boundaries; a delicate balance as the role is non-clinical role and is not a short-cut to services. E.g., they were contacted by a carer whose mother with dementia had suddenly deteriorated; participant suspected a UTI and requested a one-off GP appointment. This was agreed and a UTI was confirmed.
- Relieving carers stress can help to improve the lives of people with dementia.

Pros/cons of meeting modalities (face-to-face, telephone, emails):

- Telephone calls are quite effective. Main challenge relates to hearing difficulties in older people. Solutions are raising one's voice or offering to meet in person.
- People often prefer telephone rather than face-to-face meetings (less effort).
- When supporting carers, carers may take the telephone call to a different room so they can speak honestly and openly out of the hearing of the person with dementia, or they sometimes prefer a 1-1 meeting in-person for these reasons.

Benefits of volunteering in social prescribing:

- Offering a space to talk about things other than dementia, away from professionals.
- Able to offer informal support (e.g., over a cup of tea)
- Can take a flexible approach to fit the person; they are not tied to delivering a service.

Challenges or shortfalls in volunteering in social prescribing:

- Lack of volunteer opportunities especially since Covid-19 (e.g., loss of respite support).
- People with dementia may not accept or want support from a volunteer or service, and carers often feel compelled to accept these wishes.
- A need for support for younger people with dementia (e.g., outside of Age UK)

Challenges with access to services:

- Waiting times and lack of availability of many services
- A need for greater availability of care package, befriending, and respite services

Anonymised summary SP002

Service profile and ways of working:

- A team of four social prescribers (usually five, currently understaffed).
- Receive a large number of referrals (approx. 10 per day), mainly from GP services and some from councils, agencies, and voluntary sector (e.g., foodbanks, the police).
- Referrals are assigned at a weekly team meeting depending on who can meet the needs of a person based on team members' strengths, skills, and interests. E.g., participant experienced with PIP forms, children and families.
- A lot of work is with the carers who support a person.
- Link with local/county councils and social care to share information about services.

Role of social prescribing in general:

- Signposting to relevant services (e.g., social care, social security benefits, housing).
- Having a basket full of knowledge and taking out the bits that people want or need.
- Always about what the person needs/wants; the only time it isn't is when there is a safeguarding need that must move forward.
- Supporting a wide spectrum of people.
- Navigating social care when individuals do not want to disclose financial information.
- Providing a space for individuals to express and process difficulties when waiting for other services, or when services are unavailable, or they do not meet their thresholds.

Professionals' understanding of the social prescriber role:

- GP services do not always understand the role and limits of social prescribers and sometimes treat them as an easy option; whilst social prescribers support mental health, they are not trained mental health workers, and this misunderstanding can be difficult/burdensome. Participant shared an experience of a client who died by suicide.
- GPs may not fully understand the role as, unlike other social prescribing teams, this participant's team does not have strict guidelines (e.g., they accept most referrals).
- Social prescribers might see themselves as unpaid and unqualified social workers, as they do the same work.

Enabling personalised care:

- Having the luxury of time, as the PCN has not placed a limit on how long social prescribers can work with a client, e.g., some clients have ongoing contact.
- Helping people to deal with day-to-day tasks and the little things that matter to them in daily life (e.g., mobility aids to go shopping, sorting out prescriptions).
- Checking-in with people every now and then.
- Participant feels privileged in their role, to be able to enter people's lives and build relationships/trust with hard-to-reach people. Participant built trust with an older person with complex needs, who they supported to start receiving carer support.
- Always prioritising the person's needs (e.g., they tend to visit older people in-person).

How social prescribing supports people with dementia and carers:

- Supporting older people and dementia patients during a 40-week wait for mental health assessment (e.g., getting carers involved if needed).
- Recognising carers' needs: if carers are OK, the person they care for will likely be OK.
- Example: person with dementia feared being put into a care home, but their partner/ carer could not cope. Participant supported the person to understand their rights, factoring in mental capacity, and supported the partner by arranging carer support.
- Example: supported a carer whose partner with dementia did not want support but whose behaviours were risky, and they could not be left alone. Participant started conversations with the carer about their own needs and potential support available.
- Providing an outsider's perspective on what is going on, listening to what the person says. Example: supported a carer who felt guilty about the prospect of moving their partner to a care home and dealing with bereavement. Participant helped them to take care of their own wellbeing (e.g., going on dog walks with a friend).
- Getting an insight into what is going on by visiting people at home. E.g., participant witnessed unusual behaviours and had honest conversations with the person and their carer in the home, but the person with dementia behaved lucid at the GP service.

