The Impact of social prescribing on demand for acute care in West Kent

A summary of report findings February 2023

Summary

Social prescribing schemes in West Kent have been found to significantly reduce demand on NHS acute care, especially A and E attendances, by up to **23%**

Four social prescribing schemes delivered by Involve Kent were analysed; data was reviewed for patient usage 6 months prior to the social prescribing intervention, and 6 months post, for 5908 people. This showed the following reductions.

A and E attendance	
	Percentage decrease in patient usage
Adult 'Carers'	-19.83%
Over 55s with frailty / ill health	-23.64%
18-55 years olds with ill health	-18.78%
Primary Care Network 'ARRS' patients	-15.41%

Unplanned Inpatient Stays	
	Percentage decrease in patient usage
Adult 'Carers'	-4.79%
Over 55s with frailty / ill health	-5.18%
18-55 years olds with ill health	-2.80%
Primary Care Network 'ARRS' patients	-8.29%

Introduction

Social Prescribing is part now part of NHS 'Personalised Care' and widely available. 'Social prescribing' enables all local agencies to refer people to a link worker. Link workers give people time and focus on what matters to the person as identified through shared decision making or personalised care and support planning. They connect people to community groups and agencies for practical and emotional support.

Social prescribing particularly works for a wide range of people, including people:

• with one or more long-term conditions

• who need support with their mental health

• who are lonely or isolated

• who have complex social needs which affect their wellbeing.

Involve Kent deliver a range of social prescribing services and interventions, funded by NHS Kent and Medway and Kent County Council Social Care.

In February 2023, NHS Kent and Medway (Integrated Care Board, ICB) agreed to provide NHS system usage data (acute care) for patients accessing Involve social prescribing in West Kent, to assess the impact and value of their investment in social prescribing services. Predominantly this was for a scheme 'Connect Well West Kent' which was originally funded as a pilot by the Department of Health and Social Care in 2019 and is now funded by the ICB. This scheme features four strands; two focused directly on patient support, and two focused on support to the voluntary and community sector to enable the wider social prescribing eco-system in West Kent to thrive. A full report on this programme is available.

To understand the full impact of this programme, the patients directly supported were reviewed, alongside three other West Kent Involve social prescribing services, to demonstrate the value of investment and development work with the wider voluntary sector.

The social prescribing services reviewed, including 'Connect Well West Kent', are not focused on reducing demand for acute care; this is not their primary purpose or goal. They are focused on improving the person's wellbeing in general; their happiness, life satisfaction, sense of life worthwhileness and reducing anxiety and loneliness. This is done through addressing issues such as housing, financial concerns, social isolation and access to groups and activities in the community. Accessing this support could be expected to improve health in the long term, but no immediate impact on acute care usage (eg A and E attendance) was necessarily expected. Involve have now developed a specific pilot to understand if a social prescribing scheme focused on acute care can reduce demand on the NHS; this will be evaluated in autumn 2023.

Methodology

To understand the full impact of Connect Well West Kent programme, four cohorts of patients were reviewed. With the intention of completing this system impact review from the inception of the programme, NHS numbers are collected from patients when they join the programme and their consent to this reporting is secured.

This analysis was initially undertaken in 2019 for a small cohort, and also showed reductions (13%). At this time, a pseudonymising tool was provided to Involve by Optum, a business intelligence company working in partnership with West Kent NHS Clinical Commissioning Group, who were funding the social prescribing programme. The use of a pseudonymising tool is essential, as NHS commissioners and business intelligence officers are not able to access data which contains personally identifiable information, such as NHS numbers, under GDPR and other legislation. Therefore, NHS numbers and dates of intervention cannot be submitted directly by social prescribing providers to NHS business intelligence teams for review, they must first be pseudonymised, but in a way which enable the NHS to track the individual's actual NHS usage. This approach also ensures confidentiality and objectivity in

analysis. The original pseudonymising tool was used once again to complete this review in 2023.

The NHS numbers of patients supported by Involve are processed through the pseudonymising tool and coded. Dates are provided for the first social prescribing intervention for each patient. This data was submitted to the ICB commissioner who then requested support from the Business Intelligence team at the ICB. The data is de-coded and analysed against identified wider NHS system data.

