LITERATURE REVIEW

PERSONALISED CARE, SOCIAL PRESCRIBING AND COMMUNITY STRENGTHENING

PART 1 - PERSONALISED CARE AND SOCIAL PRESCRIBING

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The Health Creation Alliance is a UK national cross-sector organisation addressing health inequalities through Health Creation. Its mission is to increase the number of years people live in good health in every community.

Health Creation is the process through which individuals and communities gain a sense of purpose, hope, mastery and control over their own lives and immediate environment; when this happens their health and wellbeing is enhanced.

As a not-for-profit community interest company, it comprises community leaders, people with lived experience of poverty and discrimination and professionals from many sectors working together to transform systems from the bottom up so that Health Creation becomes business as usual and is recognised as equally important as treating illness and prevention of ill health.

In Control is a national charity whose mission is to help create a society where people at risk of being excluded have the support they need to live a good life and where everyone is able to make a valued contribution. They operate as an extensive network and 'community for change' that aims to work directly with people who need support, and with their families to provide them with the knowledge, power and tools to take control of their lives, to influence and improve the delivery of self-directed support, to develop and test new innovative ways for people to be in control of their lives and to measure the impact of self-directed support and personal budgets on people's lives.

In Control is the main delivery partner for the Leadership for Personalised Care programme, and also hosts the #SocialCareFuture and BeHuman movements.

Leadership for Personalised Care is a unique, highly skilled specialist team working inside and outside the NHS delivering cutting-edge learning and development programmes across health and care. They help leaders to champion personalised care, community development and co-production and lead system transformation from the ground up. They work as a partnership of people and organisations, collaborating and co-producing programmes of work. Together, they provide learning and development opportunities to support leaders to embed the principles of personalised care, co-production and community-building into local systems, services and communities.

Foreword and acknowledgments

I was commissioned through The Health Creation Alliance by In Control Partnerships on behalf of the Leadership for Personalised Care programme to conduct a literature review of the evidence for personalised care, social prescribing and community strengthening. This was partly in response to an evaluation of the programme by the Institute of Employment Studies which found that leaders on the ground wanted to do the right things but did not always have easy access to the evidence to convince others.

This is part 1 of that review – the evidence for personalised care and social prescribing.

I was assisted in the task of updating the review by the amazing network the Health Creation Alliance brings together. As well as these colleagues, I would also like to thank Catherine Wilton for her support with editing.

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EXECUTIVE SUMMARY

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on 'what matters' to them and their individual strengths and needs.

This happens within a system that makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences.[1]

Personalised Care is one of the five major shifts set out in the NHS Long-Term Plan. It has six components, including personal budgets, care and support planning, shared decision-making, support for self-management and social prescribing. Social prescribing is a way to connect people with valuable community supports and social capital.

This review was commissioned by In Control Partnerships on behalf of the Leadership for Personalised Care programme, to help leaders make a case for change by investing in new ways of working. It has looked in-depth at the literature on personalised care in general, on social prescribing, and on community strengthening approaches, which support the personalised care agenda.

Part 1 of the review has found:

A: PERSONALISED CARE

- The evidence for improving long-term conditions is strong. Benefit has been seen in asthma, cancer, diabetes, COPD, musculo-skeletal conditions and mental illness.
- The evidence for reducing demand on healthcare is mixed, but positive overall. Better outcomes may result from more, but focused, care. There is positive evidence in asthma, cancer, A+E use and mental illness.
- Some initiatives were well regarded by staff who engaged wholeheartedly. Other studies suggest personalised care can be difficult for staff who are likely to need extra training and support.
- There is some data on good practice in Personalised Care.

B: SOCIAL PRESCRIBING

- There are many examples of social prescribing offering positive outcomes for individuals. This includes impacts on well-being, quality of life, patient activation, health-related confidence, community involvement and experience of services, as well as reducing anxiety, emotional problems, loneliness and healthcare use. However, the evidence base needs to be improved. Initial findings have often not been corroborated by controlled studies.
- Some of the benefit appears to result from involvement with community assets and the power of connection.
- The evidence for Social Prescribing reducing demand for healthcare is mixed. It is not clear why some interventions reduced demand on services.
- There are few studies on Social Return On Investment, but they are generally positive.
- Investing in high quality staff training, ensuring a balance between provision of a quality service and meeting targets, and investment in community to support a strong and vibrant voluntary and community sector are key to success. More can be seen about the benefits of community strengthening in the second part of this literature review.

