Personalised Care Kirklees

Personalised Care Quarterly Report

Quarter 3
October - December 2023

Working in partnership: NHS Kirklees Council

Personalised Care Quarterly Report

Kirklees Personalised Care enables individuals to focus on "what matters to them" and make positive change for an improved quality of life. Our vision is to promote more choice and control in people's lives by providing an inclusive, person-centred approach to people's health & wellbeing. We enable holistic conversations to encourage lasting change as what matters to you matters to us.

Quarterly Summary

This report highlights the data for people referred to the personalised care service during 1st October to 31st December 2023.

At the end of quarter 3 we have received a total of 4927 referrals into the personalised care service. 85% of referrals were for social prescribing, 9% for care coordination and 5% for health and well-being coaching.

We continue to work to the indicators as set out in the NHSE Impact & Investment Fund (IIF) 22/23 for social prescribing referrals. Despite this indicator being removed in the 23/24 IIF we will continue to use the lower and upper thresholds of 0.8%-1.2% of registered patients referred to the social prescribing service by the end of the financial year. To date we have received 1.1% of Kirklees registered patients into social prescribing and aim to reach 1.6% by the end of the financial year, succeeding our target of 1.2%.

This quarter highlights a continued reduction in primary care attendances for patients who frequently access each service. Through our interventions we have supported patients who frequently attend primary care to reduce their access by 50% for those referred to social prescribing and by 48% for patients referred into care coordination. This has also resulted in 509 GP appointments being made available.

Personalised Care Quarterly Report

Referral Information

Social Prescribing referrals in Q3
1432

Social Prescribing referrals YTD
4214

Care Coordinator referrals in Q3
98

Care Coordinator referrals YTD
446

Health Coaching referrals in Q3
123

Health Coaching referrals YTD
267

Q3 Referrals by PCN

PCN name	SPLW referrals	CC referrals	HBWC referrals
3 Centres	109	N/A	N/A
Batley & Birstall	202	N/A	N/A
Greenwood	131	N/A	N/A
Dewsbury & Thornhill	136	N/A	N/A
The MAST	126	8	123
Spen	227	39	N/A
Tolson	130	N/A	N/A
Valleys	153	N/A	N/A
Viaduct	218	51	N/A

Characteristic Information

Gender breakdown	SPLW referrals	CC referrals	HBWC referrals
Female	52%	42%	54%
Male	39%	18%	46%

Sexuality breakdown	SPLW referrals	CC referrals	HBWC referrals
Heterosexual	63%	41%	75%
Bi-Sexual	0.8%	0%	2%
Male Homosexual	0.5%	1%	0%
Female Homosexual	0.6%	0%	2%
Sexual Orientation Unknown	8%	0%	0%
Not Stated (person asked but declined)	1.4%	0%	10%
Not able to gather	3%	10%	12%

Employment status	SPLW number	CC number	HBWC number
Unemployed	19%	16%	11%
Employed	13%	9%	28%
Long term sickness	9%	9%	2%
Retired	23%	18%	24%
Student	2%	0%	2%
Disabled	1.2%	0%	0%
Unknown	9%	2%	32%

Personalised Care Quarterly Report

Ethnicity breakdown	SPLW referrals	CC referrals	HBWC referrals
African	1%	1%	0%
Bangladeshi/British Bangladeshi	0%	2%	0%
White British	31%	28%	62%
Caribbean	1.4%	1%	0.06%
Black British	0.3%	0%	0%
British or mixed British	15%	11%	3%
Ethnic Category Not Stated	0.06%	0%	0%
Indian or British Indian	3%	3%	0%
Irish	0.5%	4%	0%
Other Black Background	0.4%	0%	0%
Other White Background	1.7%	0%	0%
Other Mixed Background	0.4%	0%	0.06%
Pakistani or British Pakistani	9%	14%	0%
White and Black Caribbean	0.9%	2%	0%
Other Asian Background	1.3%	2%	0%
Asian or Asian British	0.1%	0%	0%
White and Asian	0.6%	0%	0%
White and Black African	0.2%	0%	0%
Any Other Group	0.6%	2%	0%
Not able to gather	2%	1%	0.2%