It was determined that assessment of NHS usage six month prior to intervention and six months post would be the most effective approach. Ideally, the review would be a full year prior and post, to show long term impact. However, this would mean assessing a much smaller cohort, as no patient supported by Involve after December 2021 could be assessed, so that at least 12 months had passed. This also risked including data during the pandemic period (2020), when NHS system usage was significantly reduced for many people, meaning changes could not necessarily be attributed to the social prescribing intervention.

Therefore, patients who accessed social prescribing from 1st January 2021 until 31st July 2022 were reviewed, as this would enable 6 months pre and post intervention data to be assessed, and a large enough cohort to avoid outliers and errors. All patients with NHS numbers and consent who accessed the social prescribing service in this period and had a least one onward referral to another agency/ organisation were included.

The ICB returned the data to Involve in the following format showing number of attendances pre and post. This was used to calculate percentage reductions.

Row Labels	Sum of Number of Attends
COHORT 1	**363**
COHORT 2	**1,633**
COHORT 3	**229**
COHORT 4	**1,032**
Grand Total	**3,257**

The critical success factor in completing this review and analysis is effective partnership between the NHS commissioning team and the social prescribing provider (Involve). The commissioner needs to secure commitment from the business intelligence function either within the NHS or their commissioned independent provider. This includes securing usage for the social prescribing provider of the pseudonymising tool and advice on its use. The social prescribing provider needs the infrastructure, knowledge, and workforce development approach to effectively and sensitively collect NHS numbers and consent from patients, to store these appropriately and utilise the pseudonymising tool to provide the data for analysis.

The four cohorts

To demonstrate the impact of social prescribing in West Kent, four cohorts of patients were identified who had accessed an Involve service which met the criteria above as ‘social prescribing’. This means a patient working alongside a professional Navigator or Link

Worker to develop a personalised support or action plan, focused on what matters to the person, and then support to access a range of non-clinical statutory and voluntary sector services to improve health and wellbeing.

Cohort One- Unpaid Carers

Cohort One are people who have accessed Involve's 'Community Navigation for Carers' service. This is a service funded by social care to support people who are looking after someone; a friend, family member, neighbour, who relies on them for care and support. This service includes the provision of statutory Carers Assessments, and practical and emotional support as well as 'social prescribing'. The primary rationale for investment in this service is to reduce demand on social care; to enable the 'cared for' to remain supported at home by the Carer rather than reliant on social care provision. It would be expected that this would lead to a reduction in NHS usage for the 'cared for', but not necessarily the Carer.

However, in practice many Carers have their own significant health problems; they are living in similar environments as the cared-for and therefore exposed to many of the same negative social determinants of health. Caring can be a very stressful and demanding role (many Carers are supporting someone for over 50 hours per week) and this will impact on their own health. The Navigators focus on the health and wellbeing of the Carer; ensuring they can take a break, having something positive in their lives which they enjoy, and plans in place to reduce anxiety and worry. Carers are encouraged to connect with others, to join groups and to be physically active.

1486 patients accessing the Carers Navigation service were reviewed.

Cohort Two- People over 55 with complex health or frailty

Cohort Two are people who have accessed Involve's 'Community Navigation for Over 55s' service. This is a service funded by social care to support people who have, or are at risk of having, care and support needs to stay well and independent in the community. It is a 12-week service and includes both social prescribing, and additional practical support such as the assessment and provision of community equipment such as grab rails and assistive technology such as falls sensors. Navigators work intensively with many patients including multiple home visits and support with paperwork and benefits applications. Patients typically have multiple long-term conditions, and the average age is 77.

2579 patients accessing Community Navigation were reviewed.

Cohort Three- People aged 18-55 with long term conditions experiencing inequalities.

Cohort Three are people who have accessed the Connect Well West Kent social prescribing service focused on health inequalities. This programme has two strands; one focused on referrals from secondary and specialist NHS teams (eg diabetes nurses, pain management services) and the second focused on people experiencing inequalities with long term health problems, who are not necessarily accessing healthcare. These patients are identified through proactive outreach with community partners such as food banks and housing support services.

