Evaluating the Impact of Social Prescribing: Learning from Leeds and Kirklees

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Connect for Health

Leeds South and East CCG

- Launched in January 2016, Connect for Health covers Leeds South and East funded by LSE CCG.
- This social prescribing service was launched in January 2016 and is for anyone aged 14 and upwards.
- Connect for Health received in excess of 1500 referrals in their first year with 70% of individuals engaging with the service following referral.

Leeds Beckett University, Evaluation of Connect for Health, January 2017 Initial Findings

Bunyan, A-M., Woodall, J. and Raine. G. (2017) Evaluation of Connect for Health: Interim report. Leeds, Institute for Health and Wellbeing

Leeds Beckett University, Evaluation of Connect for Health, January 2017 Initial Findings

112 Connect for Health service users have completed questionnaires and interviews have been carried out with 10 individuals.

Key Outcomes:

- **Wellbeing**: average wellbeing scores improved significantly from baseline to post stage for both males and females.
- **Health:** analysis revealed a statistically significant improvement in health from baseline to post stage
- **Self-care:** the proportion of individuals with no self-care problems increased slightly from 61% at baseline to 63% at post stage.
- **Usual activity:** number of individuals who had 'severe' problems performing usual activities decreased by half between baseline and post stage.
- ***Anxiety/depression:*** sizeable decreases in the proportion of participants who reported being severely or extremely anxious/depressed at post stage.

Patient Empowerment Project (PEP)

Leeds West CCG

Description

- Evaluation based on the data collected October between 1st 2014 and September 30th 2016;
- 1,411 people referred to PEP;
- Around half by GPs, a further 46% self referred;
- Focus on individuals with one or more of: depression, diabetes, chronic obstructive pulmonary disorder or cardio vascular disease;
- 89% referred have a mental health condition – stress, anxiety, not coping, isolation, pressures of debt.

Outcomes

- Two comprehensive external evaluations
  - Year 1 Yorkshire & Humber Commissioning Support Unit
  - Year 2 EMBED & York Health Economics Health Consortium
- 70% engaged with service following referral
- Significant improvements in self reported wellbeing, health related quality of life and confidence in managing their long-term conditions
- Fewer people who DNA medical appointments post intervention
- Reduction in Primary Care appointments at 9 & 12 months post intervention
- PEP most active in most deprived areas - the most referrals to community based services in these areas
- Improvements noted in management of diabetes and hypertension
- Number of people smoking reduced from 31% to 23% at 3rd review
- Engaged PEP clients with over 100 services
  - IAPT / MIND Peer Support / Carers Leeds / Let's Get Active /Adult Social Care / Welfare Rights
- 13 new groups and courses developed by PEP
  - e.g headspace, diabetes management, pain management

Connect Well Service

Leeds North CCG

Connect Well Service:

Practice Supported Cohort

- Started January 2014;
- Operated in Seven GP practices;
- GP referral into service;
- Differing cohorts in different practices;
- Majority at least one chronic condition.

Consortia Supported Cohort

- Started April 2016;
- Operated across the rest of LNCCG GP practices;
- GP referral into the services;
- Tier 1- Signposting;
- Tier 2- Social Prescribing Plan.

Methodology

- Assessed using the Leeds Data model including data from:
  - GP Practice Systems;
  - Hospital Activity;
  - Adult Social Care Service Provision;
  - Community Health.
- Evaluation using measures:
  - GP Consultations;
  - GP Consultations 10 minutes plus;
  - A&E attendances;
  - Non elective bed nights.

Outcome Measures

	GP Employed Co-ordinator			Consortium Employed Co-ordinator		
Pre and Post Intervention Measures	Social Prescribing Plan	No Social Prescribing Plan	Diff	Tier 2 Intervention	None Tier 2 Intervention	Diff
GP Consultations	6.9%	7.8%	-0.9%	-28.0%	-32.4%	4.4%
GP Consultations 10 minutes+	3.4%	13.0%	-9.6%	7.3%	27.6%	-20.3%
A&E Attendances!	18.9%	24.1%	-5.2%	-50.0%	30.8%	-80.8%
Non Elective Bed Days!	27.4%	67.1%	-39.7%	-56.3%	62.0%	-118.3%

!=Small samples of activity

Outcomes

- Two services work with slightly different groups of patients;
- Different levels of involvement with different services deliver different results with longer term interventions performing better across multiple measures;
- Evidence of positive impact in the reduction of the number of GP consultations for the cohort receiving long term interventions such as a social prescribing plan;
- Whole cohort access secondary care less than GPs with lower A&E attendances and non elective bed nights but some evidence of benefits her also;
- Statistically significant improvements in WEMWBS scores for the cohort supported by the consortia;
- Potential for the service to target more male population and 18- 44 year olds;
- Service has been funded for a further year and will be evaluated after that period using the greater evidence base.

