



National
Academy
for Social
Prescribing

NASP webinar: The impact of social prescribing on health service use and costs

Thank you for joining us. The webinar will begin shortly.



Housekeeping

- Please note we are **recording** this webinar (*you will be sent the slides and the link to the recording, and they will be on NASP's website too.*)
- Please submit questions via the **Q&A function**. We will hold a Q&A session at the end of presentations.
- Please use the **chat function** for introducing yourself and networking. If you have any technical issues, please raise these in the chat, and a member of the NASP team will assist.
- BSL Interpreters will be on screen throughout. **Closed Captions** are available (turn these on at the bottom of your screen)
- There will be a short poll at the end asking you for your feedback about the webinar.



Chair:

Joelle Bradly, Deputy Director of Evidence and Impact at the National Academy for Social Prescribing

Speakers:

Joelle Bradly, Deputy Director of Evidence and Impact at the National Academy for Social Prescribing

Jag Mundra, National Association of Primary Care (NAPC)

Professor Chris Dayson, Sheffield Hallam University





Joelle Bradly, Deputy Director of
Evidence and Impact at the National
Academy for Social Prescribing

The impact of social prescribing on health service use and costs

Dr Elaine O'Connell Francischetto (Lead author), Joelle Bradly and Katy Knight - Evidence and Evaluation Team at the National Academy for Social Prescribing (NASP).

Full report available here: [The economic impact of social prescribing on the NHS - NASP evidence | NASP](#)

Introduction

- Social prescribing has been found to have a positive impact on a wide range of outcomes, including reductions in loneliness, and improvements to mental health, wellbeing and social connectivity.
- A 2023 NASP rapid [review](#) on the health economic impact of social prescribing, identified evidence that social prescribing can save money and have a positive economic impact.
- It was found to deliver social and economic impact between £2.14 and £8.56 for every £1 invested. However, more data from practice is needed to demonstrate the benefits to the health service more clearly.
- The evidence base for the impact of social prescribing in practice is currently fragmented across integrated care systems, with no evaluation completed at a National level.
- The purpose of this report was to highlight examples from practice of the impact of social prescribing on health service use and costs

Calderdale

- A £350 reduction in hospital cost per patient per year
- An average reduction in 4 GP contacts per patient per year

Tameside and Glossop

- 42.2% reduction in GP appointments compared to 5.6% reduction in control

Frome

- Unplanned hospital admissions in Frome reduced by 14% compared to an increase in Somerset as whole of 28.5%

Sussex (Mid Sussex Healthcare)

- 25% reduction GP appointments
- 15% rise in hospital admissions compared to 57% in those starting support

Sussex (Mile Oak medical Centre)

- 6% reduction GP appointments
- 23% reduction in hospital admissions

Newcastle

- Secondary care cost per patient was 9.4% (£107 per head) lower than the comparison cohort

Kirklees

At 3 months (frequent users)

- 50% reduction in GP attendances
- 66% reduction in A&E attendances

At 9 months

- GP appointments, 50% of patients saw an increase, 39% saw a decrease and 11% saw no change
- A&E attendances, 46% saw an increase, 41% saw a decrease and 13% saw no change

Rotherham

- 39-43% reduction in A&E attendance
- 33-40% reduction in non-elective inpatient spells
- Cost reduction of 20-42%³

Kent

- 2.8-8.3% reduction in unplanned inpatient stays
- 15.4-23.6% reduction in A&E attendances



Area(s)	Population	Type of evaluation	Impact on service use and costs
Calderdale	4,170 patients from across Calderdale who has access to a Social Prescribing Link Worker	12 months prior compared to 12 months post	<ul style="list-style-type: none"> • A £350 reduction in hospital cost per patient • An average reduction of four GP contacts per patient
Frome	Population of Frome (n=28,510) which had access to an enhanced model of primary care and compassionate communities (which included social prescribing)	Observational data comparing Frome to Somerset as a whole	<ul style="list-style-type: none"> • Unplanned hospital admissions in Frome reduced by 14%, compared to an increase in Somerset as a whole of 28.5%
Kent	Patients seen by Social Prescribing Link Worker, split into four groups (more detail in text) (n=5,908)	6 months prior compared to 6 months post	<ul style="list-style-type: none"> • A&E attendance reduced by 15.4-23.6% • Unplanned inpatient stays reduced by 2.8-8.3%
Kirklees	Frequent health service users who accessed social prescribing (GP n=199/A&E n=125)	3 months prior compared to 3 months post	<ul style="list-style-type: none"> • 50% reduction in GP attendances • 66% reduction in A&E attendances
	Whole social prescribing service cohort (GP n=993/A&E n=495)	9 months prior compared to 9 months post	<ul style="list-style-type: none"> • GP appointments: 50% of patients saw an increase, 39% saw a decrease and 11% saw no change • A&E attendances: 46% saw an increase, 41% saw a decrease and 13% saw no change
Newcastle	Way to Wellness full eligible cohort in the West of Newcastle (n = 14,652)	Comparison over 12 months to matched 'counterfactual' group in an area with no access to the service	<ul style="list-style-type: none"> • Secondary care cost per patient was 9.4% (£107 per head) lower than the comparison cohort, equating to an annual cost reduction of £1.56 million. The authors estimate a 27% lower cost per head than the comparison cohort if only focusing on patients engaging with social prescribing

