

Leeds North CCG Social Prescribing Evaluation

Version History

Version	Date	Status	Author	Comment
0.1	03/02/2017	Draft	Will Ridge	Initial draft.
0.2	10/04/2017	Draft	Will Ridge	First revision of the initial draft.
0.3	12/04/2017	Draft	Will Ridge	Major reworking including full restructure.
0.4	20/04/2017	Draft	Will Ridge	Following Comments From Frank Wood
1.0	27/04/2017	Finalised	Will Ridge	Following Comment from Lindsey Bell

1.0.0 Executive Summary

This evaluation has been carried out comparing groups of patients receiving long term, social prescribing interventions against those referred to the service, who either received no intervention, or a shorter term intervention. Its main findings are that:

- There is emerging evidence of positive impact of the social prescribing service commissioned by Leeds North CCG. This includes both the service operated by the Connect Well Consortia and those social practitioners employed by GP practices;
- Different levels of performance have been observed and grouped by the level of support provided to the individual;
- Emerging evidence suggests that the consortia employed social practitioners have helped reduce GP consultations against the target population of high consuming GP users, and have had a statistically significant impact in reducing of accident and emergency attendances in the 84 days after a tier 2 intervention;
- There is evidence of positive impact of the GP employed practitioners- though this is often in a reduction the speed of increase in GP activity, A&E attendances and non-elective bed nights than a reduction in activity for those who have a social prescribing plan;
- There are a number of reasons why the consortium employed practitioners seems to have a greater impact- one of these is that the service works with less frail patients than the GP employed staff;
- Patients supported by the consortia are likely to exit the service with improved WEMWBS scores- especially if the service is closed with a planned completion. This relationship is statistically significant;
- Recording of social prescribing activity in Leeds North CCG GP practices by GP employed practitioners is inconsistent. Standard processes and recording practices should be introduced to ensure that those who receive Social Prescribing are captured consistently across all practices in the CCG using both SystemOne and EMIS systems;
- Action should be taken to ensure that the consortium employed staff can view, record and maintain data on SystemOne and EMIS;
- Further investigation is required into the gender and age split of the service users, which seems to be predominantly supporting females and has lower engagement of patients aged 18- 44;

- A second evaluation will need to be carried out when the service has been operating for a longer period to enable us to draw more reliable conclusions from a greater evidence base.

2.0.0 Introduction

This is an evaluation of the social prescribing service provided by Leeds North CCG- Connect Well. The document will cover the whole service provided across Leeds North CCG practices, however, it will be split into two operating models—one a GP service provided by staff employed by GP practices, the second provided by a consortium of providers. These services are also provided in GP practices. These models will be evaluated separately, but differences between the two have been identified and commented on.

This document is structured with a relatively brief overview of the service followed by a section describing the cohorts of people who accessed it, and then the sections of the evaluation identifying the cross system impact on GP consultations, accident and emergency attendances, and non-elective hospital bed nights.

3.0.0 Service Overview

The Social Prescribing Service was commissioned by Leeds North CCG. The service was targeted at patients who regularly attended a Leeds North GP practice and supported them by putting the patient in contact with a social practitioner who could refer them on to community based services better suited to meet their needs in place of medical interventions. Examples of this may include: debt advice, referrals to the citizens advice bureau, or statutory and non-statutory social care services.

3.1.0 GP Practice Employed Model

Services are provided in the practice by a practice employed well-being co-ordinator. The co-ordinator provides a level of support ranging from a small amount of signposting over the phone to an ongoing service referring the patient to specialist services. Well-being co-ordinators are employed by seven North Leeds practices- The Avenue Surgery, The Light Surgery, Meanwood Health Centre, Oakwood Lane Medical Practice, Rutland Lodge Medical Practice, St Martin's Medical Practice, and The Street Lane Practice which have been pseudonymised for this evaluation.

The social prescribing service was rolled out to seven practices in the CCG. The names of these practices have been randomly pseudonymised to practices: A, B, C, D, E, F and G. Standard recording procedures were not introduced when the project was initiated. A template was created for TPP SystmOne by one practice working with the Primary Care Team at the CCG, though this was never rolled out more widely. Consequently no standard way of capturing Read coded social prescribing activity has been developed.

Data for this evaluation is taken from the Leeds Data Model which incorporates all Read coded activity on SystmOne and EMIS systems in Leeds. This data has been matched with other datasets including demographic data and health activity data such as A&E attendances and hospital admissions for the cohort supported by the service.

The Primary Care Team at the CCG have requested information about the recording of social prescribing activity in practices and have so far received responses from five practices: A, B, C, E and G. It has been possible to identify activity recorded by practices A, B, E and G limiting the scope of the evaluation to these four practices. The lack of consistency of recording has also resulted in different data items being captured by different practices, meaning there will be times where this evaluation cannot compare like with like, but instead will have to compare different activity types across different practices. This lack of consistency does cause issues with the evaluation of the service but also, and arguably more importantly, makes it more difficult for a clinician to understand the services offered to patients in different practices.

3.2.0 Connect Well Model

Wellbeing coordinators are provided by the Connect Well Consortium based at the Reginald Centre in North Leeds, and in GP practices. People are referred to the service- often by their GP and Connect Well works with them carrying out an assessment of the person's needs and support. This consortium used and recorded an evaluation using the Supporting People Outcomes and Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) as the person enters and exists the service. The hub at the Reginald Centre fulfils a coordinating role and refers people into the most appropriate Well-being co-ordinators.

This element of the evaluation is based on data from the Connect Well service which has been matched with the pseudonymised data in the Leeds data model. Age, gender, deprivation, long term conditions and risk data are all taken from the Leeds data model and as a consequence can only be provided where an NHS number has been provided for a positive match with the Leeds Data Model.

Referrals are made to the Connect Well Service and a Wellbeing Coordinator is allocated to the contact. Often the individual only requires a minimal, or tier 1, support in the form of signposting to a local service. If it is felt that the individual needs more support a face to face assessment is undertaken and services put in place- including potentially up to ten sessions with a Wellbeing Coordinator this is referred to as tier 2 support. This evaluation will make use of these different levels of support to assess the service.

4.0.0 Descriptive Statistics

4.1.0 Throughput

4.1.1 GP Employed Service

It should be noted that this dataset is based on recording practices, and should not be viewed as an absolute meter on throughput for the service as the count of activity is based on recording of that activity, not the activity itself. As a result this analysis is likely to be influenced by a variety of factors that do not relate to the actual service including the creation and formalisation of recording practices.

This activity has been grouped up using the Read codes provided by the practices as shown in figure 1. The descriptions used in this activity will be used through the evaluation. The codes are as follow:

A: Referral into Social Prescribing: Patient referred to a social prescriber, but no further information on the types of service they are given;

B: Signposting: A referral is made which results in the patient being signposted by the social prescriber, but no on-going support;

C: Social Prescribing Plan: The patient receives a detailed plan addressing their needs following referral to a professional who provides a social prescribing service;

D: Social Prescribing Service Offered: The patient is offered a social prescribing service- though this may be for signposting, or a plan- often used with the code for Referral into Social Prescribing;

E: Social Prescribing Declined: The patient is not offered a social prescribing service, or declines the service themselves- again often used with the code for referral into the service.