Consolidated Learning

- Positive evidence across the three services of impact on GP activity and mental well being;
- Need to ensure back office systems are in place early and consistently to support recording and evaluation of the services;
- Greater benefit to primary care than to secondary;
- Some evidence that longer term interventions have a greater impact- but needs differentiated approaches in analysis to pick these up.

Community Partnerships

Evaluating the impact of social prescribing: learning from Kirklees

Fiona Weir, Kirklees Council

May 2017

NHS North Kirklees Clinical Commissioning Group

NHS Greater Huddersfield Clinical Commissioning Group

Kirklees COUNCIL

About us

- Community Partnerships is part of Kirklees Council's Adult Services (currently).
- Key areas of work are:
  - Community investment focused on prevention (jointly with Clinical Commissioning Groups);
  - Development support;
  - **Better in Kirklees (BiK) - 'social prescribing'**– supporting people into community activity (commissioned and delivered by Touchstone)

→ **All work supports 'people helping people' to be more independent and healthy, preventing the need for statutory support.**

Key figures (2016-17)

Grants*

- £973.5K invested in 99 projects
- Match/'community contribution' of £2.4 million (ratio =1:2.39 per £ invested)
- Estimated 13,743 beneficiaries
- 147,223 volunteer hours.

**Provisional figures*

Development

- 172 VCOs supported with business development, income generation, etc.

Better in Kirklees Social Prescribing

- 647 individuals supported: 353 into community activity; 294 supported to self-serve.

Measuring outcomes and impact

We use these methods to measure wellbeing and 'prevention' impacts:

- Storyboards
- Case studies
- Output data from grant monitoring
- Outcome data from group tools
- Tailored outcome measures, negotiated with groups
- Directorate performance data
- Client case management data – social prescribing only

→ **No 'one size fits all'. We build a 'jigsaw' of impact evidence:**
http://www.kirklees.gov.uk/beta/grants-and-funding/pdf/evidencing-impact-of-social-action.pdf

BiK Social Prescribing – Client tracking data

The service:

- BiK is integrated across health and care, and takes referrals from GPs, social work teams, community health providers, VCO, self;
- Initially 100% social care; currently 50% SC, 26% health, 24% other;
- Commissioned VCS provider from 01/02/16;
- ALL referrals taken and clients tracked through central Care Management System.

The analysis:

- Analysis based on activity between 15/10/2013 to 16/11/2016;
- 1,252 referrals; 1,143 referrals progressed (91%);
- 761 users/66.6% Care Act eligible.

Outcomes from funded activities

- Analysis (of self-reported individual wellbeing measures collated by funded community groups) shows positive outcomes for participants across a range of different domains of wellbeing:
  - Improves health
  - Increases connectedness and reduces loneliness
  - Increases physical activity levels
  - Reduces unhappiness
  - Gets people more involved in their communities.