Patients in this cohort are aged 18-55 (older patients are referred to Community Navigation). More than 90% have multiple health conditions, there is a high prevalence of serious mental ill health. 38% of patients are living in the most deprived areas of West Kent. 98% were not in employment despite being working age. They are supported by Link Workers specialising in supporting people impacted by inequalities working to the NHSE guidance for social

prescribing. Typically, this involved multiple and intensive working with people over 12- 36 weeks.

339 patients supported by specialist Health Inequalities Link Workers were reviewed.

Cohort Four- Patients supported by Primary Care Network Link Workers 18+

Cohort Four are people who have accessed social prescribing within their Primary Care Network (PCN), delivered by an 'Additional Role Reimbursement Scheme' funded Link Worker. Involve employ and manage more than 20 Link Workers within GP practices in West Kent, on behalf of various PCNs. The Link Workers work to the NHSE guidance for social prescribing and adhere closely to the Workforce Development Framework. Patients are typically referred by GPs or primary care clinicians to the Link Worker. The patient will be supported to develop a goal-focused action plan and to access services and groups over a 12-week period. Although the service is for people of all ages, only patients aged over 18 were considered in this review and will have a wide range of health and social needs. However, typically they are less complex patients, as if they have care and support needs they would generally be referred by the Link Worker to Community Navigation, and if they are experiencing significant inequalities they may be referred to the Health Inequalities specialist Link Workers outlined above.

1504 patients supported in PCNs were reviewed.

In total, 5908 patients were reviewed.

Results

The review showed significant reductions in A and E attendances for all cohorts.

Cohort	Number of attendances pre	Number of attendances post	Average number of attendances per patient (first 6 months)	Percentage change
COHORT 1 Adult 'Carers'	**363**	**291**	0.24	**-19.83%**
COHORT 2 Over 55s with frailty / ill health	**1,633**	**1,247**	0.63	**-23.64%**
COHORT 3 18-55 years olds with ill health	**229**	**186**	0.67	**-18.78%**
COHORT 4 Primary Care Network 'ARRS' patients	**1,032**	**873**	0.68	**-15.41%**
Grand Total	**3,257**	**2,597**		
		Average percentage decrease		**-20.26%**

The review showed meaningful reductions in unplanned hospital admissions for all cohorts.

Cohort	Number of impatient stays pre	Number of inpatient stays post	Average number of stays per patient (first 6 months)	Percentage change
COHORT 1 Adult 'Carers'	**167**	**159**	0.11	**-4.79%**
COHORT 2 Over 55s with frailty / ill health	**907**	**860**	0.35	**-5.18%**
COHORT 3 18-55 years olds with ill health	**107**	**104**	0.31	**-2.80%**
COHORT 4 Primary Care Network 'ARRS' patients	**386**	**354**	0.25	**-8.29%**
Grand Total	**1,567**	**1,477**		
		Average percentage decrease		**-5.63**

Conclusions

The data strongly indicates that all four social prescribing services at Involve Kent provide support which leads to a reduction in demand on acute care, despite this not being the focus or purpose of the services. Significant reductions are seen in A and E attendances. The most significant reductions are for people over 55 who have complex health or frailty, even though this cohort do not have the highest attendance rate per person. As patients were not selected on the basis of their acute care usage (all patients referred to Involve for community support for any reason were analysed) this is unlikely to be as a result of regression to the mean. However, this could be confirmed through reviewing a matched control group.

5908 patients were reviewed; this is a statistically significant number indicating findings that are substantive and replicable.

The data for cohort 4, PCN social prescribing demonstrates that this national programme rolled out by NHSE, if delivered locally according to the guidance, directly reduces demand on acute care; this learning should be shared nationally.

There will be significant savings in other areas of health and social care system usage and statutory services; acute care is just one part of the system that social prescribing benefits. For example, reductions in demand for social care, mental health services, criminal justice, pharmaceutical prescribing, welfare and housing services. A holistic review of statutory service demand reduction should be undertaken to assess the true value of social prescribing and return on investment, which includes the full range of NHS services and statutory support. This should be undertaken on one cohort to build a complete picture of people's use of statutory services and the impact on this usage following social prescribing.

Charlotte Osborn-Forde, CEO, Involve Kent 01.03.23