Fig 1: Social Prescribing Starts by Month and Service Type

Service Type	2015												2016												Total
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	
A: Referral into Social Prescribing					1	2	2	1	1	1				1		1	15	46	26	12	17	3	12		
B: Signposting	45	8	11	15	8	21	9	15	18	13	11	7	22	16	8	6	9	14	17	12	8	5	25		
C: Social Prescribing Plan	38	9	13	16	6	16	13	12	15	11	7	3	17	9	7	3	11	47	28	13	7	3	30		
D: Social Prescribing Service Offered						1	1	1		1				2		2	10	45	25	11	7	3	10		
E: Social Prescribing Declined		1		1	1	1	1	3	1	1		1			1	1	1	2		1	1		1		
Total	83	18	24	32	16	38	26	33	36	26	20	11	39	28	16	13	46	154	96	49	40	14	85		

As is shown in figure 1 of the three practices in this evaluation Practice B has the most activity with 624 recorded cases of signposting since January 2015- an average of around 30 a month, this activity covers 280 people. This practice has also coded 457 cases with a social prescribing plan (averaging 21 a month) covering 236 patients.

Practice A, meanwhile, has recorded 117 referrals to the service since May 2015- covering 90 patients, 99 of these referrals have resulted in an offer of Social prescribing- 85 patients, and 55 social prescribing plans for 50 patients. A large proportion of this activity has been captured in June, July and August of 2016 and this accounts for 77% (90) of referrals, 79% (78) of offers of social prescribing and 85% (47) of plans.

Practice E shows 32 referrals for social prescribing recorded since May 2016 covering 28 patients, and 29 cases of people being offered the service covering 24 patients. Practice G has recorded 10 referrals into the service, all in September.

Fig 2: Social Prescribing GP Practice and Service Type

Practice	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered	E: Social Prescribing Declined	Total
Practice A	90			50	85	2
Practice B		298	254			5
Practice E	29				24	18
Practice G	10					
Total	129	298	304	109	18	8

Codes B and C have largely been used by one practice. Multiple patient episodes have been removed from this evaluation which includes just the first of each service type per patient.

4.1.2 Consortia Employed Service

Those who receive a social prescribing service from the consortia have been grouped based on the outcome of the intervention. A spell of service can only be identified when an outcome is recorded on the case:

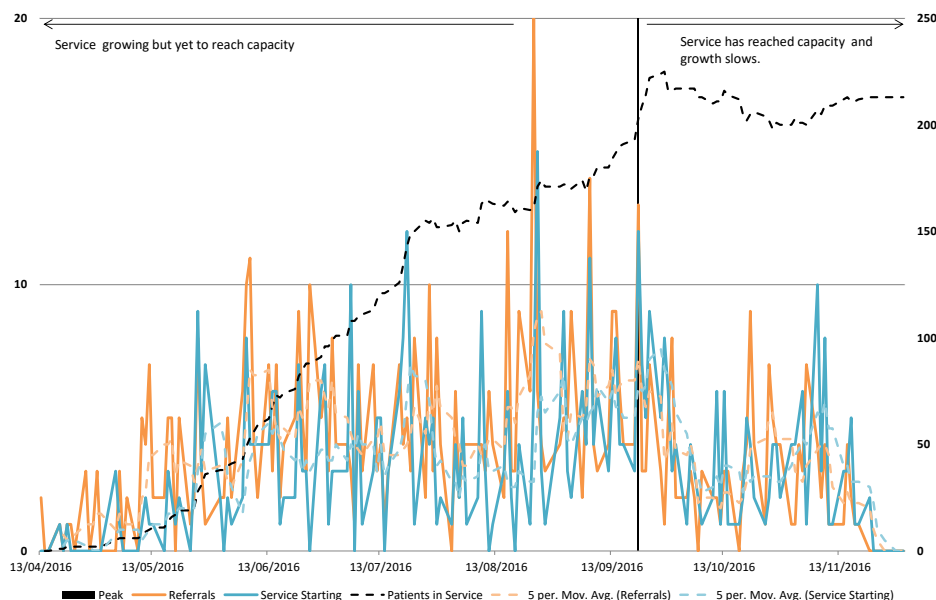
- **A: Closed: Tier 2, Planned Closure:** Those with an assessment of need and package of support which ended with a planned closure;
- **B: Closed: Disengaged:** Those who chose to disengage from the service;
- **C: Closed: Tier 1:** Those who received no long term support but some signposting to services;
- **D: Closed: Failed To Engage:** Those who did not answer or return Connect Wells calls;
- **E: Closed: Other or No Reason:** includes those who had no service closure reason recorded (n= 19), died (5), or the one case which 'moved out of service area';
- **F: Service Still Open:** those who are still in contact with the service.

Fig 3: Service Starts by Month by Outcome

	2016											
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total		
A: Closed: Tier 2, Planned Closure		11	24	49	32	17	3	1		137		
B: Closed: Disengaged	2	12	22	12	9	7	1			65		
C: Closed: Tier 1		4	6	11	12	20	16	11		80		
D: Closed: Failed To Engage		7	17	10	21	19	6	2		82		
E: Closed: Other or No Reason		10	9	2	2	2				25		
F: Service Still Open		4	15	15	28	77	38	42		219		
Total	2	48	93	99	104	142	64	56		608		

According to the data provided the first referral into the service was received on April 13th 2016. Between this date and November 21st 2016 the service received and actioned a total of 608 referrals at just under four referrals per working day. In the same period they provided a total of 608 episodes of care- 13.2% (n=80) tier one support and 22.5% (137) with tier two support and a planned closure, and 36% (219) where service has started and is still open. In addition to these a small number of cases never engaged the service, so could not be offered either tier one or tier two