A. PERSONALISED CARE – THE EVIDENCE

Our literature search included a range of personalised care elements: self-management, care plans, personal health budgets and group appointments. These are all techniques by which people can be offered care and support tailored to their needs.

The BMA Library was asked to search for key terms linked with Personalised Care. These did not include telehealth. The author went through every reference, focusing on all those with measured outcomes.

The review found:

1. Personalised care and health improvements

- **Patient-centred communication has been linked to improved clinical outcomes**, including patient-clinician relationships, diagnostic accuracy, patient understanding of medical information and recommendations, adherence to therapy, patient satisfaction with care, and physician wellbeing.[2]

- A review[3] of personalised asthma care compared 105 different self-management and self-monitoring models against usual care and education to determine which are most effective at reducing healthcare use and improving quality of life in asthma. It found that **regularly supported self-management reduces the use of healthcare resources and improves quality of life across all levels of asthma severity**. The researchers suggest that future healthcare investments should provide support that offer reviews totalling at least two hours to establish self-management skills, reserving multidisciplinary case management for patients with complex disease.

- **Personalised care reduced anxiety and improved symptom control for breast cancer patients. A group of patients allocated to self-management** were provided with a detailed summary of cancer treatment, with contact numbers for the Breast Care Nursing team and rapid re-access. Care planning was found to help people manage their future living with cancer. Staff in this study did find, however, that collaborative working was complicated between different NHS providers.[4]

- **Personalised care led to better diabetes control**. People with complex diabetes in Manchester received a blend of bespoke mentoring, education, pathways and resources and virtual, face-to-face or group appointments. After 2 years, mean HbA1c in this cohort reduced from 81 to 64 mmol/ mol. The number of patients with a HbA1c >75 mmol/mol reduced by 50%. Patients with suboptimal blood pressure and lipids showed improved levels, achieving NICE-recommended targets-[5]

- **Patient education increased medical adherence** by 20% and knowledge scores in diabetes.[6] Culturally tailored diabetes educational interventions improved glycaemic control.[7] Ricci-Cabelo et al. reported that 59% of studies observed significant improvements in HbA1c and 57% of studies observed improvements in fasting blood sugar levels.[8]

- **Peer Support is associated with better diabetes control**: Mogueo et al showed that empowerment-based interventions, when compared to routine care, were associated with reduced glycated haemoglobin levels resulting in a pooled mean difference of -0.57% for

HbA1c.[9] Chen et al., 2021 showed that peer support increased diabetes empowerment scores, and increased diabetes knowledge scores.[10]

- **Personal Health Budgets can help people with mental health issues**. People with severe brief mental illness were offered a Personal Health Budget (PHB) to standard pharmacotherapy over 24-months. A significant decrease in all Global Assessment of Functioning scale, Health of the Nation Outcome Scale and Brief Psychiatric Rating Scale scores along the 24 months of follow-up was observed and shown to be the result of the PHB.[11]

- **Chronic pain conditions can be improved** by self-management education programmes, including booster sessions.[12] These reduced pain and pain catastrophizing in patients.

- **Aspects of COPD can be improved through support for self-management:** Song et al found a reduction in exacerbation frequency, a significant reduction in BMI and an improvement in quality of life.[13]

- Schrijver J et al[14] evaluated self-management interventions and found a **significantly better health-related quality of life as well as an improvement in exercise capability**. Additionally, self-management interventions that included action plans and smoking cessation programmes were found to contribute to significant improvements in health-related quality of life. Similar results were found by Lenferink et al.[15]

2. Personalised care and reduction in service use

- **People who are more confident and able to manage their health conditions (that is, people with higher levels of activation) have 18% fewer GP contacts** and 38% fewer emergency admissions than people with the least confidence.[16]

- **Supported self-management reduces the use of healthcare resources**[17] including fewer hospital admissions and GP visits.[18]

- **Personalised care plans for frequent users of A&E services decreased the number of emergency department (ED) visits**, **reduced health care expenditure, and were well-received by the staff.**[19] Super-utilizers of A+E comprise 4.5% to 8% of all ED patients, but account for 21% to 28% of all ED visits.