Benefits of volunteering in social prescribing:

- Volunteers could help by staying with the person with dementia so carers can go out and do what they like/need, to take care of their own wellbeing (e.g., meeting a friend)
- Lots of volunteer-ran support for people with dementia (e.g., a cafe, singing group, seated exercise classes).

Challenges or shortfalls in volunteering:

- Lack of support to give carers time for themselves. Participant gave an example of a carer who would like someone to sit with their partner whilst they go out. Carer worked out a creative solution where she paid someone to give an exercise class for her partner for 1.5 hours, while she goes to an exercise class for 1 hour.
- Where someone lives influences access to support: access issues in villages, as the number of volunteers has declined.
- Volunteers offer phone calls since the Covid-19 pandemic, however a lot of older people would like to see somebody face-to-face.

Professional qualities, and knowledge and experience of dementia:

- Received mandatory induction/annual training, including on the Mental Capacity Act.
- Questioned how much can be learnt from classroom-based training. It is important to take each client/person on their own merits and listen to what they want.
- Participant initially shied away from dementia as they felt they did not know much about it.
- Increasing workloads led the participant/colleagues to work in other areas and with groups they had less experience with; over time, they have become more comfortable with working with people with dementia.
- Participant has learned more about dementia as they have moved along in their role, e.g., learned to work with the truth of a person with dementia on that day.

- Colleagues are encouraged to share situations or groups they feel less comfortable/experienced around (e.g., colleagues will visit homes in twos for safety).
- Personality of the social prescriber is key for building connections with people.

Anonymised summary SP003

Service Profile and ways of working

- Team of 4 Social Prescribers (SPs) total to cover large, very rural PCN area
- Take referrals from GPs, attend regular Multi-Disciplinary Team meetings, also get referrals from Hospital, various health teams, Assistant Practitioners, Occupational Therapists (OT), and other partners (increasing)
- All referrals logged onto the referral spreadsheet
- Inherited a backlog when first started a year ago and still have waiting list of 100, have set up a triage system that each week looks at the previous week's referrals and when needed urgently they make phone contact and refer on to OT or Mental Health teams, or Carers' Support.
- This backlog has meant that by the time the contact occurs around 20% of cases have been able to resolve their initial crisis, another proportion of cases may sadly have worsened or even died. This participant said there are 'nowhere near enough Social Practitioners'.
- This team work face-to-face and will do home visits, or meet at GP surgeries or at community spaces, whatever the person prefers, as well as do phone assessments.

Understanding of the social prescriber role

- Initially information on Social Prescribing was hard to find but fortunately this participant had access to their organisation's resources that were useful
- Through working with frequent flyers (repeat callers for ambulance service/repeat attendees at A&E) this participant identified that, especially with younger callers, it is often about health anxieties or not managing health conditions and that SP could have more of a preventative role if were working upstream to prevent those people reaching crisis stage.
- this participant felt strongly that SPs should be working in a broad range of services, including hospitals, prisons and probation services and Dementia Cafes
- This team are setting up Walking and Talking groups for some of the people they work with, these are invite-only groups that aim to give ongoing support by promoting physical activity and building social networks. The walks are usually planned to end at a café or community space where people can get a hot drink.

Example of Social Prescribing when working with people living with dementia and their carers

- If a referral comes in for a person with dementia the SPs usually end up working with both that person and their carer or carers.
- Gave example of a husband and wife who were referred post dementia diagnosis for low mood, social isolation, and financial stress. The couple chose to meet at a community centre, initially they needed the time and space to talk through the life-changing adjustments they were having to make. The SP organised a meeting with CAB for them to sort finances, then the person with dementia agreed to meet with Mental Health support worker and was interested in joining the Men's Shed and a local Men's Craft groups. The SP also linked the carer to Carers' Support service.

Role of social prescribing in enabling personalised care

- Enables an understanding that people's physical health is clearly affected by their social situations, whether that be economics, or their mental health or physical things like housing, so it requires holistic approach that addresses those issues as well as medical approaches.
- It puts the patient at the centre of the service – key questions are What matters to you? and What's going well? What's not going so well? this approach aims to empower the patient rather than make them feel 'done to'.
- The frequency and number of meetings (usually between 6-12) enables time to build relationships and trust, and enables progress to be made in creative ways.

