



Humber and North Yorkshire
Health and Care Partnership

NHS

Humber and
North Yorkshire
Integrated Care Board (ICB)

Social Prescribing in action across Humber and North Yorkshire

March 2026



Social Prescribing in action across Humber and North Yorkshire

The following case studies illustrate how social prescribing operates at neighbourhood level and the impact it delivers for individuals, communities, and the wider system.

They demonstrate how social prescribing:

- **Addresses social determinants of health**
- **Reduces escalation and preventable service demand**
- **Supports prevention and early intervention**
- **Complements clinical pathways**
- **Strengthens neighbourhood and VCSE partnerships**

Each case study demonstrates how investment in neighbourhood social prescribing delivers both personal and system-level value.

Case Study:

Supporting Cancer Pathway

Situation / Context

- Newly diagnosed patient identified at 3-month cancer care review
- Experiencing isolation and loneliness
- Managing caring responsibilities and financial uncertainty while off work
- Practical non-clinical needs not yet addressed

Social Prescribing Contribution

- Safe space to explore non-clinical needs post-diagnosis
- Benefits advice via Macmillan support line
- Connection to York Cancer Care Centre
- Accompaniment and confidence-building for appointments
- Weekly community-based social support
- Coordinated working with VCSE and local services

Outcomes for Individual

- Accessed appropriate prosthetic fitting, improving comfort and confidence
- Reduced isolation through regular attendance at support centre
- Increased confidence to attend appointments independently
- Improved emotional wellbeing and social connection

Wider Service Impact

- Early identification of unmet non-clinical needs
- Reduced risk of escalating emotional distress
- Appropriate use of community and VCSE support

Social prescribing adds value by identifying and addressing non-clinical needs alongside cancer care, supporting prevention, wellbeing, and confidence.

Case Study: Supporting Cancer Pathway

Following a three-month cancer care review, a newly diagnosed patient was identified as managing her diagnosis alone while balancing childcare and wider family responsibilities. She was experiencing isolation and financial uncertainty while off work.

The social prescribing link worker provided practical support, connecting her to the Macmillan benefits advice line and introducing her to the York Cancer Care Centre. During an initial visit, it became clear she had not attended her prosthetic breast fitting and was still using an uncomfortable temporary prosthesis. An appointment was arranged immediately, and the link worker accompanied her to build confidence.

She now attends the centre weekly, has built social connections, and feels more confident attending appointments independently. Social prescribing created time and space to identify non-clinical needs that had not surfaced within the clinical pathway, strengthening recovery and emotional wellbeing alongside cancer care.



Case Study:

Supporting integration, financial stability, and independence

Situation / Context

- Newly arrived in the UK with limited English
- Difficulty navigating benefits, housing, and employment systems
- No income and reliant on emergency food support
- At risk of isolation and financial instability

Social Prescribing Contribution

- Time to understand needs and build trust despite language barriers
- Coordination of interpreter-supported and specialist services
- Support with benefits advice, debt support, and emergency provision
- Connection to volunteering, employment, and community integration pathways
- Clear written follow-up to aid understanding and continuity

Outcomes for Individual

- Engagement with benefits appeal and financial advice
- Improved access to food and essential support
- Increased confidence navigating services and attending appointments
- Progression towards volunteering and employment
- Strengthened social connection and integration

Wider Service Impact

- Early intervention reduced risk of crisis escalation
- Improved coordination across VCSE, welfare, and employment services
- Appropriate use of specialist services
- Demonstrates social prescribing's role in addressing wider determinants of health

Social prescribing supports early, preventative intervention by helping people navigate systems, build stability, and connect with appropriate community and statutory support.

Social Prescribing in North Yorkshire

Case Study:

Supporting integration, financial stability, and independence

A client who had recently moved to the UK from Venezuela was referred due to financial hardship, housing concerns and difficulty navigating services. With limited English and no income following a stop in benefits, they were relying on family abroad while also managing health issues.

The social prescribing link worker coordinated interpreter-supported conversations to understand needs fully. They connected the client to specialist support through SWIFT for foreign nationals, arranged a benefits check with Age UK, referred to Rainbow Money for debt and utility advice, and linked to Rise to Thrive for employment guidance. Emergency food provision was arranged through the Salvation Army, and community integration support was provided via CAVCA.

Recognising the complexity of navigating unfamiliar systems, the link worker provided extended appointments, clear communication, and follow-up email summaries to reinforce understanding. The client is now engaging with multiple services, supported in a DWP appeal, preparing to volunteer with Age UK, and building community connections.