Patients referred with 2 or more Long term health conditions

25%

Patients on SMI Register

6%

Patients on Learning Disability register

2%

Personalised Care Quarterly Report

Age breakdown	SPLW referrals	CC referrals	HBWC referrals
0-9	0.3%	0%	0%
10-19	1.5%	1%	2%
20-29	7%	2%	6%
30-39	13%	1%	10%
40-49	11%	15%	12%
50-59	16%	15%	21%
60-69	13%	3%	24%
70-79	11%	7%	20%
80+	12%	15%	4%

*Any unknown or missing data is due to a mixture of some patients coming to a drop-in or a group at which we don't collect demographic data, patients who have declined the service, and patients we have been unable to contact or are still trying to establish contact with.

Patient Feedback

"Thank you for all your help. Prior to your support I was feeling so stressed out, but since your referral into admiral nurses I feel a lot better and have the support I need"

Batley & Birstall PCN patient who is a carer for a parent with dementia

Personalised Care Quarterly Report

Reducing Demand and Improving Access

Reducing the demand on Primary Care

Patients who have actively worked with the service have shown an overall 50% reduction in GP attendances 3 months after being referred. This data is based on patients referred in July, August and September who have had 3 or more GP attendances in the 3months prior to their referral. We will continue to measure this over a 6-month period to identify if there has been a sustained change in accessing appointments.

Patients referred to social prescribing

PCN	No of patients	3 months prior	3 months during	Increase/Decrease	%
3 Centres	15	65	30	-35	-54%
Batley and Birstall	39	171	75	-96	-56%
Dewsbury & Thornhill	11	59	51	-8	-14%
Greenwood	12	45	0	-45	-100%
MAST	13	99	53	-46	-46%
Spen	38	157	80	-77	-49%
Tolson	5	28	13	-15	-54%
Valleys	28	131	58	-73	-56%
Viaduct	38	149	89	-60	-40%
TOTAL	**199**	**904**	**449**	**-455**	**-50%**

Patients referred to Care Coordinators

PCN	No patients	3 months prior	3 months during	Increase/decrease	%
MAST	6	38	5	-33	-87%
Spen	8	31	30	-1	-3%
Valleys	4	14	6	-8	-57%
Viaduct	6	29	17	-12	-41%
TOTAL	**24**	**112**	**58**	**-54**	**-48%**

Personalised Care Quarterly Report

Reducing the demand on A&E

Patients who have actively worked with the service have shown an overall 64% reduction in A&E attendances 3 months after being referred. This data is based on patients referred in April, May and June who have had 3 or more A&E attendances in the 3months prior to their referral. We will continue to measure this over a 6-month period to identify if there has been a sustained change.

Patients referred to social prescribing

PCN	No of patients	3 months prior	3 months during	Increase/Decrease	%
3 Centres	10	20	5	-15	-75%
Batley and Birstall	34	44	19	-25	-57%
Dewsbury & Thornhill	3	5	2	-3	-60%
Greenwood	15	28	7	-21	-75%
MAST	15	24	5	-19	-79%
Spen	15	16	6	-10	-63%
Tolson	1	1	2	1	100%
Valleys	6	7	0	-7	-100%
Viaduct	25	36	15	-21	-58%
TOTAL	**125**	**181**	**62**	**-119**	**-66%**

Patients referred to Care Coordinators

PCN	No patients	3 months prior	3 months during	Increase/decrease	%
MAST	8	13	13	0	0%
Valleys	3	3	11	8	267%
Viaduct	9	16	8	-8	-50%
TOTAL	**20**	**32**	**32**	**0**	**0%**

Personalised Care Quarterly Report

Appointments Delivered

Appointments by Role	
Social Prescribing	85%
Care Coordinators	10%
Health & Well-being Coaches	5%
Appointments Breakdown	
Initial	38%
Active	45%
Review	13%

6209
appointments delivered in quarter 3

Patient Feedback

''Thank you for your support, your positivity, for listening to me, for hearing me, for referring me to relevant agencies that have been able to further support me and for caring about your clients. You are an excellent advocate and very good at what you do. Keep up the good work.'

