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Evaluation of the Rotherham Mental Health Social Prescribing Service 2015/16-2016/17

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Evaluation of the Rotherham Mental Health Social Prescribing Service 2015/16-2016/17

November 2017

Rotherham Clinical Commissioning Group

Evaluation of the Rotherham Mental Health Social Prescribing Service 2015/16-2016/17

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Introduction

1

This report provides updated findings of an independent evaluation of the Rotherham Social Prescribing Mental Health Service undertaken by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University. It covers the first two years of the service (April 2015 to March 2017) which is delivered in partnership by Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH) and a group of local voluntary sector organisations led by Voluntary Action Rotherham on behalf of NHS Rotherham Clinical Commissioning Group (CCG). The service aims to help users of secondary mental health services build and direct their own packages of support, by accessing tailored voluntary activity in the community, with a view to achieving sustainable discharges from mental health services.

1.1. Evaluation Aims

This report has a number of aims:

- to understand the impact of the service on the well-being of service users;
- to identify wider outcomes and social benefits associated with the service;
- to understand the impact of the service on discharge from secondary mental health services;
- to explore the potential economic benefits of the service.

An earlier report, published in November 2016 provided emerging findings around each of these aims[1]. It also provided analysis of different stakeholder perspectives on the effectiveness of the Service and identified key learning to inform future delivery and commissioning.

1.2. Methodology

This report draws on a variety of data sources to reflect on achievements and learning from the activities of the service to date:

- Well-being outcome questionnaires completed by 161 service users at two points in time: upon first engaging with the Service (baseline) and after approximately 4-6 months (follow-up) as part of a review.

[1] Dayson, C. and Bennett, E. (2016) *Evaluation of the Rotherham Mental Health Social Prescribing Pilot*. Sheffield: CRESR, Sheffield Hallam University.

- Monitoring data from VAR on the number of people referred to the Service, take-up of services, discharge rates from secondary mental health services and a series of wider outcome measures.
- Case studies of three social prescribing service users to illustrate the different ways in which people are benefitting from the service.

1.3. Report Structure

The remainder of this report is structured as follows:

- Chapter 2 provides an overview of the Rotherham Social Prescribing Mental Health Service;
- Chapter 3 provides analysis of the outcomes and impact of the service;
- Chapter 4 is the conclusion and provides a summary of the main findings from across the two evaluation reports.

2

An Overview of the Rotherham Social Prescribing Mental Health Service

This chapter provides an overview of the Rotherham Social Prescribing Mental Health Service. It discusses the background to the service, including how it links to local and national priorities; the service pathway, and the types of social prescribing activities provided for mental health service users; and provides an overview of the number of service users referred to the service.

2.1. Background to the service

The Rotherham Social Prescribing Mental Health Service was developed to help people with mental health conditions overcome the barriers which prevent discharge from secondary mental health care services. Initially commissioned as a pilot to run from April 2015 to March 2016 it was quickly extended to March 2017 and is now funded until March 2018. The service helps service users build and direct their own packages of support, tailored to their specific needs, by encouraging them to access personalised services in the community provided by established local voluntary and community organisations, and to develop their own peer-led activities.

The service is funded by NHS Rotherham Clinical Commissioning Group (CCG) and delivered in partnership between Rotherham, Doncaster and South Humber Foundation Trust [2] (RDASH) and a consortium of 18 local voluntary sector organisations led by Voluntary Action Rotherham. It builds on and is integrated with the successful Rotherham Social Prescribing Service for people with long term health conditions which has been operating since 2012.

The service has three central key aims:

1. To create opportunities for mental health service users to sustain their health and well-being outside secondary mental health services;
2. To create capacity within secondary mental health services;
3. To improve efficiency within mental health services.

It also provides a new model of partnership working between mental health services and the local voluntary and community sector based on a 'single point of contact' contracting model.

[2] RDASH has historically provided mental health and learning disability services across South Yorkshire and North East Lincolnshire, but recently expanded its remit to include community services such as district nursing and health visitors.

The service focusses on three service user care pathway clusters:[3]

- **Cluster 4:** This group suffers from severe depression and/or anxiety and/or other non-psychotic disorders that increase the complexity of their needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risk to themselves of others.
- **Cluster 7:** This group suffers from issues associated with long term anxiety and depression or other non-psychotic disorders. They will have received treatment for a number of years and although their symptoms are improved and stable, as a result of long term ill-health they are likely to have a level of social disability that affects their day to day functioning, and leads them to be over dependent on others.
- **Cluster 11:** This group will have a history of psychotic symptoms that are currently controlled and causing minor problems if any at all. They are likely to be experiencing a sustained period of recovery, but require support to regain confidence with day to day life skills, such as sustaining meaningful relationships, and re-entering the work place. They may also have some long term dependence issues.

The service was co-produced with service users, carers, RDASH staff and voluntary and community sector organisations. This involved an initial focus group (in October 2014) with service users to engage them in the design of the service and a wider consultation with service users and carers between December 2014 and January 2015. Service users are also involved in a Steering Group overseeing the delivery of the service and a patient reference group that guides service development. This co-production approach is part of an overall vision for the service that service users will be encouraged and supported to be active, not passive recipients, in their own recovery.

There are also a number of national and local contextual and strategic policy drivers that provided a strong rationale for service and continue to influence its development. Nationally, in February 2016 the Mental Health Taskforce to the NHS in England, in their 'Five Year Forward View for Mental Health'[4] recommended expanding proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible and a commitment to promoting good mental health and preventing poor mental health. Locally, the RDASH transformation plan[5] prioritises a step-change in service provision in which patients are encouraged and supported to live more independent lives and receive the care they need according to their individual circumstances, delivered closer to home where possible. In addition, the South Yorkshire and Bassetlaw Sustainability and Transformation Plan (STP)[6] focusses on prevention, and outlines plans to invest in, reshape and strengthen primary and community services to support people to be as mentally and physically well as possible. Mental health is seen as integral to the STP's ambitions around improving population wellbeing.

[3] 21 care clusters have been identified to capture the needs of most people who use mental health services. Each care cluster describes a group of people according to their mental health needs and difficulties and focuses on a period of care (rather than individual contacts). Clusters identify a needs based profile which determines what 'core' and 'essential' interventions and support are offered to meet needs as well as expected outcomes. Each care cluster has a built in review period to monitor progress and effectiveness of intervention.