Area(s)	Population	Type of evaluation	Impact on service use and costs
Rotherham	Frequent users referred to a Social Prescribing Link Worker (inpatient spells n=352 /A&E attendances n=332)	12 months prior compared to 12 months post	<ul style="list-style-type: none"> • Non-elective inpatient spells were reduced by 33-40% • A&E attendances were reduced by 39-43% • 20-42% reduction in average costs for non-elective inpatient spells (n=327) • 29-39% reduction in average costs for A&E attendance (n=204)
Sussex (Mid Sussex Healthcare part of Burgess Hill & Villages PCN)	Had support from Social Prescribing Link Workers over 12 months ago (n=150) and those who had started support from Social Prescribing Link Workers in the last 12 months (n=164). (Note: the category 'starting support in last 12 months' may include service use before first contact with social prescribing.)	12 month period compared to previous 12 months and comparison between groups	<ul style="list-style-type: none"> • 15% increase in hospital admissions for people supported by social prescribing over 12 months ago, compared to a 57% rise for those who are starting social prescribing support • 25% fall in demand for GP appointments among those supported by social prescribing over 12 months ago, compared to 78% rise in those starting support
Sussex (Mile Oak Medical Centre)	Had support from Social Prescribing Link Workers over 12 months ago (n=231) and those who had started support from Social Prescribing Link Workers in the last 12 months (n=172). (Note: the category 'starting support in last 12 months' may include service use before first contact with social prescribing)	12 month period compared to previous 12 months and comparison between groups	<ul style="list-style-type: none"> • 6% fall in demand for GP appointments among patients who received social prescribing support more than 12 months ago, compared to 56% rise in those starting support • 23% (0.28 to 0.21) fall in average hospital admissions for people supported by social prescribing over 12 months ago, compared to a 208% (0.07 to 0.22) rise for those starting support
Tameside and Glossop	1,751 referrals to Social Prescribing Link Worker	Compared to control group (who were referred but did not take up the offer of social prescribing) after 12 months	<ul style="list-style-type: none"> • 42.2% reduction in GP appointments compared to 5.6% reduction in control group

Conclusion

- Evaluations of social prescribing services have found reductions in the number of GP appointments, secondary care use, A&E attendances and costs.
- Evaluations of social prescribing in Kirklees and Rotherham found that when data is segmented by those that are more costly to the NHS (in terms of more frequent service use) social prescribing could reduce GP appointments by 50% and A&E attendances by 66% in Kirklees and 33-44% in Rotherham
- Cost savings were also reported in Newcastle, Calderdale and Rotherham. In Newcastle they found secondary care costs to be 9.4% lower when compared to a control group. In Calderdale a £350 reduction in hospital cost per patient per year was reported. A pre and post analysis in Rotherham also reported a reduction in costs ranging from 29-39% for A&E attendance.

Limitations

- It is important to note that the data presented in this report is from evaluations of social prescribing in practice, which vary in methodological approach and quality.
- The process to identify these case studies was not systematic and was opportunistic based on publicly available evaluations of social prescribing known to the authors, as well as case studies where the authors have worked with colleagues across England to understand the impact of social prescribing in their Integrated Care Systems.
- The evaluations presented in this report are limited by data availability; some evaluations only had access to service user data, making control group analysis problematic.
- The most common analysis completed when evaluating services was pre and post service use, but there are limitations to this design
- The data included in the evaluations or approaches to data collection were not quality checked by the authors, so it is unclear whether the quality of data collected could have impacted results.