- **Compared to usual care, the establishment of a personalised care plan for people with type 2 diabetes** reduced unplanned care and improved blood pressure and overall monitoring.[20] Plans were associated with better and more frequent monitoring of glycosylated haemoglobin A1c, low-density-lipoprotein cholesterol, systolic blood pressure, and renal function, and there was more frequent prescription of all cardiovascular and antihyperglycemic medication.

- A 2-year pilot by the same author used a variety of methods to offer personalised care, including social prescribing and came to the same conclusion.[21] Commissioned by Manchester Health and Care Commissioning Group, CoDES prevented 295 secondary care referrals.[22]

- Schriver reported a lower risk of emergency department visits in people who had had personalised care for COPD.[23]

- Long et al[23] examined the impact on COPD of an intervention on hospital admissions, reporting a significant reduction in hospital admissions, based on five studies.

- NHS England reports that **Personal Health Budgets in NHS Continuing Healthcare (CHC) have also been shown to achieve an average 17% saving on the direct cost of home care packages.** Whilst NHSE does not expect this 17% saving to be repeated in a system operating at scale, it creates a compelling case to change the approach to delivering CHC home care.[16]

3. Recommendations on implementation and best practice

- Some initiatives were well regarded by staff who engaged wholeheartedly but others suggest personalised care may require additional training and support for staff to help them embed different ways of working.

- The authors of this paper[24] describe decades of evidence on the benefits of a self-management approach in COPD and suggest the ideal components of a self-management plan: 1) **better education for healthcare professionals** on disease management and consultation skills; 2) new targets and **priorities for patient-focused outcomes**; 3) skills gap audits to **identify barriers to self-management**; 4) best practice **sharing within primary care networks** and ongoing professional development; 5) **enhanced initial consultations** to establish optimal self-management from the outset; and 6) negotiation and **sharing of self-management plans** at the point of diagnosis.

- The Personalised Care Interventions: Rapid Evidence Review (diabetes, MSK & COPD)[25] identified a range of mediating factors. Frequency of reporting, smart technology, using a variety of methods, low health literacy, face to face work, simpler interventions were all found to enhance effectiveness.

B. SOCIAL PRESCRIBING – THE EVIDENCE

Social prescribing is a way for local agencies to refer people to a link worker. Link workers give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support. Link workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners.[26]

1. Social prescribing and health improvements

- **Social prescribing initiatives have been shown to enhance service-users' well-being, quality of life, patient activation, health-related confidence, community involvement and experience of services, as well as to reduce anxiety, emotional problems, loneliness and healthcare use. Economic return on investment has also been evidenced,** with some reports showing better return from services delivered by voluntary/community organisations.[27]

- Thomas et al, in a summary report,[28] say that **positive well-being outcomes were achieved as a result of a mutual relationship between service providers and service users**. Outcomes included an increase in confidence, empowerment, and self-sufficiency as well as reduction in social isolation. Positive well-being outcomes were reported among individuals with long term conditions, mental health problems and a co-produced SP intervention also led to feelings of ´connectedness among individuals living with early onset dementia. They were also evident among larger, deprived communities suffering from health inequalities.

- One study[29] suggests that an **NHS social prescribing programme improved hemoglobin A1c (HbA1c) levels among patients with type 2 diabetes.** A difference-in-differences analysis was conducted over 8 years among 8086 patients in 24 NHS primary care practices in a city in North East England. The social prescribing group experienced a small beneficial HbA1c reduction of -0.10 percentage points compared with the control group which increased over time. The association was stronger for white patients compared with non-white patients, those with fewer additional comorbidities, and those living in the most socioeconomically deprived areas.

- **Significant improvements were achieved in participants' concerns, wellbeing, Patient Activation Measure levels and emotional loneliness** in a 3-month follow-up evaluation of the Shropshire Social Prescribing service´.[30] Participants overall reported feeling supported, listened to, guided and reassured by the social prescribing advisor. It had given them the confidence to put changes into action and access appropriate groups when the time was right.