[4] Mental Health Taskforce to the NHS in England (2016). *The five year forward view for mental health: A report from the independent Mental Health Taskforce*

[5] RDASH (2016). *Recommendations for Transforming Rotherham Adult (18+) Mental Health Services*

[6] STPs have been developed by the NHS at a regional level to support implementation of the Five Year Forward View. See NHS England (2017) *Health and care in South Yorkshire and Bassetlaw: Sustainability and Transformation Plan*

In this context the Rotherham Social Prescribing Mental Health Service is strategically important. It provides an example of a locally developed patient-centred approach to mental health services based on the principles of prevention, recovery and well-being. If it is successful it will provide a model for further involvement and integration of the voluntary and community sector in mental health services in a way that facilitates sustainable discharge, leading to a more efficient and effective system..

2.2. The social prescribing mental health pathway

During the development of the service VAR and RDASH developed a six month pathway to support a smooth transition from mental health services to social prescribing activities and, hopefully, discharge. The pathway also supports primary care practitioners, social prescribing staff and voluntary organisations to respond appropriately to signs of relapse and re-access to secondary mental health services should a service user's health deteriorate during the project. It was developed as a guideline and is applied flexibly so that individuals' engagement with and experience of social prescribing can tailored to their personal circumstances:

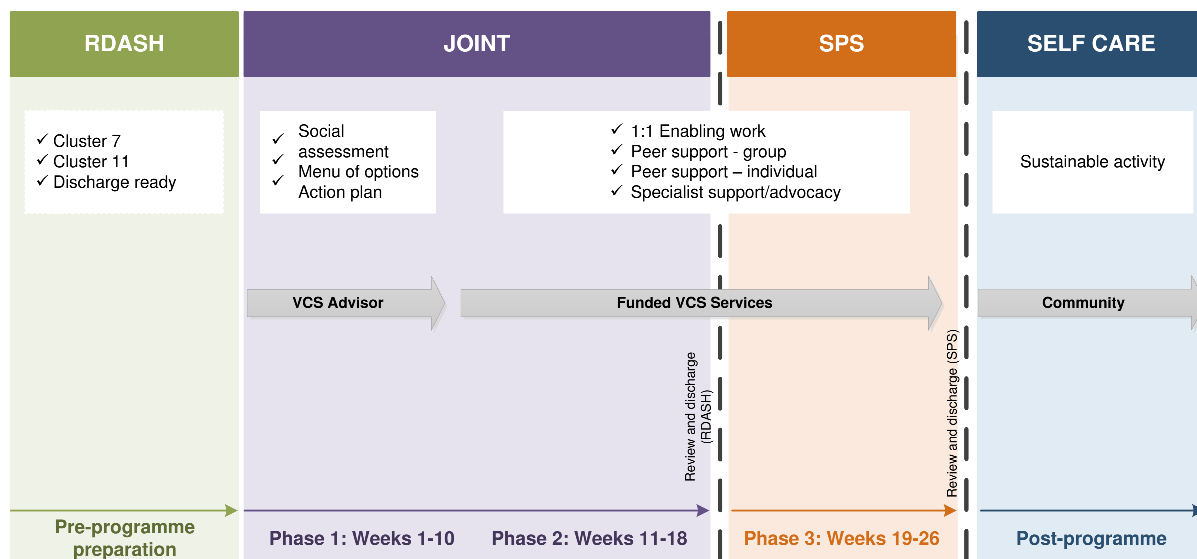
- **Phase 1 (typically weeks 1 – 10):** Referrals are made for individual service users by an RDaSH practitioner. In most cases an initial meeting is held between the RDaSH practitioner, the VCS Advisor and the service user to establish the service user's suitability for social prescribing. If the service user wishes to proceed with social prescribing, the VCS Advisor undertakes an assessment meeting with them to establish their support needs and create an action plan. A range of referrals and signposts to services are then agreed with the service user and referrals actioned by the VCS Advisor. A period of joint working between social prescribing and RDaSH continues during this period during which the VCS Advisor will liaise with the RDaSH practitioner if there are any problems. The service user case remains an open RDaSH case during this period and any concerns and observations are discussed with the RDaSH practitioner and transition delayed if appropriate.

- **Phase 2 (typically weeks 11 – 18):** A discharge review meeting is normally held between the RDaSH practitioner, the VCS Advisor and the service user to assess progress with social prescribing. If the service user is progressing well with social prescribing, RDaSH will withdraw and the service user discharged. If concerns are identified and it is felt that social prescribing engagement cannot be sustained, the service user will remain in the care of RDaSH and continue social prescribing with increased support, or they will return to the care of RDaSH and withdraw from social prescribing.

- **Phase 3 (typically weeks 19 – 26):** During this phase, the service user's primary contact is the VCS Advisor or one of the voluntary sector organisations providing support through the programme. If there are concerns, the RDaSH practitioner is available to provide advice. If a re-referral to mental health services is necessary, the RDaSH triage worker assesses the emerging risk and initiates a rapid re-access back into RDaSH services.

An overview of this pathway is provided in figure 2.1.

Figure 2.1: The Rotherham Social Prescribing Mental Health pathway



2.3. Social prescribing activities

A range of different types of voluntary and community sector activities were developed and received funding to provide a combination of individual and group based opportunities across four broad themes:

- **Befriending plus**, providing peer support for people lacking confidence to engage in community activities independently (five providers), including two services to support engagement in physical activity and one for vulnerable women.
- **Education and training** opportunities, enabling people to build practical skills and confidence in areas of interest including working towards employment.
- **Community activity groups**, providing opportunities for people to engage social activities base around a particular hobby or interest (five providers).
- **Therapeutic services,** enabling people to develop relaxation and mindfulness techniques in a supportive environment.

A more detailed overview of the activities delivered between April 2016 and March 2017, including the number of service users accessing each opportunity and the number of hours support provided, is summarised in table 2.1.