What we still need to know

- To understand the long term impact of social prescribing and answer questions around whether appropriate short term increases in health service use can yield benefits in the longer term and potential implications of this for NHS prevention programmes of work
- The implementation of the PRSB's Social Prescribing Information Standard in practice
- The quality of social prescribing data
- The feasibility of data linkage at a national level (e.g. primary, secondary, social care and VCS data)
- Whether we can reduce reliance on local evaluations by putting social prescribing data into a usable format at a national level, for example using a visualisation dashboard for the data would allow insights to be drawn from personalisation and segmentation of datasets (e.g. specification of time periods, geographical regions and population groups)

Next steps

- NASP is engaging with NHS England colleagues regarding the social prescribing information standard and its implementation into practice.
- NASP staff are a member of the NIHR Social Prescribing Evaluation Expert Reference Group and will continue to engage with the national evaluation.
- NASP is bringing key stakeholders who use social prescribing data together in December 2024 to look at the key challenges around developing a data driven system and exploring next steps to address issues



Jag Mundra, National Association
of Primary Care (NAPC)



NAPC | National Association
of Primary Care

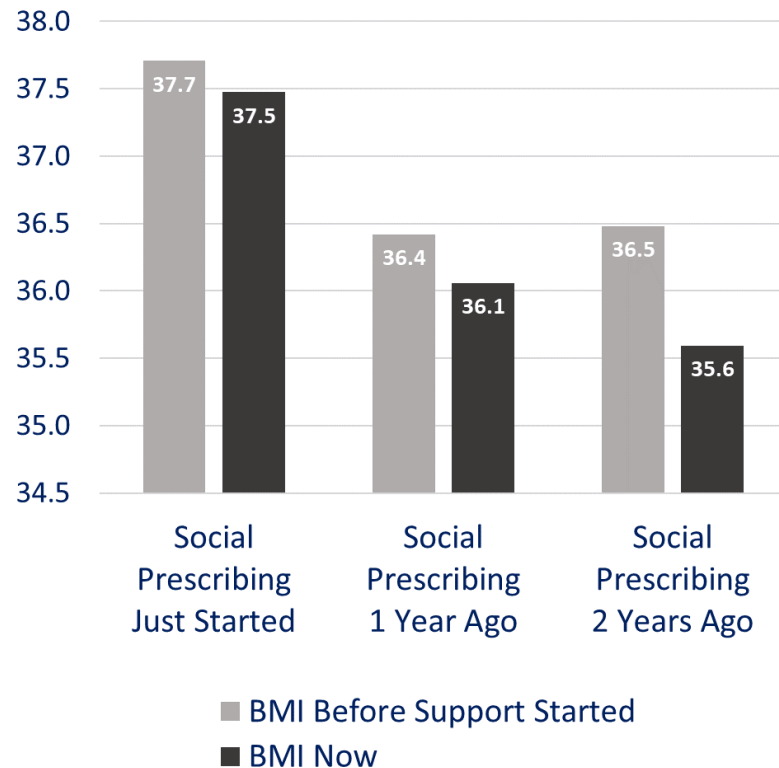
The Impact of Social Prescribing on Health and NHS Demand