Fig 4: Referrals to the Connect Well Social Prescribing Service by Day

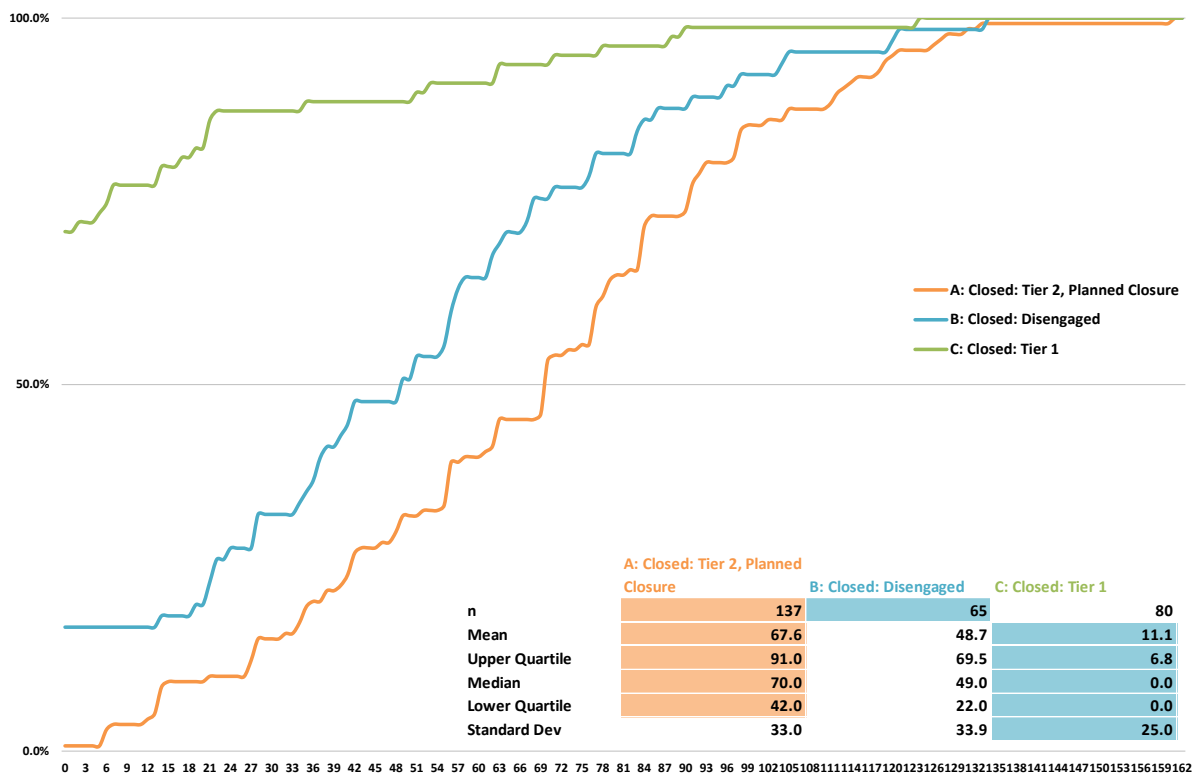


support, finally patients disengaged in 12.4% (65) of instances.

As is shown in figure 4 the service filled from April 2016 until it reached a capacity of around 225 patients in mid-September. Since this the number of referrals accepted has dampened, ensuring that it continues to operate with an allocated caseload of between 200 and 225 cases.

As figure 5 shows tier two interventions with a planned closure result in the longest service lengths- a mean average of 67.6 days (70.0 median), while these are 48.7 and 49 for those who actively disengaged from the service and 11 days and 0.0 days for those offered tier one interventions only:

Fig 5: Length of Service by Service Type



4.1.3 Comparison

The Social Prescribing service has been established for a longer time in GP practices, with significant amount of activity recorded since January 2015, while the consortia employed coordinators came on line in April 2016. However, while the evidence base from consortia employed staff is strong with significant activity recorded consistently across different service levels, recording in GP practices is not so robust with practice employed co-ordinators where different practices using different Read codes to record activity and this will influence the results of this evaluation. In combination this means that it will be difficult to use the available data to develop a robust evaluation of either service as the service has not been in place long enough for one source and does not have robust enough data from the other.

4.2.0 Age and Gender

4.2.1 GP Employed Service

The individuals referred to this service are predominantly female- 65% against 35% male across the different service levels. There is a small amount of variation in the proportions of males and females supported by service type with signposting having the lowest proportion of females (61%) and social prescribing offered the highest (73.4%). This is a small sample, but there is likely to be value in carrying out further investigation into if this service is more likely to be taken up by females than males and if there is some unmet need in the male population.

Fig 6: Proportion by Gender, Age and Service Type for the GP Based Cohort

	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered	E: Social Prescribing Declined	Total	Total GP Populations	Diff SP Cohort to Total GP Pop
Gender								
Female	72.1%	61.4%	63.2%	73.4%	66.7%	65.3%	51.1%	-14.2%
Male	27.9%	38.6%	36.8%	26.6%	33.3%	34.7%	48.9%	14.2%
Age Group								
A: 18- 24 years old	1.6%	4.0%	3.9%	1.8%	16.7%	3.6%	6.8%	3.2%
B: 25- 34 years old	4.7%	6.0%	3.6%	2.8%	27.8%	5.0%	34.2%	29.2%
C: 35- 44 years old	3.9%	8.4%	6.9%	2.8%	11.1%	6.5%	16.9%	10.4%
D: 45- 54 years old	5.4%	10.1%	9.9%	5.5%	11.1%	8.7%	14.5%	5.8%
E: 55- 64 years old	17.8%	21.8%	21.4%	18.3%	11.1%	20.4%	11.5%	-8.9%
F: 65- 74 years old	17.8%	13.8%	15.5%	18.3%	5.6%	15.4%	8.0%	-7.4%
G: 75- 84 years old	24.0%	17.4%	19.4%	24.8%	11.1%	19.9%	5.2%	-14.7%
H: 85- 94 years old	22.5%	15.8%	16.8%	22.9%	5.6%	17.8%	2.6%	-15.2%
I: 95+ years old	2.3%	2.7%	2.6%	2.8%	0.0%	2.6%	0.3%	-2.3%

The age breakdown is relatively similar across most service levels with a bias toward older people with around 75% of patients aged 55 or over. However, there is some variation within these groups with a relatively large proportion of younger patients declining the service with 44% of them aged 18- 35- though this was of a small total cohort, and from one practice.

In comparison to the total population of the four GP practices included in this evaluation there is an under representation of males (34.7% accessing the service, 48.8% of practice populations) and the groups aged 18 to 44 years on January 1st 2017- 15.2% in the service cohort against 57.9% of the GP population.

4.2.2 Consortia Employed Service

Fig 7: Proportion by Gender, Age and Service Type for the Connect Well Cohort

	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed: Other or No Reason	F: Service Still Open	Total	Total LNCCG Population	Diff SP Cohort to Total LNCCG Pop
Gender									
Female	64.8%	62.7%	61.4%	56.0%	73.3%	67.0%	63.9%	50.2%	-13.7%
Male	35.2%	37.3%	38.6%	44.0%	26.7%	33.0%	36.1%	49.8%	13.7%
Age Group									
A: 18- 24 years old	3.2%	6.8%	4.3%	13.3%	0.0%	4.7%	5.6%	7.9%	2.3%
B: 25- 34 years old	7.2%	8.5%	11.4%	13.3%	26.7%	7.3%	9.3%	35.4%	26.1%
C: 35- 44 years old	8.8%	8.5%	12.9%	6.7%	6.7%	7.3%	8.4%	15.2%	6.8%
D: 45- 54 years old	12.0%	13.6%	18.6%	14.7%	13.3%	18.3%	15.7%	13.6%	-2.1%
E: 55- 64 years old	19.2%	20.3%	11.4%	10.7%	13.3%	14.7%	15.3%	10.8%	-4.5%
F: 65- 74 years old	12.8%	5.1%	10.0%	17.3%	6.7%	12.0%	11.8%	8.6%	-3.1%
G: 75- 84 years old	16.8%	18.6%	17.1%	16.0%	26.7%	19.9%	18.3%	5.5%	-12.9%
H: 85- 94 years old	16.0%	16.9%	10.0%	8.0%	0.0%	13.1%	12.7%	2.6%	-10.1%
I: 95+ years old	4.0%	1.7%	4.3%	0.0%	6.7%	2.6%	2.8%	0.3%	-2.5%

As is shown in figure 7 this population is also predominantly female- 63.9% (342/535) where gender is captured. Ages have been calculated as the person's age on January 1st 2017. Based on the available data 84.8% of those supported by this service were aged over 45 years old- though when put into ten year age bands the split between 45 and 94 years of age is relatively even across the different groups with the smallest ten year age band 65- 74 year olds (15.4%) and the largest 55- 64

(20.4%). These are relatively consistent across the cohorts, however, there are signs that those aged 18- 44 are slightly more likely to receive a Tier 1 intervention, fail to engage, or have their case closed with no reason given.