Social prescribing provided coordinated, person-centred support that stabilised immediate crisis needs while supporting longer-term integration and independence.

Case Study:

Addressing complex non-clinical needs alongside health care

Situation / Context

- Homeless following release from prison
- History of domestic abuse, mental health needs, and hearing impairment
- No stable accommodation and difficulty navigating housing and health systems
- At risk of disengagement from primary care and crisis presentation

Outcomes for Individual

- Improved access to primary care and medication continuity
- Greater stability and confidence navigating services
- Reduced stress linked to housing insecurity
- Stronger engagement with housing and support pathways

Social Prescribing Contribution

- Early assessment of risks and coordinated support for non-clinical needs
- Support to register with a GP and access urgent prescriptions
- Liaison with housing officers to secure appropriate accommodation
- Connection to homelessness charities and welfare advice
- Ongoing review and coordination across services

Wider Service Impact

- Reduced risk of avoidable GP, urgent care, or crisis presentations
- Non-clinical needs addressed outside NHS services where appropriate
- Improved coordination between NHS, local authority, and VCSE partners
- Demonstrates social prescribing's role in addressing wider determinants of health

Social prescribing supports the NHS by stabilising non-clinical factors that impact health and demand on services

Social Prescribing in East Riding

Case Study:

Addressing complex non-clinical needs alongside health care

A female client was referred due to homelessness following release from prison. She had a history of domestic abuse and presented with complex needs, including mental health challenges and a hearing impairment. She had no stable housing and was at risk of disengaging from health and support services.

The social prescribing link worker completed an initial assessment to identify immediate risks and priorities. Support was provided to engage with Citizens Advice, register with a GP, and access emergency medication via NHS 111. Regular reviews were held to monitor risk and coordinate support.

The link worker worked closely with housing services, liaising with the housing officer to explore accommodation options, including those requiring a guarantor. The client was signposted to homelessness charities such as Emmaus and Shelter, and supported to explore benefit entitlements, including Personal Independence Payment and attendance allowance.

Through sustained contact and coordination across health, housing and voluntary sector partners, the client was supported to reapply for priority housing status, stabilise her situation, and improve access to healthcare and welfare services.

This case study demonstrates how social prescribing addresses complex non-clinical needs alongside health care, reducing crisis risk and enabling joined-up working across the NHS, local authority and VCSE partners.

Case Study:

Supporting Financial Crisis and Wellbeing

Situation / Context

- Sudden financial change following separation
- Unmanageable debt leading to bailiff action
- High anxiety and distress linked to enforcement visits
- Sickness absence from work due to stress
- Risk of ongoing mental health impact and disengagement from employment

Outcomes for Individual

- Increased understanding of debt enforcement and available options
- Reduced anxiety and fear linked to bailiff action
- Greater confidence and sense of control
- Access to specialist debt advice and ongoing support
- Improved ability to focus on recovery and return to work

Social Prescribing Contribution

- Time and space to explore the situation and reduce immediate distress
- Clear explanation of debt options, rights, and bailiff processes
- Referral to Citizens Advice Debt Team for specialist support
- Written information to strengthen understanding and confidence

Wider Service Impact

- Early intervention prevented escalation of financial and mental health crisis
- Reduced likelihood of repeated GP or crisis presentations
- Non-clinical needs addressed outside NHS services where appropriate
- Demonstrates social prescribing's role in supporting financial wellbeing as a determinant of health

Social prescribing supports the NHS by addressing financial stressors that directly impact mental health, wellbeing, and service demand.

Social Prescribing in North Lincs

Case Study:

Supporting Financial Crisis and Wellbeing

The client had recently separated from her husband, and the change in her financial situation led to debt accruing. Unable to pay, she was visited by bailiffs seeking repayment or goods, which left her frightened and unsure how to respond.

The stress of the situation became overwhelming, and she took sick leave from work, feeling unable to return due to her anxiety and worry.

The social prescribing link worker explained that she could access specialist debt advice through Citizens Advice North Lincs Debt Team and provided clear information on how to deal with bailiffs. This helped her understand her rights, feel more in control, and regain confidence.

A referral was made to the Citizens Advice Debt Team, and the client received printed guidance to support her next steps.