November 2024



The Impact of Social Prescribing on Physical Health

**Average BMI for Patients Who are Obese
(BMI>30)**

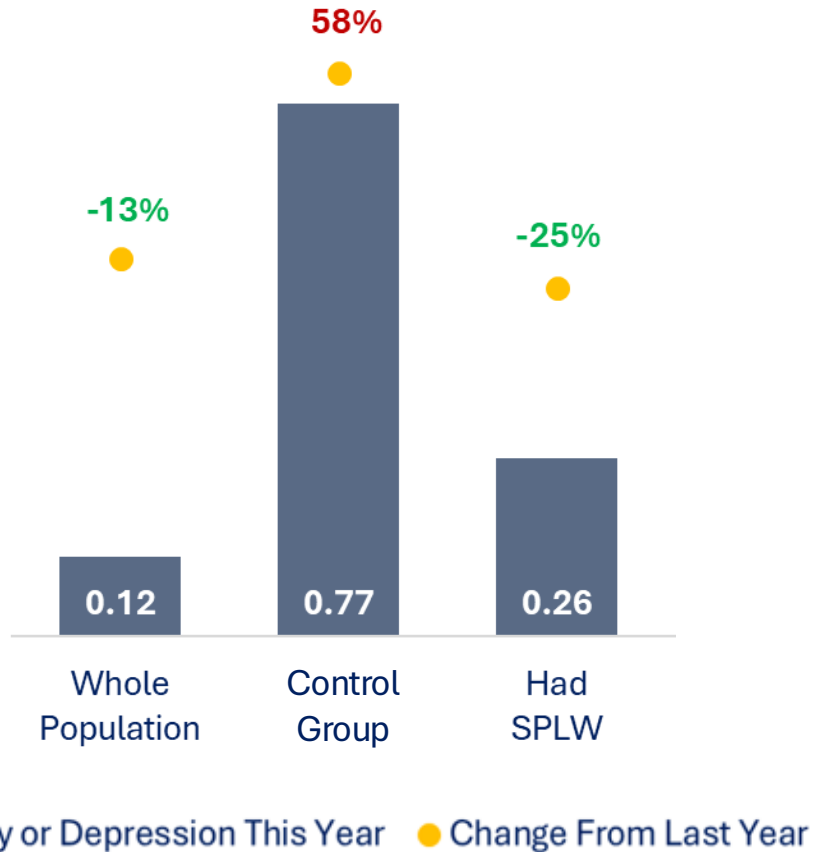


Social Prescribing is linked to reduced BMI in obese patients.

- Patients supported by social prescribing see an average **0.6-point drop** in BMI.
- **The improvement grows over time** with a 0.2-point drop for new patients and a 0.9-point drop for patients after 2 years.
- No significant changes observed in medications or other physical health measures so far, except for **chronic pain**.

Obese patients may have up to **twice as much GP contact**.

The Impact of Social Prescribing on Mental Health

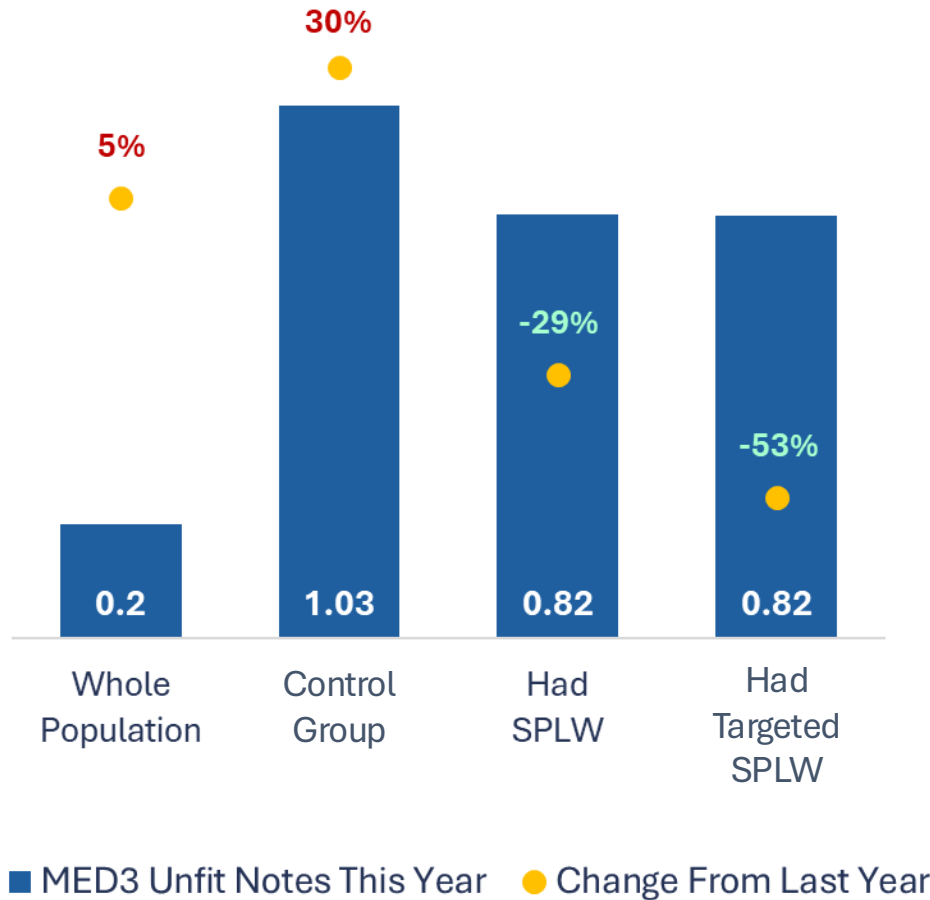


Social Prescribing is linked to improvements in mental health.

- Control Group: **0.77** anxiety or depression events this year on average, a **58% increase**.
- Patients Supported by SPLWs: **0.26** events, a **25% decrease**.