The patient population has been compared to the total Leeds North population, and similar observations can be made about the gender and age make up with an over representation of females against the CCG population and those aged under 45- 15.2% of the supported population against 57.9% of the total CCG population.

4.2.3 Comparison

The populations supported by the Connect Well and GPs are relatively similar. Both are predominantly female and aged 45+. However, both datasets shows some emerging evidence of lower levels of long term engagement for the age groups aged 18- 44.

4.3.0 Deprivation

Data on the access to the Connect Well service has been linked to the lower super output areas (LSOA) those patients lived in, and the 2015 indices of multiple deprivations. The matching has been done using files already matched to LSOA and the match rate is poor- 126 (14.7%) of the GP based cohort and 286 (47%) of the patients supported by consortium employed staff. As a result this data should be considered indicative.

4.3.1 GP Employed Service

Fig 8: Deprivation by Decile for the Cohort Supported by GP Employed Staff

Index of Multiple Deprivation Decile (1 most deprived)	A: Referral into		C: Social	D: Social	E: Social	Total	Total GP Populations	Diff SP Cohort to Total GP Pop
	Social Prescribing	B: Signposting	Prescribing Plan	Service Offered	Prescribing Declined			
1	32.3%	25.8%	31.6%	27.3%	25.0%	29.4%	16.9%	-12.4%
2	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.9%	4.9%
3	0.0%	3.2%	2.6%	0.0%	0.0%	1.6%	2.5%	0.9%
4	0.0%	3.2%	2.6%	0.0%	25.0%	2.4%	1.6%	-0.7%
5	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.8%	1.8%
6	9.7%	3.2%	2.6%	13.6%	0.0%	6.3%	7.9%	1.5%
7	3.2%	38.7%	28.9%	4.5%	25.0%	20.6%	15.0%	-5.6%
8	9.7%	0.0%	0.0%	13.6%	25.0%	5.6%	8.2%	2.6%
9	32.3%	12.9%	21.1%	36.4%	0.0%	23.8%	16.6%	-7.2%
10	12.9%	12.9%	10.5%	4.5%	0.0%	10.3%	24.6%	14.3%

This data set suggests that those who live in the 10% most deprived LSOAs are slightly over represented in the cohort of patients accessing support from the GP practice employed social prescribing staff against the most total for the practices employing staff. Equally there is some evidence that those in the least deprived LSOAs are under-represented in the cohort.

4.3.2 Consortia Employed Service

As with the GP employed cohort the evidence base here is limited by the proportion of records that have been linked to their LSOA. However, based on the available evidence the population supported by the social prescribers based in the practices is broadly in line with the population of the CCG with the majority of the populations in the 7th, 8th, 9th and 10th least deprived deciles, and the most deprived decile.

Fig 9: Deprivation by Decile for the Cohort Supported by Consortium Employed Staff

Index of Multiple Deprivation Decile (1 most deprived)	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed: Other or No Reason	F: Service Still Open	Total	Total LNCCG Population	Diff SP Cohort to Total LNCCG Pop
1	17.3%	19.4%	11.5%	19.5%	11.1%	10.6%	14.7%	11.2%	-3.5%
2	9.3%	0.0%	0.0%	7.3%	0.0%	3.8%	4.9%	3.8%	-1.1%
3	5.3%	0.0%	7.7%	2.4%	0.0%	6.7%	4.9%	4.1%	-0.8%
4	0.0%	6.5%	0.0%	4.9%	0.0%	1.0%	1.7%	2.1%	0.4%
5	1.3%	0.0%	0.0%	4.9%	0.0%	1.9%	1.7%	3.1%	1.3%
6	8.0%	19.4%	7.7%	9.8%	11.1%	5.8%	8.7%	6.5%	-2.2%
7	8.0%	6.5%	11.5%	4.9%	33.3%	12.5%	10.1%	12.0%	1.8%
8	16.0%	16.1%	7.7%	12.2%	11.1%	8.7%	11.9%	10.2%	-1.7%
9	21.3%	6.5%	38.5%	12.2%	22.2%	19.2%	19.2%	19.8%	0.5%
10	13.3%	25.8%	15.4%	22.0%	11.1%	29.8%	22.0%	27.3%	5.2%

4.3.4 Comparison

The available evidence suggests that the cohort supported by consortium employed social practitioners are more representative of the CCG population that those supported by the GP employed ones are of those practices.

4.4.0 Long Term Conditions

4.4.1 GP Employed Service

As shown in figure eight 90% of the patients accessing the social prescribing service at a GP practice have at least one chronic condition, 46% of the total population have at least one chronic condition that is mental health related and 29% have a flag for frailty. The 'declined' group are less likely to have a chronic condition, a mental health related long term condition or frailty. All groups accessing these social prescribing services have higher rates for all three of these indicators than expected for these seven practices.

Fig 10: Number of Chronic Conditions, Mental Health Needs and Frailty by Service Type

Chronic Conditions	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered	E: Social Prescribing Declined	Total	Total GP Populations
0	8	24	27	4	10	73	21857
1	6	39	29	6	2	82	8449
2	10	36	31	8	0	85	3573
3	18	30	33	13	1	95	1909
4	14	32	35	13	0	94	1040
5	14	17	20	12	1	64	642
6	15	10	17	14	1	57	408
7	4	16	15	4	0	39	260
8	5	9	8	4	0	26	173
9	9	10	13	8	1	41	101
10	8	6	9	7	0	30	51
11	4	9	8	4	1	26	25
12	1	4	5	1	0	11	18
13	2	5	4	2	0	13	15
14	0	0	0	1	0	1	6
15+	2	2	2	2	1	9	12
1+ Chronic Condition	93.3%	90.4%	89.5%	96.1%	44.4%	90.2%	43.3%
Mental Health LTC	38.2%	50.8%	49.5%	38.7%	22.7%	46.3%	16.1%
Frailty Flag	24.4%	31.3%	28.9%	25.2%	22.7%	28.5%	7.9%

There is some discrepancy between service levels with higher proportions of patients who are accessing the signposting support and social prescribing plans having at least one mental health condition from Depression, Bipolar Disorder or Schizophrenia. This is likely to be partially down to practice makeup as a large proportion of the patients in this cohort are from one practice which has a larger than average proportion of registered patients with mental health needs. The most common

conditions across the cohort are: Hypertension (49%), Depression (45%) and Lipid Metabolism disorders (30%) and Asthma (21%).

4.4.2 Consortia Employed Service

As is shown in figure nine the proportions of patients accessing the service with one or more chronic condition are broadly similar to those supported in the GP practice with in total 87.4% of patients with one or more condition. The tier 2, planned closure and service still open groups- those groups with longer term interventions from Connect Well, are both 89.1%.

Over half of this population have at least one mental health related long term condition. Again this is relatively consistent across the planned closure and still open groups at 54.6 and 53% respectively. 15.3% of the cohort have a flag for frailty with this rate highest amongst those with a confirmed tier one or tier two intervention- 18.8 and 19.1% respectively. As with the previous cohort the proportions with at least one chronic condition, one or more mental health conditions and a flag for frailty are higher amongst the supported cohort than the wider CCG registered population.