Greenwood PCN patient

Personalised Care Quarterly Report

Patient Outcomes

Social Prescribing	Care Coordination	Health & Wellbeing
2370 Patient goals identified	**199** Patient goals identified	**108** Patient goals identified
1238 Patient goals achieved	**186** Patient goals achieved	**47** Patient goals achieved

Goals	Goals Identified	Goals Achieved
Housing support	14%	8%
Financial support	22%	28%
Connecting to Social Activities	24%	24%
Mental well-being support	29%	44%
Improve Lifestyle	26%	7%
Employment/Volunteering support	5%	0%
Support with Personal Care	0.7%	27%
Support with mobility	0.8%	8%

Supporting people living in areas of deprivation

It's widely recognised that social and economic factors impact on people's health.

The World Health Organization states that factors such as stress, unemployment, debt, loneliness, lack of education and support in early childhood, insecure housing and discrimination can impact 30-55% of the health outcomes that people experience. We know that one in five GP appointments are about issues wider than health, especially for people living in areas of high deprivation. Individuals living with multiple long-term conditions, disability, frailty or who live in ethnic minority communities are bearing the brunt of the widening gap in health inequalities.

Evidence shows that those living in the most deprived areas of England face the worst healthcare inequalities in relation to healthcare access, experience and outcomes. Analysis of NHS data found that areas with more income deprivation are more likely to have a range of health conditions including serious mental illness, obesity, diabetes, and learning disabilities. This is where social prescribing can demonstrate its value in linking people to community-based services that provide coordinated, integrated, and proactive care.

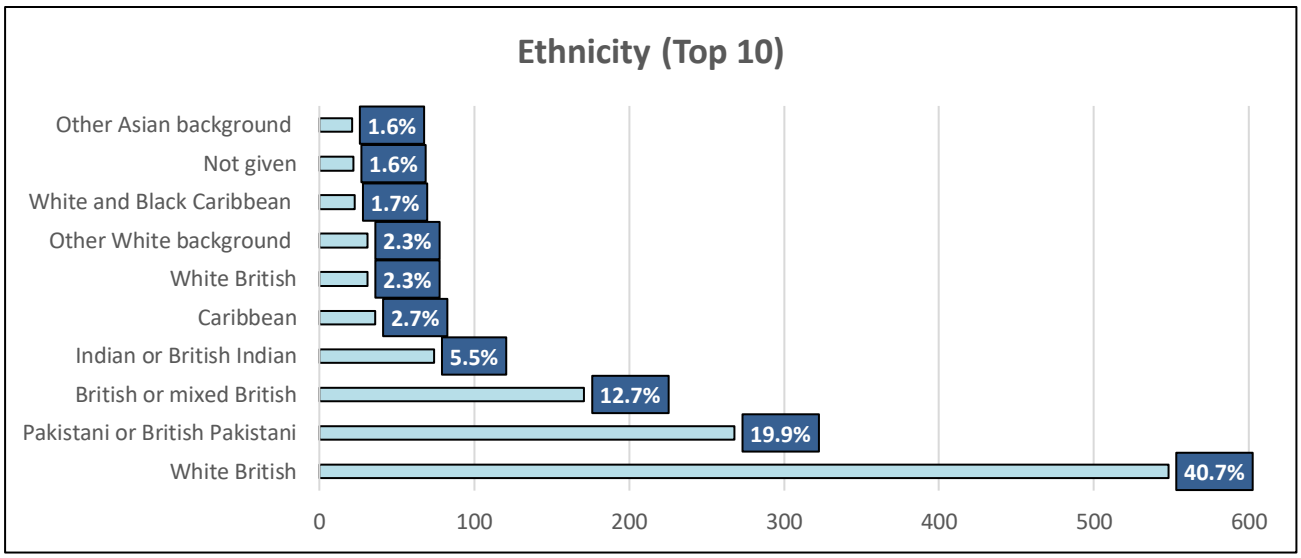
35% of all referrals into the Kirklees Personalised Care service from April-October 2023 have been for people living in the top 20% most deprived areas in Kirklees. Patients were referred for support with the following;