2.4. Overview of referrals

Overall, **317 mental health service users were referred to the service** between April 2015 and March 2017. Of these **260 (82 per cent) engaged in an initial meeting between representatives of the service and RDASH**, and **246 (78 per cent) had taken-up a service** on an individual or group basis. Table 2.2 provides a breakdown by year: in 2015-16 156 service users were referred to the service, of whom 141 (90 per cent) had an initial meeting with the service and RDASH, and 136 (87 per cent) took-up a service; in 2016-17 160 service users were referred to the service, of whom 119 (74 per cent) had an initial meeting with the service and RDASH, and 110 (69 per cent) took-up a service.

Table 2.1: Overview of organisations and activities funded through the Rotherham Social Prescribing Mental Health Service (2016/17)

	No of service users supported	No of hours support provided
Services for individuals		
Befriending plus (generic):		
British Red Cross	47	581*
You Asked We Responded	53	497*
Befriending plus (physical activity):		
Places For People	51	431*
Rotherham United Community Sport Trust	56	248*
Befriending plus (support for women):		
Rotherham Rise	22	385*
Education / Training:		
Learning Community	70	615*
Services for groups		
Education / Training:		
Elmet Archaeological	4	146**
Workers Educational Association	8	140**
Community Activity Groups		
Zest Health For Life (Cookery)	17	204**
ABC Forum (Arts and Crafts)	6	221**
Casting Innovations (Metal Craft)	20	426**
Rotherham United Community Sport Trust (Physical Activity)	29	280**
Mind (Arts and Crafts)	19	147**

* For services for individuals this is direct delivery hours to individuals
**For group activities this is the combined group support hours provided

Table 2.2: Overview of referrals to the Rotherham Social Prescribing Mental Health Service (2015/16-2016/17)

	2015/16	2016/17	Total
Referrals-in to the service			
Number	156	161	317
Referrals resulting in VCSA-RDASH meeting			
Number	141	119	260
Per cent	90	74	82
Referrals taking-up a service			
Number	136	110	246
Per cent	87	69	78

Outcomes and impact of the service

3

This chapter presents evaluation findings about the outcomes and impact of social prescribing for mental health service users. It draws on quantitative and qualitative data to provide an assessment of the well-being outcomes experienced by social prescribing service users, the impact of social prescribing on discharges from mental health services, and the impact on wider outcomes such as employment and volunteering. These findings provide the basis for an analysis of the potential economic benefits of social prescribing for mental health service users.

3.1. Well-being outcomes

Overall the evaluation found a range of **positive impacts on the well-being of mental health service users following their engagement with social prescribing**. This assessment is based on a mix of quantitative and qualitative data that has collected and analysed. The main findings of this analysis are presented in the following sections.

Quantitative data on service users' progress towards well-being outcomes was collected through a bespoke well-being measurement tool. The tool was originally developed for the Long Term Conditions Social Prescribing Service and adapted for the Mental Health Service. Data was by collected by VCSAs from service users when they were first referred to the Service (baseline) with progress measured after approximately 4-6 months (follow-up) as part of a telephone follow-up. It has eight measures associated with different aspects of personal, social and emotional well-being:[7]

- **Feeling positive:** identity/self-belief; confidence/self-esteem; motivation; hope/feeling happy; coping from day to day.
- **Lifestyle:** smoking, alcohol, drugs, gambling; diet and eating habits; activities and exercise; sleeping patterns.
- **Looking after yourself:** personal care/hygiene; household chores; living skills; shopping; physical health.

[7] For each measure a five point scale was used: 1 = Not thinking about it/not doing anything; 2 = Finding out/thinking about; 3 = Making changes/doing something; 4 = Getting there/could do more; 5 = As good as it can be.

- **Managing symptoms:** understanding/managing triggers; dealing with stress/setbacks; anxiety, panic attacks, self-harm; managing medication; trying new things.
- **Work, volunteering and other activities**: interest in volunteering; ability to work; social groups/social contact at home; learning; activities of interest or hobbies; interest in attending groups or activities.
- **Money:** debt; paying bills; accessing benefits; managing money.
- **Where you live:** living conditions; neighbour nuisance / keeping safe; managing tenancy; fire safety and alarms; local facilities.
- **Family and friends:** relationships/family understanding; friends/social networks/peer support; interest in meeting new people or trying new things; feeling lonely or isolated; carer support.

Analysis was undertaken on data for 161 service users for whom baseline and follow-up data was available. An overview of this analysis is provided in Figures 1-3 and discussed below.

Overall, **93 per cent of service users made progress against at least one outcome** and increases were recorded for almost half (48 per cent) of all outcome scores. Figure 3.1 shows that the average (mean) score for each outcome measure improved significantly between baseline and follow-up, with greatest progress made against the 'work, volunteering and social groups', 'feeling positive', 'lifestyle' and 'managing symptoms' outcomes.

Figure 3.2 provides an overview of data for service users who provide a 'low' score[8] for each outcome measure when they first engaged with the service. Analysis of low scores provides an indication of how effective the service has been at improving outcomes for service users in the particular aspects of well-being where their needs are greatest. As with figure 3.1, this shows that the average (mean) score for each outcome measure improved significantly between baseline and follow-up, with greatest progress made against the 'work, volunteering and social groups', 'feeling positive' and 'lifestyle' outcomes. It also shows that for service users with a 'low' baseline score for any outcome the average improvement was greater than for the sample as whole - 0.99 for low scores compared to 0.60 for all scores across the eight well-being outcome measures.

[8] Those who provided a baseline score of two or less for a particular outcome.