Fig 11: Number of Chronic Conditions, Mental Health Needs and Frailty by Connect Well Cohort

Chronic Conditions	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed: Other or No Reason	F: Service Still Open	Total	Total LNNCC Population
0	14	8	10	12	4	21	73	128728
1	31	14	12	22	1	31	123	48158
2	20	10	13	16	2	39	105	19105
3	17	6	12	7	0	35	82	9682
4	9	7	7	7	1	20	54	5455
5	15	7	6	7	2	10	49	3116
6	9	3	1	2	2	9	27	1922
7	4	0	1	1	0	8	16	1155
8	3	1	2	0	2	9	17	745
9	3	2	2	0	1	4	12	455
10	2	1	3	1	1	2	12	267
11	1	0	0	2	0	1	5	162
12	0	0	0	1	0	2	3	89
13	0	0	0	0	0	1	1	66
14	0	0	0	0	0	0	0	36
15+	0	0	0	1	0	0	1	46
1+ Chronic Condition	89.1%	86.4%	85.5%	84.8%	75.0%	89.1%	87.4%	41.3%
Mental Health LTC	54.6%	61.5%	52.5%	59.3%	29.6%	53.0%	54.5%	15.2%
Frailty Flag	19.1%	13.8%	18.8%	15.1%	14.8%	12.8%	15.3%	5.8%

The most common long term condition was depression affecting exactly 350 patients (53%), closely followed by Hypertension (273 instances at 41.2%) with Osteoporosis (93 at 14%), and Asthma (84 at 12.7%).

4.4.3 Comparison

The headline level of chronic conditions is relatively similar across the two groups and particularly in that the majority of patients have between one and five existing conditions. This is consistent across the comparable social prescribing plan group in the GP cohort (89.5% one condition plus) and the tier two planned closure intervention (89.1%) and the signposting (90.4%) and tier one interventions (85.5%). However, there are some slight differences between the two groups with a higher proportion of the cohort having mental health conditions in the consortium supported cohort (54.5% in total- 54.6% for Tier two interventions, and 52.5% Tier One) against the GP based cohort- 46.3% in total, 49.5% with a plan and 50.8% signposted. This difference is larger in the groups which do not include patients registered at Practice B- though the coding of this activity makes more direct comparison with the Connect Well Cohort more difficult. Finally the levels of frailty are slightly higher across the GP supported cohort of patients where 28.5% of patients have a flag for frailty while 15.3% of the consortium supported cohort do. The GP based cohort is on average, slightly

proportion than the cohort supported by a GP employed co-ordinator. As with the GP based cohort the risk of high total cost care (0.17) is higher than the risk of hospital admission (0.12).

This group exhibits a higher than average level of risk in comparison to the rest of the CCG- more than 88.7% of the population have a risk of high total cost of less than 0.1 and 93.6% a similar level of risk of hospital admission within the next six months.

4.5.3 Comparison

Both cohorts have a relatively low level of clinical risk based on the ACG tool with risk associated with lower average levels of risk for the Connect Well Cohort than the GP based group. However, it should be noted that these levels of predicted risk are higher for both groups than the adult population of the CCG and the practices.

5.0.0 Patient Outcomes

In addition to the descriptive analytics above service users were assessed using two tools at entry to an exit from the social prescribing service. The service used the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS). Where possible Scores from entry to and exit from the service for each service user have been analysed.

5.1.0 GP Employed Service

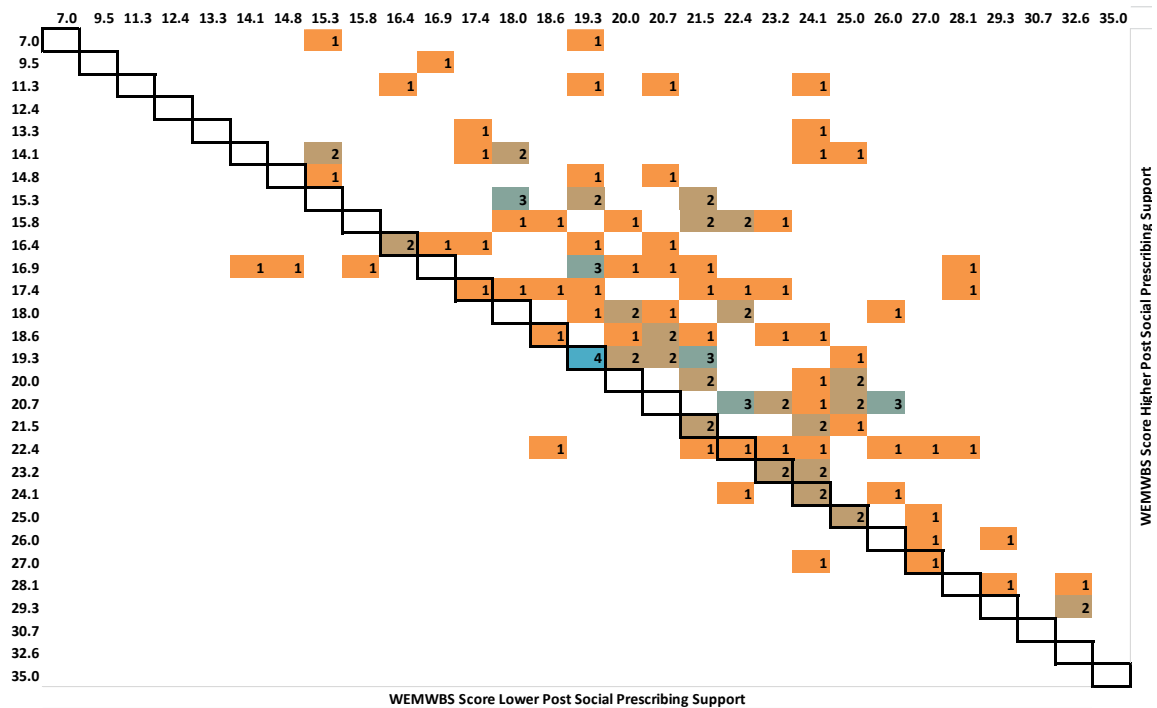
It has not been possible to collect data for WEMWBS. A number of practices captured scores on entry to and exit from the service, but often on paper.

5.2.0 Consortia Employed Service

The consortia employed coordinators captured WEMWBS scores for service users they supported, this was done most consistently for tier two patients who had a planned discharge. As a consequence the dataset covering both an entry and an exit using WEMWBS is relatively small at 126 patient episodes 83 (66%) of which are for planned closures, and 25 (20%) for those who disengaged from the service.

88% of those supported and with a planned completion of the service saw their WEMWBS score improve ($p < 0.05$). Of these 19 (23%) improved by at least 5 points, leaving 54 (77%) with a more modest improvement. All other cohorts here are relatively small, making further comparison relatively difficult- though there is similar levels of performance for those who disengaged from the service with 20 out of 25 (80%) receiving the service improving. Figure 14 shows the performance of the whole cohort with scores on entry on the Y axis and exit on the X axis. The bold diagonal of boxes shows where scores on entry were the same to those on exit, with scores below this line suggesting WEMWBS scores getting worse between entrance and exit, and improvements, above.

Fig 14: Changes in WEMWBS Scores Between Entrance and Exit



5.3.0 Comparison of Services

As there is no data from the GP employed model, it has not been possible to compare outcome data.