Social prescribing reduced clinical anxiety severity (GAD) by 4.7 points, comparable to NHS Talking Therapies, **at 1/8th of the cost.**

The Impact of Social Prescribing on Fitness For Work

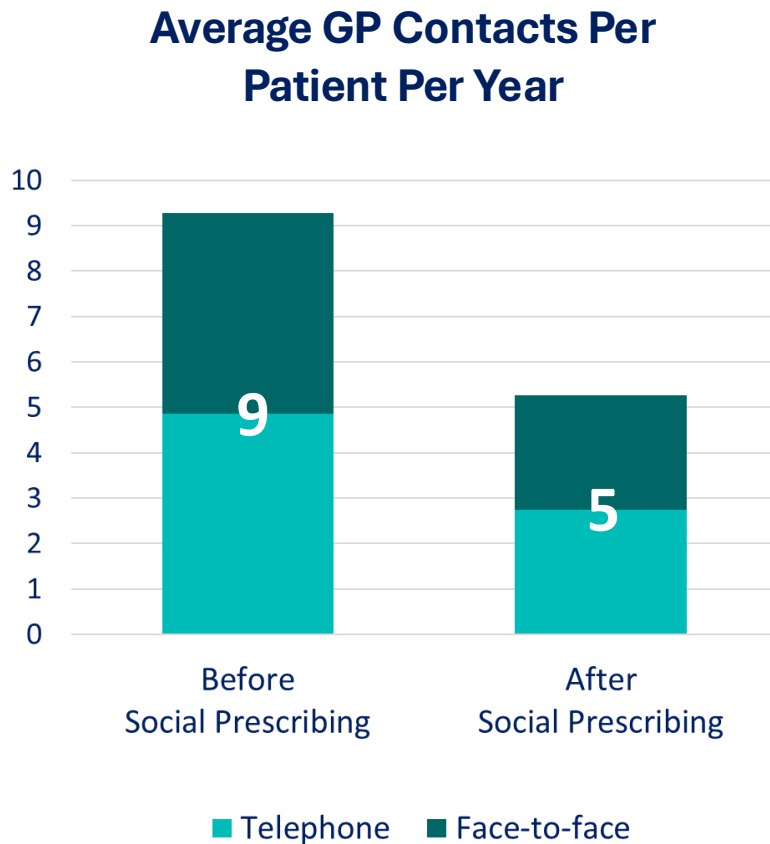


Social Prescribing is linked to reductions in sick notes.

- Control Group: 1 sick note this year on average, a **30% increase**.
- Patients Supported by SPLWs: **0.82** sick notes, a **29% decrease**.
- Proactively Targeted and Supported: **0.82** sick notes, a **53% decrease**.

Proactively targeting appropriate and high-demand patients can magnify the impact of social prescribing.