Figure 3.1: Overview of baseline and follow-up outcome scores for all service users (mean)

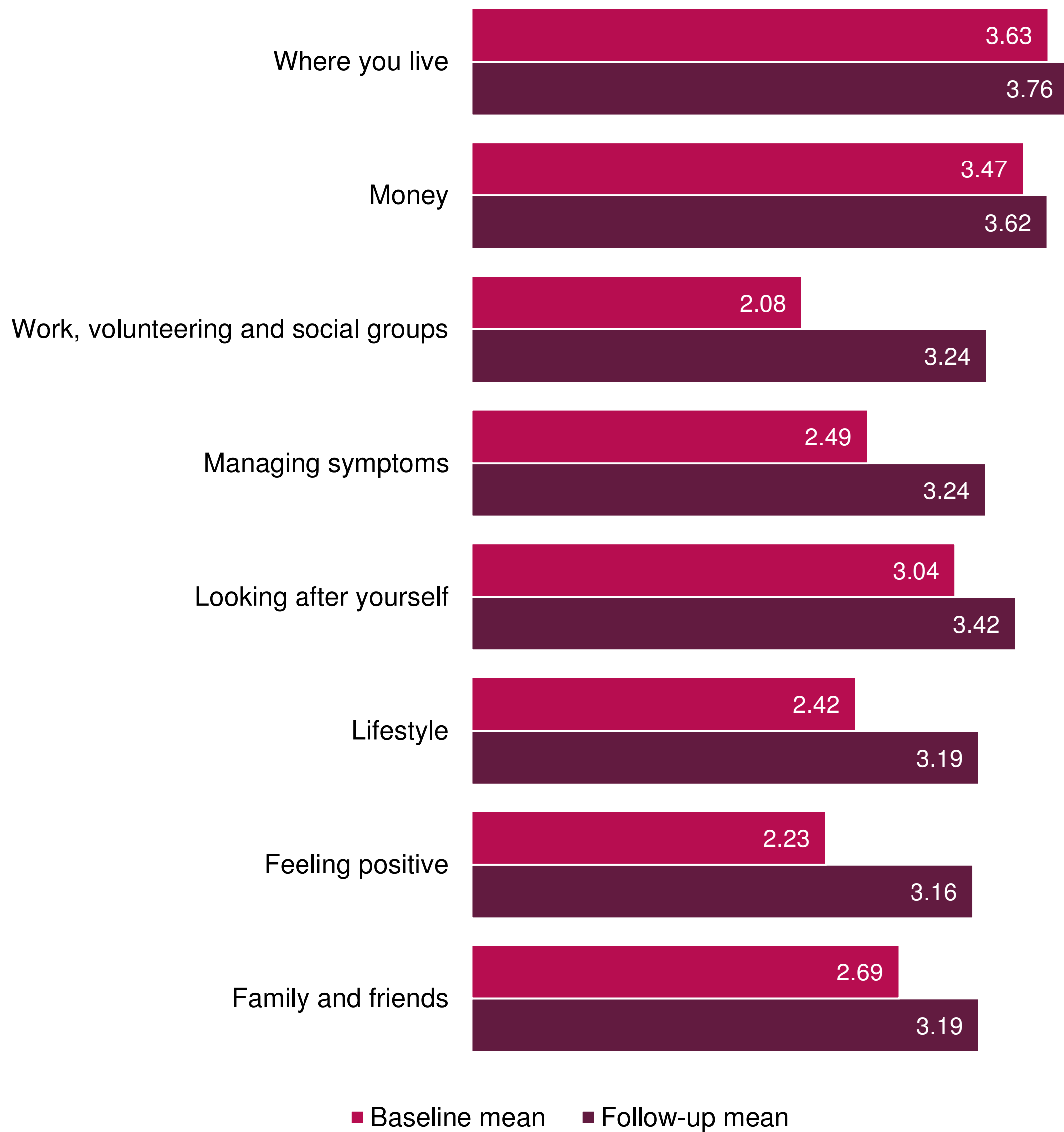


Figure 3.2: Overview of baseline and follow-up outcome scores for service users with a low baseline score (mean)