- A small mixed method study[31] into a pilot social prescribing intervention found **frequent attenders had improved health and wellbeing outcomes and were less reliant on health-care resources** (decreased usage of health-care units, GP consultations and prescriptions issued).

- In an evaluation of Waltham Forest's SP service,[32] **social prescribing was found to have had a positive impact on respondents' mental well-being, health, well-being, quality of life, and patient activation**, with the last three of these being statistically significant. Respondents also reported large improvements in their concerns about Housing, Practical Support, Work & Finance.

- **Starting to participate in community assets was associated with an increasing gain in QALYs over 18 months** in a prospective 18-month cohort survey[33] which explored 4377 older people's

self-reported participation in community assets and quality of life. Stopping participation was associated with larger negative impacts.

Social prescribing significantly improved wellbeing in a small study[34] which evaluated a community service offering physical and mental activities to people with dementia and family carers in some of the most disadvantaged neighbourhoods in the NW of England. 25 people with dementia and family carers participated in the service.

- A mixed methods study[35] into a social prescribing service run by The British Red Cross to combat loneliness found that **the majority of service users felt less lonely after receiving support**. Service-users could receive up to 12 weeks of support from a link worker. Additional benefits included improved wellbeing, increased confidence and life having more purpose.

- **Social prescribing had benefits on young people's mental health** in this evaluation[36] of the 'Linking Leeds' service which provides social prescribing for people aged 16 years and above. Two main mechanisms were identified which underpin social prescribing in young people: social connectedness and behavioural activation.

- The psychosocial Leg Club model of lower limb care, now with 10,400 members, was designed to improve the care for people suffering from, or at risk of, problems of the lower limb and leg ulceration. **There were significant improvements in a range of quality of life indicators, including healing rates, pain levels, mobility and morale, for patients attending Leg Clubs.**[37] Findings have shown that non-concordance with treatment and occurrence of infection had been virtually eliminated, many long-standing ulcers had been healed, and an exceptionally low incidence of recurrence had been recorded, highlighting an improvement in patients' quality of life in conjunction with substantial savings in the cost of treatment.

- **Social prescribing engendered feelings of control and self-confidence,** reduced social isolation and had a positive impact on health-related behaviours including weight loss, healthier eating and increased physical activity in this qualitative study[38] of a link worker programme in Newcastle. Management of long-term conditions and mental health in the face of multimorbidity improved and participants reported greater resilience and more effective problem-solving strategies.

- **Social prescribing may have the potential to increase the physical activity levels of service users** and promote the uptake of physical activity in inactive patient groups, according to this study[39] in Luton. Service users were referred to 12 sessions (free of charge), usually provided by third sector organisations. Energy expenditure from all levels of physical activities increased post intervention, particularly for those who were inactive at the start of the programme.

- **Compared to standard diabetes services, a social prescribing approach was found to be broad and supportive of patients' wider socio-economic problems**; inclusive; sustained, extending beyond early behaviour change to lifestyle maintenance; and embedded within the local community and primary care infrastructure, which enhanced service accessibility. They concluded that SP holds considerable promise in contributing to holistic, accessible, sustained and integrated type 2 diabetes prevention activities in communities at high risk.[40]

2. Social prescribing - impact on services and service use

- A Social Return on Investment (SROI) study in Waltham Forest showed that **for every £1 invested in the social prescribing service in Waltham Forest, the expected return to society could range between £1.09 and £1.92**. This is considered a good investment, despite being below the average reported by other studies (£1:£2.3).[41]

- In the SP pilot in Shropshire, outlined above,[42] **GP visits were significantly reduced** by 40% for people who used the social prescribing service compared to the control group.

- Participants in the frequent attenders study mentioned above[31] were **less reliant on health-care resources** (decreased usage of health-care units, GP consultations, and prescriptions issued). Cost variance results show a direct cost saving of £8109 or £77.22 per frequent attender over the 5 months.

- The Red Cross study[43] referred to above, exploring the impact of SP on loneliness, estimated a **social return on investment of £3.42 per £1** invested in the service.