The Impact of Social Prescribing on GP Appointments

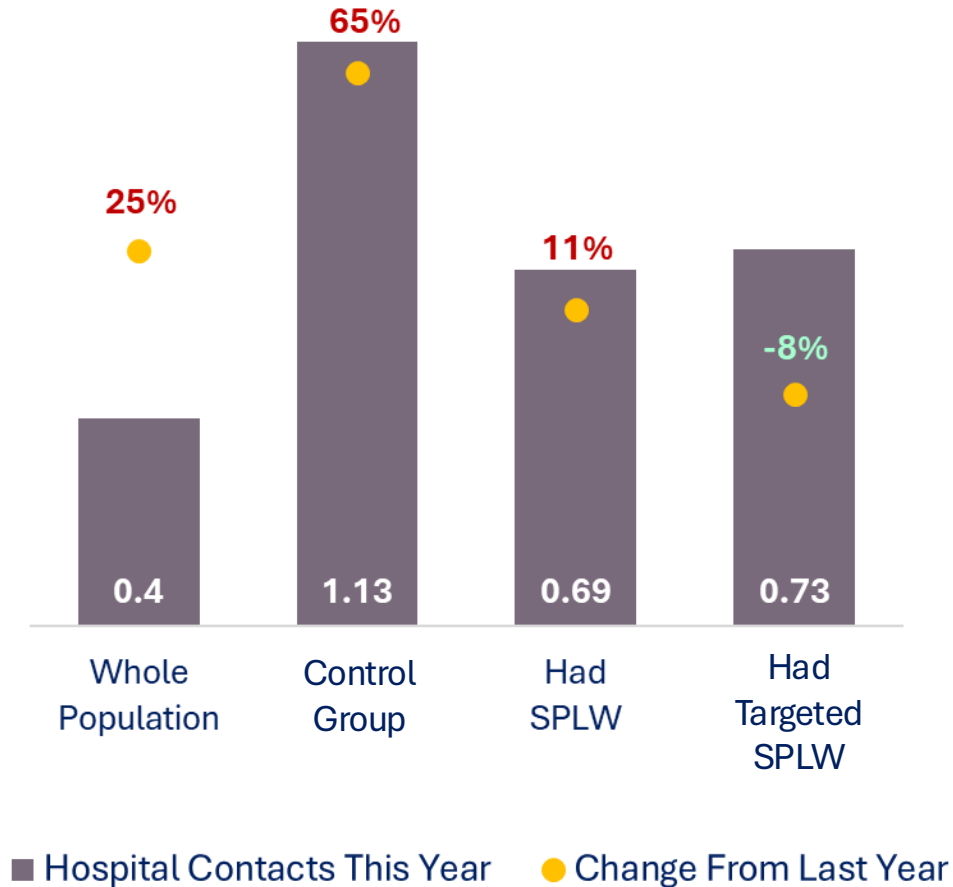


Social Prescribing is linked to lower GP demand.

- Patients had an average of **9 GP contacts** per year before starting social prescribing.
- This dropped to an average of **5 GP contacts** per year afterwards.
- We also observe a significant drop in **missed appointments (DNAs)**.

A potential 'saving' of **4 GP contacts** per patient annually.

The Impact of Social Prescribing on Hospital Contacts



Social Prescribing is linked to reductions in hospital contacts.

- Control Group: **1.13** hospital contacts this year on average, a **65% increase**.
- Patients Supported by SPLWs: **0.69** hospital contacts, a **11% increase**.
- Proactively Targeted and Supported: **0.73** hospital contacts, an **8% decrease**.
- Social prescribing is linked to **£350** less hospital cost per patient annually.

Social prescribing is linked to a 4:1 return on investment (£4 saved per £1 spent) in reduced NHS costs

The Impact of Social Prescribing on Patient Behaviour



One Question to
Pinpoint, Activate and Measure:

**How good are you at taking
care of your health?**

Social Prescribing is linked to greater patient activation.

- Activation scores can rise by **1 point**, from **2 to 3** in 6 months.
- We know that higher activation is linked to better physical and mental **health**.
- A 1-point activation rise is linked to a reduction of **4 GP** contacts per patient annually.
- And is linked to **£327** less NHS cost per patient annually.

Get started with measurement by **asking this simple question.**

3 Tips for Even Greater Impact

- **1 Identify: Proactively target in need patients** with high GP demand and multiple preventive care needs.
- **2 Intervene: Work at scale with large patient groups** using webinars, ‘nudges,’ apps (e.g., WhatsApp & Strava), and peer support.
- **3 Impact: Use simple questions to measure** and demonstrate your impact to secure more support and inspire a social movement!



Professor Chris Dayson, Sheffield
Hallam University

Social Prescribing and Secondary Care Utilisation

*Evidence from Rotherham – findings... reflections...
provocations...*

Chris Dayson
Sheffield Hallam University
NASP Evidence Webinar, 26th November 2024



Introduction to the Rotherham Social Prescribing Service (RSPS)

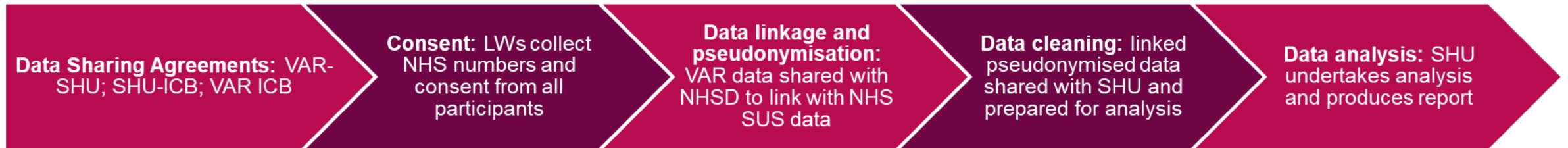
- One of the **largest and most high-profile SP services** in England. Provided by **Voluntary Action Rotherham (VAR)**

Some defining features:

- A **£10m+, multi-year investment** by NHS Rotherham CCG and NHS SY ICB (since 2012)
- 50 per cent of funding **reinvested in local VCS services to support SP through** ‘micro-commissioning’
- **Two pathways:** long term conditions (LTCs) and secondary mental health (MH) – PCN LWs now alongside too
- Circa **1,000 people** supported each year
- **Long term academic evaluation** (2013-24) has provided data and insights to **understand impact**, plus learning to **support RSPS development**