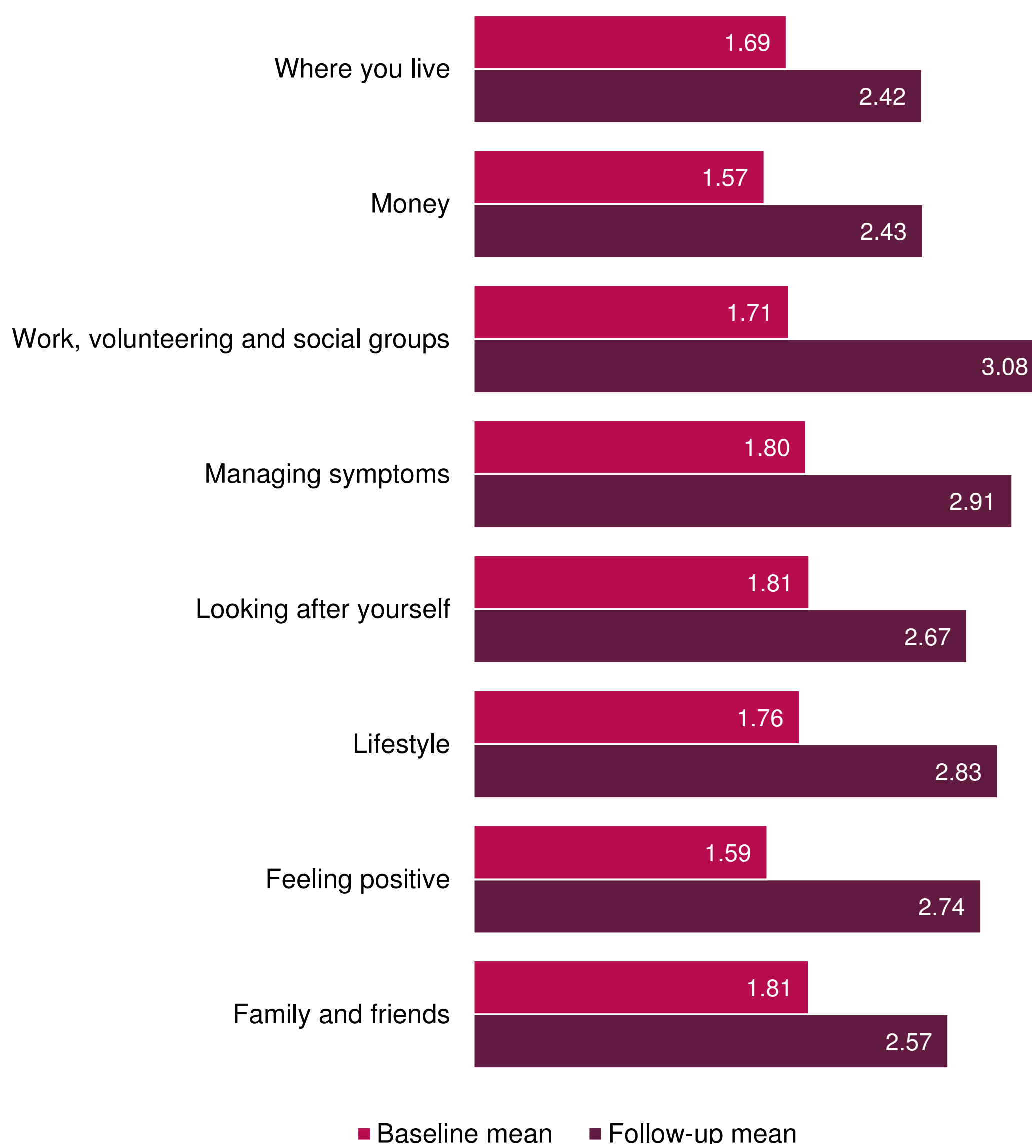
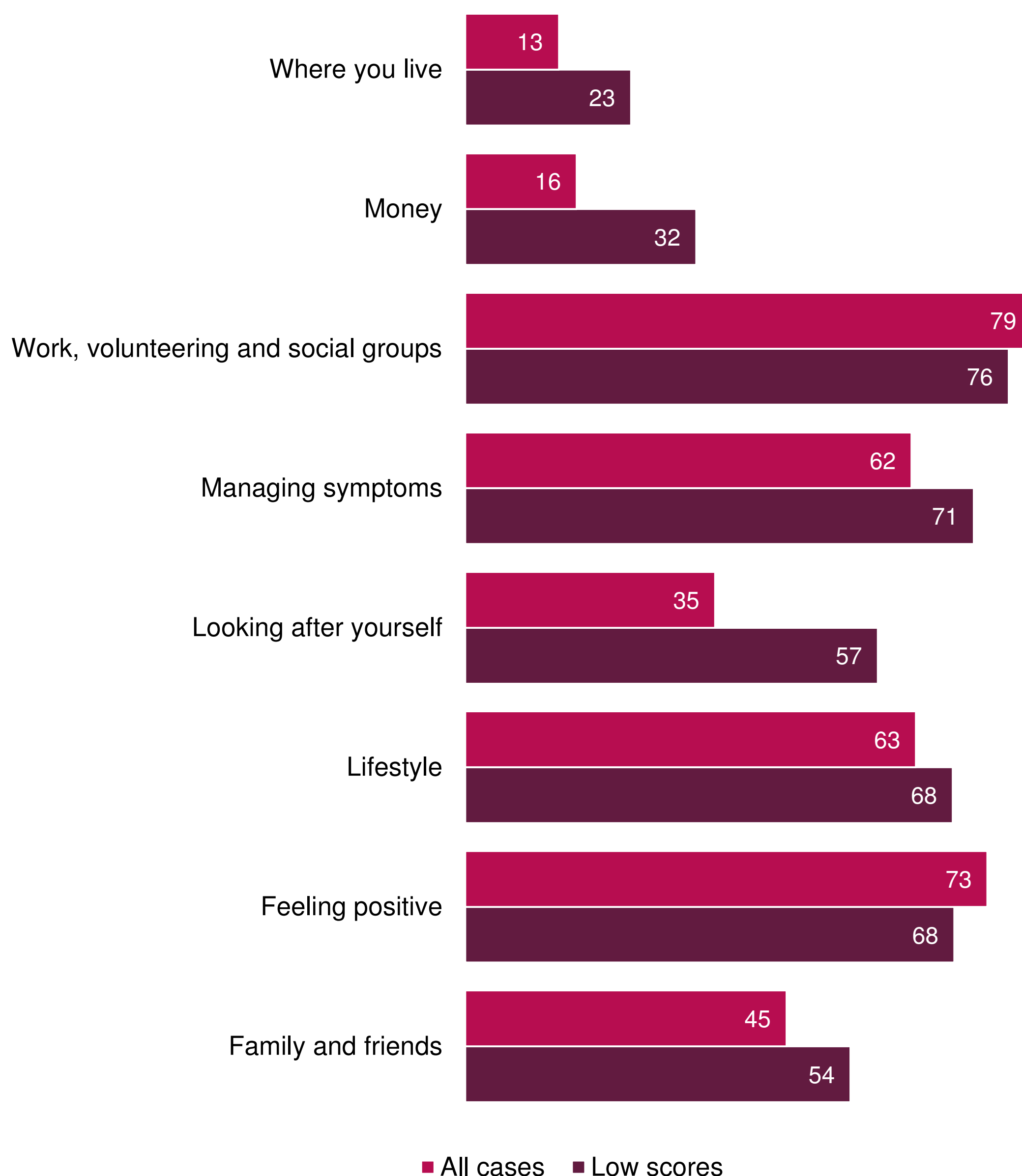


Figure 3.3 provides an overview of the proportion of service users making progress against each outcome, with figures for all cases and those with low baseline scores. This shows that, across all service users, a majority made progress in four outcome areas: 'work, volunteering and social groups'; 'feeling positive'; 'lifestyle'; and 'managing symptoms'. For service users with a 'low' baseline score the picture was even more positive. A majority progress against each outcome with the exception of two - 'Where you live' and 'Money' - although it is important to note that these are the two outcomes with the highest mean scores and fewest low scores, suggesting that fewer service users have support needs in these two areas. That outcome progress was greatest and most likely for the areas where the mean baseline scores were low, and where there were higher proportions of service users with a 'low' baseline score, is positive, and suggests that the **social prescribing service has been effective at addressing the most acute well-being needs** of mental health service users.

Figure 3.3: Proportion of service users making progress against each outcome (per cent - all cases and low baseline scores)



Further evidence about the outcomes of service users is provided by case studies presented at the end of this chapter

3.2. Discharge from mental health services

One of the core aims of the Rotherham Mental Health Social Prescribing Service was to improve discharge rates from statutory mental health services and improve extent to which discharge is sustained (i.e. reducing re-referrals to mental health services). As such, the VAR social prescribing team and RDASH have closely monitored service users' progress following their engagement with the service. A 'discharge review meeting' is held around 10 weeks after a service user begins receiving support during which an assessment is made about the *potential for* and likely *timescales of* discharge.

