ASSOCIATION OF AMBULANCE CHIEF EXECUTIVES

CARE CLOSER TO HOME | ARTICLE SERIES

Ambulance services and social prescribing: connecting patients to community support and reducing repeat 999 calls

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Ambulance crews arrive at a patient's door with clinical skills and equipment - but also with eyes. They see the half-empty fridge, the unopened post, the person who mentions they haven't spoken to anyone in days. Social prescribing recognises that it is important to consider the whole person, not just the clinical symptoms.

Social prescribing enables ambulance clinicians to connect people - through a structured referral - to non-clinical support already available in their communities: befriending groups, financial advice, voluntary sector activities, bereavement support. For the ambulance service, it represents an opportunity to act on what crews see and hear in a way that could prevent the next call, not just respond to the current one.

North West Ambulance Service NHS Trust (NWAS) is one of the first ambulance trusts in England to develop a systematic social prescribing referral offer. This article describes how the model works, what it has achieved so far, and what the experience of implementing it reveals for services considering a similar approach.

What this model tells us: context and transferable learning

Social prescribing is not a new concept. It is well established in primary care, where link workers routinely support GP patients with non-medical needs. What is novel - and what the NWAS experience demonstrates - is its application in the ambulance setting, where the opportunity to identify social need often arises in a patient's home, in a moment of crisis, with no GP in attendance.

The ambulance service has a unique vantage point

Unlike most healthcare contacts, an ambulance response often takes place in the patient's own home. Crews can directly observe living conditions, social isolation, environmental hazards and unmet needs that would be invisible in a consulting room. Social prescribing harnesses that insight, turning an emergency or urgent care response into an opportunity for longer-term support.

The model addresses demand, not just need

Social, economic and environmental factors are significant drivers of emergency calls. Loneliness, financial stress, bereavement, housing problems and loss of community connection all contribute to acute presentations and to repeated use of 999 and 111 services. One referral to social prescribing - connecting a patient to a befriending service, welfare advice or community activity - may prevent a cycle of repeat calls that no clinical intervention would have addressed.

Implementation requires sustained system partnership

Social prescribing in an ambulance context depends on the availability and quality of social prescribing and community link worker services in each local area - services commissioned and funded by local authorities and primary care networks, not by the ambulance service. Where those services are strong, referral pathways work well. Where they are patchy or underfunded, the ambulance service's ability to refer is constrained regardless of clinical will.

Sustainability requires commissioning support and digital infrastructure

The NWAS model currently operates without dedicated ambulance service funding and relies on support centre capacity and manual referral processes. Formal commissioning support - and investment in digital referral systems that reduce the administrative burden on crews - are consistently identified as the most important enablers of scaling the model. Inhouse evaluation that quantifies impact on repeat demand and patient outcomes materially strengthens the case for that investment.

Common facilitators and barriers

Common facilitators	Common barriers
• Strong trust strategy backing (health inequalities)	• Patchy availability of social prescribing services across areas
• Interested, motivated clinical champions Community Specialist Paramedics (CSPs) or Sector Clinical Leads (SCLs), Advanced Paramedic Practitioners (APPs), and new Pathway Development Lead (PDL) roles.	• Referral criteria variable within and across ICBs
• Public health team engagement from the outset	• No dedicated ambulance service funding
• Support centre processes to receive and route referrals	• No digital referral system; reliance on telephone via support centre
• Making Every Contact Count (MECC) mandatory training modules and Health Inequalities training	• No feedback loop to crews on outcomes of referrals to celebrate positive cases
• NHS Service Finder / Directory of Services (DoS) providing up-to-date local pathway information	• Tension between time on scene and MECC conversation requirements

917 referrals in 2024; 1,350 in 2025 - a 47% year-on-year increase in NWAS social prescribing referrals, with patient stories showing meaningful improvements to health and wellbeing for those referred – NWAS

North West Ambulance Service: connecting patients to community support through social prescribing

NWAS model at a glance
• Area covered: North West England (Cumbria, Lancashire, Greater Manchester, Cheshire and Merseyside)
• Model type: secondary referral - crew-initiated social prescribing referral via support centre to community link workers, using a platform called CLERIC which sends a referral form to the relevant social prescriber
• Patient group: adults (18+) with non-medical support needs - social isolation, financial stress, bereavement, housing problems
• Launched: initial pilot 2018/19; East Lancashire pathway 2020; Bolton Age UK pilot pathway 2021 followed by expansion to Greater Manchester from October 2023, now available to the wider NWAS footprint.
• Hours: 24/7 (supported by Carlisle Support Centre and CLERIC platform)
• Key clinicians: any ambulance crew member; championed by Sector Clinical Leads and Area Pathway Development Leads
• Funding: no dedicated ambulance service funding; external services funded by local commissioners

The model

NWAS's social prescribing model recognises that ambulance crews, who often attend patients in their own homes, are uniquely placed to identify these needs and act on them.

The programme began as a test of change in West Lancashire in 2018/19, under the name SPACE (Social Prescribing in an Ambulance Community Environment). Following positive early learning, the East Lancashire pathway was implemented in 2020 with direct referrals to community link workers processed via Carlisle Support Centre. Greater Manchester pathways were introduced from October 2023, piloting in Wigan before expanding across Greater Manchester and other areas not previously covered across Cumbria, Lancashire, and Cheshire and Merseyside.

The model is embedded in the NWAS Trust Strategy 2026–2031, which commits to target health inequalities by optimising assessment and proactive interventions for priority groups, shifting from reactive to preventative care, and is supported by mandatory staff training modules on health inequalities and MECC.