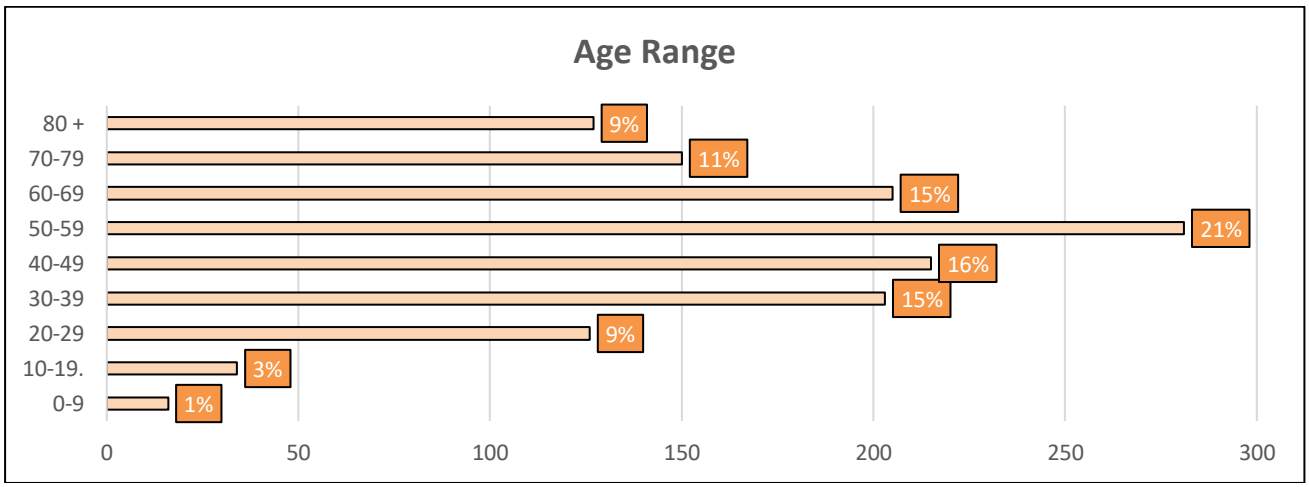
- Housing, financial or employment issues - 39%
- To improve mental and social well-being - 41%
- To improve lifestyle – 21%

As a result of working with a Social Prescribing Link Worker patients were able to achieve the following goals;

- Improved mobility and independently managing own care – 7%
- Housing problems solved – 8%
- Better able to manage finances/more financially secure – 16%
- Ability to better manage personal health – 18%
- No longer socially isolated – 20%
- Improved mental well-being – 31%

Characteristic data for people living in deprivation





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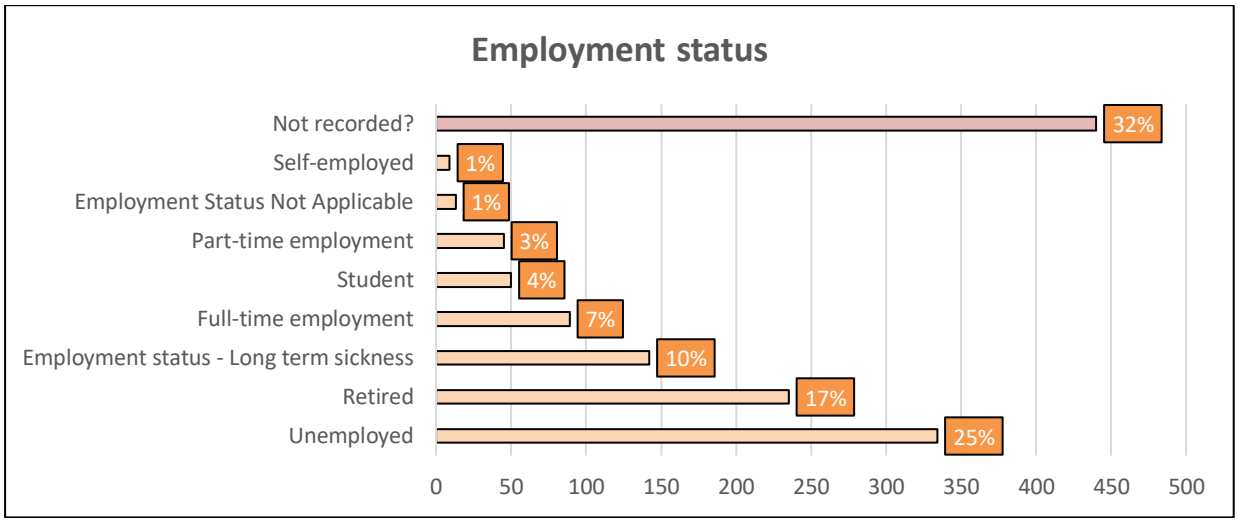