Table 3.1 provides an overview of the number of discharge review meetings and subsequent discharges for 2015/16 and 2016/17. It shows that, overall, 156

discharge review meetings have been held and **85 service users had been discharged from mental health services (54 per cent of those eligible for discharge review).**

Table 3.1: Overview of reviews and discharges for social prescribing service users (2015/16-2016/17)*

	2015/16	2016/17	Total
Discharge review meetings			
Number	72	84	156
Discharges from statutory mental health services			
Number	39	46	85
Per cent (of those eligible)	54	55	54

*Excludes March 2017 discharges

This is clearly very positive evidence from the first year of the service: many patients referred to the service had been supported by secondary mental health services for between 5-20 years without being discharged successfully. However, it will be important to monitor patterns of discharge over a longer period to fully understand the impact. These patterns should also be compared to broader RDASH discharge data for comparative purposes. In particular, the discharge rates and sustainability of discharge for mental health service users should be compared to previous years for these cohorts, and to other cohorts engaging with mental health services.

3.3. The wider outcomes of social prescribing for mental health service users

The evaluation also found **a range of evidence about the wider social benefits of the service.** Voluntary Action Rotherham is monitoring a number of service user outcomes in addition to the well-being measures discussed earlier in this chapter. These include whether the found employment whilst engaging with social prescribing, whether they took part in training, whether they volunteered, whether they took-up physical activity and whether they continued to be involved in voluntary sector activity once their engagement with social prescribing was complete.

An overview of this data is provided in table 3.2. It shows that between April 2015 and March 2017:

- 10 service users had found employment;
- 48 had engaged in training or education;
- 38 had volunteered;
- 59 had taken-up activity to improve their physical health;
- 59 had accessed peer support opportunities (2016-17 only);
- 84 had continued to engage in voluntary or community sector activity once their social prescription had ended.

Table 3.2: Overview of wider outcomes for social prescribing service users (2015/16-2016/17)*

	2015/16	2016/17	Total
Employment			
Number finding employment	3	7	10
Training and education			
Number accessing education or training opportunities	24	24	48
Volunteering			
Number engaging in volunteering	14	24	38
Physical activity			
Number taking-up physical activity to improve their health	25	34	59
Peer support			
Number accessing peer support	N/A	59	59
Voluntary and community sector activities			
Number accessing activities after completing the programme	40	44	84

*Note that data refers only to closed cases

3.4. The value of social prescribing for mental health service users

Fiscal and economic value

One of the long term aims of the Rotherham Social Prescribing Mental Health Service is to improve the efficiency and effectiveness of secondary mental health services. The measure of whether this has been achieved will be an **improvement in the rates and sustainability of discharge for patients with mental health conditions** that appear to have become 'stuck', some for up to 20 years, because of the lack of clear pathway for sustainable discharge. In response to this challenge the service is helping to support a transition to a more preventative and recovery focussed model of mental health services, with patients increasingly being referred earlier in their mental health pathway. If sustainable discharge can be achieved this will have clear fiscal (public savings) and economic benefits that can be realised over an extended time period.

Drawing on the wider evidence, it is possible to estimate that for each service user discharged from secondary mental health services who would not have been discharged without engaging with social prescribing, and for whom discharge is sustained for 12 months, there will be a fiscal and economic benefit of £4,281 per year.[9] This means that 93 service users will need to achieve a sustainable discharge each year if the service is to create fiscal and economic benefits greater than the costs of delivering the service (i.e. a positive return on investment). However, if

[9] This is the **average annual fiscal and economic costs** per adult suffering from any type of mental health disorder (excluding dementia). The **fiscal value** component of this cost is the average annual cost of service provision to the NHS (£757), local authority (£98) and criminal justice (£15). The **economic value** comprises lost earnings (£3,501 per person on average, at 2007-08 prices) and costs falling to informal carers (an estimated £136 per person). Other social costs (e.g. from reduced well-being) are not monetised. These figures are drawn from the New Economy Unit Cost Database and based on evidence collected in the King's Fund report: Paying the Price: the cost of mental health care in England to 2026 (King's Fund, 2008)

discharge can be sustained for more than a year then the number of service users required to achieve a positive return on investment would reduce. This highlights the importance of monitoring discharge figures, including the sustainability and additionality of discharge, over an extended period to properly understand the fiscal and economic benefits of social prescribing for mental health service users.

A more nuanced understanding of the benefits of social prescribing could be gained through analysis of service users not discharged but for whom other intermediate benefits are evident. For example, it may be that the number and intensity of their contacts with RDASH services reduces, or that prescription costs reduce as they become less reliant on medical remedies. Social prescribing may also reduce the length of people's treatment in the longer term and make therapies more effective as patients have the opportunity to apply what they have learnt in real life situations. This is an area for future evaluation activity to explore.

Social value

It is possible to assess the social value of the Mental Health Social Prescribing Service by using financial proxies to provide a monetised estimate of social return on investment (SROI) drawing on analysis of the well-being outcome data discussed in earlier in this chapter. This approach to monetising well-being draws on social value work undertaken by the New Economics Foundation and New Economy Manchester[10] to value the subjective well-being benefits associated with social interventions and has been applied in the Evaluation of the Rotherham Social Prescribing Service for people with long term conditions.

In this approach well-being is equated with mental health to monetise the social value created. Analysis by the Centre for Mental Health[11] placed a cost on mental illness through the use of QALYs (Quality Adjusted Life Years), derived from a measure of health-related quality of life. Their analysis identified the average loss of health status in QALYs from a level-three mental health problem (a severe problem - 0.352 QALYs) and valued this by using the NICE (National Institute for Health and Care Excellence) cost effectiveness threshold of £30,000 per QALY. Equating well-being with mental health therefore provides an overall well-being valuation of £10,560 per year (0.352 x £30,000). As the Rotherham Social Prescribing Service do not use a recognised QALY-based tool (such as EQ-5D), the well-being outcome tool was used as a proxy measure of well-being and health-related quality of life.