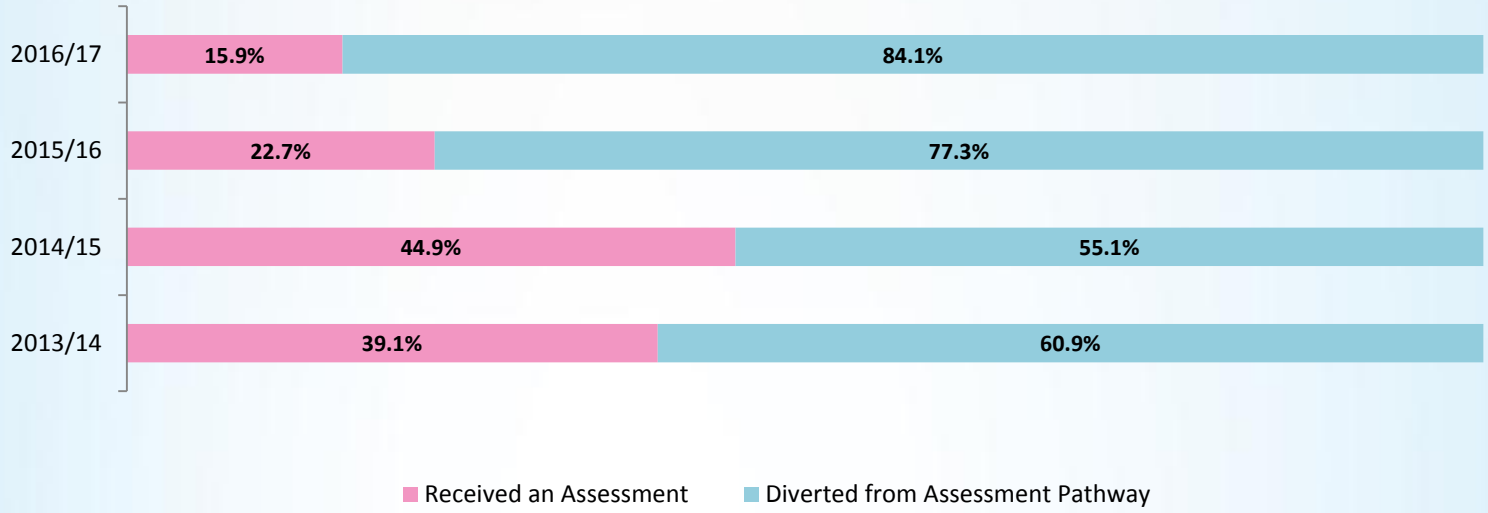
- Detailed analysis here: http://www.kirklees.gov.uk/beta/grants-and-funding/pdf/community-partnerships-investment-outcomes-january-2017.pdf

- These are the activities social prescribing service users are referred into. We infer these wellbeing impacts for SP users among others.

What happens to individuals who are eligible for services?

- 27.9% (212) had an assessment in the year of their BiK referral;
- 72.1% (549) navigated through a non-assessed pathway via the BIK intervention – i.e. 'diverted'.

%/No BiK Service Users (Eligibility MET) Receiving/Diverted From an Assessment



Modelling of potential savings

- 26.3% (200 of 761) BiK service users with eligible levels of need (MET), and were not receiving packages of care at the point of starting with BiK and did not receive an assessment;
- Based on a potential assessment cost saved of £620.17 per person (Source: PSSEX1 2013/14 unit cost of assessment), potential **assessment savings = £124,034**.
- 57% of all service users are likely to receive ongoing services following assessment (Source: Adult Social Care Performance and BI Dashboard)
- Using homecare costs as a simple proxy measure of average service costs per user* for 113 (57%) of eligible BiK service users suggests further potential **service savings = £1,008,304**.

*(12.17 hours of care per week at an hourly rate of £14.10 an hour = ongoing service cost of £171.60 per person per week).

Future analysis

- New CareTrak system should enable us to do detailed cohort analyses, across health and care systems – e.g. comparing BiK cohort with cohort supported by reablement;
- We will be able to look at the impact of BiK social prescribing on :
  - Acute hospital episodes such as A&E attendances
  - Emergency Admissions to Hospital and length of Stay
  - Delayed Transfers of Care;
- Will be able to look at longer-term impacts, over many years;
- Need to get more sophisticated about analysis of real/actual rather than modelled savings.

Key learning

- This approach to SP ensures we get the ‘right people’ – i.e. those with highest needs – into community support;
- This type of analysis ‘closes the gap’ on demonstrating prevention impacts;
- Enables analysis of impacts across systems, by using NHS numbers, even when individuals participate in non-NHS services;
- Must ensure any external provider can manage client data within existing systems – or previous analysis is not possible;
- Avoids some of the most difficult challenges relating to collecting data directly from community groups, by focusing on ‘events’;
- However, this approach evidences service impacts better than individual wellbeing benefits – there is still a place for case studies, storyboards and survey data.

More info at:

Community Partnerships:
Tel: 01484 221000
Email: community.partnerships@kirklees.gov.uk
Web: http://www.kirklees.gov.uk/communitypartnerships
Facebook: KirkleesCommunityPartnerships

Better in Kirklees Social Prescribing:
Tel: 01924 846808
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Web:https://www.touchstonesupport.org.uk/services/better-in-kirklees-bik/

Discussion time:

Question 1: What do you make of these findings?

Question 2: What other key lines of enquiry can you suggest?