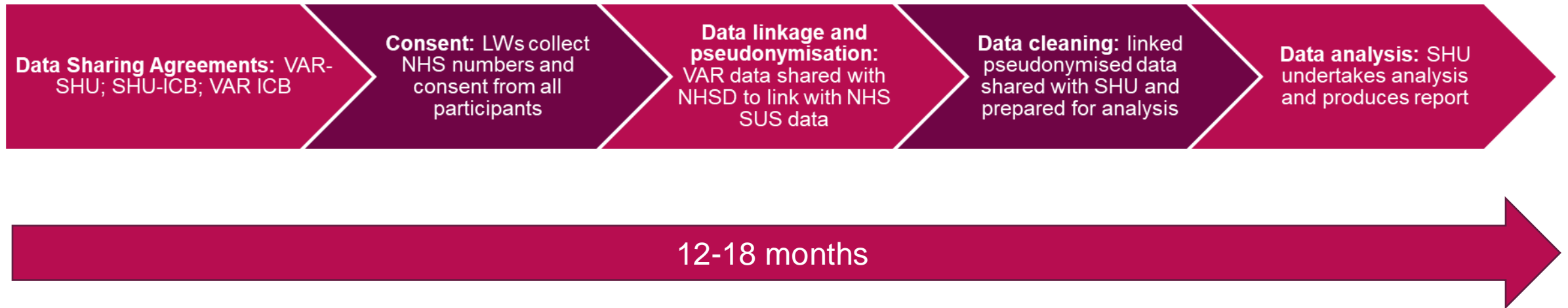
Approach to Accessing Secondary Care Data

Approach to data access co-designed from outset between VAR-CCG/ICB-SHU-NHS Digital



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Secondary Care Outcome Measures

Understanding change within the RSPS population and sub-groups



Change in (mean) no
of non-elective in-
patient stays 12m
post SP referral



Change in (mean) no
of A&E attendances
12m post SP referral



Sub-groups:
age, gender,
ethnicity,
frequency of
attendance

What does the data show?

In-patient Data 2015/16-2020/21

	Average (mean) no of In-patient Spells			
	<i>Number of patients</i>	<i>12 months before</i>	<i>12 months after</i>	<i>Change</i>
2016-2017	758	1.63	1.56	-0.07
2017-2018	972	1.27	1.37	0.10
2018-2019	Unavailable	Unavailable	Unavailable	Unavailable
2019-2020	798	1.27	1.18	-0.09
2020-2021	688	1.05	1.27	0.21
2021-2022	879	1.35	1.30	-0.05

Damm, C., & Dayson, C. (2024). *Evaluation of the Rotherham Social Prescribing Service: Data and Insights 2016/17-2021/22*. Sheffield Hallam University, Centre for Regional Economic and Social Research.

What does the data show?

Most SP LTC patients are **not high users** of unplanned care

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What does the data show?

Very limited evidence that the number of episodes changes post-intervention

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What does the data show?

Note: COVID years problematic

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What does the data show?

Accident and Emergency Data 2015/16-2020/21

	Average (mean) no of Accident and Emergency Attendances			
	<i>Number of patients</i>	<i>12 months before</i>	<i>12 months after</i>	<i>Change</i>
2016-2017	758	1.03	1.07	0.04
2017-2018	972	1.04	1.12	0.08
2018-2019	Unavailable	Unavailable	Unavailable	Unavailable
2019-2020	798	1.21	1.22	0.01
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What does the data show?

The picture for A&E attendances is the same

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What does the data show?

The devil is in the detail!

No of Spells in 12 months before SP	Average (mean) no of In-patient Spells			
	Number of patients	12 months before	12 months after	Change
0	1,209	0.0	0.7	0.69
1	548	1.0	1.1	0.12
2	256	2.0	1.4	-0.57
3	138	3.0	1.8	-1.18
4	87	4.0	2.7	-1.32
5+	127	8.7	5.2	-3.50

What does the data show?

Most patients had no in-patient spells 12m before SP referral

The devil is in the detail!

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What does the data show?

Sub-group analysis
does reveal some
reductions

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What does the data show?

The most intensive users see the greatest reductions

The devil is in the detail!

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What does the data show?

Once again, we see the same picture for A&E attendances

The devil is in the detail!