Methodology

As a start point, it was assumed that each category on the well-being outcome tool provided an equal contribution to well-being. As such, the total value of well-being was distributed evenly across the outcomes (£1,320 per outcome). Two approaches to valuing the well-being benefits were then taken:

1. All outcome change was valued, and it was assumed that a one point change on each outcome measure equated to 20 per cent of the outcome value. In this approach a Service user progressing one point on an outcome measure accrued £264 of social value while a Service user progressing five points accrued £1,320.
2. Outcome change was only valued for Service users who progressed from a low score (of two or less) to a high score (of three or more). In this approach a

[10] Cox, J et al (2012) *Social Value: Understanding the wider value of public policy intervention.* New Economy Working Paper 008.
[11] Centre for Mental Health (2010) *The economic and social costs of mental illness*, (June 2003, updated October 2010).

Service user progressing from low to high on the each outcome measure accrued the full social value of £1,320.

In both approaches the equivalent amount of negative value was allocated to negative outcome change. This process is summarised in Table 4.1.

Table 4.1: Allocation of financial proxies

Proportion of overall value (£10,560) per outcome (%)	1: Valuing all outcome change	2: Valuing low to high outcome change
	Value of a 1pt change (+/-)	Value of low to high change (+/-)
12.5	£264	£1,320

An estimate of the well-being value created

An overview of the estimated well-being value created for users of the Mental Health Social Prescribing Service is provided in Table 4.2. The total value was calculated by multiplying the per-user value by the total number of users substantively engaged by the Service across the first two year of operation (n=246).

Table 4.2: Overview of the estimated annual well-being value created by outcome category

Outcome area	1: Valuing all outcome change		2: Valuing low to high outcome change	
	Per Service user value	Total value	Per Service user value	Total value
Family and friends	£133	£32,674	£303	£74,625
Feeling positive	£244	£60,103	£541	£133,115
Lifestyle	£205	£50,422	£467	£114,963
Looking after yourself	£100	£24,606	£254	£62,524
Managing symptoms	£197	£48,405	£517	£127,064
Money	£39	£9,681	£74	£18,152
Where you live	£34	£8,471	£49	£12,101
Work, volunteering and social groups	£307	£75,432	£738	£181,520
Total	**£1,259**	**£309,795**	**£2,943**	**£724,065**

It shows that the two approaches to valuation provided very different results:

- Valuing all outcome change produced an estimated total well-being value of £310,000;
- Valuing low-to-high outcome change produced value of £724,000.

These values can be compared with the costs of delivering the Service to provide an estimate of the annual return on investment provided (Table 4.3). This demonstrates

that the estimated social return on investment from well-being benefits for the pilot was between £0.79 and £1.84 (between seventy nine pence and one pound and eight four pence for each pound invested). This means that there is likely to have been **a positive social return on investment based on the well-being benefits experienced by service users resulting from the service**.

Table 4.3: Estimated social return on investment (ROI) from well-being benefits

No of Service users engaged	Input costs	1: Valuing all outcome change		2: Valuing low to high outcome change	
		Total value	ROI	Total value	ROI
246	£394,300	£309,795	£0.79	£724,065	£1.84

3.5. Case studies

This section provides three case studies of social prescribing service users. Collectively they illustrate the interlinked nature of the different types of outcomes experienced by mental health services and highlight the range of ways in which they have been supported by the service.

Case study 1 – Brian

Initial issues

Brian (aged) 60 was initially referred to the social prescribing service in 2015. At the time, his mental health was poor and he had tried to take his life with pills. Married with a grown-up family, he felt quite anxious as he no longer worked, having lost his job as a manager some 8 years earlier. Brian's anxiety was fuelling negative thoughts and a decline in his general wellbeing. He also had limited physical capabilities due to a back problem and spasms in his neck. Money had become tight and he was spending more time at home; not feeling like getting out or socialising or meeting people. He felt unable to get involved in activities he previously enjoyed such as fishing and fell running and felt he had lost his sense of purpose.

Interventions

Brian was visited by a VCSA and was supported to develop an action plan he was happy with. He was then referred to a benefits advisor to check he was receiving all the benefits he was entitled to and to an enabler from the local football club to link him in to activity groups that would be appropriate for him. He also received support to explore volunteering opportunities to get him out and do something positive. Although the benefits advisor who visited him revealed his benefits were as they should be, his wife was also supported to apply for a benefit she was eligible for to boost the family's finances. Brian felt better for having this help as he no longer felt unsure about his entitlements and the family income could increase. The referral to the football club enabler resulted in Brian accessing a fishing group that met weekly. Brian really enjoyed attending the group and, after the initial introduction from the enabler, he continued to go along and eventually became a longer-term volunteer, helping others who joined the group with his knowledge of the sport.

Outcomes

Brian was discharged from mental health services in July 2016 as he was doing so well following his social prescription. Despite a brief relapse in early 2017 when he was re-admitted to the community mental health team, he has since been discharged again following a re-engagement with the social prescribing service. Following re-assessment from a VCSA, Brian received further support to access group activities and resumed his volunteering at the fishing group which he continued until, with renewed self-confidence, he found a new job as a depot manager supervising over 20 people (something he previously expressed he would not be able to do again). He has found a real sense of worth and is happier than ever in his new job. He reports that regaining employment at the age of 60 after an eight year period out of work has reinvigorated him and he is now feels very positive about his life and the future.

Case study 2 – John

Initial issues

John was referred to the social prescribing service in late 2016. He lives in supported accommodation and has depression, psychosis and short-term memory problems although he is managing with medication. Due to an inactive lifestyle, John's weight had increased and had become a concern to him - he felt he needed help and support to motivate him to address this issue. John explained to the VCSA that he was open to trying new things but was not sure where to get support to help him to access activities that may improve his health and wellbeing. Despite living in supported sheltered accommodation, John felt lonely in his flat as staff had little time to chat and he did not spend much time with neighbours. His family were supportive but don't see John as much as he would like. John' depression was worst when he felt lonely and not involved with people socially.

Interventions

The VCSA referred John to commissioned services including a home befriender / enabler to help him to access physical activities and volunteering opportunities, and a leisure centre enabler to support and link him into activities in the local gym and an 8-week cookery starter class. The VCSA made a number of enquiries to organisations that work with animals on John's behalf as he was keen to volunteer with animals. This did not yield a suitable opportunity at the time so John was linked to the Volunteer Centre at Voluntary Action Rotherham for help finding a suitable volunteering opportunity. This enabled him to look more broadly at the range of volunteer roles to available and he decided to include helping people as well as animals. John was also referred to Rotherham United's Community Sports Trust as part of his social prescription where, following one to one support, he began attending a badminton group regularly.