The role of volunteering in social prescribing

- Refer on to a huge number of agencies that are run by volunteers – may have paid roles but predominantly volunteer-led
- Critical to social prescribing that these organisations exist because of the need to have as large a range of options as possible as it is not a one-size-fits-all service.
- Need as many services in the community as possible to find the right activity for someone

Formal training to support patients and carers with dementia

- PCN gave the SP team dementia training delivered by a GP that was useful
- Literature on dementia from Norfolk and Waveney NHS
- Various skills and experience in this team mean that some of the SPs have specialisms including working with people with dementia and these are shared at the weekly team meetings case file supervision and in allocation discussions
- This helps build other team members understanding and confidence in working with people with dementia and their carers
- The participant listed skills/training and experience of the team member as covering everything from: Children and family services, hospital work, Mental Health carer, CAB and benefits advice, to working with vulnerable people with dementia in Care Homes
- They flagged up that essential training for SP role has come online now. The training for the role needs to include finance advice, Mental Health and Dementia and other topics and will be useful in increasing qualifications and skills with the SP teams
- Increasing the development of the role through building its skill base will be crucial for the service going forward

Key strength of Social Prescription

- It is able to put the patient at the centre of the service.

Anonymised Summary SP004

Service description and ways of working:

- Social prescribing in this locality is made up by five providers/charities, each targeted towards a specific group or area (such as older people, or housing and homelessness) but which cover a wide range of issues/needs within this. For example, this participants' team focusses on people aged 50+ and covers welfare rights, benefits, housing, debt advice, employment and wellbeing activities to combat isolation/loneliness.
- Referrals come mostly from GP services. The person referring (e.g., Integrated Care Coordinators/ICC; General Practitioner; third sector) will write a brief request after gaining the client's verbal consent.
- A CFICS form is sent digitally to the ICC, who triage the request through Team Leaders at Citizens Advice, who then decide which provider is best placed to deal with the case.
- ICCs should contact the client, when a triage has been made, to discuss the referral and details, although this does not always happen.
- Sometimes, information is missing in the referral and can be quite basic.
- GPs need patient consent to share personal details with Social Prescribers and external agencies. Medical details are not needed in most cases to Social Prescribers at point of referral, although may be requested later for eg. applications to apply for benefits (Attendance Allowance).
- Participant currently has approx. 22 live cases, and they take approx 2 referrals a week. Each referral could last between 1 week to 1 year, dependent on the complexity of the case and if advocacy is needed.
- The service does not close any referrals until an outcome has been reached ie. if a benefit application has been refused and client requires help with an appeal.
- Team Leaders monitor workload using a spreadsheet of live cases.
- Social Prescribers meet fortnightly with their Team Leaders as a group, to learn about current/new services, share good news stories, what might not have gone well, if anybody requires additional help and to brainstorm ideas. This is also an opportunity to have speakers in, for extra training. Social Prescribers can come from different backgrounds and there is usually somebody in the team that has an area of expertise, should another Social Prescriber require extra support.

Role of social prescribing in general:

- Clients referred to the service often have a range of needs, e.g., benefits, housing, employment, bereavement, social isolation.
- Social prescribing is a holistic service; it delves into the underlying reasons why something is happening through gentle questioning, to reveal issues in a person's life and how they can be helped with information and advice and through advocacy if required.
- It can be difficult to explore some areas, e.g., some do not want to discuss finances. The relationship is built on trust and can take several months with a client.

- Participant has spotted things that seem not quite right or alarming in home visits, which they reported to adult safeguarding for escalation (local social services) eg. self neglect, scammers, poor personal care.
- Participant shared an example of a client who has significant mobility issues, lives in social housing and with limited finances. Client experienced the bereavement of her husband and does not have good family relations with remaining family members. As well as referring the person to telephone befriending, the participant liaised with the council to fix her boiler, as they find forms/telephone calls challenging, looked into benefits and helped through a Hardship Fund for payment towards her electric/gas bill. The client was secured the higher rate of Attendance Allowance and received a large back payment; the client was so delighted to have extra income, that she booked a taxi for a round-trip to the coast, so she could see the sea, as didn't know when she would get the chance again.

Enabling personalised care:

- Whilst GP services are pressed for time, Social Prescribers can offer more time to a client, to explore in detail what the main issues are. The initial call is particularly crucial for working out what the main concerns are and building up trust.
- Each case is different: some involve straightforward signposting to information; others involve longer-term advocacy work, home visits and regular calls to the clients and external agencies.
- A well-rounded approach to a person's life. One comment can stimulate other avenues by asking: have you got any worries on your mind?
- Having time to explore different avenues in a safe environment, e.g., at home.
- Exploring relevant issues at the time, e.g., rising cost of living has led to greater need for food vouchers and energy bills support.
- Supporting a client in their journey to ultimately become more independent and to have the tools to continue looking after themselves, with their health/home/finances and other areas.