- In the study on SP in older people referred to above,[33] **cumulative effects on care costs progressively reduced over 18 months.**

- However, In the study of a generic SP service referred to above,[44] **the data on reductions in future access to primary care was inconclusive**.

- This quality-improvement study[45] in Northern found that **social prescribing did not decrease GP workload** in terms of prescribing nor GP attendance.

- Work by Loftus et al,[45] reported that while **social prescribing was linked with better patient outcomes, GP workload overall was not reduced**.

3. Recommendations on implementation and best practice

- **The evidence base for social prescribing needs to be improved.** Studies are often small and uncontrolled. Husk et al outline the many challenges,[46] Chatterjee et al[47] mapped outcomes for 86 projects in the UK and highlighted significant evidence gaps in outcomes across a range of SP interventions. Bickerdike et al[48] conclude that better evidence in order to judge success or value for money is needed, including comparative studies and evaluations of what works best for whom and at what cost.

- **The literature offers examples of SP not fulfilling its potential**. A quality-improvement study[45] in Northern Ireland found no statistically significant difference in GP contacts (visits to GP, home visits or telephone calls) or number of repeat prescriptions. No significant associations in mental well-being scores by gender, age or working status were found in another study[49] which assessed the change in the mental well-being of service users after participation in the Luton social prescribing programme. A meta-analysis[50] of 40 social prescribing projects in the UK and Ireland suggests that the benefits of social prescribing for people with type 2 diabetes is unproven.

- A qualitative study[51] into link workers' own experience of their roles, highlighted the need to provide **a holistic service focusing on the wider social determinants of health** and the

importance of having 'well-networked' link workers with the time and the personal skills required to develop a trusting relationship with clients while maintaining professional boundaries by fostering empowerment rather than dependency. Link workers also found **challenges in balancing quality of intervention provision and meeting referral targets** and **public sector cuts negatively impacted upon link workers' ability to refer patients into suitable services** due to unacceptably long waiting lists or service cutbacks. Inadequate training was also highlighted as an issue.

- The Waltham Forest evaluation[52] recommends linking with and supporting the community and voluntary sector, which is indispensable for the success of SP. There is a need to plug gaps in service provision and provide funding for delivery.

- Skivington[53] identified some benefits of collaborative working, particularly the Link Workers' ability to act as a case manager for patients, and their position in GP practices as a bridge between organisations. Challenges were related to capacity and funding for community organisations in the context of austerity. The capacity of link workers was also an issue given that their role involved time-consuming, intensive case management.

- A study explored a key challenge for SP - meeting the social needs of people disinclined to join groups. Groups can be detrimental to health and well-being if there are barriers to integration.[54]

- Processes which increased the likelihood of success included the sustained and flexible relationship between the service user and the Wellbeing Coordinator and a strong and vibrant voluntary and community sector.[55]

- Morris et al[56] explore a model of community enhanced social prescribing (CESP) which has the potential to improve both individual and community wellbeing. CESP combines two evidence-informed models – Connected Communities and Connecting People – to address both community capacity and individual need. When fully implemented the theory of change for CESP may improve both individual and community wellbeing.

APPENDIX ONE – SEARCH STRATEGIES

A.1 Medline

	Ovid MEDLINE® ALL <1946 to July 22, 2022>	Results per line
	Date: 25/07/2022	
1	(social prescrib$ or social prescrip$).ti,ab.	300
2	(community referral$ or social referral$ or non-medical referral$ or non medical referral$ or non-clinical referral$ or non clinical referral$).ti,ab.	213
3	(link work$ or care navigator$).ti,ab.	202
4	or/1-3	664
5	personali?ed care.ti,ab.	1600
6	("personalised support and care planning" or PSCP or supported self management or supported self-management or self-management of health or self management of health or personal$ health budget$).ti,ab.	755
7	or/5-6	2354
8	4 or 7	3008
9	limit 8 to (english language and last 5 years)	1775
10	exp animals/ not humans/	5039010
11	9 not 10	1770