Outcomes

The social prescriptions were very beneficial to John, as combined, they led to an increase in his self-confidence, improved his physical and mental health, helped him to lose weight, to cook healthier meals and to work independently in the local gym. The Leisure Centre enabler put together a gym programme for John and after the support ended he was able to continue attending the gym independently, seeing

good results in weight loss, which gave his confidence a boost. John's cookery class enabled him to cook more nutritious meals at home as well as offering him a group environment where attendees provided each other with mutual support. He has also been put forward to volunteer working with young people as a mentor. John continues to access social prescribing and is currently considering another volunteering role at the local hospice.

Case study 3 – Emma

Initial issues

Emma had been accessing statutory mental health services for a number of years before a referral was made to the social prescribing service to support her to begin engaging in activities in order to meet more people and to make her feel more actively involved within her community. She lives alone, does not eat well and has battled anorexia for over 10 years which has caused osteoporosis. As part of her anorexia, Emma also had significant problems with over-exercising. Emma functions well while supported by services but her mental health deteriorates when they are removed. She is currently receiving help from a psychologist and dietician amongst other professionals, so there is a concern that when this support ends, Emma may lose impetus despite saying she currently feels quite positive.

Interventions

Emma was referred to the social prescribing service to see if it could provide a supportive transition pathway into wider voluntary sector services as well as opportunities for personal development and improved mental health. The VCSA met Emma and agreed an action plan with her that included a referral to a relaxation group and a cookery class. As Emma showed interested in volunteering, the VCSA also spent time helping her to explore a range of volunteering opportunities. This included linking her with the Volunteer Co-ordinator at the local hospital and a referral to the Volunteer Centre at Voluntary Action Rotherham for wider support.

Outcomes

Emma has been discharged from mental health services following her social prescription. She has increased her confidence and now cooks her own meals after attending a cookery class. The class offers progression to higher level classes and Emma is considering the next level. She has also begun volunteering at a community park and following support from the VCSA, is in the process of meeting volunteer co-ordinators at the hospital and one of the town's cinemas. At Emma's request, the VCSA is now supporting her to take part in a relaxation group. Emma has become very keen to explore new options and now needs support to make sure that she does not take part in more activities than she is able to cope with.

Conclusion

4

This report has provided the main findings of an evaluation of the outcomes and impact of the Rotherham Social Prescribing Mental Health Service. It builds on an earlier evaluation report that provided emerging findings about outcomes and impact and identified key learning to inform future service delivery. The main findings from across the two reports are as follows.

1. **The service has engaged with more than 240 users of secondary mental health services in Rotherham**

   These service users have been supported through the service to build and direct their own packages of support, tailored to their specific needs. They have accessed bespoke activities in the community provided by established local voluntary and community organisations and many have gone on to be involved in or develop their own peer-led activities.

2. **The service has made a significant and positive impact on the well-being of mental health service users**

   More than 90 per cent of service users made progress against at least one well-being outcome measure and increases were recorded for almost half (48 per cent) of all outcome scores. Service users who provided an initially low score against each outcome measure tended to make the greatest amount of progress and the areas where progress was most marked were 'work, volunteering and social groups'; 'feeling positive'; 'lifestyle'; and 'managing symptoms'. These findings have been reinforced by qualitative case studies which found that social prescribing provided service users with renewed sense of worth by enabling them engage proactively in new opportunities, leading to increased confidence and improved mental and physical well-being, in a way that developed and utilised skills in new and interesting areas.

3. **Service users also experience a range of wider benefits**

   This included gaining employment, taking part in training, volunteering, taking-up physical activity and sustained involvement in voluntary sector activity once engagement with social prescribing was complete. The qualitative research highlighted the importance of peer support and the opportunities service users have to progress from social prescribing activities to wider volunteering and social participation.

4. **The role of VAR is vital to the development, operation and sustainability of social prescribing**

   Similar to the Evaluation of the Rotherham Social Prescribing Service for People with Long Term Health Conditions, the evaluation has highlighted the vital role that VAR has played in the development, delivery and sustainability of the service.

As the local voluntary sector infrastructure organisation VAR can act as a local accountable body with no conflict of interest. VAR's knowledge and understanding of the local voluntary sector, and the fact that it does not deliver front line services means that it can commission social prescribing services in the best interests of service users, both individually and collectively. In addition, VAR is ideally placed to support the sustainability of social prescribing activity through its wider services that can support new groups to implement appropriate structures, policies and procedures. VAR also supports providers to access additional funding and develop business models that are appropriate to their activities.

5. **The initial evidence about discharge from mental health services is positive**

More than half of service users eligible for a discharge review have been discharged from secondary mental health services. A test of the efficacy of the Service will be the extent to which these discharges are sustained, and for how long. If discharge can be sustained for at least a year, longer if possible, there is potential for the service to provide a positive fiscal and economic return on investment. If the intermediate benefits for patients not discharged from services but for whom dependency is reduced are taken into account this return will be greater still. However, our earlier qualitative research highlighted the importance of not focussing too much on discharge, and applying a more nuanced understanding of discharge that considered reductions in reliance on and need for mental health services, particularly when full discharge is not possible.

6. **The service has already created significant social value and a positive social return on investment**

It is estimated that the well-being benefits experienced by service users equate to social value of up to £724,000: a social return on investment of £1.84 for every £1 invested in the service.

7. **The social prescribing service is closely aligned with the aim and vision of mental health policy, nationally and locally**

Nationally, the Five Year Forward View for Mental Health advocates the type of community based integrated and preventative services that the Social Prescribing Service provides. Locally, the service is closely aligned with the priorities of the RDASH transformation plan and the South Yorkshire Sustainability and Transformation Plan (STP), particularly in the way that it provides an alternative to secondary mental health services and facilitates discharge to more appropriate and sustainable forms of community-based support. In addition, the service has supported a broader series of local strategic benefits, by achieving outcomes in priority areas such as physical health and employment.

Given these important strategic benefits, the commitment from RDASH and the CCG to explore the potential for wider roll-out of social prescribing within secondary and primary mental health care services is important and should enable the benefits identified to be realised more broadly than the current model(s).