Social Prescribing in **North Lincs**

Case Study:

Supporting Long-Term Conditions, Physical Activity, and Financial Stability

Situation / Context

- Individual living with COPD, osteoarthritis and asthma
- Reduced mobility affecting daily activities and full-time work as a taxi driver
- Smoking and alcohol use impacting health
- Financial pressure and need for support to manage health and employment

Outcomes for Individual

- Award of PIP, enabling reduced working hours and improved financial stability
- Completion of 24 activity sessions and continuation with gym membership
- Weight loss, reduced alcohol intake and improved respiratory management
- Increased confidence, motivation and overall wellbeing
- Improved work-life balance and self-management of long-term conditions

Social Prescribing Contribution

- Person-centred goal setting around health, activity and wellbeing
- Access to NHS healthy eating and physical activity resources
- Referral to local wellbeing services for smoking reduction
- Referral to Active Forever programme for safe, supported exercise
- Support with Personal Independence Payment (PIP) application

Wider Service Impact

- Improved self-management, reducing risk of deterioration
- Reduced likelihood of avoidable GP or secondary care contact
- Financial and lifestyle needs addressed outside clinical services
- Demonstrates social prescribing's role in prevention and long-term condition management

Social prescribing supports the NHS by enabling people with long-term conditions to improve health, manage finances, and reduce reliance on clinical services.

Social Prescribing in North East Lincs

Case Study:

Supporting Long-Term Conditions, Physical Activity, and Financial Stability

An individual living with COPD, osteoarthritis and asthma self-referred for support. Their conditions were affecting mobility, daily functioning and ability to maintain full-time work as a taxi driver. They wanted to improve health, increase physical activity and access financial support. At assessment, smoking, regular alcohol use and concerns about managing work alongside symptoms were identified.

The link worker provided person-centred support to set realistic health and lifestyle goals. The individual was connected to NHS healthy eating and activity resources, referred to local wellbeing services for smoking reduction, and enrolled onto the Active Forever programme for supported exercise. Support was also provided to apply for Personal Independence Payment (PIP) through Centre4.

As a result, the individual was awarded PIP, including a back payment, enabling a reduction in working hours and improved work-life balance. They completed 24 activity sessions and continued with an independent gym membership. Physical activity increased, weight reduced, alcohol intake decreased, and respiratory symptoms became better managed.

At 12-month review, the individual reported feeling more positive, more confident in managing their conditions, and better able to sustain lifestyle changes.

This case highlights how social prescribing supports long-term condition management by addressing non-clinical needs, improving independence, supporting prevention, and reducing reliance on clinical services.

Case Study:

Supporting Access to Secondary Care

Situation / Context

- Patients identified through neighbourhood teams as unable to attend secondary care appointments
- Barriers include transport, mobility, or confidence travelling independently
- Not eligible for, or unable to use, statutory patient transport
- Increased risk of missed appointments and health deterioration

Outcomes for Individuals

- Able to attend essential hospital appointments they would otherwise miss
- Reduced anxiety and increased confidence in accessing care
- Maintained independence, including during periods of vulnerability
- Improved experience of care through personalised, reliable support

Social prescribing enables access to care by connecting individuals to practical community-based solutions that complement clinical pathways.

Social Prescribing Contribution

- Identification of need through social prescribing link workers
- Referral and coordination with community transport provider
- Practical support planning and door-door access to care
- Confidence-building and reassurance around to attend appointments
- Partnership working with VCSE, primary care teams and neighbourhood teams

Wider Service Impact

- Reduces missed appointments (DNAs) in secondary care
- Supports timely access to treatment and intervention
- Contributes to admissions avoidance and reduced escalation
- Complements statutory patient transport by filling gaps
- Strengthens partnership working across VCSE, primary care, and neighbourhood teams
- Helps to deliver [Health Neighbourhood Framework](#) goals and priorities, especially around access, prevention and community

Social Prescribing in North Yorkshire Coast

Case Study:

Supporting Access to Secondary Care

Patients in rural areas such as Whitby, Scarborough, and Filey Bay can face significant barriers to attending secondary care appointments, particularly where transport, mobility, or confidence are limiting factors.

Through neighbourhood teams, social prescribing link workers identify individuals who may otherwise be unable to access care. In partnership with a local community transport provider, patients are supported through a coordinated approach, including referral, planning, and door-to-door transport with volunteer drivers.

This support enables patients to attend appointments they would otherwise miss. As one patient reflected, “If you didn’t take me, I wouldn’t go to my appointment.” Others highlighted challenges with existing patient transport, including long waits, complex processes, or ineligibility.