A.2 Embase

	Embase <1974 to 2022 July 22>	Results per line
	Date: 25/07/2022	
1	(social prescrib$ or social prescrip$).ti,ab.	354
2	(community referral$ or social referral$ or non-medical referral$ or non medical referral$ or non-clinical referral$ or non clinical referral$).ti,ab.	359
3	(link work$ or care navigator$).ti,ab.	302
4	or/1-3	957
5	personali?ed care.ti,ab.	2361
6	("personalised support and care planning" or PSCP or supported self management or supported self-management or self-management of health or self management of health or personal$ health budget$).ti,ab.	963
7	or/5-6	3318
8	4 or 7	4265
9	limit 8 to (english language and last 5 years)	2509

A.3 Cochrane

	Cochrane Central Register of Controlled Trials (CENTRAL) and Cochrane Database of Systematic Reviews (CDSR)	Results per line
	Date: 25/07/2022	
#1	(social NEXT prescrib* or social NEXT prescrip*):ti,ab,kw	19
#2	(community NEXT referral* or social NEXT referral* or non-medical NEXT referral* or non medical NEXT referral* or non-clinical NEXT referral* or non clinical NEXT referral*):ti,ab,kw	54
#3	(link NEXT work* or care NEXT navigator*):ti,ab,kw	37
#4	{OR #1-#3}	105
#5	(personali?ed care):ti,ab,kw	3493
#6	("personalised support and care planning" or PSCP or "supported self management" or "supported self-management" or "self-management of health" or "self management of health" or personal* NEXT health NEXT budget*):ti,ab,kw	99
#7	{OR #5-#6}	3588
#8	#4 AND #7 with Cochrane Library publication date Between Jan 2017 and Jul 2022	7

A.4 Google Scholar

	Google Scholar	Results
	Date: 21/07/2022	
1	intitle:"personalized care" (intitle:"health gain"|"health outcome"|benefits|costs) Date limit:2012-2022 https://www.google.co.uk/search?q=intitle%3A%22personalized+care%22+%28intitle%3A%22health+gain%22%7C%22health+outcome%22%7Cbenefits%7Ccosts%29&lr=lang_en&safe=images&as_qdr=all&biw=1536&bih=754&tbs=lr%3Alang_1en%2Ccdr%3A1%2Ccd_min%3A1%2F1%2F2012%2Ccd_max%3A7%2F21%2F2022&ei=jl7ZYq7rLYbQgQagx4q4Bw&ved=0ahUKEwiu6tbYlIr5AhUGaMAKHaCjAncQ4dUDCA8&oq=intitle%3A%22personalized+care%22+%28intitle%3A%22health+gain%22%7C%22health+outcome%22%7Cbenefits%7Ccosts%29&gs_lcp=Cgdnd3Mtd2l6EAxKBAhBGAFKBAhGGABQjwlYnQtgrSRoAXAAeACAASiIAU-SAQEymAEAoAEBwAEB&sclient=gws-wiz **Please note that as the results are ordered by relevance, the first few pages of results will be the most useful*	~547
2	intitle:"social prescribing" (intitle:"health gain"|"health outcome"|benefits|costs) Date limit 2012-2022 https://www.google.co.uk/search?q=intitle%3A%22social+prescribing%22+%28intitle%3A%22health+gain%22%7C%22health+outcome%22%7Cbenefits%7Ccosts%29&lr=lang_en&safe=images&as_qdr=all&biw=1536&bih=754&tbs=lr%3Alang_1en%2Ccdr%3A1%2Ccd_min%3A1%2F1%2F2012%2Ccd_max%3A7%2F21%2F2022&ei=CjzZYpOXNM3qgQakppLICg&ved=0ahUKEwiTxLLj84n5AhVNdcAKHSSTBKkQ4dUDCA8&oq=intitle%3A%22social+prescribing%22+%28intitle%3A%22health+gain%22%7C%22health+outcome%22%7Cbenefits%7Ccosts%29&gs_lcp=Cgdnd3Mtd2l6EAxKBAhBGAFKBAhGGABQjQlY-xVg0zVoAXAAeACAASmIAbYCkgEBOJgBAKABAcABAQ&sclient=gws-wiz **Please note that as the results are ordered by relevance, the first few pages of results will be the most useful*	~2720

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