6.0.0 Whole System Impact

The following section covers the impact of the service in the wider health services in Leeds. Activity data submitted by both the practice workers and the Connect Well Service have been integrated with GP consultations, accident and emergency and non-elective inpatient activity in the Leeds data model. This has allowed for an analysis of the amount of health resources patients receiving social prescribing consume before and after they receive the service.

As the GP consultations, accident and emergency and non-elective inpatient datasets are taken from the Leeds data model there is a delay in the data being made available. This has reduced the potential cohort of users receiving the service, and resulted in the tracking of some relatively small cohorts- especially for the consortium employed service which came into operation in April 2016. An evaluation should be carried out when the service has been in place for longer and with more consistent recording practices to more thoroughly evaluate its impact. Figure 15 shows the data used in this evaluation for the GP employed social prescribing service- which was in place in 2015, and figure 16 the consortium employed service which started in April 2016.

Fig 15: Data used for the Whole System Evaluation of GP Based Patients

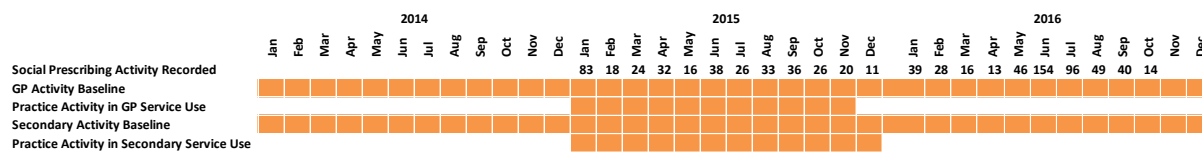
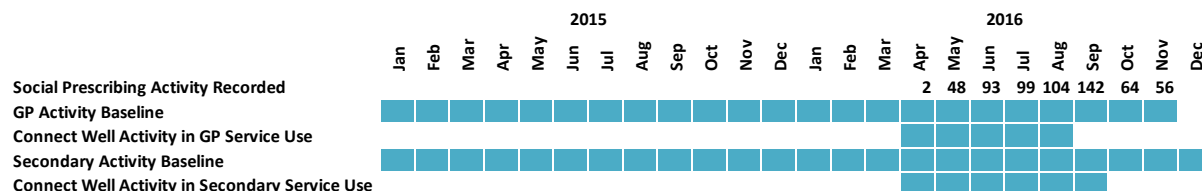


Fig 16: Data used for the Whole System Evaluation of Connect Well Patients



6.1.0 GP Consultations

One of the main aims of the service was to reduce the number of GP consultations spent with a relatively small number of frequent attendees. The records of patients accessing the social prescribing service have been matched with their GP appointment records, and increases and decreases in their consumption of GP appointments and planned time have been identified for both the cohort that accessed the service through the GP employed model and those supported by the consortia employed staff. This activity has been used to try and identify if there has been a significant reduction in the numbers of them seeing a GP, or a reduction in the amount of time GPs plan to spend with them.

6.1.1 GP Employed Service

A brief evaluation of the impact of the social prescribing service at one GP practice in November 2016 suggested some positive impacts of the service. This evaluation will build on this initial document including a greater number of practices, and a longer time scale.

This evaluation has been built using activity since January 1st 2014 for the four practices. The activity has been looked at through two prisms- first activity in the 364 days before and after a patient was first referred to the Connect Well Service, and the second looking at the totality of GP based activity for this cohort of patients in between January 1st 2014 and late November 2016 to understand the total activity for cohorts of patients determined by the level of support they received from the service. Where practices have estimated the amount of time spent on a consultation consultations of less than 10 minutes have been stripped out of a second analysis to provide a proxy for face to face consultations.

In 2014 the cohort of patients supported by social prescribing consumed an average of 7.3 GP consultations, increasing to 12.8 in 2015 before falling again to 8.8 in 2016. However, a relatively large proportion of these were relatively short, and with those contacts of less than 10 minutes stripped out these numbers fall to 2.3, 2.9 and 2.9 respectively.

Fig 17: Differences in GP Consultation Activity Before and After Social Practitioner Intervention

	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered All GP Appointments	E: Social Prescribing Declined	Total	No Social Prescribing Plan Total (Group)	
GP Appointments in the 364 days Before Social Prescribing		92	2218	1987	39	55	4391	2404
GP Appointments in the 364 days After Social Prescribing		103	2388	2124	55	45	4715	2591
% Difference	12.0%	7.7%	6.9%	41.0%	-18.2%		7.4%	7.8%
GP Appointments Lasting 10 Minutes or more								
GP Appointments in the 364 days Before Social Prescribing	-		459	407	-	40	906	499
GP Appointments in the 364 days After Social Prescribing	-		525	421	-	39	985	564
% Difference		14.4%	3.4%			-2.5%	8.7%	13.0%

Looking at the year before and after a social prescribing intervention suggests some benefits in terms of reductions in GP consultations where a social prescribing plan is in place. As is shown in figure 17 those with a social prescribing plan show a 3.4% increase in consultations of 10 minutes or more, while those with a code that suggests they did not receive a plan saw an increase of 13%, while a more modest benefit can be seen when including all consultations.

Fig 18: GP activity in 2014, 2015 and 2016 for the GP Social Prescribing Cohort

	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered All GP Appointments	E: Social Prescribing Declined	Total	No Social Prescribing Plan Total (Group)	Service Practices Total
Cohort	8	181	159	4	11	363	204	-
2014 Week 1- 47	73	1401	1300	30	35	2839	1539	66183
2015 Week 1- 47	88	2463	2184	42	37	4814	2630	74803
2016 Week 1- 47	80	1694	1462	47	46	3329	1867	74644
Difference- 2014- 2015	15	1062	884	12	2	1975	1091	8620
% 2014- 2015	20.5%	75.8%	68.0%	40.0%	5.7%	69.6%	70.9%	13.0%
Difference- 2015- 2016	7	293	162	17	11	490	328	8461
% 2014- 2016	9.6%	20.9%	12.5%	56.7%	31.4%	17.3%	21.3%	12.8%
GP Appointments lasting 10 minutes or more								
Cohort size	8	181	159	4	11	363	192	-
2014 Week 1- 47	-	385	338	-	24	747	409	19139
2015 Week 1- 47	-	463	393	-	31	887	494	19326
2016 Week 1- 47	-	485	385	-	39	909	524	23998
Difference- 2014- 2015	-	78	55	-	7	140	85	187
% 2014- 2015	-	20.3%	16.3%	-	29.2%	18.7%	20.8%	1.0%
Difference- 2015- 2016	-	100	47	-	15	162	115	4859
% 2014- 2016	-	26.0%	13.9%	-	62.5%	21.7%	28.1%	25.4%

Figure 18 shows the number of GP consultations for the social prescribing service for weeks 1- 47 in 2014, 2015 and 2016. GP activity for weeks 48- 52 is not available for 2016 and so has been excluded from this analysis for all three years. Two cuts of this data have been presented. The top table is all GP appointments, or consultations, the second one is GP appointments or consultations expected to last 10 minutes or more- this is partly to mitigate for the introduction of a 'Doctor first' system in one of the practices.

This dataset shows that GP attendances have increased across all groups for the social prescribing cohort since 2014 for both attendances over and under 10 minutes in length. However, this increase is smaller for the cohort of patients who have a social prescribing plan (12.5% increase for 159 contacts) than a control group made up of social prescribing interventions, but no plan (21.3% increase for 204).