By addressing these practical barriers, social prescribing reduces anxiety, builds confidence, and supports continued independence. It also strengthens partnership working between primary care, VCSE organisations, and neighbourhood teams.

This approach contributes to reduced missed appointments, supports timely access to treatment, and demonstrates how social prescribing complements clinical care by addressing wider determinants of health.

Case Study:

Proactive Neighbourhood-Based model

Situation / Context

- Growing demand on health services and need for earlier, preventative support
- Traditional service models focused on reactive care rather than community-led solutions
- Opportunity to test a new approach inspired by international (Brazilian) models

Outcomes for Individuals

- Increased connection to local community and support networks
- Earlier identification of non-clinical needs
- Improved wellbeing through ongoing, relational support
- Reduced reliance on formal health services

Social Prescribing Contribution

- Development of a neighbourhood-based, community-led model
- Integration of social prescribing within wider community and primary care teams
- Strong partnership working across VCSE, health, and local communities
- Focus on proactive engagement rather than referral-only support
- Emphasis on building relationships, trust, and community resilience

Wider Service Impact

- Strengthens neighbourhood working and integrated care approaches
- Shifts focus from reactive to proactive preventative support
- Builds community capacity and resilience
- Supports more sustainable models of care aligned to local need
- Demonstrates adaptability of social prescribing within different models

This model shows how social prescribing can evolve beyond individual referrals into proactive whole-system, community-led approach that strengthens prevention and neighbourhood working.

“Inspired by a Brazilian community health model, this approach demonstrates how international learning can be adapted locally”

Social Prescribing in North Yorkshire - Selby

Case Study:

Proactive Neighbourhood-Based model

This case study highlights a neighbourhood-based approach to social prescribing in Selby North Yorkshire, where a model inspired by Brazilian community health systems has been adapted locally to strengthen prevention and community support.

Recognising increasing demand on health services and the need to move beyond reactive care, partners across primary care, VCSE organisations, and local communities have worked together to develop a more proactive, relationship-based approach. Social prescribing is embedded within neighbourhood working, enabling earlier identification of non-clinical needs and ongoing support within communities.

Rather than relying solely on referrals, this model focuses on building trusted relationships, connecting people to local networks, and supporting individuals before needs escalate. This approach helps reduce isolation, improve wellbeing, and strengthen confidence in accessing support.

By working collaboratively across sectors, the model enhances community capacity and resilience, while also supporting more sustainable use of health services. It demonstrates how social prescribing can evolve into a whole-system, community-led approach that aligns clinical pathways with local, community-based solutions.

Case Study:

Sustained partnership-based support for complex needs

Situation / Context

- Referred by CMHT following mental health related leave
- Experiencing fluctuating mental health and undergoing chemotherapy
- Aimed to return to work and reconnect with community support
- Required flexible, longer-term support due to complexity

Social Prescribing Contribution

- Ongoing, relationship-based support over 12+ months
- Flexible contact, increasing during periods of higher need
- Coordinated support through close partnership with CMHT and community providers
- Gradual introduction to community activities at individual pace
- Accompanied visits to reduce anxiety and build confidence
- Connected to recovery college gardening group, craft group and Humber wellbeing hub

Outcomes for Individual

- Improved confidence and mental wellbeing
- Reduced isolation
- Return to work alongside treatment
- Ongoing engagement in community activity
- Increased independence and self-management

Wider Service Impact

- Prevented escalation to crisis services
- Supported sustained engagement with CMHT
- Strengthened connections to local VCSE provision
- Demonstrated value of long-term, flexible support
- Reinforced importance of continuity and stability in delivery models

Social prescribing enables sustained, partnership-based and relationship-led approaches that support long-term outcomes and prevents escalation

Social Prescribing in Hull

Case Study:

Sustained partnership-based support for complex needs

This case study highlights the role of social prescribing in supporting an individual with complex mental and physical health needs, including fluctuating mental health and ongoing cancer treatment.

Working alongside Humber CMHT, the link worker provided flexible, responsive support over an extended period, adapting to changing needs and maintaining consistent contact during periods of increased risk.

Through gradual, supported engagement, the individual was connected to community-based activities including gardening groups, The Shed and the Humber Wellbeing Hub, helping to rebuild confidence and reduce isolation.

This approach supported a return to work, improved wellbeing and strengthened community connections, while preventing escalation of mental ill health.

The case demonstrates the importance of sustained, partnership-based and relationship-based support, and the value of continuity of provision in achieving long-term outcomes.