How social prescribing supports people with dementia and carers:

- Social prescribing team does not support people who do not have the mental capacity to consent to or engage with the service. Outside of Social Prescribing, the charitable group, runs specialist activities for people with dementia (e.g., reminiscence groups, trips, community hall events, training for carers).
- Participant spends one day a week in a GP service as a Social Prescriber and also, provides information regarding dementia to staff and families in situ. E.g., a staff member whose mother has advanced dementia asked for information; they attended a local care provider to learn the tools in how to deal with their loved one. Any literature the participant receives in her line of work concerning dementia, is passed onto the surgery to let the GP's assess.
- Some people accessing the service, who show signs of dementia, have not been formally assessed or diagnosed with dementia but have been referred into Social Prescribing eg. a client divulged to the participant, that she was concerned by a conversation she recently had with her granddaughter, where she forgot her relatives

name and thought they were speaking to their daughter. Participant gently suggested having a chat with their GP and maybe requesting a memory assessment, requested that she start to write things down in a pad to remember later, discussed coping mechanisms for everyday life ie. wall calendar and to chat to her close family on how she was findings things difficult to remember lately.

- Participant assesses a person's capacity, whether they can make a decision on information they could receive. Participant may receive clients with mild dementia symptoms (undiagnosed); those with progressed dementia will not be admitted.
- Participant uses gentle questioning to explore what is going on, e.g., have they got family members that help them? Do they consent to information being sent to them?
- The service deals with family members, with the client's consent (also if an LPA is in place). Family support is important as this might be the only interaction a person will receive, so relatives need to be equipped with the right information (e.g., labelling cupboards; keeping to routine; not having too many visitors; low noise; managing sundowning).
- Sometimes, speaking over the phone can be difficult if the person shows signs of confusion. In this case, it would be better to have an initial home visit so the participant can fully assess their living situation and how they are managing, to spot signs of concern and how help could be given.

Benefits of volunteering in social prescribing:

- Volunteers are interviewed by a team to find the right people for the right roles.
- Volunteers perform a range of roles. E.g., community outreach team; trustees; working on the main switchboard number; befriending (activities and/or telephone).
- Clients are matched to a befriender by asking them what they like, their hobbies, interests, and preferences. Client chooses how often they engage with the befriender.
- As a person's confidence improves through befriending, they may be empowered to leave their home to access activities, if they are able to (e.g., to visit a coffee shop).
- Some particularly engaged clients may become a volunteer themselves in the future.

- Participant has previous experience/training in dementia in the care sector. They can spot mild signs of dementia during initial chats with patients, such as memory loss (e.g., forgetting a phone call or the referral) and difficulties retaining information.
- Participant recognises they are not a doctor. They take a holistic approach and suggest things that might be useful (e.g., a clock that specifies the year, day, time).
- Received extensive in-house training from their organisation to perform their information and welfare advisory role (e.g., looking at case studies; covering confidentiality, safeguarding, welfare benefit, including dementia).