It should be noted that a combination of small cohort sizes and confounding factors in the data mean these results must be treated with great caution- especially as the largest portion of cases with a social prescribing plan were registered and received support from the social practitioner at one practice.

6.1.2 Consortia Employed Service

GP data set starts on January 1st 2015 and runs to the middle of November 2016. As a result only patients supported by the service up to and including August 2016 have been included in this analysis. In the year leading up to their receiving support the 346 patients supported by the Connect Well service saw a GP 7 times on average, and were estimated to take up 46.9 minutes per patient, 52% of the appointments made were scheduled to last 10 minutes or longer.

A comparison of activity in the three months pre and post the start of the social prescribing service shows that in the short term all levels of service seem to have a positive impact on a reduction in the number of GP appointments as shown in figure 19 below showing a 28% reduction in the number of GP appointments for those with a tier 2 intervention and planned closure, and a 30% reduction for those who disengaged from the service. The group who failed to engage with the service had the greatest reduction in GP appointments- a 44% reduction. However, when shorter appointments are stripped out this benefit is reduced with increases in the amount of activity for most groups, but smaller increases for the planned closure cohort.

Fig 19: GP Consultations Before and After Intervention by Service Level

	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed, Other or No Reason	F: Service Still Open	Total	Closed with No Tier 2 (Grouped)
All GP Appointments								
GP Appointments 84 Days Before Connect Well Intervention	264	112	56	125	31	134	722	324
GP Appointments 84 Days After Connect Well Intervention	190	78	43	70	28	112	521	219
Difference	-74	-34	-13	-55	-3	-22	-201	-105
% Difference	-28.0%	-30.4%	-23.2%	-44.0%	-9.7%	-16.4%	-27.8%	-32.4%
GP Appointments Lasting 10 Minutes or More								
GP Appointments 84 Days Before Connect Well Intervention	110	46	44	49	13	163	425	152
GP Appointments 84 Days After Connect Well Intervention	118	49	64	68	13	214	526	194
Difference	8	3	20	19	0	51	101	42
% Difference	7.3%	6.5%	45.5%	38.8%	0.0%	31.3%	23.8%	27.6%

An alternative analysis which looks at levels of GP based activity for the whole population receiving the service over the period January 1st 2015 to mid-November 2016- irrespective of when they were supported. This analysis compared numbers of GP appointments between mid-September and November 2015 with mid-September and November 2016.

Fig 20: GP Consultations Year on Year by Service Level

	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed, Other or No Reason	F: Service Still Open	Total	Closed with No Tier 2 (Grouped)	LNCCG Total
All GP Appointments									
2015 W 37- 47	219	80	98	102	29	376	904	309	95455
2016 W 37- 47	211	95	153	109	20	391	979	377	90255
Difference- 2015-2016	-8	15	55	7	-9	15	75	68	-5200
% Difference 2015- 2016	-3.7%	18.8%	56.1%	6.9%	-31.0%	4.0%	8.3%	22.0%	-5.4%
GP Appointments Lasting 10 Minutes or More									
2015 W 37- 47	156	63	65	67	15	243	609	210	46989
2016 W 37- 47	144	70	90	83	16	307	710	259	44429
Difference- 2015-2016	-12	7	25	16	1	64	101	49	-2560
% Difference 2015- 2016	-7.7%	11.1%	38.5%	23.9%	6.7%	26.3%	16.6%	23.3%	-5.4%

As shown in figure 20 this analysis suggests a small benefit from the Tier 2 planned closure group, while the group that disengaged from the service, and tier 1 interventions both saw an increase in the number of GP consultations- including both consultations of all lengths, and those of 10 minutes or more.

There are a number of explanations for this apparent discrepancy, and further analysis with a larger data set over a longer period of time is required before definitive conclusions are drawn. However, it seems that the most effective method of delivery is the one that is intended to be the longest term- Tier 2 with a planned closure, while those who disengaged from the service, or who received a signposting service are more likely to re-commence the patterns of high consumption of primary care resource.

6.1.3 Comparison of Services

Both the datasets from the GP employed and consortium employed services suggest that the patients supported by social prescribing can tend toward lower levels of consumption of GP time and consultation events. Inconsistencies in the data for the GP employed staff and short timescales for the consortium provided service make it difficult to quantify the benefit to the system at this time; however, both datasets suggest that these reductions are most likely to be for patients who are in receipt of a long term service with a social prescribing plan in place. Evidence suggests that the greatest benefit is for those patients accessing the service through the consortium, however, this is likely to be in part due to the seasonality of the service- as the cohort used in this evaluation covers patients starting the service in the spring and summer months while the dataset used for the practice based service draws from a complete calendar year.

6.2.0 A&E Attendances

The cohort of patients supported by the Social Prescribing Service are typically expected to have a lower level of secondary health resource utilisation- attending A&E and being admitted to hospital less than their consumption of primary care services, this is partly seen in their relatively low risk scores.

6.2.1 GP Employed Service

The group receiving social prescribing support in GP practices attended A&E on 1.0 occasion in 2014, 1.0 in 2015 and 1.4 in 2016. This relatively low level of attendance compared to access to primary care resources is to be expected given the relatively low risk scores that the cohorts were found to have.

Fig 21: A&E Attendances in the 364 days Before and After GP Social Prescribing Intervention

	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered	E: Social Prescribing Declined	Total	No Social Prescribing Plan	
A&E Attendances 364 days Before GP Based Social Prescribing Intervention		5	133	122	2	5	267	145
A&E Attendances 364 days After GP Based Social Prescribing Intervention		20	152	145	5	3	325	180
Difference		15	19	23	3	-2	58	35
% Difference		300.0%	14.3%	18.9%	150.0%	-40.0%	21.7%	24.1%

This data is based on the cohort of patients receiving social prescribing from a GP practice in the 2015 calendar year, comparing activity in the year before this intervention- the start of the social prescribing service, against the same time period after the intervention. Because of this time frame the only cohorts large enough for meaningful conclusions are those Signposted- 152 interventions, up 14.3% post intervention and with a Social Prescribing Plan- 145 interventions, up 18.9%.

Fig 22: A&E Attendances in 2014, 2015 and 2016 for the GP Social Prescribing Cohort

Cohort	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered	E: Social Prescribing Declined	Total	No Social Prescribing Plan	Service Practices Total
2014	113	351	299	95	10	868	569	6637
2015	99	401	306	82	10	898	592	6581
2016	160	494	420	114	6	1194	774	6993
Difference- 2014- 2015	-14	50	7	-13	0	30	23	-56
% 2014- 2015	-12.4%	14.2%	2.3%	-13.7%	0.0%	3.5%	4.0%	-0.8%
Difference- 2014- 2016	47	143	121	19	-4	326	205	356
% 2014- 2016	41.6%	40.7%	40.5%	20.0%	-40.0%	37.6%	36.0%	5.4%

Based on this evidence the rate of A&E attendance is increasing for the cohort accessing social prescribing via a GP employed well-being co-ordinator. When comparing the change between 2014 and 2016 the rate of increase is broadly the same for the cohort with a social prescribing plan (40.5%) than the cohort who just received signposting (40.7%) or a group of all without a plan (36.0%)

6.2.2 Consortia Employed Service

A&E attendance data has also been taken from the Leeds data model. At the time of this evaluation this data set ran up to the end of December 2016. As a result those measures based on 3 months of activity before and after intervention include patients referred into the service up to the end of September 2016.