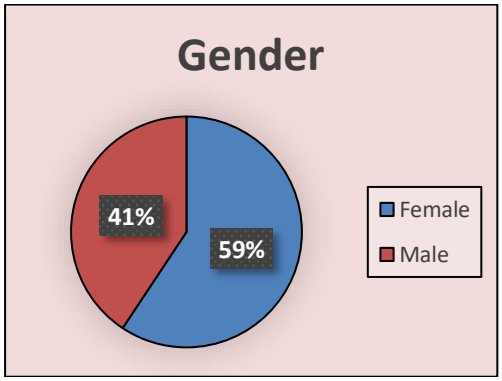

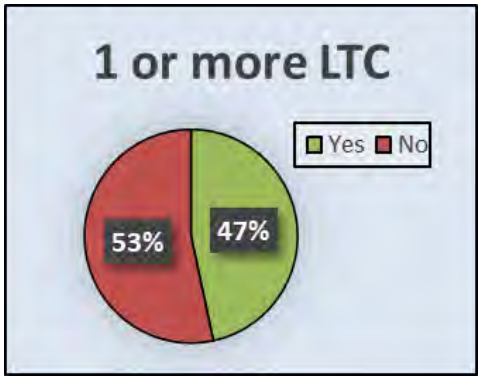

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Kelly's Journey

This diagram sets out the financial and economic costs for a patient who has had ongoing mental health issues over a period of several years and shows the comparative costs of personalised care to specialist mental health provision. It highlights the possible saving and prevention of health deterioration if personalised care was introduced earlier.

Kelly, 49 is a registered mental health Nurse and has 4 children. Kelly started having issues with her Mental Health following the birth of her second child in 2003. In 2020 she had to retire from work due to ill health leading to financial difficulties and a declining standard of living which had a negative impact on both her mental and physical health due to increased pain from Fibromyalgia. When Kelly's CPN retired in 2020 she was transferred back to GP care which led to regular reliance on them for support.

In February 2023 Kelly's GP referred her to a Mental Health Social Prescribing Link Worker.

Timeline		Costings*
First referred to core services. Supported by CPN weekly for 3 months and then fortnightly for 9 months.	**2003**	**£8,094** MH support with CPN.
Pregnant with twins - referred to core services for 3 monthly contact with CPN and 6 monthly appointments with Psychiatrist until 2022.	**2005-2022**	**£52,917** Continued specialist MH support, MH assessments and economic costs of sickness absence over a period of 17 years .
2006 - Referred for psychiatric assessment and diagnosed with Psychotic Depression. 2012 - Diagnosed with Fibromyalgia	**2006-12**	**£76,544** Kelly has been receiving PIP since 2012 to present day.
Retired from work due to ill health. Continued care under GP and core team. Financially supported by ESA	**2020**	**£49,850** ESA support and regular GP appointments
Crisis relapse and attendance to A&E – core team support increased to weekly CPN appointments for 3 months and then fortnightly for 9 months.	**2022**	**£485** A&E attendance.
Working with MHSPLW since Feb 2023 – no longer under core service. 1 GP appt, no A&E or crisis Renewed nursing pin, applied for volunteering role and accessed financial support.	**2023**	**£0**

*The costings included in this timeline have been taken from the Greater Manchester Combined Authority (GMCA) unit cost database. The database was developed in 2012 as part of work under the Investment Agreement and Partnerships Exemplar project to produce a framework to assist local partners in reforming the way they deliver public services.

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