No of Spells in 12 months before SP	Average (mean) no of Accident and Emergency Attendances			
	Number of patients	12 months before	12 months after	Change
0	1164	0	0.72	0.72
1	573	1	1.04	0.04
2	296	2	1.30	-0.70
3	146	3	1.82	-1.18
4	69	4	2.43	-1.57
5+	117	8	4.57	-2.98

What does the data show?

For low intensity users of secondary care **other outcome measures will be more relevant**

The devil is in the detail!

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Key Learning and Critical Reflections

- **Good quality data across** and beyond the SP referral pathway is possible – local commitment to this from CCG and VAR from the start
- But...**resource intensive and time-consuming process** – need for systematisation and greater inter-operability
- **Deep level of analysis necessary** to understand patterns and change over time
- **Absence of control/comparator is a limitation** - how much of the change is just 'regression to the mean'? But some **SP contribution to change** likely...
 - **Consistent patterns** over time
 - Findings **align with RSPS theory of change**
 - Evidence **'good enough'** for commissioners, and **'better' than similar interventions**

Concluding Provocation

If this type of evidence is important then health systems need to get their act together!

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In practice this means...

- Reduce **onus and burden on VCSEs** to prove their worth in relation to SP
- Invest in **inter-operable data systems across the full SP pathway** to collect, link and analyse data and enable consistent system level evaluation, data and insight
- Provide **greater clarity** around the role of evidence, and type of evidence needed, in relation to SP commissioning
- **Co-producing evidence requirements** with patients and VCSE partners

Concluding Provocation

But we also need to think differently about the SP evidence base and how this informs policy and commissioning...

Concluding Provocation

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- Complexity of SP means the focus **needs to be on contribution** rather than attribution to outcome change
- Consider **what other types of evidence** – that might be **more appropriate and proportionate** to ‘what matters’ to patients - could be used to make **SP commissioning decisions** i.e.:
 - **WELLBYs** – making use of the widely collected ONS4 measures to demonstrate value (see GSP)
 - **Health inequalities lens** – how far and to whom is SP reaching? Is it reaching far enough?
 - **Creative methods** – might be better aligned with SP practices and activities
 - **Narrative approaches** – capturing stories that go beyond anecdote
- Greater emphasis on **understanding what works** for whom, why, how in what contexts – codifying **mechanisms of change and active ingredients** of effective SP interventions

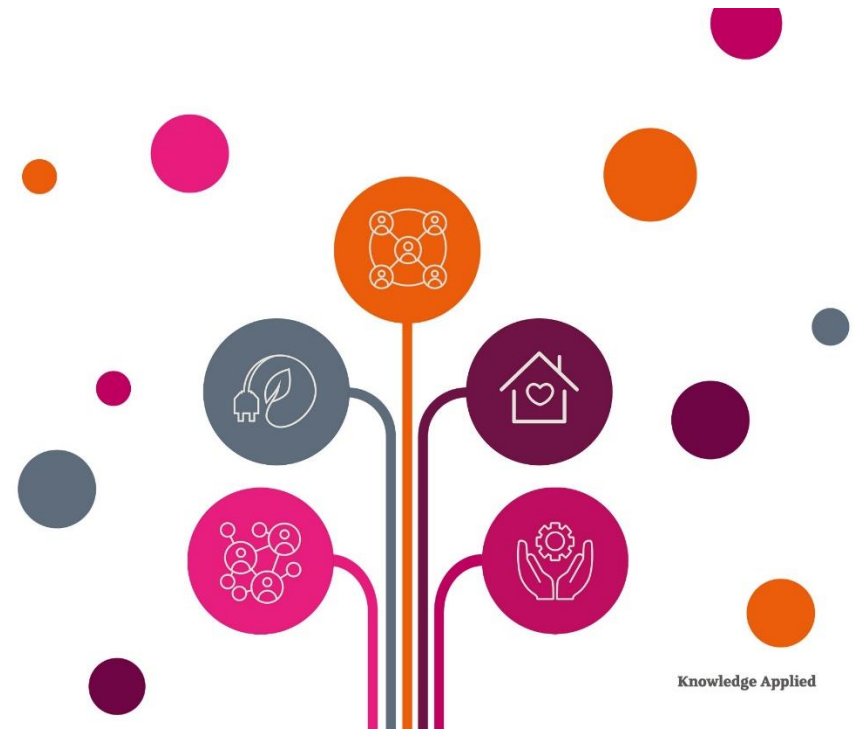
Thank You – Happy To Answer Questions

Latest report:

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Q&A