The group of patients supported by the Connect Well service exhibited lower levels of A&E attendances than GP consultations in the year 2015 with 281 attendances in total, giving a mean of 0.5 attendances in the year per patient supported.

A comparison of the different service outcomes provides some emerging evidence of a positive impact for the Tier 2 planned closure and service still open cohorts which see a reduction of 50% (22-11) and 36% (25- 16) when comparing the 84 days before and after the start of intervention. While the disengaged cohort and tier 1 support cohorts both saw an increase in attendances- 43% (7-10) and 114% (7-15). Those with a closed case, but no social prescribing plan saw an increase of 30.8% giving a statistically significant difference.

Fig 23: A&E Attendances in the 84 days Before and After Connect Well Social Prescribing Intervention

	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed: Other or No Reason	F: Service Still Open	Total	Closed with No Tier 2 (Grouped)	
A&E Attendances 84 days Before Connect Well Intervention	22	7	7	11	1	25	73	26	
A&E Attendances 84 days After Connect Well Intervention	11	10	15	7	2	16	61	34	
Difference	-11	3	8	-4	1	-9	-12	8	
% Difference	-50.0%	42.9%	114.3%	-36.4%	100.0%	-36.0%	-16.4%	30.8%	

These conclusions are supported by a comparison of the levels of activity between the two cohorts between weeks 37 and 51 of 2015 and 2016- on both these measures the cohort receiving a tier two intervention and with support still open both show a reduction in the number of attendances at accident and emergency. As with the analysis above it is too early to draw concrete conclusions about the sustainability and significance of these trends as they may be influenced by factors such as seasonality.

Fig 24: A&E Attendances in 2015 and 2016 for the Connect Well Social Prescribing Cohort

	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed: Other or No Reason	F: Service Still Open	Total	Closed with No Tier 2 (Grouped)	LNCCG Total
2015 W 37- 51	23	9	5	9	2	46	92	25	11343
2016 W 37- 51	19	16	20	15	3	35	105	54	12157
Difference- 2016- 2015	-4	7	15	6	1	-11	13	29	814
% Difference	-17.4%	77.8%	300.0%	66.7%	50.0%	-23.9%	14.1%	116.0%	7.2%

6.2.3 Comparison of Services

The cohort of patients supported by this service were more likely to consume GP based resources than attend accident and emergency or be admitted to hospital. Evidence from their risk profiles, and counts of activity back up this expectation. As a consequence the largest potential savings are likely to be in terms of GP time, rather than commissioner savings through reduced activity in the secondary sphere. This is especially the case for the cohort receiving social prescribing from Connect Well which has a much lower level of A&E attendances than the GP based cohort before intervention- 0.5 attendances in 2015 against 1.0.

There is evidence in the consortium supported cohort that a long term, plan based social prescribing intervention can help reduce the number of A&E attendances.

6.3.0 Non Elective Admissions

This evaluation has been built around monitoring the number of non-elective bed nights in 28 day periods for patients receiving the Connect Well service. The number of beds nights consumed by each patient have been split into 28 day periods giving 13 28 day long silos and a count of the number of days patients in each category were taking up a non-elective hospital bed. Measures have then been created to look at the number of bed days before and after the intervention started.

Non elective bed days have been used in the place of a count of admissions to help account for the severity, or length of hospital stays. The previous section included counts of accident and emergency attendances. It should be noted that hospital spells are only available to the intelligence

hub when the patient has been discharged, and so there is likely to be a slight undercount on activity, but this should affect all groupings consistently.

6.3.1 GP Employed Service

As shown in figure 25 the number of non-elective bed days is relatively low amongst this cohort- on average 2.6 nights per patient per year. The majority of this activity is in the cohorts receiving signposting or with a social prescribing plan. Both of these cohort see an increase in activity pre and post intervention from the social prescribing service- 41% for the cohort who received signposting and 27.4% for those with a plan suggesting that the longer term interventions have a greater impact, however, as with previous points this may be a product of practice of a specific practitioner, rather than the impact of the wider scheme.

There is a large deterioration in the performance of the group 'referred into social prescribing'. 128 of the 135 days in this group are from a single patient, so this should not be considered significant.

Fig 25: Non Elective Bed Nights for the GP Based Social Prescribing Service

	A: Referral into Social Prescribing	B: Signposting	C: Social Prescribing Plan	D: Social Prescribing Service Offered	E: Social Prescribing Declined	Total	No Social Prescribing Plan Total (Group)
Cohort Size	8	181	159	4	11	363	20
Non Elective bed Days in the 364 Days Before GP Employed Intervention	0	456	464	0	21	941	47
Non Elective bed Days in the 364 Days After GP Employed Intervention	135	643	591	0	19	1388	79
Difference	135	187	127	0	-2	447	32
% Difference	-	41.0%	27.4%	0.0%	-9.5%	47.5%	67.1%

6.3.2 Consortia Employed Service

As with Accident and Emergency attendances patients accessing the Social Prescribing service through Connect Well do not consume a large number of non-elective beds nights. In the year in the run up to their referral to Connect Well the cohort received on average 2.06 bed nights in hospital (1,006 nights over 488 patients). There was a limited amount of variation between the different groups with the small group that failed to engage with the service having the highest rate of days in hospital in the year before intervention- 3.0 (225/74), while the lowest group was those who disengaged- 1.5 (94/64) and planned closures- 1.5 (197/133).

Fig 24: Non Elective Bed Nights for the Connect Well Social Prescribing Service

	A: Closed: Tier 2, Planned Closure	B: Closed: Disengaged	C: Closed: Tier 1	D: Closed: Failed To Engage	E: Closed, Other or No Reason	F: Service Still Open	Total	Closed with No Tier 2 (Grouped)
Cohort Size	133	64	53	74	25	139	488	216
Non Elective Bed Days in the 84 Days Before Consortium Employed Intervention	80	11	28	51	18	73	261	108
Non Elective Bed Days in the 84 Days After Consortium Employed Intervention	35	75	50	45	5	70	280	175
Difference	-45	64	22	-6	-13	-3	19	67
% Difference	-56.3%	581.8%	78.6%	-11.8%	-72.2%	-4.1%	7.3%	62.0%

The available evidence suggests that there was a reduction in average bed days in the 84 days before and after the start of the Connect Well intervention for the planned closure and service still open groups, -56.3% and 4.1% respectively, while the cohort that disengaged themselves from the service saw an almost six fold increase in bed nights- this is likely to be the result of a business process coding hospital admission as disengagement- though it should be noted that the closed tier 1 cohort sees a smaller increase in bed nights, so is performing relatively poorly in comparison to the planned closure and service still open cohort.

6.3.3 Comparison of Services

This evidence suggests that the potential benefits identified at accident and emergency attendances remain in the numbers of non-elective bed nights for both the GP practice employed and consortium supported cohorts with improved performance for those with social prescribing plans in the GP cohort and longer term relationships such as tier 2 interventions in the Connect Well cohort. Greater benefits have been observed in the cohort supported by the consortium, however, as pointed out above this may be a product of seasonality, and a thorough evaluation using at least one, full years data pre and post intervention will be required before conclusions can be drawn on this.