B: Primary Care Networks (PCNs) Practices

Practice	Primary Care Network	Locality
Acle Medical Partnership	North Norfolk 4 PCN	North Norfolk
Aldborough Surgery	North Norfolk 2 PCN	North Norfolk
Alexandra and Crestview Surgeries	Lowestoft PCN	Great Yarmouth and Waveney
Andaman Surgery	Lowestoft PCN	Great Yarmouth and Waveney
Attleborough Surgery	Ketts Oak PCN	South Norfolk
Bacon Road Medical Centre	West Norwich Neighbourhood	Norwich
Beccles Medical Centre	South Waveney PCN	Great Yarmouth and Waveney
Beechcroft and Old Palace	West Norwich Neighbourhood	Norwich
Birchwood Medical Practice	North Norfolk 2 PCN	North Norfolk
Blofield Surgery	North Norfolk 4 PCN	North Norfolk
Boughton Surgery	Fens and Brecks PCN	West Norfolk
Bridge Road Surgery	Lowestoft PCN	Great Yarmouth and Waveney
Bridge Street Surgery	Swaffham and Downham PCN	West Norfolk
Brundall Medical Partnership	North Norfolk 4 PCN	North Norfolk
Bungay Medical Centre	South Waveney PCN	Great Yarmouth and Waveney
Campingland Surgery	Swaffham and Downham PCN	West Norfolk
Castle Partnership	Central neighbourhood	Norwich
Chet Valley Medical Practice	SNhIP PCN	South Norfolk
Church Hill Surgery	SNhIP PCN	South Norfolk
Coastal Villages	Great Yarmouth and Northern Villages PCN	Great Yarmouth and Waveney
Coltishall Medical Practice	North Norfolk 3 PCN	North Norfolk
Cromer Group Practice	North Norfolk 4 PCN	North Norfolk
Cutlers Hill Surgery	South Waveney PCN	Great Yarmouth and Waveney
Drayton St Faiths and Horsford	North Norfolk 3 PCN	North Norfolk
East Harling and Kenninghall Medical Practice	Ketts Oak PCN	South Norfolk
East Norfolk Medical Practice	Great Yarmouth and Northern Villages PCN	Great Yarmouth and Waveney
East Norwich Medical Partnership	East Norwich Neighbourhood	Norwich
Elmham Surgery	Mid Norfolk PCN	South Norfolk
Fakenham Medical Practice	North Norfolk 1 PCN	North Norfolk
Feltwell Surgery	Fens and Brecks PCN	West Norfolk
Fleggburgh Surgery	Great Yarmouth and Northern Villages PCN	Great Yarmouth and Waveney
Great Massingham and Docking	Coastal PCN	West Norfolk
Grimston Medical Centre	Coastal PCN	West Norfolk
Grove Surgery	Breckland PCN	South Norfolk
Harleston Medical Practice	SNhiP PCN	South Norfolk
Heacham Group Practice	Coastal PCN	West Norfolk
Heathgate Medical Practice	SNhIP PCN	South Norfolk
Hellesdon Medical Practice	East Norwich Neighbourhood	Norwich
High Street Surgery	Lowestoft PCN	Great Yarmouth and Waveney
Hingham Surgery	Ketts Oak PCN	South Norfolk
Hollies Surgery	Swaffham and Downham PCN	West Norfolk
Holt Medical Practice	North Norfolk 1 PCN	North Norfolk
Howdale Surgery	Swaffham and Downham PCN	West Norfolk
Hoveton and Wroxham Medical Centre	North Norfolk 4 PCN	North Norfolk
Humbleyard Practice	Ketts Oak PCN	South Norfolk
Kirkley Mill Health Centre	Lowestoft PCN	Great Yarmouth and Waveney
Lakenham Surgery	Central Neighbourhood	Norwich
Lawson Road Surgery	Norwich North Neighbourhood	Norwich
Litcham Health Centre	Swaffham and Downham PCN	West Norfolk

C: Anonymised patient data

This data covers 90 out of 105 GPs, which have signed up for data sharing. The figures include anyone with a code of dementia recorded in the 12 months to 31st Dec 2022.

PCN	Sum of NumberWithDementia	Sum of raw practice list size
Great Yarmouth and Waveney	**2,318**	**242,309**
Gorleston	506	44,696
Lowestoft	756	79,366
South Waveney	639	53,484
Yarmouth	417	64,763
North Norfolk	**1,871**	**178,727**
NN1	425	42,719
NN2	401	40,464
NN3	501	46,521
NN4	544	49,023
Norwich	**1,657**	**241,540**
Central	436	79,842
East Norwich	570	58,980
Norwich North	296	45,053
West Norwich	355	57,665
South Norfolk	**1,473**	**241,623**
Breckland	367	44,978
Ketts Oak	458	64,466
Mid Norfolk	502	46,536
SNHIP	146	85,643
West Norfolk	**1,368**	**181,415**
Coastal	237	23,499
Fens & Brecks	306	39,965
Kings Lynn	509	71,884
Swaffham & Downham	316	46,067
Grand Total	**8,687**	**1,085,614**

D: Social Prescribing Link Workers across Norfolk and Waveney

According to the NHS Digital (2023) General Practice Workforce statistics for Primary Care Networks in NHS Norfolk and Waveney, February 2023, a total of 157.3 FTE staff are employed as Care Coordinators (87.5 FTE), Health and Wellbeing Coaches (22.8 FTE) and Social Prescribing Link Workers (47 FTE). This covers 178 individual staff, 14 of which are through contracted services.

This compares to 6,448.8 FTE nationwide covering 7,590 individuals of which 1,230 are through contracted services.

Additional local information suggests that there are likely 80 to 100 more individuals employed as part of the social prescribing workforce across Norfolk and Waveney suggesting a total of approximately 250 to 300.

According to information from NHS Norfolk and Waveney ICB not all staff involved in social prescribing are employed by Primary Care Networks:

	PCN	LA	VCFSE	Acute
Norwich	51	7	17	2
North	57	11		
South	30	11		
West	20	5		2
East	40		2	2
Total	**198**	**21**	**19**	**6**

Of this PCN ARRS funded

Social Prescribing Link Workers:	57
Health and Wellbeing Coaches:	28
Care Co-ordinators	101