The problem it addresses

Without a structured referral pathway, ambulance clinicians had no way to act on what they observed. The patient's clinical need might be addressed; the underlying circumstances that generated the call - and might generate future calls - would remain unaddressed.

Key benefits for patients

- Patients feel heard, valued and understood - not just treated and left.

- Social prescribing can provide an alternative or complement to medication, addressing root causes of health and wellbeing problems.
- Isolation and loneliness are actively addressed: patients can be connected to befriending groups, arts activities, community gardening and similar.
- Financial and housing stress can be resolved through appropriate referral to debt management, benefits advice and housing support services.
- Frequent high-intensity users of 999/111 may have underlying social needs that, once addressed, reduce their reliance on emergency services.
- Support for patients with dementia or complex needs to maintain social connection and independence.

Key benefits for the ambulance service / system

- Evidence from nine local health systems found social prescribing can substantially reduce NHS pressure, including a 42% reduction in GP appointments in Tameside and Glossop and up to a 23% reduction in A&E attendances in Kent.
- Ambulance service research in the North East found social prescribing to be particularly beneficial for patients calling about mental health, loneliness or isolation - key drivers of repeat 999 demand.
- Reducing the cycle of repeat calls driven by unmet social need frees ambulance resource for higher-acuity incidents.
- Supports the NHS prevention agenda by intervening upstream before social need becomes acute clinical need.
- Strengthens the ambulance service's contribution to health inequality reduction, supporting the NHS 10 Year Plan ambition to move from a model of cure to one of prevention, early intervention and community-based support.

How it works

Any NWAS crew member can initiate a social prescribing referral when they identify a patient with a non-medical support need during an attendance. The crew member checks NHS Service Finder (accessible via an optimised-for-mobile interface) to confirm whether a social prescribing pathway exists for the patient's area. If a pathway is available and the patient consents, the crew contacts Carlisle Support Centre, which receives and processes the referral 24/7 and routes it to the appropriate social prescribing or community link worker team via the CLERIC system.

Social prescribing pathways across the NWAS footprint are provided by a range of organisations including local authorities, primary care networks and individual voluntary sector bodies. Because the offer differs by area, it is important crews are familiar with their local service model. The approach is designed to accommodate this local variation rather than impose a single model.

Referrals are logged in CLERIC, with monthly reporting on volumes, areas, services used, and acceptance, rejection and pending status.

Outcomes and evidence

CLERIC data shows 917 referrals were made in 2024 and 1,350 in 2025, representing a 47% year-on-year increase. Around 90% of referrals were made by 999 Paramedic Emergency Service crews. There is variation across areas, reflecting the uneven availability of social prescribing pathways across the NWAS footprint.

Patient stories shared by social prescribing teams illustrate the impact:

- A patient discharged from hospital following a fall was connected to a food shop service, a local befriending service, and referrals to mental health and continence teams - addressing multiple unmet needs from a single ambulance attendance.
- A patient experiencing loneliness and depression following bereavement was referred to community meals (reducing malnutrition risk), strength and balance activities, benefits advice, and bereavement and befriending services.

No formal evaluation has yet been completed. NWAS identifies that a formal evaluation quantifying impact on repeat demand, patient outcomes and system costs would be a significant enabler of further expansion. Combined with a feedback loop that shares referral outcomes with frontline staff, this would help demonstrate impact, strengthen clinician buy-in and increase appetite for making referrals.

Implementation challenges and lessons learned

The primary implementation challenge is the patchiness of social prescribing provision across the NWAS footprint. Referral criteria and pathway availability vary within and between ICB areas, meaning that not all patients with a social need can be referred. The model relies on community link worker capacity commissioned and funded by others; where that capacity is constrained, NWAS's ability to act is limited regardless of crew willingness.

Operationally, the reliance on telephone referral via Carlisle Support Centre - rather than a digital system - creates friction and delays. There is no automated feedback loop to inform crews of referral outcomes, which limits motivation and learning. Managing rejected referrals and ensuring patients are informed when a referral is not accepted, remain gaps in the current model.

With hindsight, NWAS would prioritise earlier engagement with commissioning teams across the system to develop and test pathways jointly. Digital infrastructure - a system that prompts crews when a social prescribing pathway is available and enables digital completion of referrals - is identified as the single most important enabler of scaling the model and ensuring it reaches patients regardless of which service line they contact (999, 111, PTS).

> ***Ambulance crews often visit patients in their own homes, giving them a unique insight into the daily struggles people face - and an opportunity to impact patients' health and wellbeing beyond the emergency call – NWAS***

Conclusion

Social prescribing represents a different kind of ambition for the ambulance service: not just responding to the crisis in front of the crew but acting on what that crisis reveals about the person's wider circumstances. The NWAS model demonstrates that this ambition is achievable - that ambulance crews can identify social need, make a referral, and contribute to a patient's long-term wellbeing in a way that may prevent future emergencies.

NWAS experience consistently points to the necessary conditions to scale the offer, which includes: system partnership with commissioners and link worker services; digital infrastructure that makes referral straightforward and reduces reliance on telephone processes; a formal evaluation of the

current model that builds the evidence base; and sustainable funding that treats the ambulance service's contribution to prevention as a core part of the urgent and emergency care offer rather than an add-on, enabling implementation at scale.

AACE will continue to support the sharing of learning across the sector through this series of Care Closer to Home articles. Trusts wishing to share their own models or to discuss the themes covered in this piece are encouraged to make contact through AACE.

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This article is part of AACE's Care Closer to Home series, highlighting innovation in out-of-hospital urgent care.